

**PacifiCare**  
*SignatureValue<sup>SM</sup>*  
*A select group of providers*



CALIFORNIA

*Dental 160*

**Smile,**  
*We've Got  
You Covered.*

Individual dental benefits made *affordable.*

Mail the complete application to:  
OLEG SKURSKIY  
18375 VENTURA BLVD # 226  
TARZANA , CA 91356

OR BY FAX : 818-776-9865

# WE GIVE YOU SOMETHING TO *Smile about!*

Your health benefits just aren't complete without dental coverage.

**W**hether you need coverage for yourself or for a growing family, you'll appreciate the Dental 160 plan's comprehensive benefits. Routine exams are covered at no charge. And the plan covers a range of preventive, routine and major services at a fraction of what you would pay without coverage. There's even an orthodontic plan with special pricing. Now, that's worth smiling about!

The Dental 160 plan is simple to use. There are no claim forms and no deductibles. Annual premiums are low. You make affordable copayments for common covered dental procedures. (See the Benefit & Copayment Highlights inside.)



## The Dentist Just For You

**W**hen you join PacifiCare Dental, you'll select a contracted dentist from our directory to oversee your dental care. All dentists are rigorously screened before they're added to our network. With one of the largest dental HMO networks in California, you're sure to find a dentist you're comfortable with at a location that's convenient for you.

For a provider directory, please visit our Web site at [www.pacificare-dental.com](http://www.pacificare-dental.com) or contact Member Service at 1-800-22-TEETH (1-800-228-3384).



## Brace Yourself: Orthodontia Is Included Too

**S**traight teeth are important, not only for a great-looking smile, but for the lifelong health of your teeth, gums and mouth. That's why Dental 160 includes a value-priced orthodontic program. You pay a specially negotiated fee (most orthodontists accept payment plans), plus startup, retention and final records fees.

Your PacifiCare Dental primary care office submits a referral form. Then, PacifiCare Dental sends you an *Explanation of Benefits* which includes the name and location of a contracted orthodontist who can provide the orthodontic treatment.



## It's Easy To Enroll



Fill out the attached enrollment application.



Indicate which dental office you've chosen.  
Choose the dental office from our Dentist Directory  
by downloading the list : [Click Here](#)



Include a check for your enrollment fee and annual premium payable to PacifiCare Dental. Make sure we receive your application and payment by the 20th of the month to ensure coverage begins the first of the following month. Send application and payment to:

Oleg Skurskiy  
18375 Ventura Blvd # 226  
Tarzana, CA 91356

or by Fax 818-776-9865



Make payments even easier by selecting our monthly auto pay, which allows us to automatically debit your personal checking account each month. This payment option authorization can be found on the enrollment form inside.

**PacifiCare**<sup>®</sup>  
Dental

# Dental 160 Rates Are Noted Below By Region

You may select to pay on a monthly basis or save by making an annual payment.



1

**Region 1:** Alameda, Contra Costa, El Dorado, Fresno, Kern, Los Angeles, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Ventura counties:

<u>Monthly Auto Pay:</u>		or <i>save</i> when you select the <i>Annual Payment Option...</i>	<u>Annual Payment Option</u>	
Subscriber	\$15.50		Subscriber	\$179.40
Couple	\$24.53		Couple	\$283.80
Family	\$34.61		Family	\$399.36

2

**Region 2:** Butte, Marin, Solano, Sonoma, Stanislaus counties:

<u>Monthly Auto Pay:</u>		or <i>save</i> when you select the <i>Annual Payment Option...</i>	<u>Annual Payment Option</u>	
Subscriber	\$23.36		Subscriber	\$270.12
Couple	\$36.97		Couple	\$427.44
Family	\$52.16		Family	\$603.00

3

**Region 3:** Monterey, San Luis Obispo, Santa Barbara, Tulare counties:

<u>Monthly Auto Pay:</u>		or <i>save</i> when you select the <i>Annual Payment Option...</i>	<u>Annual Payment Option</u>	
Subscriber	\$30.37		Subscriber	\$351.12
Couple	\$48.06		Couple	\$555.60
Family	\$67.81		Family	\$783.96

Quality dental care ...

Comprehensive coverage ...

Low premiums and copayments ...

So, are you smiling yet?

