BlueCross
of California

Blue Cross
Dental SelectHMO℠

Plans For Families and Individuals of All Ages

Information in this brochure highlights features of the Blue Cross Dental SelectHMO plans. For more detailed plan information, be sure to read the Evidence of Coverage you receive once you are enrolled.

www.bluecrossca.com

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- *Three plans from which to choose*
- *The Blue Cross Dental Saver SelectHMO, Blue Cross Dental SelectHMO and Blue Cross Dental Premier SelectHMO plans offer various levels of coverage to suit your needs*
- *No waiting periods for most services*
- *No annual maximums*
- *More than half of the most frequently billed procedures are covered at a $5 per office visit fee*

Great savings

- *Affordable premiums*
- *$5 office visit fee for exams, routine cleanings and x-rays*
- *Low out-of-pocket expenses*
- *No hidden costs*
- *No deductibles*
- *No age limitation*

About Blue Cross Dental SelectHMO

Blue Cross of California offers three affordable dental health maintenance organization (DHMO) plans—Blue Cross Dental Saver SelectHMO, Blue Cross Dental SelectHMO and Blue Cross Dental Premier SelectHMO. With our large network of dedicated professionals, you have access to complete dental care, including cosmetic and specialty care, either as a covered benefit or at a discount. We think you will find our Blue Cross Dental SelectHMO plans refreshingly straightforward and easy to understand.

Because preventive dental care is so important, Blue Cross Dental SelectHMO provides regular check-ups, x-rays and teeth cleanings for just a $5 office copay.

Soon after enrollment, you should call your Participating Dental Office for an initial diagnostic examination. X-rays will usually be taken at this time to determine the overall condition of your teeth. Through routine checkups, minor dental problems can often be diagnosed and treated before they become major problems.

Blue Cross Dental SelectHMO provides you and your family with access to important dental care without taking a big bite out of your budget. By choosing Blue Cross of California, you know your dental plan comes with the strength of an industry leader. Call your Participating Dental Office whenever you need dental care. Blue Cross does not limit the number of times you can see your dentist.

The Blue Cross Dental SelectHMO Provider Network*

Only the services you receive from a Blue Cross Dental SelectHMO Participating Dental Office are covered by the plan.

The quality of our provider network sets us apart from the competition. We require prospective providers meet rigorous administrative and clinical requirements. After a provider is accepted as a Blue Cross Dental SelectHMO Participating Dental Office, a Blue Cross quality assurance team ensures each office meets rigorous quality standards throughout the time the office participates.

**Limited availability in these counties: El Dorado, Fresno, Kern, Kings, Monterey, Placer, Riverside, San Bernardino, San Mateo, Santa Cruz, Tulare and Ventura. Contact your agent for more information on locations of participating providers.*

How Our Plans Work

Benefits are available immediately for many services when provided by a Participating Dental Office and you won't have to meet a deductible. Most other services are available at a discount from participating dentists and specialists. Each procedure has an associated copayment. You are responsible for paying your network provider at the time service is rendered. The copayment represents the discounted rate on services for which you are eligible as a plan member. Benefits and applicable copayments are listed on the table below or see page 10 for more information.

Covered Benefits and Copayment Highlights *(see page 10 for more benefit information)*

These copayments apply only to services rendered by a Participating Dental Office. Specialty services provided by a Participating Specialty Office are included on a separate schedule on 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			
Fillings – Permanent *1 surface amalgam*	$54	No Charge**	No Charge**
Fillings – Permanent *2 surfaces amalgam*	$64	No Charge**	No Charge**
Fillings – Permanent *3 surfaces amalgam*	$75	No Charge**	No Charge**
Fillings – 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	$300	$300	$300
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.*

Regular diagnostic and preventive dental care is essential to maintaining sound oral health. To encourage regular checkups and teeth cleanings, our plans provide these services at a low $5 copay. All other benefits are available at low, discounted fees with no deductibles. You choose the plan with the level of coverage you want.

With our plans, you don't have to worry about missing important details by not reading all the fine print. A level of coverage or discount is provided for all dental care – cosmetic, periodontics, orthodontia and more.

Eligibility

You and your dependents must select the same Blue Cross Dental SelectHMO Participating Dental Office, 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 spouse for support.

Waiting Periods

For the Blue Cross Dental SelectHMO and Blue Cross Dental Premier SelectHMO plans, you must meet a six-month waiting period before receiving benefits for fillings.

For the Blue Cross Dental Premier SelectHMO plan, you must meet a six-month waiting period before receiving scaling/root planing and oral surgery. Please read your Evidence of Coverage booklet for more detailed information.

Date Coverage Begins

Coverage is not guaranteed. Your application must be approved and accepted in writing by Blue Cross.

The effective date of your plan is assigned by Blue Cross of California and will be the first of the month following approval. Only the services you receive from a Blue Cross Dental SelectHMO Participating Provider are covered by our plan. We urge you not to terminate existing coverage prior to your effective date.

*Blue Cross Dental Saver SelectHMO, Blue Cross Dental SelectHMO and Blue Cross Dental Premier SelectHMO General Plan Limitations and Exclusions**

- Unless an exception is specifically authorized by Blue Cross in writing, dental services must be received from the member's Participating Dental Office or Participating Specialty Office.
- No benefits are provided for hospital or associated physician charges for any dental treatment that cannot be performed in the participating dental office because of the member's general health, mental, emotional, behavioral or physical limitations.
- No benefits are provided for a treatment plan determined to be not dentally necessary by the Participating Dentist and/or Blue Cross of California.

