



your key to a healthy smile  
and clearer vision

Individual and family dental and dental + vision coverage

Effective March 1, 2012

blue  of california

# Breaking it down, plain and simple

If you have a tough time understanding dental coverage, you're not alone. We've simplified the most important facts with an easy-to-follow breakdown on what you need to know about selecting dental coverage, and the benefits you receive as a dental plan member.

Choose a comprehensive Dental PPO or Dental HMO plan, or an affordable Value Smile<sup>SM</sup> PPO\* plan. In addition, we also offer a dental and vision plan package – Specialty Duo<sup>SM,\*</sup> – that includes comprehensive dental and vision coverage to give you the extra protection that your teeth and eyes deserve. These dental plans are now available to people of all ages living in California.†

## Healthy teeth and eyes, healthy body

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### Did you know?

More than 90% of all common diseases have oral symptoms?<sup>1</sup>

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During a dental exam, your dentist will check your teeth and gums for cavities, gum disease, and other health problems. So when you keep your teeth healthy, you're also helping to keep your body healthy.

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### Did you know?

Eye exams can often detect serious chronic conditions such as diabetes, hypertension, and high cholesterol?<sup>2</sup>

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Routine eye exams can help detect both eye and systemic health problems. When detected early, many serious health conditions can be managed more effectively – with less costly treatments and a better chance for a healthy outcome.

Whether you need treatment or just want preventive care, it's never too late to get dental or combined dental + vision coverage to help maintain your overall health.

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval.

† You must be a California resident at the time of enrollment.

1 "Prevent Oral Health Problems: Visit a Dentist Twice a Year," Academy of General Dentistry, January 2007.

2 "The Eyes are the Windows to Wellness," *Employee Benefit News*, August 1, 2009.

Note: This brochure is only a summary of the individual and family dental plans and Specialty Duo dental + vision package. For a complete list of the benefits, exclusions, and limitations, please refer to the *Evidence of Coverage and Health Service Agreement* or the *Value Smile PPO Plan Policy*, *Specialty Duo Dental Plan Policy* and *Specialty Duo Vision Plan Policy for Individuals and Families*.

# Blue Shield helps in three important ways

## 1 **Simplicity**

- All dental plans and the Specialty Duo dental + vision package\* are available with or independent of Blue Shield medical plans<sup>3</sup>
- Combined dental and vision benefits are offered together in one package
- Know exactly what you pay up front when using a network dentist

## 2 **Advantages**

- Access to an extensive network of dentists, specialists, and vision care providers, providing you access to one of the state's largest dental networks and one of the state's largest vision networks<sup>4</sup>
- A broad choice of covered benefits with the Dental PPO plan, Dental HMO plan, and Specialty Duo dental + vision package
- No waiting period for dental diagnostic or preventive services<sup>5</sup>
- Orthodontic benefits are available for adults and children with the Dental PPO plan, Dental HMO plan, and Specialty Duo package<sup>5</sup>

## 3 **Ease of doing business**

Blue Shield can be your single-source provider for medical and dental, or medical, dental + vision coverage.

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval.

3 To qualify for a dental plan or Specialty Duo package, you must be a California resident. If you had a Blue Shield individual and family dental plan or dental + vision package cancelled, you must wait six months from the date of cancellation before you can reapply.

4 Dental providers in California are available through a contracted dental plan administrator. Vision providers in California are available through the contracted vision plan administrator.

5 For the Specialty Duo Dental and Dental PPO plan, the following waiting periods apply: three-month waiting period for minor restorative services and procedures (such as fillings), endodontics, periodontics, and oral surgery; 12-month waiting period for major restorative services (such as crowns), orthodontics, and removable and fixed prosthetics. For the Dental HMO plan, there is a 12-month waiting period for orthodontics.

# See how the savings can add up

## Dental plan savings

Dental plans can pay for themselves in the first year of coverage. The charts below show the potential savings when using a network dentist.