# Benefit & Copayment Highlights

## Preventive Services

Member Pays:

Office visit.....	No Charge
X-rays, full mouth.....	No Charge
Single film.....	No Charge
Each additional film.....	No Charge
Teeth cleaning.....	No Charge
Topical fluoride (under age 18).....	No Charge
Sealants (per tooth; under age 18).....	Not Covered
Diagnostic casts (non-orthodontic).....	\$ 10.00
Emergency treatment (palliative).....	\$ 10.00
Office visit (after-hours).....	\$ 20.00

## Routine Services

### Restorative Dentistry

Amalgam restorations (cavities involving permanent teeth)	
One tooth surface.....	\$ 15.00
Two tooth surfaces.....	\$ 20.00
Three tooth surfaces.....	\$ 26.00
Resin restorations, per tooth (anterior).....	\$ 25.00
As above, involving incisal edge.....	\$ 28.00
Resin restoration (posterior).....	\$66.00-\$102.00
Pin retention in addition to final restoration, per tooth.....	\$ 5.00
Sedative base.....	\$ 7.00

### Oral Surgery

Extraction (uncomplicated).....	\$ 16.00
Each additional tooth (same visit).....	\$ 10.00
Soft tissue impaction.....	\$ 50.00
Partially bony impaction.....	Not Covered
Completely bony impaction.....	Not Covered
Biopsy of oral tissue (soft).....	\$ 10.00
Biopsy of oral tissue (hard).....	\$ 16.00
Surgical removal of an erupted tooth.....	\$ 40.00
Alveoloplasty (not in conjunction with extractions), per quadrant.....	\$ 80.00
Alveoloplasty in addition to tooth extraction, per quadrant.....	\$ 90.00
Drain abscess/intraoral.....	\$ 30.00
Drain abscess/extraoral.....	\$ 30.00
Frenectomy.....	\$ 50.00

### Endodontics

Pulp capping (direct).....	\$ 10.00
Pulp capping (indirect).....	\$ 24.00
Therapeutic pulpotomy.....	\$ 22.00
Root canals - Anterior.....	\$100.00
Root canals - Bicuspid.....	\$130.00
Root canals - Molar.....	\$175.00
Prefabricated post.....	\$ 50.00
Cast post and core.....	\$ 65.00

### Periodontics

Gingival curettage, per quadrant.....	\$ 40.00
Gingivectomy, per quadrant.....	\$115.00
Muco-gingival surgery, per quadrant.....	Not Covered
Gingivectomy, per tooth.....	\$ 20.00
Periodontal maintenance (once every 6 months).....	\$ 20.00
Occlusion adjustment.....	No Charge



## Major Services

Member Pays:

### Crowns and pontics

Stainless steel, primary tooth.....	\$ 30.00
Resin crown †.....	\$ 85.00
Full metal crown*.....	\$145.00
3/4 metal crown*.....	\$140.00
Porcelain crown †.....	\$130.00
Porcelain with metal crown* †.....	\$165.00
Cast post and core, in addition to crown*.....	\$ 65.00
Pontic, cast metal (base).....	\$145.00
Pontic, porcelain with metal*.....	\$165.00
Inlay recementation.....	\$ 12.00
Crown recementation.....	\$ 12.00
Bridge recementation.....	\$ 18.00

### Prosthetics

Denture adjustment.....	\$ 12.00
Replace tooth, per tooth.....	\$ 23.00
Denture repair.....	\$ 28.00
Denture reline (office).....	\$ 35.00
Denture reline, lab-processed.....	\$ 65.00
Interim partial denture.....	\$ 60.00
Partial denture, upper or lower (including any conventional clasps, rests, and teeth)*.....	\$225.00
Partial denture (cast metal base with resin saddle), upper or lower (including any conventional clasps, rests, and teeth)*.....	\$255.00
Complete denture, upper or lower.....	\$250.00
Add tooth or clasp to existing partial.....	\$ 31.00
Fixed space maintainer.....	\$ 55.00
Removable acrylic space maintainer.....	\$ 55.00
Clasps, each additional, for space maintainer.....	No Charge

\* plus actual lab cost of gold. † not for molars.

Dentist may charge \$20.00 for broken appointments if not notified at least 24 hours in advance.

## Orthodontics

Class I (teeth straightening).....	\$1,895.00
Class II (correction of overbite).....	\$1,895.00
Class III (correction of underbite).....	\$1,895.00

Specific copayment levels have also been set for startup and retention services. The orthodontic benefit covers: consultation, retention, banding, and monthly office visits for 24 months.

Orthodontic treatment must be provided by a DBP-CA Panel Orthodontist. A referral must be submitted by the assigned general dentist, and an orthodontist will be assigned by DBP-CA.

Refer to the Evidence of Coverage and Disclosure Form booklet and the Orthodontic Information Sheet for complete details of benefits, exclusions, limitations, and plan description. There is no specialty referral for the Dental 160 plan. **Copayments are applicable at participating general dentist offices only.**

**PacifiCare**<sup>®</sup>  
Dental

A Dental Benefit Providers of California, Inc. Product.

# Application Instructions For **PacifiCare**

## Just Follow These 3 Easy Steps...

### Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.**

Be sure you follow the instructions on the application carefully.

