

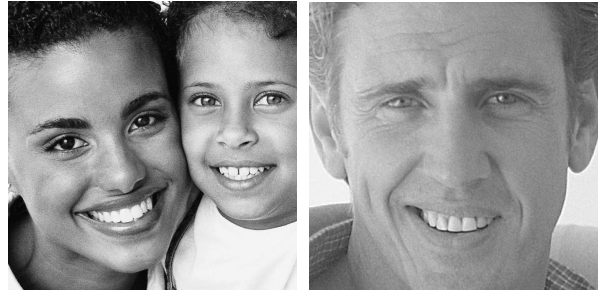
BlueSelect[®]

Dental



Customized dental coverage:

- **for you**
- **for your spouse**
- **for your children**
- **for any family members you choose.**



It's about security.

Your health coverage may make you feel secure, but what will you do when you need your teeth cleaned or a cavity filled? That's why Blue Cross and Blue Shield of Oklahoma offers BlueSelect Dental and BlueSelect Children's Dental – dental plans for individuals.

It's about flexibility.

You can use BlueSelect Dental and BlueSelect Children's Dental to:

- Complement existing Blue Cross and Blue Shield health plans; or to
- Add dental coverage to any health plan, even if it's not a Blue Cross and Blue Shield of Oklahoma health plan. Children age 19 and above may apply separately for dental coverage.

Applicants must be residents of the state of Oklahoma to apply for coverage. Members who already have Blue Cross and Blue Shield of Oklahoma dental coverage are not eligible for individual dental coverage.

It's about choice.

Both plans use an extensive dental network, so you can select your dental care provider from hundreds of dentists throughout Oklahoma. And when you travel, BlueSelect Dental has network dentists across the country.

It's about great care.

BlueSelect Dental has two options: Option 1 covers your basic dental needs at a great price; Option 2 is an enhanced plan that covers more complex dental procedures, such as crowns and inlays.

Turn the page to see which option is the right choice for you



**BlueCross BlueShield
of Oklahoma**

www.bcbsok.com

BlueSelect Dental and BlueSelect Children's Dental will cover 100% of the following preventive procedures with no waiting period if received by an in-network dentist:



100%

- Oral examinations (*two per year*)
- Cleaning, scaling and polishing (*two per year*)
- Bitewing X-rays (*two per year*)
- Full mouth X-rays (*one during a five-year period*)
- Fluoride application for children under 19 (*two per year*)
- Space maintainers for children under 19
- Sealants for children under 14 (*with some restrictions*)

OPTION S

1 **2**



These restorative procedures are covered at 80% if received from an in-network dentist (after a \$50 deductible and six-month waiting period):

80%

- Fillings (*except gold*)
- Simple extractions
- Root canal treatment
- Extraction of impacted teeth
- Periodontic treatment of the gums (*one scaling/root planing treatment per quadrant, per year*)
- Repair of dentures
- IV sedation or general anesthesia (*when medically necessary for covered services*)



- Re-cementing of crowns, inlays and bridges
- Stainless steel crowns
- Surgical removal of teeth
- Diagnosis and treatment of gum disease



The following complex restorative procedures are covered at 50% if received from an in-network dentist (after a \$200 deductible and 12-month waiting period):

- Inlays, onlays and crowns (*not part of bridge*)
- Veneers or similar properties of crowns and bridges
placed on or replacing the 10 upper and lower front teeth
- Dentures and bridges
- Denture adjustments, relining and rebasing
- Fixed bridge repairs

50%



BlueSelect Dental has an annual benefit maximum of \$1,000 (per person, per benefit period). You are not required to see a participating dentist within the Blue Cross and Blue Shield of Oklahoma dental network. When covered treatment is performed by a non-participating dentist outside the network, the preventive procedures are covered at 80 percent, the restorative procedures are covered at 60 percent (after the \$50 deductible) and complex restorative procedures are covered at 30% of allowable charges (after the \$200 deductible). The complex restorative and some restorative procedures are only available on Option 2 (see above).

Monthly rates*

BlueSelect Dental and BlueSelect Children's Dental are low-cost ways to complete health coverage for you and your family. Best of all, they're offered by Blue Cross and Blue Shield of Oklahoma, the state's largest and most trusted private health insurer.

	Option 1	Option 2
Child only (age 18 and under).....	\$21.60	\$25.30
Adult (age 19 and over).....	\$28.70	\$33.80
Adult and spouse.....	\$55.10	\$66.70
Adult, spouse and one child.....	\$76.70	\$92.00
Adult, spouse and two or more children.....	\$109.60	\$130.90
Adult and one child.....	\$50.30	\$59.10
Adult and two or more children.....	\$83.20	\$98.00

Enroll today. Your acceptance is guaranteed.

