

Dental Blue® Plans for Individuals and Families

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 checkups 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 Blue plans from Anthem Blue Cross Life and Health Insurance Company 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.

How the Dental Blue plans work:

We offer two great Dental Blue plans to choose from: Dental Blue Basic and Dental Blue Enhanced. The Dental Blue Basic plan provides coverage for many diagnostic services and preventive care such as cleanings, exams and X-rays, as well as fillings, with an annual maximum of \$500. The Dental Blue Enhanced plan includes cleanings, exams, X-rays and fillings — plus certain major services like root canals, periodontal procedures and crowns, with an annual maximum of \$1,250. It also includes orthodontic coverage for children after a 12-month waiting period.

A unique feature of Dental Blue is that members have access to the rates Anthem has negotiated with providers during any applicable waiting periods, after the annual maximum has been met, and for certain noncovered services like veneers, dental implants and TMJ treatment. These discounts are available only at in-network providers.

Lastly, as a Dental Blue plan member, **you can see any dentist you want**; however, you do have the potential for lower costs when you choose a dentist in the Dental Blue 100 network. This is because in-network dentists have agreed to accept our fee schedule for services rendered.

If you choose to go to a provider outside of the Dental Blue 100 network, you can be billed the difference between what we pay our in-network dentists and what your chosen dentist wishes to charge. But, with more than 18,000 California dentists in our Dental Blue 100 network, it's likely your dentist is part of our network!

Dental Blue benefits at-a-glance...

The chart below shows the covered benefits and amounts we pay for both of our Dental Blue plans.

| | Dental Blue Basic | | Dental Blue Enhanced | |
|---|--|----------------|---|----------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Annual Deductible | \$25 per member | | \$50 per member/\$150 maximum per family | |
| Waived for Diagnostic and Preventive | Yes | No | Yes | No |
| Annual Maximum | \$500 | | \$1,250 | |
| Diagnostic and Preventive Services Cleanings, Exams and X-rays | 100% | 80% | 100% | 80% |
| Basic Services | | | | |
| Fillings | 80% | 60% | 80% | 60% |
| Other Minor Restorative | Not covered | | | |
| Major Services | | | | |
| Oral Surgery | Not covered | | 50% | |
| Endodontics | 50% – coverage for pulpotomies on primary teeth only | | 50% | |
| Periodontics | Not covered | | 50% | |
| Prosthodontics | 50% - coverage for stainless steel crowns on primary teeth only | | 50% | |
| Orthodontics | Not covered | | Children only 50%, \$100 deductible, \$500 annual/\$1,000 lifetime maximum | |
| Waiting Periods | No waiting period for cleanings, exams and X-rays; six-month waiting period for all other covered services | | No waiting period for cleanings, exams and X-rays; six-month waiting period for basic services; 12 months for major services/orthodontics | |

The amounts shown above reflect what we will pay after any deductibles have been met.

Rating areas

Dental Blue plans are available in the areas listed below. To determine your monthly plan premium, locate your rating area based on the ZIP code of your primary residence, and then refer to the rate charts on Page 3.

Availability

Availability may be limited in some counties. If you live in any of these areas, please review the Statement of Understanding on the application before choosing this plan.

Counties with limited availability*

Area 3: Alpine, Amador, Inyo, Mono

Area 4: Calaveras

Area 5: Del Norte, Humboldt, Lake, Lassen, Modoc, Plumas, Sierra, Siskiyou, Tehama, Trinity

Area 6: Inyo

*As of 11/30/09.