Description	Patients without coverage (standard list price for two preventive visits) <sup>6</sup>	Blue Shield Dental PPO member out-of-pocket costs (\$38.50 x 12 months)	Blue Shield Value Smile PPO* member out-of-pocket costs (\$23.50 x 12 months)	Blue Shield Dental HMO member out-of-pocket costs (\$18.40 x 12 months)
Annual individual premium	\$ 0.00	\$ 462.00	\$ 282.00	\$ 220.80
Annual dental exam, teeth cleaning, and X-rays	\$ 392.00	\$ 0.00	\$ 0.00	\$ 0.00
6-month follow-up	\$ 182.00	\$ 0.00	\$ 0.00	\$ 0.00
<b>Your total cost</b>	<b>\$ 574.00<sup>6</sup></b>	<b>\$ 462.00</b>	<b>\$ 282.00</b>	<b>\$ 220.80</b>
<b>Your first-year savings</b>		<b>\$ 112.00</b>	<b>\$ 292.00</b>	<b>\$ 353.20</b>

The following chart compares costs during the second year of coverage, showing the potential savings for members who need more extensive dental care.

Description	Patients without coverage (standard list price) <sup>6</sup>	Blue Shield Dental PPO member out-of-pocket costs (network dentist)	Blue Shield Value Smile PPO member out-of-pocket costs (network dentist)	Blue Shield Dental HMO member out-of-pocket costs
Calendar-year deductible	N/A	\$ 50.00	\$ 25.00	\$ 0.00
One filling	\$ 207.00	\$ 37.00	\$ 37.00	\$ 18.00
Root canal	\$ 1,309.00	\$ 234.00	Not covered	\$ 290.00
High noble metal porcelain crown	\$ 1,411.00	\$ 320.00	Not covered	\$ 300.00 <sup>8</sup>
Charges above the calendar-year benefit maximum <sup>7</sup>	N/A	\$ 0.00	\$ 0.00	\$ 0.00
<b>Your total costs</b>	<b>\$ 2,927.00<sup>6</sup></b>	<b>\$ 641.00</b>	<b>\$ 2,782.00</b>	<b>\$ 608.00</b>
<b>Your savings if you have dental coverage</b>		<b>\$ 2,286.00</b>	<b>\$ 145.00</b>	<b>\$ 2,319.00</b>



## Orthodontic savings

Orthodontic benefits with a single copayment are available for both children and adults with the Dental PPO and Dental HMO plans.<sup>9</sup> Save as much as 54% on what you would pay for braces without dental coverage.

Description	Patients without coverage (standard list price) <sup>6</sup>	Blue Shield Dental PPO member out-of-pocket costs (\$38.50 x 24 months)	Blue Shield Dental HMO member out-of-pocket costs (\$18.40 x 24 months)
24-month individual rates	N/A	\$ 924.00	\$ 441.60
Calendar-year deductible	N/A	\$ 50.00	\$ 0.00
Braces (ages 19-64)	\$ 6,718.00	\$ 2,650.00	\$ 2,650.00
<b>Your total cost</b>	<b>\$ 6,718.00<sup>6</sup></b>	<b>\$ 3,624.00</b>	<b>\$ 3,091.60</b>
<b>Your savings if you have dental coverage</b>		<b>46%</b>	<b>54%</b>

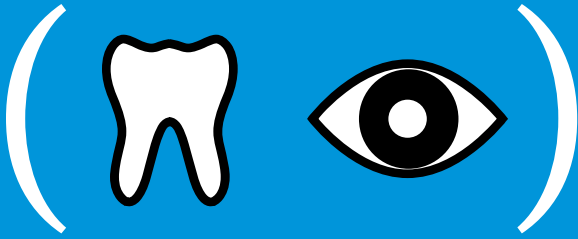
\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval.

6 The dental rates are based on a 90% average of fees charged in San Francisco as reported in 2011 by the National Dental Advisory Services. Vision costs are based on a national average out-of-pocket retail cost for eye exam, eyewear lenses, and frames as reported in May, 2011 by the National Association of Vision Care Plans (NAVCP).

7 For the Dental PPO plan, there is a \$1,000 per member, per calendar-year benefit maximum, of which up to \$500 per member, per year can be used for non-network benefits. For the Value Smile PPO plan, there is a \$500 per member, per calendar-year benefit maximum. Each calendar year, the Dental PPO and Value Smile PPO plan member is responsible for all charges incurred after the plan has paid these amounts for dental services. Dental HMO plans have no calendar-year benefit maximum.

