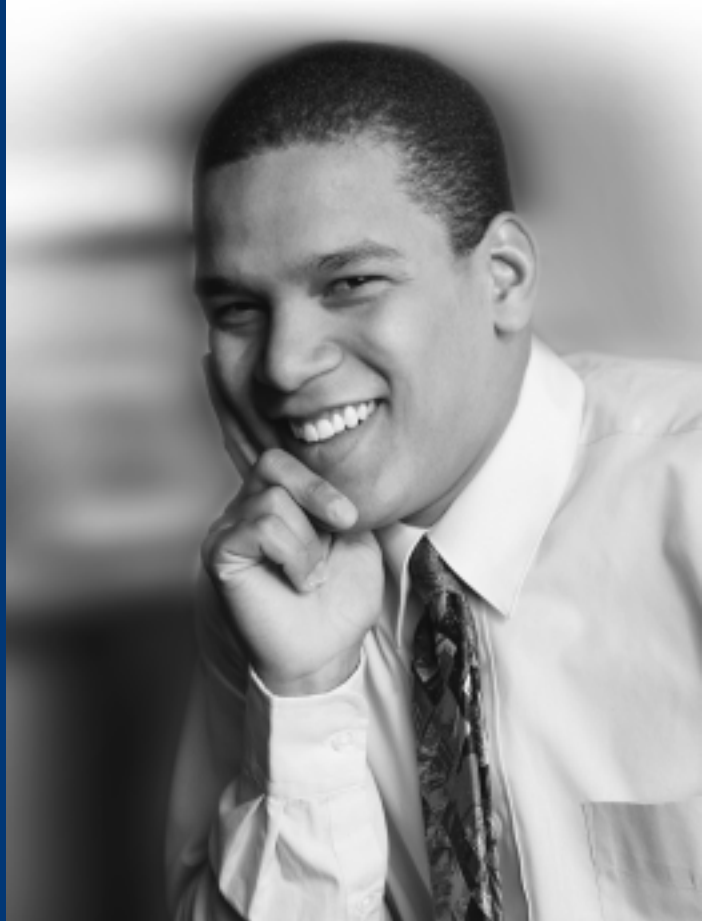
BlueCross of California

Blue Cross Dental SelectHMO℠

BlueCross of California

Dental Plans for Individuals and Families



This is only an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Evidence of Coverage booklet. Review the Exclusions and Limitations listed in the Evidence of Coverage booklet prior to applying for coverage. For a copy, contact your agent or call Blue Cross of California at 800-333-0912.

Blue Cross of California
2000 Corporate Center Drive
Newbury Park, CA 91320

IS 7152 4/04

Why You Need Dental Coverage

The first-ever Surgeon General's Report on Oral Health confirms that good oral health and your overall wellness are inseparable, calling the mouth "a mirror for general health and well-being." Because it is so vital to the quality of your life, dental coverage should be an essential part of your health and wellness at any age. It helps you:

- Maintain good oral health throughout your life
- Enjoy the self-esteem that comes from looking your best
- Prevent oral diseases and craniofacial disorders
- Receive quality care

Remember: Regular dental checkups and cleanings can help detect early signs of oral health problems, reducing the risk of permanent damage to your teeth and gums and preventing costly treatments later on. Also, your dentist may be the first to see signs of a health problem … helping you to keep it from becoming more serious.

Blue Cross Dental HMO coverage gives you the comprehensive coverage you want with the low cost you need. So give yourself the rewards of good dental coverage … because your smile is a reflection of you.

Choose The Power of Blue℠

By selecting a Blue Cross dental plan, you receive the quality benefits you deserve from an industry-leading company you can trust, including:

- **More choices** – three HMO plans and a large network of dentists to choose from
- **Comprehensive benefits** – a broad range of preventive, basic and major services
- **Specialty services** – orthodontic and cosmetic
- **Affordable monthly rates** – choice of payment options with low $5 office visit fees for exams, cleanings and X-rays

Take advantage of the plan's many features including no hidden costs, no deductibles, no annual maximums and no age limitations. Choose any Blue Cross Dental SelectHMO by itself or in combination with your Blue Cross medical coverage. Take advantage of these features and much more – including discounts of 10-50% on health-related products and services through the Blue Cross HealthyExtensions℠ Program. It's so affordable, you'll want to keep the entire family smiling.

Blue Cross Dental SelectHMO Plans

Blue Cross invites you to put your best smile forward with one of our three affordable plans: Dental Saver SelectHMO, Dental SelectHMO or Dental Premier SelectHMO.

Please use this side-by-side comparison chart to help find the plan that works best for you. Additional plan details are included on the following pages.

Covered Benefits and Plan Highlights

These copayments apply only to services rendered by a Participating Dentist.