Rating areas

| | | |
|-----------------|---|--------------------------------------|
| Alameda | ZIP codes starting with 945, 946 and 953, except 94505, 94514 All other Alameda ZIPs | Area 4 Area 3 |
| Alpine | | Area 3 |
| Amador | | Area 3 |
| Butte | | Area 5 |
| Calaveras | | Area 4 |
| Colusa | 95957 Except 95957 | Area 3 Area 5 |
| Contra Costa | All except 94551 94551 | Area 3 Area 4 |
| Del Norte | | Area 5 |
| El Dorado | | Area 3 |
| Fresno | 93313 All except 93313 | Area 5 Area 6 |
| Glenn | | Area 5 |
| Humboldt | | Area 5 |
| Imperial | 92225 and 92274 92004 All except 92225, 92274, 92004 | Area 4 Area 5 Area 6 |
| Inyo | All except 93527 93527 | Area 3 Area 6 |
| Kern | ZIP codes starting with 933 All other Kern ZIPs | Area 5 Area 6 |
| Kings | | Area 6 |
| Lake | | Area 5 |
| Lassen | | Area 5 |
| Los Angeles | ZIP codes starting with 901-904 and 913 ZIP codes starting with 905-908, 935, 91709 and 93243 ZIP codes starting with 900, 914 or 916 ZIP codes starting with 910-912, 915, 917 or 918, except 91709 | Area 4 Area 6 Area 2 Area 7 |
| Madera | | Area 6 |
| Marin | | Area 1 |
| Mariposa | 95329 All except 95329 | Area 4 Area 6 |
| Mendocino | | Area 5 |
| Merced | 95380 All except 95380 | Area 4 Area 6 |
| Modoc | | Area 5 |
| Mono | | Area 3 |
| Monterey | All except 95076 and 93451 95076 93451 | Area 1 Area 4 Area 6 |
| Napa | 94589, 94590 All except 94589, 94590 | Area 3 Area 5 |
| Nevada | 95602 All except 95602 | Area 3 Area 5 |
| Orange | ZIP codes starting with 926 all Orange ZIPs | Area 5 Area 6 |
| Placer | All except 95692, 96161 95692, 96161 | Area 3 Area 5 |
| Plumas | | Area 5 |
| Riverside | ZIP codes starting with 922 except 92248 92028 All other Riverside ZIPs | Area 4 Area 5 Area 6 |
| Sacramento | ZIP codes starting with 958 All other Sacramento ZIPs | Area 5 Area 3 |
| San Benito | 93930, 95004 All except 93210, 93930, 95004 93210 | Area 1 Area 4 Area 6 |
| San Bernardino | Except 91766, 91792 91766 and 91792 | Area 6 Area 7 |
| San Diego | | Area 5 |
| San Francisco | | Area 3 |
| San Joaquin | 94505, 94514, 95632, 95690 All except 94505, 94514, 95632, 95690 | Area 3 Area 4 |
| San Luis Obispo | 93426 All except 93426 | Area 1 Area 6 |
| San Mateo | Except 94303 94303 | Area 1 Area 3 |
| Santa Barbara | | Area 6 |
| Santa Clara | ZIP codes starting with 940, 943 94550, 95023, 95076 All other Santa Clara ZIPs | Area 3 Area 4 Area 5 |
| Santa Cruz | All except 95033 95033 | Area 4 Area 5 |
| Shasta | | Area 5 |
| Sierra | | Area 5 |
| Siskiyou | | Area 5 |
| Solano | All except 94503, 95616, 95618, 95694 94503, 95616, 95618, 95694 | Area 3 Area 5 |
| Sonoma | | Area 5 |
| Stanislaus | All except 95322 95322 | Area 4 Area 6 |
| Sutter | All except 95645, 95692, 95836, 95948, 95837 95645, 95692, 95836, 95837, 95948 | Area 3 Area 5 |
| Tehama | | Area 5 |
| Trinity | | Area 5 |
| Tulare | | Area 6 |
| Tuolumne | 95230, 95329 All except 95230, 95329 | Area 4 Area 6 |
| Ventura | ZIP codes starting with 930 or 932 All other Ventura ZIPs | Area 6 Area 4 |
| Yolo | | Area 5 |
| Yuba | | Area 5 |

Monthly rates*

| Dental Blue Basic | | | | | | | | Dental Blue Enhanced | | | | | | | |
|---------------------|------|-------|------|------|------|------|------|----------------------|-------|-------|-------|-------|-------|-------|-------|
| Area | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Area | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Member | \$22 | \$23 | \$20 | \$21 | \$20 | \$19 | \$21 | Member | \$44 | \$54 | \$45 | \$50 | \$49 | \$46 | \$62 |
| Member and Spouse | \$42 | \$45 | \$39 | \$40 | \$39 | \$37 | \$41 | Member and Spouse | \$84 | \$102 | \$84 | \$93 | \$92 | \$86 | \$116 |
| Member and Child | \$45 | \$49 | \$43 | \$44 | \$43 | \$40 | \$44 | Member and Child | \$77 | \$94 | \$78 | \$86 | \$85 | \$79 | \$107 |
| Member and Children | \$77 | \$83 | \$72 | \$73 | \$72 | \$67 | \$74 | Member and Children | \$125 | \$152 | \$125 | \$139 | \$137 | \$128 | \$173 |
| Member and Family | \$93 | \$101 | \$87 | \$89 | \$87 | \$82 | \$90 | Member and Family | \$157 | \$192 | \$158 | \$176 | \$174 | \$162 | \$218 |
| One Child | \$24 | \$26 | \$22 | \$23 | \$22 | \$21 | \$23 | One Child | \$33 | \$40 | \$33 | \$37 | \$36 | \$34 | \$46 |
| Two Children | \$48 | \$52 | \$45 | \$46 | \$45 | \$42 | \$46 | Two Children | \$66 | \$80 | \$66 | \$73 | \$72 | \$67 | \$91 |
| Three+ Children | \$78 | \$84 | \$73 | \$74 | \$73 | \$68 | \$75 | Three+ Children | \$107 | \$131 | \$108 | \$119 | \$118 | \$110 | \$149 |

*Subject to change.