1. Print all pages of the application including instructions.
2. Complete all questions.

If you have any questions, or you are not sure how to answer a question, simply contact us: Tel. **(818) 654-4548** fax: **(818) 776-9865**

### Step 2

**SELECT THE TYPE OF BILLING YOU WANT**

### Step 3

**SEND THE COMPLETED APPLICATION TO:**

**Oleg Skurskiy**  
18375 Ventura Blvd. # 226  
Tarzana , CA 91356

Please make your check payable to: **PacifiCare**

**If you have questions please contact us:**

**Oleg Skurskiy**

*Authorized Independent Agent*

Tel.: 1-818-654-4548

Fax: 1-818-776-9865

[oleg@askoleg.com](mailto:oleg@askoleg.com)

Thank you for choosing...

***PacifiCare***<sup>®</sup>

# SignatureValue - Dental 160 Plan Individual Member Enrollment

**PacifiCare®**  
Dental

A Dental Benefit Providers of California, Inc. Product.

## INSTRUCTIONS FOR COMPLETING ENROLLMENT FORM



- **Check all appropriate boxes and print all information clearly.** (Please retain the brochure information until you receive your ID card.)
- **Subscriber:** Fill out section completely. Remember to indicate the Provider Group Number/Dentist/City you have selected.
- **Dependents:** All dependents you wish to be covered should be listed in this section with their selected Provider Group. Don't forget to indicate their Provider Group Number/Dentist/City selections.
- **Method of Payment:** Please indicate your preferred method of payment, Monthly Auto Pay or Annual Payment. Should you choose the Monthly Auto Pay option, complete and sign the Pre-Authorized Payment Application on the adjacent page. DBP-CA will then automatically deduct the monthly premium from your checking account. Or, if you select the Annual Payment option, please include a check made payable to DBP-CA for the annual premium and one-time enrollment and processing fee of \$15.00.
- **Terms and Conditions:** Read the Terms and Conditions on the adjacent page and sign in the box at the "X" on the bottom of the sheet. This form must be signed for coverage to be effective. Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the 1st of the following month.

Cut here

### SUBSCRIBER (You)

Please complete all sections. This form cannot be processed if information is incomplete.

Last Name		First Name		MI
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security Number / /		Home Phone ( )
Mailing Address		City	State	ZIP ( )
Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No		

### DEPENDENTS (Your spouse and/or children)

<b>1</b>	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2</b>	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3</b>	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4</b>	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### METHOD OF PAYMENT

**Monthly Auto Pay**

Complete the attached Pre-Authorized Payment Application and include a voided check. A one-time non-refundable enrollment and processing fee of \$15.00 will be debited from your checking account along with your first month's premium.

or *save* when you select the **Annual Payment Option...**

**Annual Payment**

Include a check payable to Dental Benefit Providers of California, Inc. for your annual premium. In addition to the annual premium amount, please include a one-time non-refundable enrollment and processing fee of \$15.00.

I understand and agree to the terms and conditions on the adjacent page.



X

Enrollee Signature

Date

Mail to:

Oleg Skurskiy  
18375 Ventura Blvd. # 226  
Tarzana, CA 91356

Tel (818) 654-4548

Fax (818) 776-9865



- Remember to select a provider!
- Be sure to read the terms and conditions below and sign in the box at the "X."

**TERMS AND CONDITIONS (Please read and sign on adjacent page)**

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and PacifiCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than \$5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than \$5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in PacifiCare Dental both member (including any heirs or assigns) and PacifiCare entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage.

**PRE-AUTHORIZED PAYMENT APPLICATION**

Complete this section only if you want your monthly premium automatically deducted from your checking account.

**Our Pre-Authorized Payment Plan**

It's the forget-proof method of paying your premium — almost as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no more paperwork for you and no more checks to write. No worries about monthly late-payment charges. And you'll save on postage and envelopes. It's easy, reliable, and automatic.

**Authorized Agreement for Pre-Arranged Payments (Debits)**

I (we) hereby authorize PACIFICARE DENTAL to initiate debit entries to my (our) checking account indicated below, and the bank named below, herein called BANK, to debit the same to such account.

Account No. (please enclose one voided check) \_\_\_\_\_

Bank Name \_\_\_\_\_ Bank Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

This authority is to remain in full force and effect until BANK has received written notification from me (or either of us) of its termination in such time and in such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name (print clearly) \_\_\_\_\_ Social Security No. \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



**AGENT AND BROKER USE ONLY**

Agent Name	Agent Number	Agent Phone
Oleg Skurskiy	8823	(818) 654-4548
Agent Address	City	State ZIP
18375 Ventura Blvd. # 226	Tarzana, CA 91356	