Dental SelectHMO Plan for Individuals and Families

Anthem
Health. Join In.
HEALTH | DENTAL | LIFE

For dental benefits you can smile about!

Why dental care is important to your overall health...

Consider this: people who suffer from periodontal disease, are twice as likely to have heart disease or a stroke.[1] And there's also research linking poor oral health to diabetes, lung disease and premature births.[2]

Fortunately, regular dental check-ups can help detect the early warning signs of certain health-related issues. That's just one reason why it's so important to take good care of your teeth and gums. And the Dental SelectHMO plan* from Anthem Blue Cross can help make it easy and affordable.

[1] American Academy of Periodontology: Gum Disease Links to Heart Disease and Stroke, perio.org, 2008.
[2] National Institute of Dental and Craniofacial Research: Oral Health in America, 2008.
* Available in Alameda, Contra Costa, Fresno, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura. Limited availability in Butte, El Dorado, Imperial, Kern, Madera, Marin, Monterey, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare and Yolo. Areas are subject to change.

How the Dental SelectHMO plan works:

Our Dental SelectHMO plan offers comprehensive coverage that is designed to fit your family's budget. Services must be performed by an Anthem 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 a set copayment for some procedures. Once you pay the $5 office visit fee, most diagnostic and preventive services (such as cleanings, exams and X-rays) are covered in full.

Dental SelectHMO benefits-at-a-glance...

The charts on the next page show copayment amounts for some of the more common services available under the Dental SelectHMO plan.

Take advantage of the plan's many features, including no deductibles and no annual maximums. And people of any age may apply!

Monthly rates for Dental SelectHMO plan enrollees under age 65*	
Single	$15.80
Two Party Member & Spouse or Member & Child	$31.70
Family (three or more) (Member, Spouse & Child or Member & Children)	$47.50

Monthly rates for Dental SelectHMO plan enrollees age 65 and over*	
Single	$13
Two Party Member & Spouse or Member & Child	$26

To find a network dentist, visit anthem.com/ca.

*Subject to change

Dental HMO plans provided by Anthem Blue Cross. Dental PPO plans provided by Anthem Blue Cross Life and Health Insurance Company. Life plans offered by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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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 a separate schedule in your contract.

Dental Services	Dental SelectHMO Copayments
Office Visit	$5
Diagnostic Care	
Oral Exams	No Charge
X-rays	No Charge
Preventive Care	
Routine Cleanings (adult & child)	No Charge*
Topical Fluoride (child)	No Charge
Restorative Care	
Filling – Permanent 1 surface amalgam	No Charge**
Filling – Permanent 2 surfaces amalgam	No Charge**
Filling – Permanent 3 surfaces amalgam	No Charge**
Filling – Permanent 4 or more surfaces amalgam	No Charge**

* 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 to apply for coverage

For Anthem Blue Cross health members who want to add dental, and new members enrolling in dental coverage only:

- Complete and sign the Individual Dental SelectHMO Plan Enrollment Application. Note: The participating dentist that you choose must appear on your application. You and your dependents must select the same participating general dentist.
- Choose your payment plan.*
- Write a check payable to Anthem Blue Cross or use a credit card.
- Send the application and payment** to the appropriate Anthem Blue Cross address below, or to your agent.

For new members enrolling in Anthem Blue Cross health and dental coverage:

- See instructions on the Individual Enrollment Application.

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

Dental SelectHMO Plan enrollees under 65:

OLEG SKURSKIY
18375 VENTURAL BLVD # 226
TARZANA, CA 91356

Dental SelectHMO Plan enrollees over 65:***

OLEG SKURSKIY
18375 VENTURA BLVD #226, TARZANA, CA 91356

or your Authorized Independent Agent.

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

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

*** Eligibility, rates and billing options for the Dental SelectHMO plan varies for individuals over 65. Please contact your agent or call 800-765-2585 for more information.

MORE BENEFITS AND COPAYMENT HIGHLIGHTS

Dental Services	Dental SelectHMO Copayments
Endodontic Care	
Root Canal	
– Anterior	$289
– Bicuspid	$341
– Molar	$459
Pulpotomy	$62
Periodontal Care	
Scaling/Root Planing	
– per quadrant	$101
Gingivectomy	
– per tooth	$72
– per quadrant	$194
Osseous Surgery – per quadrant	$520
Oral Surgery	
Extraction	
– of erupted tooth or exposed root	$60
Impaction	
– soft tissue	$136
– partial bony	$176
– complete bony	$200
Prosthodontic Care	
Crowns	$432
Complete Upper or	$577
Lower Dentures	
Partial Denture	$430
Denture (broken tooth repair)	$57
Orthodontic Care	
Orthodontics (child)	$2,870
Orthodontics (adult)	$3,045
Retention	$210
Cosmetic Care	
Resin Filling (permanent, one surface, posterior)	$75
Labial Veneer (laminate) – chairside	$187
Other Services	
Office Visit After Hours	$56
Local Anesthesia	$14