8 You pay the copayment plus the cost of precious or semi-precious metals.

9 Orthodontic services have a fixed patient copayment and don't apply to the calendar-year benefit maximum. Orthodontic treatment is limited to one full case during the lifetime of the member and consists of 24 continuous months of usual and customary orthodontic care. Full-case fee includes consultation, treatment plan, tooth movement, and retention. Orthodontist may charge members separately for records, limited to \$250 per case. Treatment beyond 24 months is not covered and is the responsibility of the patient.



## Specialty Duo dental + vision package\* savings

From cavities to contact lenses, the Blue Shield Specialty Duo dental + vision package can save you money on a wide range of care with our network providers. The examples below show some potential savings in the first year of coverage when using a network dentist or vision care provider. See the Dental PPO plan in the charts on pages 4 and 5 for additional potential savings during the second year of coverage for the dental component of the dental + vision package.

Description	Patients without coverage <sup>6</sup>	Specialty Duo* package member out-of-pocket costs (\$51.70 x 12 months)
Annual individual premium	\$ 0.00	\$ 620.40
Annual dental exam, teeth cleaning, and X-rays	\$ 392.00	\$ 0.00
6-month dental care follow-up	\$ 182.00	\$ 0.00
Vision exam	\$ 73.00	\$ 0.00
Lenses	\$ 75.00	\$ 25.00
Frames	\$ 100.00	\$ 0.00
<b>Your total cost</b>	<b>\$ 822.00<sup>6</sup></b>	<b>\$ 645.40</b>
<b>Your first-year savings</b>		<b>\$ 176.60</b>

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval.

<sup>6</sup> The dental rates are based on a 90% average of fees charged in San Francisco as reported in 2011 by the National Dental Advisory Services. Vision costs are based on a national average out-of-pocket retail cost for eye exam, eyewear lenses, and frames as reported in May 2011 by the National Association of Vision Care Plans (NAVCP).

# Dental PPO

## Dental preferred provider organization

You have the freedom to see the dentist of your choice. Another bonus is that your out-of-pocket cost is lower when you select a dentist within the plan network. You can be certain that the savings will add up, even for something as simple as an annual exam and cleaning.

### Key features:

- Access to over 21,000 contracted general care and specialty dentists in California<sup>4</sup>
- Wide range of dental benefits, with teeth cleaning, X-rays, and oral cancer screening covered at 100% when using network providers
- No waiting period for diagnostic or preventive services
- Coverage even when you use a non-network dentist – the plan reimburses you up to an allowed amount for covered services, and you pay the remaining balance of the total billed charges
- Orthodontic benefits are available for both children and adults<sup>10</sup>
- A \$50 deductible per member, per calendar year
- A \$1,000 per member, per calendar-year benefit maximum, of which up to \$500 per member, per year can be used for non-network benefits<sup>11</sup>

<sup>4</sup> Dental providers in California are available through a contracted dental plan administrator. Vision providers in California are available through the contracted vision plan administrator.

<sup>10</sup> Dental PPO and Specialty Duo dental plan members have certain waiting periods: three 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.

<sup>11</sup> Each calendar year, you are responsible for all charges incurred after the plan has paid these amounts for covered dental services.

# Dental PPO highlight matrix

This chart is only a summary. For a complete list of the benefits, exclusions, and limitations of the Dental PPO plan, please refer to the *Evidence of Coverage and Health Service Agreement for Individuals and Families*.

## Diagnostic and preventive services

For your annual dental exam and six-month checkup.

**Calendar-year deductible**  
(per member)

\$50/person

**Calendar-year benefit maximum**

\$1,000 (\$500 maximum may be used for non-network dentists)<sup>11</sup>

Description	With network dentists, you pay:	With non-network dentists, we pay up to: <sup>12</sup>
Comprehensive oral exams	\$ 0.00	\$ 40.00
Periodic oral exams	\$ 0.00	\$ 16.00
Complete X-rays	\$ 0.00	\$ 56.00
Prophylaxis (cleanings, every 6 months)		
• Adult	\$ 0.00	\$ 48.00
• Child	\$ 0.00	\$ 34.00
Sealant/per tooth (covered to age 16)	\$ 0.00	\$ 22.00
Enhanced dental benefits for pregnant women <sup>13</sup>	\$ 0.00	100% of charge

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

## Major services<sup>10</sup>

Make sure the big stuff is taken care of when needed.

