

# We give you more reasons to smile!



Individual and family dental coverage available independent of Blue Shield medical plans

Effective October 1, 2010

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

## Healthy mouth, healthy body!

Did you know that periodontal (gum) disease, a chronic inflammatory disease, is linked to other serious health risks such as osteoporosis, heart disease, stroke, pregnancy problems, respiratory disease, and diabetes?<sup>2</sup> 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 health care. And with Blue Shield's dental plans, you can have the dental coverage, confidence, and smile you've always wanted at a price you can afford!

## Pick the plan that's right for you!

The Smile<sup>SM</sup> PPO<sup>3</sup> and Value Smile<sup>SM</sup> PPO<sup>3</sup> dental plans give you two affordable options to help you stay healthy now and avoid costly dental expenses in the future. Both plans provide you access to almost 20,000 general and specialty dentists<sup>4</sup> statewide!

## Why enroll?

The benefits you get with the comprehensive Smile PPO plan keeps the cost of dental work from taking a deep bite out of your wallet later. The Value Smile PPO<sup>5</sup> 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 October 2010	Smile PPO – Provides comprehensive dental benefits at an attractive rate	Value Smile PPO <sup>5</sup> – Provides preventive and diagnostic dental care, plus some minor restorative
Adult/child	\$40.60	\$21.90
Adult and spouse/ domestic partner	\$85.80	\$46.30
Adult and child	\$61.50	\$33.10
Adult and children	\$91.50	\$49.50
Family	\$142.70	\$77.00
	<b>Network plan features:</b> <ul style="list-style-type: none"> <li>• Two annual teeth cleanings plus annual X-rays and oral cancer screenings, for \$0 copayment</li> <li>• Know exactly what you pay up front when using network dentists</li> <li>• No waiting period for diagnostic or preventive services</li> <li>• Six-month waiting period for minor services, and 12-month waiting period for major restorative and orthodontic services<sup>6</sup></li> <li>• Orthodontic benefits for children and adults<sup>7</sup></li> <li>• \$50 calendar-year deductible per member</li> <li>• \$1,000 calendar-year benefit maximum per member, of which up to \$500 per member per year can be used for non-network benefits<sup>8</sup></li> <li>• Enhanced dental services for pregnant women<sup>9</sup></li> </ul>	<b>Network plan features:</b> <ul style="list-style-type: none"> <li>• Two annual teeth cleanings plus annual X-rays and oral cancer screenings, for \$0 copayment</li> <li>• Low copayments for basic services</li> <li>• Fixed copayments when using network dentists</li> <li>• No waiting periods</li> <li>• No coverage for major services</li> <li>• \$25 calendar-year deductible per member</li> <li>• \$500 calendar-year benefit maximum per member<sup>8</sup></li> </ul>

## 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 *Policy for Individuals and Families* for the exact terms and conditions of coverage.

	Smile PPO <sup>3,6,10</sup>	Value Smile PPO <sup>3,10</sup>		
<b>Calendar-year deductible</b>	\$50 per person	\$25 per person		
<b>Calendar-year maximum</b>	\$1,000 (\$500 maximum may be used for non-network dentists) <sup>8</sup>	\$500 <sup>8</sup>		
<b>Diagnostic and preventive services</b>				
<b>Service</b>	<b>With network dentist – you pay:</b>	<b>With non-network dentists – we pay up to:</b>	<b>With network dentist – you pay:</b>	<b>With non-network dentists – we pay up to:</b>
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 services for pregnant women <sup>9</sup>	\$0	100% of charge	\$0	\$48
<b>Routine services<sup>4</sup></b>				
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
<b>Major services<sup>4</sup></b>				
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
<b>Orthodontics<sup>6,7</sup></b>				
Fully banded (two year) case – child	\$2,350 <sup>11</sup>	Not covered	Not covered	Not covered
Fully banded (two year) case – adult	\$2,650 <sup>11</sup>	Not covered	Not covered	Not covered

