



BC Life & Health  
Insurance Company

# *Blue Cross Individual Dental PPO*

April 2003

*The information in this brochure only provides highlights of the Blue Cross Individual Dental PPO Plan. For more detailed information, be sure to read the Blue Cross Individual Dental PPO Policy you will receive once enrolled.*



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Insurance Company

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## *Blue Cross Individual Dental PPO Plan for Individuals & Families*

- ◆ Freedom to Choose Any Dentist
- ◆ Access to Quality Care at Discounted Fees
- ◆ Wide Range of Dental Services
- ◆ Preventive and Diagnostic Care Begins Upon Approval of Your Application

### **THIS IS A SCHEDULED POLICY.**

*Only treatments and procedures listed and identified in the Schedule of Benefits are covered.*

**BC** *Life & Health Insurance Company has created the Blue Cross Individual Dental PPO Plan, a Preferred Provider Organization dental plan, to help keep your teeth healthy and your smile bright. The thousands of dedicated professionals who comprise the Blue Cross dental network offer a wide range of dental services, including routine check-ups, cleanings, fillings, crowns and dental surgery.*

The Blue Cross Individual Dental PPO Plan was designed with two goals in mind. The first, and most important, is to promote good dental hygiene and preventive care, important elements in a total health care package. The second goal is to provide you with the dental care you need in a convenient, cost-conscious manner, thus providing many dental services at reduced or no out-of-pocket cost.

The plan features preventive and diagnostic care at little or no cost, low-cost basic care, and a benefit schedule that can help you offset the high cost of major dental care. Please read the following information for details on how the plan works, specific benefit information, and certain exclusions and limitations that apply.

### *How the Blue Cross Individual Dental PPO Plan Works*

The Plan Network is made up of a large number of dentists in California who have agreed to provide services at negotiated rates to plan members. When you choose a participating dentist, you pay nothing for preventive and diagnostic care, such as regular check-ups, cleanings and X-rays. Other benefits are provided for specified basic and major dental care. (See the Benefit Schedule on pages 3-5.)

We let you know how much the plan pays for covered services. This means that you are able to easily calculate how much you will have to pay once you have determined your dentist's fee for the specific procedure listed.

**The following is an EXAMPLE of how Blue Cross' negotiated fees may save you money. Negotiated fees may vary among participating dentists.**

<b>Participating Dentist</b>
If the total charges are <b>\$773</b>
And Blue Cross' negotiated rate is <b>\$425</b>
Blue Cross will pay the amount specified in the benefit schedule, which is <b>\$264*</b>
And you pay the difference of <b>\$161</b>

<b>Non-Participating Dentist</b>
If the total charges are <b>\$773</b>
Blue Cross will pay the amount specified in the benefit schedule, which is <b>\$264*</b>
And you pay the difference between the total amount and the scheduled benefit, which is <b>\$509</b>

\* This assumes any deductible has been met and that you have not reached your annual maximum.

It is to your benefit to use a participating dentist because BC Life & Health Insurance Company has negotiated the amounts that plan members are charged for services and you can save money. You may choose a non-participating dentist, and the plan still provides benefits, *but your savings may be less.*

The plan network is large, and your current dentist may already be part of the network. Be sure to check the Plan directory before you choose a dentist—it could save you money.

**The Calendar Year Deductible** is the amount you pay for covered services before your benefits are available. The Calendar Year Deductible is \$50 per person, with a maximum of three deductibles per family (a total of \$150). The deductible is waived for preventive and diagnostic care *only* at participating dentists.

**The Calendar Year Maximum Benefit:** All dental benefits are limited to a maximum payment by BC Life & Health of \$1,000 for expenses incurred by each enrolled member during a calendar year.

**Waiting Periods:** There is no waiting period for preventive and diagnostic care. Coverage for Basic care begins after three continuous months of coverage, and for Major Care after 12 continuous months of coverage.

**Customer Service:** BC Life & Health Insurance Company's professional Customer Service units are available to answer any questions you may have about your Policy, and to assist you with your customer service needs. The toll-free number is listed on the plan identification card that you will receive once your enrollment is approved.

### Benefit Schedules

Coverage is provided **only** for the services specified below.

To use the following schedules, first determine your dentist's fee, then look up how much the plan pays. Then you can easily calculate how much you will have to pay for the specific service after your deductible has been met (where applicable). The dollar amounts are maximums. The plan pays either the specified amount, or the actual amount charged by your dentist, whichever is lower. *You are responsible for any charges in excess of the stated benefit.*

### Preventive & Diagnostic Care

Coverage begins upon approval of your application. You are limited to two oral examinations and two dental cleanings per member, per year. The calendar year deductible is waived for these services *only* when they are received by a participating dentist.