Specialty services provided by a Participating Specialty Dentist are included on a separate schedule in your contract.

Dental Service	Blue Cross Dental Saver SelectHMO copays	Blue Cross Dental SelectHMO copays	Blue Cross Dental Premier SelectHMO copays
Office Visit	$5	$5	$5
Diagnostic Care			
Oral Exams	No Charge	No Charge	No Charge
X-rays	No Charge	No Charge	No Charge
Preventive Care			
Prophylaxis – *adult & child*	No Charge*	No Charge*	No Charge*
Topical Fluoride – *child*	No Charge	No Charge	No Charge
Restorative Care			
Filling – Permanent *1 surface amalgam*	$54	No Charge**	No Charge**
Filling – Permanent *2 surfaces amalgam*	$64	No Charge**	No Charge**
Filling – Permanent *3 surfaces amalgam*	$75	No Charge**	No Charge**
Filling – Permanent *4 or more surfaces amalgam*	$89	No Charge**	No Charge**
Periodontal Care			
Scaling/Root Planing *per quadrant*	$101	$101	No Charge**
Orthodontic Care			
Orthodontics – *Child*	$2,870	$2,870	$2,870
Orthodontics – *Adult*	$3,045	$3,045	$3,045
Retention	$210	$210	$210
Prosthodontic Care			
Denture *(broken tooth repair)*	$57	$57	$57
Other Services			
Office Visit After Hours	$56	$56	$56
Local Anesthesia	$14	$14	$14

**First two treatments in 12 consecutive months. All additional treatments within a 12-month period require copayments of $44 for adults and $35 for children.*

*** You must meet a six-month waiting period before these benefits are payable.*

How Our Plans Work

Our Dental SelectHMO Plans offer you varying coverage to fit your needs and your budget. Services must be received by a Blue Cross Dental SelectHMO participating dentist in order to be covered. Benefits are immediately available for most services, and you won't have to meet any deductibles.

Each time you visit a participating dentist, you'll pay a low $5 office visit fee and possibly a discounted copayment for some procedures. Once you pay the $5 office visit fee, most preventive and diagnostic services (such as cleanings, exams and X-rays) are covered in full.

More Benefits and Copayment Highlights

These copayments apply only to services rendered by a Participating Dentist. Specialty services provided by a Participating Specialty Dentist are included on a separate schedule in your contract.

Dental Service	Blue Cross Dental Saver SelectHMO copays	Blue Cross Dental SelectHMO copays	Blue Cross Dental Premier SelectHMO copays
Cosmetic Care			
Resin Filling – permanent, *one surface, posterior*	$75	$75	$75
Labial Veneer *(laminate)–chairside*	$187	$187	$187
Endodontic Care			
Root Canal – *Anterior*	$289	$289	$289
Root Canal – *Bicuspid*	$341	$341	$341
Root Canal – *Molar*	$459	$459	$459
Pulpotomy	$62	$62	$62
Periodontal Care			
Gingivectomy – *per tooth*	$72	$72	$72
Gingivectomy – *per quadrant*	$194	$194	$194
Osseous Surgery – *per quadrant*	$520	$520	$520
Oral Surgery			
Extraction – of erupted tooth or exposed root	$60	$60	No Charge*
Impaction – *soft tissue*	$136	$136	$136
Impaction – *partial bony*	$176	$176	$176
Impaction – *complete bony*	$200	$200	$200
Prosthodontic Care			
Crowns	$432	$432	$432
Complete Upper or Lower Dentures	$577	$577	$577
Partial Denture	$430	$430	$430

NOTE: Records, retention and certain corrective interception treatment, all of which are necessary in Orthodontic care, are excluded from coverage in many other plans, but Blue Cross Dental SelectHMO offers these services at reduced fees.

** You must meet a six-month waiting period before these benefits are payable.*

Eligibility

You and your enrolling dependents must be permanent, legal residents of California and must select the same SelectHMO participating dentist located within 35 miles of your residence. Eligible dependents include:

- the subscriber's lawful spouse
- any unmarried child of the subscriber or the enrolled spouse under age 19
- any unmarried child of the subscriber or the enrolled spouse ages 19 to 23, who qualifies as a dependent for federal income tax purposes
- the subscriber's or enrolled spouse's child, who continues to be both incapable of self-support, due to continuing mental retardation or physical handicap, and who is at least one-half dependent upon the subscriber or enrolled spouse for support

Eligibility, rates and billing options for the Select HMO dental products vary for Individuals over 65. Please contact your agent or call 800-765-2585 for more information.

Finding Your Participating Dentist

To find a participating dentist near you, visit our Web site at www.bluecrossca.com and click on the "Provider Finder" link.

