

We're giving you more reasons to smile!



Now offering individual and family dental PPO plan coverage without having a Blue Shield medical plan

Effective April 1, 2009

You can now enjoy the great value and protection of Blue Shield dental coverage, even if you aren't covered by a Blue Shield health plan. Our dental plans are now available to everyone under the age of 65 living in California!²

Healthy teeth, healthy body!

When you keep your mouth healthy, you're also keeping your body healthy. That's why it's important to stay on track with good oral care needs. And with Blue Shield's new dental plans, you can have the confidence and smile you've always wanted at a price you can afford!

Pick the plan that's right for you!

The new SmileSM PPO^{1,1} and Value SmileSM PPO^{1,1} dental plans give you affordable options to help you stay healthy now and avoid costly dental expenses in the future. When you choose Blue Shield dental PPO plan coverage, you'll have almost 20,000 general and specialty dentists* to pick from statewide!

Why enroll?

The savings you get with our Smile PPO plan keeps the cost of dental work from taking a deep bite out of your wallet later. The Value Smile PPO plan provides preventive, diagnostic, and some minor restorative services designed to aid in reduction of future costly services. Check out the monthly rates below and enroll now. You'll be doing your health and smile a huge favor.

Blue Shield dental plans – Smile PPO and Value Smile PPO plans

Monthly rates April 2009	Smile PPO – provides comprehensive dental benefits at an attractive rate.	Value Smile PPO – provides preventive and diagnostic dental care, plus some minor restorative.
Adult/child	\$39.70	\$21.40
Adult and spouse/domestic partner	\$83.90	\$45.30
Adult and child	\$60.10	\$32.40
Adult and children	\$89.50	\$48.40
Family	\$139.50	\$75.30
	Plan features: <ul style="list-style-type: none"> • Two, no charge to member, annual teeth cleanings including X-rays • Know exactly what you pay up front when using network dentists • No waiting period for diagnostic or preventive services • 6-month waiting period for minor services and 12-month waiting period for major restorative and orthodontic services⁴ • Orthodontic benefits for children and adults⁶ • \$50 calendar-year deductible per member • \$1,000 calendar-year benefit maximum per member, of which up to \$500 per member per year can be used for non-network benefits** • Enhanced dental benefits for pregnant women⁵ 	Plan features: <ul style="list-style-type: none"> • Two, no charge to member, annual teeth cleanings including X-rays • Low copayments for basic services • Fixed copayments when using network dentists • No waiting periods • No coverage for major services • \$25 calendar-year deductible per member • \$500 calendar-year benefit maximum per member**

Dental PPO plan highlights matrix for Smile PPO and Value Smile PPO plans

This chart is only a summary. For a complete list of the benefits, exclusions, and limitations of the dental PPO plans below, please refer to the *Evidence of Coverage* and *Health Service Agreement* or the *Policy for Individuals and Families* for the exact terms and conditions of coverage.

	Smile PPO ^{1,3,4}	Value Smile PPO ^{1,3}		
Calendar-year deductible	\$50 per person	\$25 per person		
Calendar-year maximum	\$1,000 (\$500 maximum may be used for non-network dentists)**	\$500**		
Diagnostic and preventive services				
Service	With network dentist – you pay:	With non-network dentists – we pay up to:	With network dentist – you pay:	With non-network dentists – we pay up to:
Comprehensive oral exams	\$0	\$40	\$0	\$40
Periodic oral exams	\$0	\$16	\$0	\$16
Complete X-Rays	\$0	\$56	\$0	\$56
Prophylaxis (cleanings, one every 6 months)				
Adult	\$0	\$48	\$0	\$48
Child	\$0	\$34	\$0	\$34
Sealant/per tooth (covered to age 16)	\$0	\$22	\$0	\$22
Enhanced dental benefit for pregnant women ⁵	\$0	100% of charge	\$0	\$48
Routine services⁴				
One-surface composite (filling)	\$37	\$30	\$37	\$30
Two-surface composite (filling)	\$56	\$44	\$56	\$44
Anterior root canal	\$156	\$125	Not covered	Not covered
Molar root canal	\$234	\$187	Not covered	Not covered
Periodontal root planing/per quadrant	\$65	\$52	Not covered	Not covered
Extraction (single tooth)	\$40	\$32	Not covered	Not covered
Major services⁴				
Crown (porcelain fused to noble metal)	\$320	\$256	Not covered	Not covered
Osseous surgery/per quadrant	\$263	\$210	Not covered	Not covered
Bridge pontic/false tooth – high noble metal (per unit)	\$293	\$234	Not covered	Not covered
Bridge retainer – porcelain fused to high noble metal (per unit)	\$313	\$250	Not covered	Not covered
Complete denture (upper or lower)	\$388	\$310	Not covered	Not covered
Removal of impacted tooth (complete bony)	\$113	\$90	Not covered	Not covered
Orthodontics^{4,6}				
Fully banded (two year) case – child	\$2,350 ⁷	Not covered	Not covered	Not covered
Fully banded (two year) case – adult	\$2,650 ⁷	Not covered	Not covered	Not covered