Description	With network dentists, you pay:	With non-network dentists, we pay up to: <sup>12</sup>
Crown (porcelain fused to noble metal)	\$ 320.00	\$ 256.00
Bridge pontic/false tooth – high noble metal (per unit)	\$ 293.00	\$ 234.00
Bridge retainer – porcelain fused to high noble metal (per unit)	\$ 313.00	\$ 250.00
Complete denture (upper or lower)	\$ 388.00	\$ 310.00

### Routine services<sup>10</sup>

Keep your teeth healthy.

Description	With network dentists, you pay:	With non-network dentists, we pay up to: <sup>12</sup>
One-surface composite (filling)	\$ 37.00	\$ 30.00
Two-surface composite (filling)	\$ 56.00	\$ 44.00
Anterior root canal	\$ 156.00	\$ 125.00
Molar root canal	\$ 234.00	\$ 187.00
Periodontal root planing/ per quadrant	\$ 65.00	\$ 52.00
Extraction (single tooth)	\$ 40.00	\$ 32.00
Osseous surgery/per quadrant	\$ 263.00	\$ 210.00
Removal of impacted tooth (complete bony)	\$ 113.00	\$ 90.00

### Orthodontics<sup>10,14</sup>

For straighter teeth and a winning smile.

Description	With network dentists, you pay:	With non-network dentists: <sup>12</sup>
Fully banded (two-year) case – child	\$ 2,350.00 <sup>15</sup>	Not covered
Fully banded (two-year) case – adult	\$ 2,650.00 <sup>15</sup>	Not covered

10 Dental PPO and Specialty Duo dental plan members have certain waiting periods: three 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.

11 Each calendar year, you are responsible for all charges incurred after the plan has paid these amounts for covered dental services.

12 Use any network dentist to take advantage of contracted rates and pay lower out-of-pocket costs. When you use dentists outside our network, the plan reimburses up to the amount listed and you're responsible for all charges in excess of that amount and a \$50 calendar-year deductible.

13 The plan covers one additional routine adult prophylaxis for women during pregnancy and one periodontal maintenance visit if warranted by a history of periodontal treatment, and one course of periodontal scaling and root planing with a documented existing periodontal condition.

14 Orthodontic services have a fixed patient copayment and do not apply to your \$1,000 calendar-year benefit maximum.

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

# Specialty Duo package\*

## Dental + vision coverage

Want convenience? We've combined the benefits of the Dental PPO plan with comprehensive vision benefits into a single package. You've also got the freedom to choose the providers of your choice, with access to one of the state's largest dental networks and one of the state's largest vision networks (your cost is lower with network providers). For more details of the dental and vision components of this package, please refer to the following key features and benefits highlight matrices.

### Key features:

#### Specialty Duo dental plan\*

Offers the same features and benefits of the Dental PPO plan. See details on pages 8 and 9. For a complete description of the benefits, exclusions, and limitations of the Specialty Duo dental plan, please refer to the *Specialty Duo Dental Plan Policy for Individuals and Families*.

#### Specialty Duo vision plan\*

- Access to more than 5,900 contracted vision care providers in California,<sup>4</sup> including retail chains open on evenings and weekends
- No copayment for eye exams
- Choice of network or non-network vision providers
- A \$25 copayment for lenses and low-vision aids
- A \$100 frame allowance that can be used towards any pair of frames
- Coverage for an eye exam once every 12 months
- Coverage for lenses or contact lenses every 24 months, or 12 months with a prescription change
- Coverage for frames every 24 months
- 90-day waiting period for vision care services
- Benefit for non-prescription sunglasses for members who have had LASIK or PRK surgery

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval.

<sup>4</sup> Dental providers in California are available through a contracted dental plan administrator. Vision providers in California are available through the contracted vision plan administrator.

# Specialty Duo vision plan highlight matrix

This chart is only a summary. For a complete list of the benefits, exclusions, and limitations of the Specialty Duo vision plan, please refer to the *Specialty Duo Vision Plan Policy for Individuals and Families*.