Participating dentists are conveniently located in the following California counties:

Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Solano and Sonoma Counties. Limited availability in El Dorado, Fresno, Kern, Kings, Monterey, Placer, Riverside, San Bernardino, San Mateo, Santa Cruz, Tulare and Ventura.

Waiting Periods

For Dental SelectHMO and Dental Premier SelectHMO Plans, a six-month waiting period is required for fillings. For Dental Premier SelectHMO Plan, a six-month waiting period is also required for scaling/root planing and oral surgery. More detailed information can be found in your policy.

Date Coverage Begins

The effective date of your plan is assigned by Blue Cross and will be the first of the month following approval.

Blue Cross Dental SelectHMO Plan Monthly Rates

	Blue Cross Saver SelectHMO	Blue Cross SelectHMO	Blue Cross Premier SelectHMO
Single	$10.00	$14.00	$17.50
Two Party (Subscriber & Spouse or Subscriber & Child)	$19.50	$28.50	$35.00
Family (three or more) (Subscriber, Spouse & Child or Subscriber & Children)	$29.50	$42.50	$52.50

Exclusions and Limitations for Dental SelectHMO Plans

- Experimental or investigative care or therapy.
- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication, settlement or otherwise, under any Workers' Compensation or occupational disease law, even if you do not claim these benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to Workers' Compensation, BC Life & Health will provide the plan benefits for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903.
- Any services for which you are entitled to receive Medicare benefits, whether or not Medicare benefits are actually paid.
- Any services provided by a local, state, county or federal government agency, including any foreign government, except when payment under the plan is expressly required by federal or state law.
- Services or supplies for which no charge is made, or for which no charge would be made if you had no insurance coverage, or services for which you are not legally obligated to pay.
- Services received before your effective date or during an inpatient stay that began before your effective date.
- Services rendered before coverage begins or after coverage ends.
- Prescribed drugs, pre-medication or analgesia (including nitrous oxide).
- No benefits are provided for hospital or associated physician charges for any dental treatment that cannot be performed in the dentist's office because of your general health, mental, emotional, behavioral or physical limitations.
- Unless an exception is specifically authorized by Blue Cross in writing, dental services must be received from your participating dentist or participating specialty dentist.
- A dental treatment plan, which in the opinion of the participating dentist and/or Blue Cross is not dentally necessary for dental health or will not produce beneficial results.
- Conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Treatment of fractures or dislocations.
- Any treatment to correct a dental condition that resulted from dental services performed by a non-participating dentist while coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dentist or Blue Cross for completion.
- Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies not covered under the medical plan.
- Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Plan will allow for observation or extraction and prosthetic replacement.
- Services received after the benefit limit under this agreement is reached.
- Orthodontic services must be received from a participating orthodontist. In the event of loss of coverage for any reason, and at the time of loss of coverage you are still receiving orthodontic treatment, you will be responsible for the remainder of the cost for that treatment.
- Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances that were broken due to negligence.
- Myofunctional therapy and related services.
- Surgical procedures incidental to orthodontic treatment, including but not limited to extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.
- Changes in treatment necessitated by an accident of any kind.
- Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.

These exclusions and limitations are an overview only. The policy contains a comprehensive list of the plan's exclusions and limitations.

Termination of Coverage

Your dental benefits will end if your premium is not received when it is due (subject to the grace period); you live 35 miles or more from any participating dental group or office; you do not pay copayments; you fail to meet the eligibility requirements listed previously; you become enrolled in any other Blue Cross non-group coverage; you live in a foreign country for more than six consecutive months; or you are absent from California for more than six consecutive months. Blue Cross must be notified within 30 days of all changes affecting your eligibility.

Non-Duplication of Blue Cross Benefits

If, while covered under this policy, you are covered by another Blue Cross of California/BC Life & Health Individual policy, you are entitled only to the benefits of the policy with greater benefits. The Blue Cross Companies will refund any premium received under the policy with the lesser benefits, covering the time both policies were in effect. However, any payments made by the Blue Cross Companies under the policy with the lesser benefits will be deducted from any such refund of premium.

Requirement for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

How to Enroll

For new members enrolling in dental coverage only:

- Complete and sign the attached application.

  Note: The participating dentist that you choose must appear on your application. You and your dependents must select the same participating general dentist.
- Determine your premium.
- Choose your payment plan.
- Write a check payable to Blue Cross of California or use a credit card.
- Send the application and payment to the appropriate Blue Cross address below, or to your agent.

For new members enrolling in Blue Cross medical and dental coverage:

- See instructions on the Individual Enrollment Application.