This overview provides only a very brief description of some of the features of the plan. This is not the insurance contract and only the Certificate of Coverage ("Certificate") provisions apply. Please refer to the applicable Certificate which sets forth, in more detail, the benefits, limitations and exclusions. If there are any conflicts between the terms of the Certificate and the information outlined above, the terms of the Certificate will prevail.

For a complete description of dental benefits, limitations and exclusions, please contact your Anthem Blue Cross sales representative.

Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 818-654-4548 fax: 818-776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

Please make your check payable to: Anthem Blue Cross

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 818-654-4548

Thank you for choosing...

Anthem Blue Cross

cut or tear along dotted line

FAX COMPLETE APPLICATION TO : 818-776-9865

Anthem Health. Join In. Blue Cross

Anthem Blue Cross
Individual Dental SelectHMO Plan Enrollment Application

If you are an Anthem Blue Cross member, please enter your current group number and certificate number.

GROUP NO.	CERTIFICATE NO.

Enter the number of the Dental Office you have chosen: ____ ____ ____ ____ ____ ____

Application Information: Applicant must complete this section. **PLEASE PRINT**

LAST NAME	FIRST NAME	MI	SEX ☐M ☐F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS ☐S ☐M	SOCIAL SECURITY NUMBER

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

HOME PHONE NO.	BUSINESS PHONE NO.
( )	( )

Spouse/Domestic Partner To Be Insured (Sign Below)

NAME OF SPOUSE/DOMESTIC PARTNER	SEX ☐M ☐F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER

Children To Be Insured

NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)
1.	☐M ☐F		3.	☐M ☐F	
2.	☐M ☐F		4.	☐M ☐F	

Language Preference – When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? *(Optional)*

☐ Spanish ☐ Chinese ☐ Korean ☐ Japanese ☐ Tagalog ☐ Vietnamese ☐ Khmer ☐ Hmong ☐ Farsi ☐ Arabic ☐ Armenian ☐ Russian ☐ Other _____

Signatures (Required)

Statement of Understanding: I understand that, once enrolled, only the services I receive from my Anthem Blue Cross Dental SelectHMO participating provider will be covered by the plan.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. 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."*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.**

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER	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	

Agent Information and Declaration

To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation. I understand that if I willfully make any false representations I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000.

SIGNATURE OF AGENT	AGENT NAME (PRINT)	AGENT NUMBER
X	OLEG SKURSKIY	BCLNGNPVMZ

FOR ANTHEM BLUE CROSS ONLY

GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST		AREA	BY	DATE

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cut or tear along dotted line

Applicant Social Security or ID No.

Payment Method **(Premium payment required. Please choose from A or B.)**

☐ **A. Please choose from the following options for initial payment and future payments. If you choose one of these options, you are not required to send in a paper check for initial payment:**

☐ Monthly Credit/Debit Card *(complete Section C)* ☐ Monthly Checking Account Automatic Premium Payment *(complete Section D)*

☐ **B. Please choose from the options below for your initial premium payment:**

☐ Paper Check* ☐ Electronic Check *(complete Section E)*

If you choose one of these two options, you will receive a bill every two or three months thereafter, depending on the billing frequency you select.

Select Frequency: ☐ Bimonthly ☐ Quarterly

C. Monthly Credit/Debit Card

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 initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. 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.

We accept Visa, MasterCard, Discover and Star*.

**For Star, we accept 16 digit card numbers only.*

Card No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ *(16 digits only)* Exp.: ☐☐/☐☐ Cardholder ZIP Code: ☐☐☐☐☐-☐☐☐☐

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

D. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. Your bank account will be debited one month's premium the day after approval. Subsequent premium amounts will be debited on the day you request below.

Requested Debit Day: ☐☐ **(1st to 28th of each month)**
If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account numbers here.

Bank Routing No.	Bank Account No.

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 Anthem Blue Cross provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. 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 Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross 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 bi-monthly. **You will incur a $25 service charge for any withdrawal not honored**.

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

E. Electronic Check

In lieu of sending a Paper Check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing No.	Account No.	Amount	Check No.
			$	

** Enclose check for first month's payment. By sending your paper check, you authorize us to convert your check to 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.*