Procedure	At a Participating Dentist the Plan Pays	At a Non-Participating Dentist the Plan Pays
Initial Oral Exam	100%	\$25
Periodic Oral Exam (limited to two per member per year)	100%	\$18
Emergency Oral Exam	100%	\$28
Bitewing X-rays - single film	100%	\$16
Bitewing X-rays - two films	100%	\$18
Single (Periapical) X-rays - first film	100%	\$13
Single X-rays - additional films	100%	\$8
Bitewing X-rays - four films	100%	\$26
Full mouth X-rays (limited to one set every 3 years)	100%	\$60
Routine Cleaning (limited to two per adult per year)	100%	\$39
Routine Cleaning (limited to two per child per year)	100%	\$30
Cleaning with Fluoride (limited to two per child per year)	100%	\$35
Topical Fluoride Only (limited to two per child per year)	100%	\$14

\*Total benefit for single and bitewing x-rays not to exceed cost of full mouth – \$60 at Non-Participating Dentists.

### Basic & Major Dental Care

After the calendar year deductible has been satisfied, benefits are paid according to the following schedules. Although the schedule is the same for both participating and non-participating dentists, *you may pay more for services from a non-participating dentist.*

### Basic Dental Care

Coverage begins after the policy has been in effect for three continuous months.

Procedure	Plan Pays
Filling - one surface, primary	\$ 38
Filling - one surface, permanent	\$ 42
Filling - two surfaces, primary	\$ 49
Filling - two surfaces, permanent	\$ 55
Filling - three surfaces, primary	\$ 60
Filling - three surfaces, permanent	\$ 72
Filling - four or more surfaces, primary	\$ 70
Filling - four or more surfaces, permanent	\$ 84
Extraction - single tooth (simple)	\$ 49
Extraction - each additional tooth (simple)	\$ 46
Surgical extraction	\$ 84
Removal of impacted tooth - soft tissue	\$111
Removal of impacted tooth - partial bony	\$148
Removal of impacted tooth - complete bony	\$180

### Some Definitions:

Adult: Any person or dependent 19 years or older covered by this policy.

Child: Any person or dependent 18 years or younger covered by this policy.

### Major Dental Care

Coverage begins after the policy has been in effect for 12 continuous months.

Procedure	Plan Pays
Scaling/Root Planing - per quadrant	\$ 48
Gingivectomy - per tooth	\$ 40
Gingivectomy - per quadrant	\$145
Osseous surgery - per quadrant (paid at \$62 per tooth to a maximum of \$277 per quadrant)	\$277
Root Canal - one canal	\$154
Root Canal - two canals	\$189
Root Canal - three canals	\$242
Inlay - one surface	\$172
Inlay - two surfaces	\$198
Inlay - three surfaces	\$220
Onlay - in addition to inlay	\$ 57
Crown (except stainless steel)	\$264
Stainless Steel Crown	\$ 57
Pontic	\$264
Post & Core - in addition to crown	\$ 75
Complete Denture (upper or lower)	\$343
Partial Denture (upper or lower)	\$308
Denture Reline (chairside)	\$ 75
Denture Reline (lab)	\$106

## Eligibility & Enrollment

To enroll, you must be...

- ◆ age 64-3/4 or younger,
- ◆ a permanent legal resident of California, and
- ◆ a U.S. resident for at least the last 3 months;
- ◆ the applicant's spouse, age 64-3/4 or younger;
- ◆ the applicant's children, or the children of the applicant's enrolling spouse, under 19 years of age; or
- ◆ the applicant's unmarried dependent children between the ages of 19 and 23 ("dependent" as defined by the Internal Revenue Service).

### Enrollment

See page 12 for instructions.

If you have any questions, please contact your Blue Cross Agent or BC Life & Health Insurance Company.

### Date Coverage Begins

The effective date of your plan is assigned by BC Life & Health Insurance Company and will be the first day of the month after approval.

### Premium Rates

The rates listed are monthly rates. Monthly payment is available only in tandem with monthly checking account deduction billing. If you wish to pay bimonthly, multiply by two; if you prefer to pay quarterly, multiply by three.