Service and eyewear	Plan coverage when provided by network providers	Plan coverage when provided by non-network providers
<b>Comprehensive examination – every 12 months</b>		
Ophthalmologic	100%	Up to a maximum of \$60
Optometric	100%	Up to a maximum of \$50
<b>Lenses<sup>16,17</sup> – every 24 months (or 12 months with a prescription change)</b>		
Single-vision	100%	Up to a maximum of \$43
Bifocal	100%	Up to a maximum of \$60
Trifocal	100%	Up to a maximum of \$75
Aphakic or lenticular monofocal	100%	Up to a maximum of \$120
Aphakic or lenticular multifocal	100%	Up to a maximum of \$200
Polycarbonate lenses for covered dependent children	Up to a maximum of \$100	Up to a maximum of \$75
<b>Frame – every 24 months</b>	Up to a maximum of \$100 <sup>18</sup>	Up to a maximum of \$40
<b>Contact lenses<sup>17,19</sup> – every 24 months (or 12 months with a prescription change)</b>		
Non-elective (medically necessary) <sup>20</sup>		
• Hard	100%	Up to a maximum of \$200
• Soft	100%	Up to a maximum of \$250
Elective contact lenses (cosmetic/convenience)	Up to a maximum of \$120	Up to a maximum of \$120
<b>Plano (non-prescription) sunglasses<sup>19,21</sup></b>	Up to a maximum of \$100 <sup>18</sup>	Not covered
<b>Diabetes management referral<sup>22</sup></b>	100%	Not covered

16 Each pair of lenses includes a pink or rose tint No. 1 or No. 2 in the allowance and up to 61 mm in size.

17 A prescription change means any of the following: a change in prescription of 0.50 diopter or more; a shift in axis of astigmatism of 15 degrees; a difference in vertical prism greater than 1 prism diopter; or a change in lens type.

18 When the participating provider uses wholesale or warehouse pricing, the maximum allowable frame allowance will be as follows: wholesale allowance – \$66.04; warehouse allowance – \$69.09. Note that this pricing replaces the frame allowance shown in the Summary of Benefits. Network providers using wholesale or warehouse pricing are identified in the *Directory of Network Vision Providers*. You pay any cost above the allowed amount.

19 In lieu of lenses and frame.

20 A report from the provider and prior authorization from a contracted vision plan administrator is required.

21 For members who have had PRK, LASIK, or custom LASIK vision correction surgery only, this benefit of plano sunglasses allowance is equal to the plan's frame allowance. An eye exam by a network provider is required to verify laser surgery, or a note from the surgeon who performed the laser surgery is required to verify laser surgery; available once every 24 months.

22 The diabetes disease management referral program is available to members who enroll in both Blue Shield medical and vision coverage.

## Value Smile PPO<sup>\*,23</sup>

### Dental preferred provider organization

This affordable plan covers preventive and diagnostic dental care, as well as some minor restorative services. Plus, you can choose any dentist you want (your cost is lower when you select a network dentist).

#### Key features:

- Access to over 21,000 contracted general care and specialty dentists in California<sup>4</sup>
- Two annual teeth cleanings, plus annual X-rays and oral cancer screening covered at 100% when using network providers
- Fixed copayments when using network dentists
- No waiting periods
- Coverage even when you use a non-network dentist – the plan reimburses you up to an allowed amount for covered services, and you pay the remaining balance of the total billed charges
- No coverage for major services
- A \$25 deductible per member, per calendar year
- A \$500 per member, per calendar-year benefit maximum<sup>11</sup>

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval.

<sup>4</sup> Dental providers in California are available through a contracted dental plan administrator. Vision providers in California are available through the contracted vision plan administrator.

<sup>11</sup> Each calendar year, you are responsible for all charges incurred after the plan has paid these amounts for covered dental services.

<sup>23</sup> Orthodontic benefits are not available with the Value Smile PPO plan.

# Value Smile PPO highlight matrix

This chart is only a summary. For a complete list of the benefits, exclusions, and limitations of the Value Smile PPO plan below, please refer to the *Value Smile PPO Plan Policy for Individuals and Families*.

## Diagnostic and preventive services

For your annual dental exam and six-month checkup.