**A more complete listing will appear in your Evidence of Coverage which you will receive once you are enrolled.*

- Prescription drugs are not covered.
- 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, Blue Cross will provide the benefits of this Plan for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903.
- 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.
- Any services provided by a local, state or federal government agency, except when payment under this Plan is expressly required by federal or state law.
- Treatment of fractures or dislocations.
- Dental treatment or expenses incurred by or in connection with any dental procedure started prior to the member's effective date.
- Any treatment to correct a dental condition that resulted from dental services performed by a Non-Participating Dentist while this coverage is in effect and any dental services started by a Non-Participating Dentist will not be the responsibility of the Participating Dental Office or Blue Cross for completion.
- Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies not covered under the medical plan.

- Services for which no charge is made to you in the absence of insurance coverage.
- 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.
- 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.
- Any services to the extent that you are entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any local, state or federal government agency (except Medi-Cal).

*Orthodontic Limitations and Exclusions**

- Orthodontic services must be received from a Participating Orthodontic Office. In the event of a Member's loss of coverage, for any reason, and at the time of loss of coverage the Member is still receiving orthodontic treatment, the Member will be responsible for the remainder of the cost for that treatment.
- Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to negligence of the Member may not be discounted.
- Myofunctional therapy and related services.

**A more complete listing will appear in your Evidence of Coverage which you will receive once you are enrolled.*

- 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.
- Treatment of orthodontic cases begun prior to the Member's effective date of eligibility or after the termination of eligibility of coverage.
- 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.

Termination of Coverage

- Coverage ceases under Blue Cross Dental SelectHMO when a subscriber does not pay the subscription charges; resides 35 miles or more from any participating dental group or office; the person fails to meet eligibility requirements listed previously; or when copayments are not made.
- The subscriber must notify Blue Cross of any change affecting any member's eligibility within 30 days of the change.

Non-Duplication of Blue Cross Benefits

If, while covered under this Policy, the member is covered by another Blue Cross of California/BC Life & Health Individual policy, he or she will be entitled only to 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 claims payments made by 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.

Enrolling in a Blue Cross Dental SelectHMO Plan

Please refer to page 12 for further enrollment instructions. All dental care will be provided by the Participating Dental Office you select. You will receive an I.D. card from Blue Cross listing your selected Participating Dental Office. Always bring your I.D. card when you visit your dental office.

Monthly payment is only available with Monthly Checking Account Deduction billing. If you wish to pay bimonthly, multiply the monthly premium by two; if you prefer to pay quarterly, multiply by three.

More Benefits and Copayment Highlights

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

Dental Service	Blue Cross Dental Saver SelectHMO copays	Blue Cross Dental SelectHMO Plan 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			
Single Extraction	$60	$60	No Charge*
Impaction – *soft tissue*	$136	$136	$136
Impaction – *partial bony*	$176	$176	$176
Impaction – *full bony*	$200	$200	$200
Prosthodontic Care			
Crowns	$432	$432	$432
Complete Upper or Lower Dentures	$577	$577	$577
Partial Denture	$430	$430	$430
Scaling/Root Planing – *per quadrant*	$101	$101	No Charge*

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.

How to Enroll

If you are a new member and want dental coverage ONLY:

- Complete and sign the attached application. The Participating Dental Office that you choose must appear on your application.
- Determine your premium from the chart below.
- Choose your payment plan (page 9).
- Write a check payable to **Blue Cross of California**.
- Send the application and payment to the appropriate Blue Cross address on the next page or to your agent.

For those applying for Blue Cross medical coverage AND dental coverage:

- See instructions in the **Individual Enrollment Application.**

For Blue Cross members who want to ADD dental coverage:

- Complete the attached application
- Determine your premium – it should be the same type of billing as your medical coverage. Even if you are on Monthly Checking Account Deduction, you must send the first month's premium with the application.
- Write a check payable to **Blue Cross of California**.
- Send the application to Blue Cross or your agent.

If you are **under 65**, please mail your application and payment to:

Blue Cross of California
P. O. Box 9051
Oxnard, CA 93031-9051

If you are **over 65**, please mail your application and payment to:

Blue Cross of California
P. O. Box 9063
Oxnard, CA 93031-9063

MONTHLY Blue Cross Dental SelectHMO 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 *(Family or subscriber & children)*	$29.50	$42.50	$52.50

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 No. | Proposed Effective Date

Plan Choice

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

Check Billing Type

☐ Monthly *(By checking account deduction only. **Complete Authorization form on reverse side.**)* ☐ Bi-monthly ☐ Quarterly

Applicant Information – Applicant must complete this section. ***Please print***

Last Name	First Name	MI	Social Security 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.
		☐ 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 authorize any physician or other health care professional, hospital, or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California or affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker, any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse,substance abuse, mental or emotional disorders,A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex) of me or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review investigation or evaluation of any application for coverage, of any claim for benefits, or of any inquiry or grievance. 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:

Any dispute between you and Blue Cross of California must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both you and Blue Cross of California and its affiliates are giving up the right to have any dispute decided in a court of law before a jury.

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.

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
Oleg Skurskiy	**BCLNGNPVMZ** –	X	

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Monthly Checking Account Deduction Authorization

INSTRUCTIONS:

1. Complete this section.
2. Attach a blank check marked "VOID" to this form. *(Deposit slips or temporary checks are not acceptable.)*
3. Submit a check for one (1) month's premium made out to BLUE CROSS OF CALIFORNIA. If the account listed below is a joint account, both account holders' signatures are required.

OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION. 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 drawn on you and 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 dues. This authority is to remain in effect until revoked by me, in writing, and until you actually receive such 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 Deduction and be billed quarterly. After 12 months, you may re-apply for the Monthly Checking Account Deduction option.

Subscriber Name

Subscriber's Social Security No.

Group No.

Name on Checking Account *(If different than above)*

Checking Account No.

Name of Bank

Bank Address

City / State / ZIP

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

X

Date

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

X

Date

FOR BLUE CROSS USE ONLY

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