**Area 1:** Del Norte, Lassen, Modoc, Monterey, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity

**Area 2:** Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Madera, Marin, Mariposa, Merced, Mono, Nevada, Placer, Sacramento, San Benito, San Joaquin, San Mateo, Santa Clara (ZIP code 94303 only), Stanislaus, Tuolumne

**Area 3:** Alameda, Butte, Colusa, Contra Costa, Glenn, Humboldt, Lake, Mendocino, Napa, San Francisco, Santa Clara (except ZIP code 94303), Santa Cruz, Solano, Sonoma, Sutter, Yolo, Yuba

**Area 4:** Orange, Riverside (ZIP code 92883 only)

**Area 5:** Los Angeles (except ZIP codes beginning with 906-912, 915, 917, 918 & 935), Ventura (ZIP codes beginning with 913)

**Area 6:** Imperial, Riverside (except ZIP code 92883), San Bernardino, San Diego

**Area 7:** Kern, Kings, Tulare

**Area 8:** San Luis Obispo, Santa Barbara, Ventura (except ZIP codes beginning with 913)

**Area 9:** Los Angeles (ZIP codes beginning with 906-912, 915, 917, 918 & 935)

*Non-network counties by rating area. If this Policy is sold in any of the following areas, review the Statement of Understanding on the application.*

*Area 1: Plumas, Sierra, Trinity*

*Area 2: Alpine, Calaveras, Inyo, Mariposa, Mono, Tuolumne*

*Area 3: Colusa, Glenn, Lake, Yolo*

Contract Type	Rating Area 1	Rating Area 2	Rating Area 3	Rating Areas 4	Rating Area 5	Rating Area 6	Rating Area 7	Rating Area 8	Rating Area 9
Subscriber	\$37.00	\$34.00	\$35.00	\$39.00	\$41.00	\$39.00	\$35.00	\$38.00	\$41.00
Subscriber & Spouse	\$73.00	\$66.00	\$67.00	\$76.00	\$79.00	\$76.00	\$68.00	\$74.00	\$80.00
Subscriber & Child	\$58.00	\$53.00	\$54.00	\$61.00	\$64.00	\$61.00	\$54.00	\$59.00	\$64.00
Subscriber & Children	\$89.00	\$82.00	\$83.00	\$94.00	\$99.00	\$94.00	\$84.00	\$91.00	\$99.00
Family	\$112.00	\$103.00	\$106.00	\$121.00	\$126.00	\$121.00	\$107.00	\$116.00	\$126.00
1 Child	\$30.00	\$28.00	\$28.00	\$32.00	\$33.00	\$32.00	\$28.00	\$31.00	\$33.00
2 Children	\$58.00	\$53.00	\$53.00	\$61.00	\$63.00	\$61.00	\$54.00	\$59.00	\$63.00
3+ Children	\$83.00	\$75.00	\$76.00	\$86.00	\$90.00	\$86.00	\$77.00	\$84.00	\$90.00

### *Termination of Coverage*

Coverage ceases under the plan when: You do not pay the premium when due, subject to the grace period; upon the first of the month in which any covered member attains age 65 (coverage will end on the first day of that month); any member becomes eligible for Medicare coverage even if no application for Medicare coverage is made; the spouse is no longer married to the principal insured; a child fails to meet the previously listed eligibility requirements; any member becomes enrolled in any other Blue Cross non-group coverage; any covered member resides in a foreign country for more than six consecutive months or is absent from California for more than six consecutive months.

You must notify BC Life & Health Insurance of all changes affecting any member's eligibility.

### *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/she will be 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 claims 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.

### *Exclusions and Limitations*

- ◆ Conditions covered by Workers' Compensation or similar laws.
- ◆ Experimental or investigative care or therapy (except for the Blue Cross Dental SelectHMO).
- ◆ Any services provided by a local, state, county or federal government agency, including any foreign government.
- ◆ Services or supplies not specifically listed as covered under the plan agreement.
- ◆ 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.
- ◆ 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 provided by relatives, and professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.
- ◆ 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 amounts in excess of the maximum amounts stated in the Benefit Schedule section.
- ◆ Any services performed for cosmetic purposes are not covered under this policy, unless they are for correction of functional disorders or as a result of an accidental injury occurring while you were covered under this policy.
- ◆ Charges for treatment by other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist.
- ◆ Replacement of an existing prosthesis which has been lost or stolen or which, in the opinion of the dentist, is or can be made satisfactory.