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

- 1 You must be a California resident and under age 65 at the time of enrollment. If you had a Blue Shield individual and family dental plan cancelled, you must wait 12 months from the date of cancellation before you can reapply.
- 2 "Mouth-Body Connection" from the American Academy of Periodontology Web site: [www.perio.org/consumer/mbc.top2.htm](http://www.perio.org/consumer/mbc.top2.htm).
- 3 Value Smile PPO and Smile PPO are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). These plans are pending regulatory approval.
- 4 Dental providers in California are available through the contracted dental plan administrator.
- 5 Orthodontic benefits are not available with the Value Smile PPO plan.
- 6 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.
- 7 The Smile PPO plan covers orthodontic services with a fixed copayment, which does not apply to your \$1,000 benefit maximum.
- 8 Each calendar year, the member is responsible for all charges incurred after the plan has paid these amounts for dental services.
- 9 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.
- 10 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.
- 11 You pay the copayment plus up to \$250 for records.

**To Apply, simply fax the completed application to: 800-995-9913**

This form is to be used by applicants applying for a Smile<sup>SM</sup> PPO\* or Value Smile<sup>SM</sup> PPO\* dental plan.

You are eligible for any Individual & Family (IFP) Dental Plan if you are a California resident and under age 65 at the time of enrollment. If you had a Blue Shield Individual & Family Dental Plan cancelled for any reason (by yourself or by Blue Shield), you must wait 12 months from the date of cancellation before you can reapply, unless there is no lapse in coverage between Blue Shield dental plans. Blue Shield will not approve concurrent enrollment in two Blue Shield IFP dental plans.

**Part 1 – Coverage, plan, and applicant information**

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

**Dental plan:** (please check one below)

Smile PPO\*  Value Smile PPO\* Requested effective date: \_\_\_\_\_

To find a Blue Shield dental provider by name location and specialty, go to our website [blueshieldca.com](http://blueshieldca.com).

**Applicant Information**

Applicant Social Security number	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mo/day/yr) / /	Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Domestic partnership: <input type="checkbox"/> Yes <input type="checkbox"/> No
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)
Do you currently have medical coverage through Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate plan	Medical subscriber number (if applicable)
Applicant business phone number	Applicant home phone number	Applicant fax number	
Applicant home address			Apt No.
City		State	ZIP code
Applicant billing address (if different from home address)			Apt No.
City		State	ZIP code
Applicant mailing address (if different from home address)			Apt No.
City		State	ZIP code
E-mail address		Best time to contact by phone	
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 <sup>SM</sup> (must complete and sign Easy\$Pay Enrollment Form, which includes credit card billing option) <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 under age 19, or under age 23 if full-time students and not married or in a domestic partnership).

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) / /	

\* 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 cancellation of coverage.
- 2. First payment of premium:** Attached is my personal check or money order in an amount equal to one month's premium made payable to Blue Shield of California Life & Health Insurance Company. 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 premium will be refunded to me.
- 3. Premium payments:** This Blue Shield dental plan is a prepaid 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 premium in a timely manner as set forth in the 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 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 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 my dependent spouse/domestic partner is enrolling for dental plan coverage, I authorize my spouse/domestic partner changes to the contract on my behalf.  Yes  No  
I 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 healthcare 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 reviewed all responses pertaining to me in this application, I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature).

_____ 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	<b>547390801</b>	Telephone number	<b>800-700-1246</b>	Fax number	<b>800-995-9913</b>
E-mail address	<b>john@johnconner.com</b>				
Producer address	<b>10425 Saddle Creek Drive</b>				
City	<b>Sacramento</b>	State	<b>CA</b>	ZIP code	<b>95829</b>
Super producer name	<b>N/A</b>	Super producer number	<b>N/A</b>		
Do you want the Policy sent directly to the subscriber? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					

_____ Producer signature	_____/_____/_____ Today's date	<b>John Conner</b> 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 Life & Health Insurance Company  
 P.O. Box 3008  
 Lodi, CA 95241-1912  
 Fax: (209) 367-6490  
**Fax Application to: 800-995-9913**

<p><b>For internal use only</b>                  DSA name: _____                  DSA number: _____                  Producer number: _____</p>
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