Eligibility

You and your enrolling dependents must be permanent, legal residents of California, ages 64 and 9 months or younger.

How to apply for coverage

If you are enrolling in dental coverage only, or if you are a new or existing Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company health member who wants to add dental coverage:

- Complete and sign the Individual Enrollment Application.
- Determine your premium.
- Choose your method of payment.
- Send the application and payment to the address below or to your agent.

Please note that when you enroll in both a health and dental plan, the same method of payment must be selected for both. For members with a health plan who are adding dental coverage, you will need to send the first month's dental premium with the application even if you currently pay your health premium by credit card or via automatic monthly checking account deduction.

Send your application and payment to:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9051
Oxnard, CA 93031-9051

Or, send to your authorized independent agent

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 Life and Health Insurance Company sales representative.



Anthem Blue Cross Life and Health Insurance Company
Individual Dental Plan Enrollment Application

If you are an Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company member, please enter your current group number and certificate number.

GROUP NO. CERTIFICATE NO. (Grid for entering numbers)

Plan choice - select one

- Dental Blue Basic
Dental Blue Enhanced

Application Information: Applicant must complete this section.

PLEASE PRINT

Form with fields: LAST NAME, FIRST NAME, MI, SEX, BIRTHDATE, MARITAL STATUS, SOCIAL SECURITY NUMBER, HOME ADDRESS, BILLING ADDRESS, CITY, STATE, ZIP CODE, HOME PHONE NO., BUSINESS PHONE NO.

Spouse/Qualified Domestic Partner To Be Insured (Sign Below)

Form with fields: NAME OF SPOUSE/DOMESTIC PARTNER, SEX, BIRTHDATE, SOCIAL SECURITY NUMBER

Children To Be Insured

Form with fields for 4 children: NAME, SEX, BIRTHDATE

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)

Language selection options: Spanish, Chinese, Korean, Japanese, Tagalog, Vietnamese, Khmer, Hmong, Farsi, Arabic, Armenian, Russian, Other

Signatures (Required)

Statement of Understanding for Dental Blue plan applicants in areas with limited availability: I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply...

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 AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE...

Signature table with fields: SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN, TODAY'S DATE, SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER, TODAY'S DATE, SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER, TODAY'S DATE

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.

Form with fields: SIGNATURE OF AGENT, AGENT NAME (PRINT), AGENT NUMBER

FOR ANTHEM BLUE CROSS ONLY

Form with fields: GROUP NO., CERTIFICATE NUMBER, AGENT NO., EFFECTIVE DATE, PRE-EXIST, AREA, BY, DATE

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: Credit/Debit Card (complete Section C) Monthly Checking Account Automatic Premium Payment (complete Section D)
 If you choose Credit/Debit Card, please select the frequency you would like your premiums deducted: Monthly Bi-Monthly Quarterly
NOTE: If no selection is made, this option will default to monthly.

B. If you did not select an option in Section A, please choose from the options below for your initial premium payment:
 Paper Check* Electronic Check (complete Section E) Credit/Debit Card (complete Section C)
 If you choose Credit/Debit Card, please select the number of months for your initial premium payment debit: One Month Two Months Three Months
NOTE: If no selection is made, the default debit will be one month's premium for initial payment. If you choose one of these three options, you will receive a bill every two months thereafter.

C. 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. If I provided my credit/debit card for the initial payment only in Section B, recurring payments will not be charged from my card. 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.

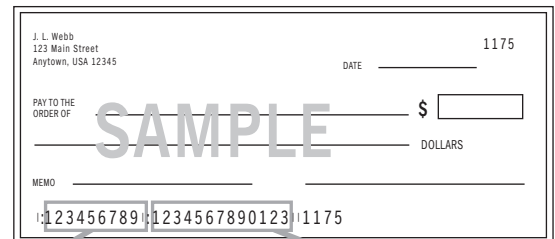
Card No. Exp. / Cardholder ZIP code.

(16 digits only)

| 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. If you have not selected an initial premium payment option from Section B, 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 6th 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 charge my account 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. 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 and/or Anthem Blue Cross Life and Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company 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 every two months. **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

Instead 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. |
|---------------------------|------------------|-------------|--------|-----------|
| | | | \$ | |

* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

cut or tear along dotted line