Simply fill out the application on the attached page and mail it to:

Blue Cross and Blue Shield of Oklahoma
Dental Network of America, Inc.
Attn: Data Management
Two TransAm Plaza Drive, Suite 500
Oakbrook Terrace, IL 60181

This is not a contract. The product description in this brochure is not intended to be more than a summary of benefits available to you. This document does not contain a complete listing of the exclusions, limitations and conditions that apply to the benefits shown, nor does it contain additional benefits that may be available to you. Full information can be found, including medical necessity and pre-existing condition provisions, in the specific product's contract or the member's certificate of benefits booklet. *Rates are subject to change.



Of Oklahoma
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www.bcbsok.com

BlueSelect Dental and BlueSelect Children's Dental

OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER	GROUP NUMBER	EFFECTIVE DATE	APPROVED BY	
	DATE PROCESSED		BROKER NUMBER	TM NUMBER	AE NUMBER

1. SELECT YOUR PLAN: Option 1 Option 2

2. TELL US WHO YOU WANT TO ENROLL (Check one box below):

<input type="checkbox"/> CHILD ONLY COMPLETE ITEMS 1 THROUGH 7, AND 9 & 10 (CHILD IS APPLICANT)*	<input type="checkbox"/> ADULT, SPOUSE AND ONE CHILD* COMPLETE ITEMS 1 THROUGH 10	<input type="checkbox"/> ADULT AND ONE CHILD* COMPLETE ITEMS 1 THROUGH 10
<input type="checkbox"/> ADULT (AGE 19 AND OVER) COMPLETE ITEMS 1 THROUGH 7 AND 9 & 10	<input type="checkbox"/> ADULT, SPOUSE AND TWO OR MORE CHILDREN* COMPLETE ITEMS 1 THROUGH 10	<input type="checkbox"/> ADULT AND TWO OR MORE CHILDREN* COMPLETE ITEMS 1 THROUGH 10
<input type="checkbox"/> ADULT AND SPOUSE COMPLETE ITEMS 1 THROUGH 10	*CHILD MUST BE UNDER AGE 19	

TELL US ABOUT YOURSELF (Please print or type):

3. NAME OF APPLICANT (LAST, FIRST, MIDDLE) _____ RESIDENCE TELEPHONE A/C _____

4. (STREET OR BOX NO.) _____ (CITY) _____ (STATE) _____ (9-DIGIT ZIP CODE) _____

5. SOCIAL SECURITY NUMBER _____ DATE OF BIRTH MO. | DAY | YR. _____ SEX M | F | _____ MARITAL STATUS MARRIED DIVORCED WIDOWED SINGLE SEPARATED _____ BUSINESS PHONE A/C _____

6. I AM EMPLOYED BY (NAME OF COMPANY) _____ ADDRESS (STREET OR BOX NO., CITY, STATE, ZIP) _____

7. DO YOU NOW HAVE BLUE CROSS/BLUE SHIELD OR BLUEINCS HMO? YES NO ID NUMBER _____ YOUR CURRENT GROUP NO. _____ LOCATION OF BLUE CROSS BLUE SHIELD PLAN (CITY & STATE) _____

TELL US ABOUT OTHER FAMILY MEMBERS APPLYING FOR COVERAGE:

8. NAME OF SPOUSE (FIRST, MIDDLE, LAST) _____ DATE OF BIRTH MO. | DAY | YR. _____ SOCIAL SECURITY NUMBER _____

DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO APPLICANT	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NUMBER
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO APPLICANT	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NUMBER
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DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO APPLICANT	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NUMBER

9. SELECT YOUR PAYMENT OPTION: DO NOT SEND MONEY NOW

<p>A. *Membership premium is to be deducted from my checking/savings account (check one):</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually</p> <p style="text-align: right;">*COMPLETE ITEM 10</p>	<p>*IMPORTANT See reverse side</p>	<p>B. Membership premium is to be individually billed to my home (check one):</p> <p><input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually</p>
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SELECT MEMBER EFFECTIVE DATE: 1ST 15TH Earliest possible effective date (as determined by the Plan)

***NOTE: PLEASE COMPLETE REVERSE SIDE**

FOR OFFICE USE ONLY

GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVR CODE	WVR CODE EXP DATE	DIV CODE	CROSS REFERENCE AGREEMENT NO.	BRK IND	BRK NO.	
			00	00-00-0000					
COB CODE	INVOICE NUMBER	MSC CODE	EFFECTIVE DATE	CHAR. CODE DATE	SUB CHAR	DEP. CHAR.	MINOR CHAR.	SUB DENT. CHAR.	DEP. DENT. CHAR.
LOB	EFF. DATE	DUES AMT.	LOB	EFF. DATE	DUES AMT.	LOB	EFF. DATE	DUES AMT.	