<b>Calendar-year deductible</b> (per member)	\$25 per person	
<b>Calendar-year benefit maximum</b>	\$500 <sup>11</sup>	
Description	With network dentists, you pay:	With non-network dentists, we pay up to: <sup>24</sup>
Comprehensive oral exams	\$ 0.00	\$ 40.00
Periodic oral exams	\$ 0.00	\$ 16.00
Complete X-rays	\$ 0.00	\$ 56.00
Prophylaxis (cleanings, every 6 months)		
• Adult	\$ 0.00	\$ 48.00
• Child	\$ 0.00	\$ 34.00
Sealant/per tooth (covered to age 16)	\$ 0.00	\$ 22.00
Enhanced dental services for pregnant women <sup>25</sup>	\$ 0.00	\$ 48.00

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

## Routine services

Keep your teeth healthy.

Description	With network dentists, you pay:	With non-network dentists, we pay up to: <sup>24</sup>
One-surface composite (filling)	\$ 37.00	\$ 30.00
Two-surface composite (filling)	\$ 56.00	\$ 44.00

<sup>11</sup> Each calendar year, you are responsible for all charges incurred after the plan has paid these amounts for covered dental services.

<sup>24</sup> Use any network dentist to take advantage of contracted rates and pay lower out-of-pocket costs. When you use dentists outside our network, the plan reimburses up to the amount listed, and you are responsible for all charges in excess of that amount and a \$25 calendar-year deductible.

<sup>25</sup> The plan covers one additional routine adult prophylaxis for women during pregnancy.

# Dental HMO

## Dental health maintenance organization

You choose from the many dentists in our Dental HMO directory of providers at [blueshieldca.com](https://www.blueshieldca.com). Your dentist will provide and coordinate all your family's dental care. It's a simple and affordable way to get the quality coverage you need to keep those pearly whites healthy.

### Key features:

- Access over 9,000 contracted dental provider locations in California<sup>4</sup>
- No deductibles and no calendar-year maximums (you have 24 months of orthodontia coverage per member lifetime)
- Wide range of dental benefits, including teeth cleaning and X-rays covered at 100%
- No waiting period for most services (except for a 12-month waiting period for orthodontic services)
- Specialty-care services available with referral from your dentist
- Orthodontic benefits are available for both children and adults<sup>26</sup>
- Virtually no claim forms

<sup>4</sup> Dental providers in California are available through a contracted dental plan administrator. Vision providers in California are available through the contracted vision plan administrator.

<sup>26</sup> Dental HMO plan members have a 12-month waiting period for orthodontics. (There's no waiting periods for other covered services.)

## Dental HMO highlight matrix

This chart is only a summary. For a complete list of the benefits, exclusions, and limitations of the Dental HMO plan, please refer to the *Evidence of Coverage and Health Service Agreement for Individuals and Families*.

### Diagnostic and preventive services

For your annual dental exam and six-month checkup.

Description	You pay: <sup>27</sup>
Comprehensive oral exams	\$ 0.00
Periodic oral exams	\$ 0.00
Complete X-rays	\$ 0.00
Prophylaxis (cleanings, every 6 months)	
• Adult	\$ 0.00
• Child	\$ 0.00
Sealant/per tooth (covered to age 16)	\$ 11.00

## Dental HMO highlight matrix (continued)

### Routine services

Keep your teeth healthy.

Description	You pay: <sup>27</sup>
One-surface composite (filling)	\$ 18.00
Two-surface composite (filling)	\$ 23.00

### Major services

Make sure the big stuff is taken care of when needed.

Description	You pay: <sup>27</sup>
Crown (porcelain fused to noble metal)	\$ 300.00 <sup>29</sup>
Osseous surgery/per quadrant	\$ 303.00
Anterior root canal	\$ 155.00
Molar root canal	\$ 290.00
Periodontal root planing/per quadrant	\$ 75.00
Extraction (single tooth)	\$ 34.00
Bridge pontic/false tooth – high noble metal (per unit)	\$ 300.00 <sup>29</sup>
Bridge retainer – porcelain fused to high noble metal (per unit)	\$ 300.00 <sup>29</sup>
Complete denture (upper or lower)	\$ 400.00
Removal of impacted tooth (complete bony)	\$ 125.00

### Orthodontics<sup>26,28</sup>

For straighter teeth and a winning smile.