- ◆ Replacement of a fixed or removable prosthesis for which benefits were paid by us, if such replacement occurs within five years of the original placement, unless the denture is a stayplate used during the healing period for recently extracted anterior teeth.
- ◆ Orthodontic services, braces, appliances and all related services. Surgery necessary in conjunction with orthodontic treatment is also not covered.
- ◆ Diagnosis or treatment of the joint of the jaw and/or occlusion services, supplies or appliances provided in connection with:
  - *Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or*
  - *Any treatment, including crowns and/or bridges to change the way the upper and lower teeth meet (occlusion); or*
  - *Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means, including the restoration of vertical dimension because teeth have worn down due to attrition, abrasion, abfraction, erosion or bruxism.*
- ◆ Procedures requiring appliances or restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusions. These include but are not limited to:
  - *Changing the vertical dimension.*
  - *Replacing or stabilizing lost tooth structure by attrition, abrasion, abfraction, erosion or bruxism.*
  - *Realignment of teeth.*
  - *Gnathological recording.*
  - *Occlusal equilibration.*
  - *Splinting.*
- ◆ Oral examinations, including prophylaxis (teeth cleaning), exceeding two visits per year.
- ◆ More than one set of full-mouth x-rays or its equivalent in a three-year period.
- ◆ Fluoride applications and sealants for patients over 18 years of age. Fluoride applications exceeding two visits per year.

- ◆ Correction of congenital or development malformation for a policyholder or dependent, including but not limited to cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- ◆ Adjustment, repairs or relines to prostheses for a period of six months from initial placement if the prostheses were paid for under this policy.
- ◆ Fixed bridges, removable cast partials and/or cast crowns, with or without veneers, and inlays for patients under 16 years of age.
- ◆ Replacement of crowns and cast restorations, including porcelain inlays and porcelain crowns, for which benefits were paid by BC Life & Health, if such replacement occurs within five years of the original placement.
- ◆ If a policyholder transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BC Life & Health shall be liable only for the amount it would have been liable for had one dentist rendered the services.
- ◆ Prescribed drugs, pre-medication or analgesia (including nitrous oxide) are excluded.
- ◆ Oral hygiene instruction.
- ◆ Services for treatment of malignancies and neoplasms are not covered dental benefits.
- ◆ All hospital costs and any additional fees charged by the dentist for hospital treatment.
- ◆ Implants (materials implanted into or on bone or soft tissue) or the removal of implants are not benefits under this policy. However, if implants are provided in association with a covered prosthetic appliance, BC Life & Health will allow the benefit for a standard complete or partial denture or a bridge toward the cost of implants and prosthetic appliances.
- ◆ Replacement of teeth missing prior to the effective date of coverage with partial dentures, complete dentures or fixed bridges.
- ◆ Crown lengthening is not covered.
- ◆ Any services performed for cosmetic purposes (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).

## ***How to enroll***

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

- ◆ Complete and sign the attached application.
- ◆ Determine your premium (see page 7) and choose your payment plan (see below).
- ◆ **Write a check payable to Blue Cross of California.**
- ◆ Send the application and payment to Blue Cross or your agent.

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

- ◆ See instructions on the Individual Enrollment Application.

*For Blue Cross medical members who want to ADD dental:*

- ◆ Complete the attached application.
- ◆ Determine your premium (see page 7). You should have 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 (see address on page 13) or your agent.

*To determine your initial premium:\**

- ◆ **If you want to pay your bill monthly**, fill out the attached Checking Account Deduction Authorization and submit it, along with a check for one month's premium and a blank check marked "VOID"
- ◆ **If you want to pay your bill every other month**, write a check for two months' premium
- ◆ **If you want to pay your bill every three months**, write a check for three months' premium

***Send your application and payment to:  
P.O. Box 9041, Oxnard, CA 93031-9041***

*When your enrollment is approved, you will receive a Blue Cross Individual Dental PPO Policy. Please review it carefully, as it contains specific details about your plan's benefits, coverage, exclusions and limitations.*

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



### Optional Monthly Checking Account Deduction

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 month's premium payable to Blue Cross of California. If the account listed is a joint account, both account holders' signatures are required.

### 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 made 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 by 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 premiums. 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 is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the forfeiture of insurance.

Name of Bank	
Address	
City / State / Zip Code	

**NOTE: You will incur a service charge for any withdrawal not honored. Should your withdrawal not be honored by your bank, you automatically will be removed from monthly checking account deduction, and will be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.**

Subscriber's Name	
Subscriber's Social Security No. / Certificate No.	Group No.
Name on Checking Account (If different than above)	
Checking Account No.	
Authorized Signature (As it appears in the financial institution's records)	
Date	
Authorized Signature (As it appears in the financial institution's records)	
Date	

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