Note: Diagnostic and preventive services are not subject to plan deductibles.

† Pending regulatory approval.

* Dental providers in California are contracted through the dental plan administrator.

** Each calendar year, the member is responsible for all charges incurred after the plan has paid these amounts for dental services.

1 Value Smile PPO and Smile PPO are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

2 You must be a California resident and under age 65 at the time of enrollment. If you had a Blue Shield IFP dental plan cancelled, you must wait 12 months from the date of cancellation before you can reapply.

3 When you use dentists who are not in the network, Blue Shield reimburses up to the amount listed, and you are responsible for all charges in excess of the amount Blue Shield pays in addition to your calendar-year deductible.

4 Smile PPO members have certain waiting periods: six months for minor restorative (such as fillings), endodontics, periodontics, and oral surgery services; 12 months for major restorative (such as crowns), orthodontics, and prosthetics (removable and fixed) services.

5 The plan covers one additional routine adult prophylaxis for women during pregnancy. Smile PPO additionally includes one periodontal maintenance visit if warranted by a history of periodontal treatment and one course (up to four quadrants) of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition.

6 The Smile PPO plan covers orthodontic services with a fixed copayment, which does not apply to your \$1,000 benefit maximum.

7 You pay the copayment plus up to \$250 for records.

It's easy to enroll! Simply complete the attached enrollment application, sign and fax to us at (209) 367-6490, or mail it back to us today.

**Blue Shield of California and
Blue Shield of California Life & Health Insurance Company
Dental Plan Application**



Fax Completed app to: 800-995-9913

This form is to be used by applicants applying for dental plans who are not currently covered under a Blue Shield individual or family medical plan.

Part 1 – Coverage, plan, and applicant information

Coverage Options: New enrollment Add dependent family member to existing coverage

Dental plan: (please check one below)

SmileSM PPO*† Value SmileSM PPO*† Other _____

To find a Blue Shield dental provider by name location and specialty, go to our Web site: blueshieldca.com.

Applicant Information

Applicant Social Security number		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mo/day/yr)
First name	MI	Last name	
Do you currently have dental coverage through Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please indicate plan		Dental subscriber number (if applicable)	
Requested effective date		Married: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applicant business phone number	Applicant home phone number	Applicant fax number	
Applicant mailing address			
City		State	ZIP code
Billing address (if different from above)			
City		State	ZIP code
E-mail address		Language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	
Payment options: <input type="checkbox"/> Easy\$Pay SM (must complete and sign Easy\$Pay Enrollment Form) <input type="checkbox"/> Monthly direct billing <input type="checkbox"/> Quarterly direct billing			

Part 2 – Dependent information

List all dependent family members you wish to cover (dependent children must be age 22 or under)

1. Husband Wife Domestic partner (circle one): Male Female

First name	MI	Last name (if different from above)
Social Security number:		Date of birth (mo/day/yr)

2. Son Daughter

First name	MI	Last name (if different from above)
Social Security number:		Date of birth (mo/day/yr)

3. Son Daughter

First name	MI	Last name (if different from above)
Social Security number:		Date of birth (mo/day/yr)

4. Son Daughter

First name	MI	Last name (if different from above)
Social Security number:		Date of birth (mo/day/yr)

* Underwritten by Blue Shield of California Life & Health Insurance Company.

† Pending regulatory approval.

Part 3 – Authorizations, terms and conditions – Please read the following terms and conditions carefully. Your authorization and signature is required below.