For Blue Cross medical members who want to add dental:

- Complete and sign the attached application.
- Determine your premium.
- Choose your payment plan.*
- Write a check payable to Blue Cross of California or use a credit card.
- Send the application and payment** to the appropriate Blue Cross address, or to your agent.

You must select the same payment option for your **dental plan that you have for your **medical** plan.*

***Even if you pay your **medical** premium by a monthly checking account automatic premium payment, you must send the first month's **dental** premium with the application.*

*To determine your initial premium:**

- If you want to pay your bill **monthly**, fill out the attached Checking Account Automatic Premium Payment Authorization or credit card authorization along with a check for one month's premium.
- If you want to pay your bill **every other month (bimonthly)**, write a check for two months' premium.
- If you want to pay your bill **every three months**, write a check for three months' premium.

If you are a Blue Cross medical plan member, you must select the same payment option for your **dental plan that you have for your **medical** plan.*

Send your application and payment to one of the following addresses:

Dental SelectHMO Plan enrollees under 65:
Blue Cross of California
P.O. Box 9051
Oxnard, CA
93031-9051

Dental SelectHMO Plan enrollees over 65:*
Blue Cross of California
P.O. Box 9063
Oxnard, CA
93031-9063

** Eligibility, rates and billing options for the Select HMO dental products vary for Individuals over 65. Please contact your agent or call 800-765-2585 for more information.

or your:
Authorized Independent Agent

Dental SelectHMO Enrollment Application

If you are a Blue Cross of California subscriber, please enter your current Blue Cross group number and certificate number below.

Group No.

Certificate or ID No.

Proposed Effective Date ___/___/___

Plan Choice

☐ Saver SelectHMO (40) ☐ SelectHMO (41) ☐ Premier SelectHMO (42) **Dental Office No:**

Applicant Information – Applicant must complete this section.

Please print

Last Name	First Name	MI	Social Security No. or ID No.

Home Phone No.	Business Phone No.	Sex	Marital Status	Age	Date of Birth
( )	( )	☐ M ☐ F	☐ Single ☐ Married		

Home Address *(Must be complete. P.O. Box not acceptable)*			Billing Address *(If different or P.O. Box)*		
City	State	ZIP Code	City	State	ZIP Code

Spouse to be Included – Signature required below.

Last Name of Spouse	First Name	Sex	Date of Birth	Social Security No. or ID No.
		☐ M ☐ F		

Children to be Included

NAME (First and Last Name)	SEX	BIRTHDATE Mo Day Yr	NAME (First and Last Name)	SEX	BIRTHDATE Mo Day Yr
1			3		
2			4		

Signatures *(Required)*

Authorization to Obtain or Release Medical Information: I understand that California law prohibits an HIV test from being required or used as a condition of obtaining medical coverage.

If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.
(Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

I have personally read and completed this application. If I am accepted,this application will become part of the contract between Blue Cross and me. I and any enrolled family members agree to abide by the terms of that contract, including the arbitration provision that provides as follows:

Even if I pay money with this application, that money is only a deposit against future premium if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it,except for the obligation to return the money submitted with this application. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Blue Cross.

I also understand that only the services I receive from my Blue Cross Dental SelectHMO participating provider are covered by the plan or are subject to a discount if not covered.

Requirement for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice. **"It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceeding. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Signature of Applicant / Parent or Legal Guardian	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	
Signature of Applicant's Dependent Age 18 or over	Today's Date	Signature of Applicant's Dependent Age 18 or over	Today's Date
X		X	

Name of Agent *(Print)*	Agent No.	Signature of Agent	Today's Date
	___–___	X	

ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

Payment Method **Premium payment required. First payment will be credited to approved applicants only.** By sending your check to us, you authorize Blue Cross of California to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

Credit Card

FAX to: (800) 327-9255

☐ **Initial premium (For new member's Medical and Dental fees only)** ☐ **Monthly premiums**

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. Credit Card: ☐ VISA ☐ MasterCard ☐ Discover

Card No.: Exp.:_____ Cardholder's Zip Code –

Cardholder's Name *(As it appears on the credit card)* PRINT	Authorized Signature *(As it appears on the credit card)*	Date
X	X	

Checking Account Automatic Premium Payment

☐ **Monthly checking account deduction premium payments**

Name of Bank or Financial Institution: _____

Account No.: Bank Routing No.:

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bimonthly. **You may incur a $25 service charge for any withdrawal not honored**.

Authorized Signature *(As it appears in the financial institution's records)*	Date
X X	

Billing

☐ **Bimonthly** (Submit 2 months premium) ☐ **Quarterly** (Submit 3 months premium)

FOR BLUE CROSS USE ONLY

Group No.	Certificate No.	Agent I.D. No.	Effective Date
Pre-Exist	**Area**	**By**	**Date**