BlueChoice Dental for Individuals and Families

BlueCross BlueShield of Georgia

For dental benefits you can smile about

Why dental care is important to your overall health

You've probably heard that dental health is an important part of overall health. But consider this: if a patient is suffering from periodontal disease, they 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 check-ups 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 a BlueChoice Dental plan from Blue Cross and Blue Shield of Georgia 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

What BlueChoice Dental coverage helps pay for

- Routine check-ups, x-rays and cleanings. Coverage begins on your effective date and there's no deductible for these services.
- Basic dental care like fillings and simple extractions. Coverage begins after you meet a $50 annual deductible (up to $150/family) and have 6 months of continuous coverage.
- Major dental work, root canals and crowns. You'll be covered after 12 months of continuous coverage and your deductible is met.
- Both in-network and out-of-network dental care. For the best savings, you should choose in-network dentists and specialists.
- Up to $1,000 of dental services per member, per year, after any deductibles or co-insurance you might have.

BlueChoice Dental benefits-at-a-glance

The charts on the next page show what BlueChoice Dental pays toward either in-network or out-of-network dental services. (But remember, in-network dentist fees are usually lower to start with so you'll save you even more money.)

It's easy to find a network dentist when you have access to the largest dental network of its kind in Georgia! Go to bcbsga.com > Find a doctor

Monthly rates*	
Adult	**$27**/month
Child	**$27**/month
Family	**$76** /month

*Subject to change

DIAGNOSTIC AND PREVENTIVE CARE

Procedure	BlueChoice Dental pays
Initial Oral Exam	$16
Periodic Oral Exam – Limited to 2 exams per member per year	$16
Bitewing X-rays – single film	$9
Bitewing X-rays – two films	$16
Single (periapical) X-rays – first film	$9
Single X-rays – additional films	$9
Bitewing X-rays – four films	$23
Full mouth X-rays – limited to one set every 3 years	$47
Routine Cleaning – limited to 2 per adult per year	$37
Routine Cleaning – limited to 2 per child per year	$26
Cleaning with Fluoride – limited to 2 per child per year	$37
Topical Fluoride Only – limited to 2 per child per year	$14

Notes for Diagnostic and Preventive Care

- Coverage begins on your effective date.
- Diagnostic and preventive services are not subject to a deductible.
- Coverage includes two oral examinations and two dental cleanings per member, per year.
- Coverage for any combination of single and bitewing X-rays not to exceed $47

BASIC DENTAL CARE

Procedure	BlueChoice Dental pays
Filling – one surface, primary	$35
Filling – one surface, permanent	$42
Filling – two surfaces, primary	$47
Filling – two surfaces, permanent	$52
Filling – three surfaces, primary	$55
Filling – three surfaces, permanent	$62
Filling – four or more surfaces, primary	$68
Filling – four or more surfaces, permanent	$76
Extraction – single tooth (simple)	$43
Extraction – each additional tooth (simple)	$43
Surgical Extraction	$72
Removal of Impacted Tooth – soft tissue	$100
Removal of Impacted Tooth – partial bony	$126
Removal of Impacted Tooth – complete bony	$150

Notes for Basic Dental Care

- Coverage begins after your plan has been in effect for six continuous months.
- These services are subject to an annual deductible of $50 (limited to $150 per family).

MAJOR DENTAL CARE

Procedure	BlueChoice Dental pays
Scaling/Root Planing per Quadrant	$48
Gingivectomy – per tooth	$30
Gingivectomy – per quadrant	$140
Root Canal – 1 canal	$150
Root Canal – 2 canals	$180
Root Canal – 3 canals	$230
Crown (except stainless steel)	$250
Stainless Steel Crown	$60
Pontic	$250
Complete Denture (upper or lower)	$300
Partial Denture (upper or lower)	$275
Denture Reline (chair-side)	$65
Denture Reline (lab)	$85

Notes for Major Dental Care

- Coverage begins after your plan has been in effect for 12 continuous months and you have satisfied the annual plan deductible of $50 (limited to $150 per family).

How to apply for coverage

If you're already enrolled in a Blue Cross and Blue Shield of Georgia health plan, simply complete the attached dental application and include the first month's premium payable to Blue Cross and Blue Shield of Georgia.

If you're also applying for health care coverage, just complete the dental section of your health plan application and include the first month's premium payable to Blue Cross and Blue Shield of Georgia. You do not need to fill out the separate dental application attached here.

Mail your completed application to:

OLEG SKURSKIY
18375 Ventura Blvd # 226
Tarzana, CA 91356

If you have any questions or need help with your application, talk to your Blue Cross and Blue Shield of Georgia representative or call us at 1-818-654-4548.

Si necesita asistencia o materials de venta en espanol, por favor contacte a su agente Blue Cross and Blue Shield.

This is only a brief description of some plan benefits. Please refer to your Certificate of Coverage for more complete details including benefits, limitations and exclusions.