1. Eligibility: I understand that Blue Shield has the right to decline my application for coverage. I also understand that I must be residing in California in order to be eligible for enrollment in this dental plan. I will notify Blue Shield upon any change regarding my eligibility for this plan. I also agree to provide, or provide access to, information requested by Blue Shield to verify my eligibility, or continued eligibility, for coverage, and understand that failure to cooperate could result in rescission/cancellation of coverage.

2. First payment of dues/premium: Attached is my personal check or money order in an amount equal to one month's dues/premium made payable to Blue Shield of California. I understand cashing of my check by Blue Shield does not constitute enrollment in the dental plan. If I am not eligible, the amount of prepaid dues/premium will be refunded to me.

3. Dues/premium payments: This Blue Shield dental plan is a prepaid dues/premium plan and payment is due in full prior to the first day of the billing period. Coverage will be cancelled for failure to pay dues/premium in a timely manner as set forth in the Health Services Agreement/Policy. If my dental coverage is cancelled for late payment, I may apply for reinstatement within 15 days.

4. Effective date of coverage: If my application is approved, Blue Shield will inform me in writing of the effective date of coverage for me and any enrolling dependents. If Blue Shield cannot honor my requested effective date, or is unable to issue coverage before my requested date, coverage will begin as soon as possible. **Charges incurred before my effective date or after termination of coverage are not covered.**

5. Entire agreement: If approved, this application, together with the Evidence of Coverage and Health Service Agreement/Policy, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for dental coverage with Blue Shield. My agent cannot approve this application for coverage or change any terms or conditions of coverage.

6. If the applicant is a minor: The parent or legal guardian must sign on behalf of the any minor under the age of 18. The parent or legal guardian is identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, the parent or legal guardian will assume all responsibility for dues/premium payments and for following the terms and conditions of coverage. Please indicate the relationship to the minor:

- A. Parent
 B. Legal guardian (attach copy of court documents)

7. Authorization for dependent spouse/domestic partner to make changes: If your dependent spouse/domestic partner is enrolling for dental plan coverage, please specify if you authorize your spouse/domestic partner changes to the contract on your behalf. Yes No
 You may discontinue this authorization at any time by sending a written request to Blue Shield.

8. HIV testing prohibited: California law prohibits an HIV test from being required or used by a health insurance company or a health care service plan as a condition of obtaining health coverage.

THIS SECTION MUST BE COMPLETED BEFORE YOUR APPLICATION CAN BE PROCESSED. KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.

I HAVE READ THE SUMMARY OF BENEFITS AND THE TERMS AND CONDITIONS OF COVERAGE ABOVE. I UNDERSTAND AND AGREE TO EACH OF THEM. I ALONE AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION. ALL INFORMATION PROVIDED ON THIS APPLICATION IS ACCURATE, TRUE AND COMPLETE. I UNDERSTAND THAT NEITHER I, NOR ANY DEPENDENTS, WILL BE ELIGIBLE FOR COVERAGE IF ANY INFORMATION IS FALSE OR INCOMPLETE. I ALSO UNDERSTAND THAT IF COVERAGE IS ISSUED, COVERAGE MAY BE RESCINDED IF BLUE SHIELD DETERMINES THAT INFORMATION ON THIS APPLICATION IS MATERIALLY INACCURATE, NOT TRUE, OR INCOMPLETE. I ALSO UNDERSTAND THAT COVERAGE MAY BE CANCELLED IF I/WE LOSE ELIGIBILITY.

Signature of applicant	Today's date (required)	Print name
Signature of spouse/domestic partner	Today's date (required)	Print name
Signature of dependents age 18 or over (if applying)	Today's date (required)	Print name
Signature of dependents age 18 or over (if applying)	Today's date (required)	Print name

Producer information

Producer number	Telephone number	Fax number
E-mail address		
Producer address		
City	State	ZIP code
Super producer name	Super producer number	

Producer signature	Today's date	Print name
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NOTICE: Please ensure each part of the application is complete. In the event of missing or incomplete information Blue Shield may contact your applicant directly to obtain complete information.

Please fax or mail the completed and signed application to: Installation and Membership
 Blue Shield of California
 P.O. Box 3008
 Lodi, CA 95241-1912
 Fax: (209) 367-6490

Fax Completed Application to: 800-995-9913