Description	You pay: <sup>27</sup>
Fully banded (two- year) case – child	\$ 2,350.00 <sup>15</sup>
Fully banded (two- year) case – adult	\$ 2,650.00 <sup>15</sup>

<sup>15</sup> You pay the copayment plus up to \$250 for records.

<sup>26</sup> Dental HMO plan members have a 12-month waiting period for orthodontics. (There's no waiting periods for other covered services.)

<sup>27</sup> All services must be performed, prescribed, or authorized by your dentist, chosen from the Blue Shield Dental HMO Dental Provider Directory. If you need to see a specialist, you must get a referral from your dental provider to receive covered services.

<sup>28</sup> Orthodontic services have a fixed patient copayment.

<sup>29</sup> You pay the copayment plus the cost of precious or semi-precious metals.

## Apply today

The value you get with Blue Shield plans can help keep your costs for dental work and for vision care from taking a deep bite out of your wallet. Check out the monthly rates below, and apply now. You'll be doing your smile and eyes a huge favor.

## Monthly rates

Description	Specialty Duo dental + vision package*	Dental PPO	Value Smile PPO*	Dental HMO
Adult/child	\$ 51.70	\$ 38.50	\$ 23.50	\$ 18.40
Adult and spouse/ domestic partner	\$ 107.20	\$ 78.00	\$ 46.30	\$ 36.60
Adult and child	\$ 78.40	\$ 58.30	\$ 35.50	\$ 32.40
Adult and children	\$ 116.50	\$ 86.90	\$ 53.10	\$ 37.80
Family	\$ 181.70	\$ 135.40	\$ 82.60	\$ 71.20

# Enrolling is Simple. 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. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department  
at: \_\_\_\_\_ fax: \_\_\_\_\_

## **Step 2**

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

## **Step 3**


**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to: Blue Shield of California**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

**Thank you for choosing...**

blue  of california

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



This form is to be used by applicants applying for a Blue Shield dental plan or dental + vision package.  
 For applicants with no Blue Shield coverage, please complete the entire form.  
 For applicants with existing Blue Shield coverage, please complete the shaded area of the form.

You are eligible for any Individual & Family (IFP) dental plan or dental + vision package if you are a California resident 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 6 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 or dental + vision packages. If you enroll in any HIPAA Guaranteed Issue plan, you are not eligible for dental plan or dental + vision package.

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

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

**Dental plan or dental + vision package:** (please check one below)

Value Smile PPO\*<sup>†</sup>  Specialty Duo (dental + vision) package\*<sup>†</sup>  DPPO  DHMO

Requested effective date: \_\_\_\_\_ **Dental HMO applicants only** – please choose a dentist from the Dental HMO Dental Provider Directory at [blueshieldca.com](http://blueshieldca.com), or call **(800) 431-2809** for assistance.

Dental HMO provider name: \_\_\_\_\_ Dental HMO provider number: \_\_\_\_\_

To find a Blue Shield dental or vision 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)			
Do you currently have vision coverage through Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate plan		Vision 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"/> 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 26).

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.

† Underwritten by Blue Shield of California Life & Health Insurance Company

### 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 and not enrolled in any HIPAA Guaranteed Issue medical plan in order to be eligible for enrollment in this plan/package. 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 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 or dental + vision package. If I am not eligible, the amount of prepaid dues/premium will be refunded to me.
- 3. Dues/premium payments:** Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the *Evidence of Coverage and Health Service Agreement/Policy*.
- 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 Services Agreement/Policy*, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for dental or dental + vision 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 my dependent spouse/domestic partner is enrolling for dental or dental + vision 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	Telephone number	Fax number
E-mail address		
Producer address		
City	State	ZIP code
Super producer name	Super producer number	
Do you want the Evidence of Coverage and Health Services Agreement/Policy sent directly to the subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Producer signature	_____/_____/_____ Today's date	_____ Print name

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:

FAX TO 818-776-9865

**OLEG SKURSKIY**  
18375 Ventura Blvd. # 226  
Tarzana, CA 91356

For internal use only
DSA name: _____
DSA number: _____
Producer number: _____