MGASH3775G 9/08

SEND COMPLETED APPLICATION BY FAX 818-776-9865

BlueCross BlueShield of Georgia

Individual/Family Dental Plan Enrollment Application

If you are a BCBSGA subscriber, please enter your current BCBSGA group number and/or member ID number.

MEMBER ID NO.

FOR BCBSGA USE ONLY:

DCN #

Billing Type

○ Monthly (***By checking account deduction only.*** **Please complete the enclosed Bank Draft Authorization form.**)

Applicant Information - Applicant must complete this section.

Last Name | First Name | MI | Social Security No.

Home Phone No. | Business Phone No. | Age | Sex ○ M ○ F | Marital Status ○ Single ○ Married | Date of Birth

Home Address (*Must be complete. P.O. Box not acceptable*) | Billing Address (*If different or P.O. Box*)

City | State | Zip Code | City | State | Zip Code

Spouse to Be Insured - Signature required below.

Last Name of Spouse | First Name | Sex ○ M ○ F | Date of Birth | Social Security No.

Children to Be Insured - Signature required below.

1. Last Name of Child | First Name | Sex ○ M ○ F | Date of Birth | Social Security No.
2. Last Name of Child | First Name | Sex ○ M ○ F | Date of Birth | Social Security No.
3. Last Name of Child | First Name | Sex ○ M ○ F | Date of Birth | Social Security No.
4. Last Name of Child | First Name | Sex ○ M ○ F | Date of Birth | Social Security No.

Signatures (Required)

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the biological parent, please submit court papers authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. By submitting an application for coverage, I have authorized every provider furnishing care to disclose all facts pertaining to our care, treatment, and physical conditions, upon your request. I agree to assist in obtaining this information if needed. I understand that receipt of money with this application does not create BCBSGA coverage. Coverage will come into effect only on approval by BCBSGA.

Signature of Applicant /Parent or Legal Guardian	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	

Agent Information

Name of Agent (Print)	Agent Number	Signature of Agent	Today's Date
OLEG SKURSKIY	18159	X	

Rep No.

FOR BCBSGA USE ONLY

Group No. | Member ID No. | Agent Tax I.D. No. | Effective Date

Area	By	Date

BlueCross BlueShield of Georgia

SOCIAL SECURITY NO. ___ - ___ - ____

BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize **Blue Cross and Blue Shield of Georgia, Inc.** to draw checks, drafts, orders or electronic funds transfer (EFT) upon my account at the:

NAME OF BANK _____ CHECKING ACCOUNT NUMBER _____

STREET ADDRESS OF BANK _____ CITY, STATE, ZIP CODE OF BANK _____

for the purpose of paying premiums on insurance issued by Blue Cross and Blue Shield of Georgia, Inc.

I understand if any check, draft, order or EFT transmission is returned due to **payment stopped** or **authorization cancelled,** this will be considered as my request to be billed directly.

CONTRACT HOLDER'S NAME _____ SOCIAL SECURITY NUMBER _____

CONTRACT HOLDER'S ADDRESS _____ CITY, STATE, AND ZIP CODE _____

PRINTED SIGNATURE OF ACCOUNT HOLDER _____ X SIGNATURE OF ACCOUNT HOLDER _____ DATE _____

NOTE: A VOIDED CHECK MUST BE ATTACHED TO THIS APPLICATION.

☐ First request for bankdraft plan

Complete entire form and attach a voided check.

INSTRUCTIONS FOR COMPLETING THE BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

Automatic Premium Payment Plan

What is it - A special arrangement for payment of premiums automatically each month to relieve you of concern with due dates and the possibilities of having your insurance lapse unintentionally.

Who can use it - Bankdraft is an extra convenience for you. It is available if you maintain a regular checking account at your bank and make arrangements with your bank to honor automatic checks and electronic fund transfers.

How it works - To initiate the bankdraft, you must complete the authorizations above.

INSTRUCTIONS

1. **Complete as follows:**
   A. Fill in the name of your bank, branch, branch number *(if any)* and the city or state in which the bank or the branch is located.
   B. Print the name of your account exactly as it appears on your bank statement or check.
   C. Include your checking account number. It will usually be found below the signature line of your personal checks.
   D. Sign your name exactly as you do on your personal checks. If there is more than one depositor, all should sign.
   E. Include the date you signed the authorizations.

2. **Attach a VOIDED check and this completed form.** Please be sure the sample check is drawn on the same account as will be used for the automatic premium payment plan.
3. The coverage provided by this policy may be terminated by you upon thirty (30) days **written** notice.
4. Written notice thirty (30) days in advance as stated above in No. 3 is preferred. However, if any check is returned for **payment stopped** or **authorization cancelled**, this will be considered as your request to be billed directly. No further checks will be presented for payment to your bank. If a check is returned for any other reason, you will be notified by Blue Cross and Blue Shield of Georgia of what is required to pay the premium.

INTERNAL USE ONLY

DCN #: _____

BANK #: _____