your key to a healthy smile and clearer vision

Individual and family dental and dental + vision coverage

Effective March 1, 2013

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[SM] PPO* plan. In addition, we also offer a dental and vision plan package – Specialty Duo[SM,*] – 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

Did you know?

More than 90% of all common diseases have oral symptoms?[1]

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.

Did you know?

Eye exams can often detect serious chronic conditions such as diabetes, hypertension, and high cholesterol?[2]

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[3]
- 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[4]
- 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[5]
- Orthodontic benefits are available for adults and children with the Dental PPO plan, Dental HMO plan, and Specialty Duo package[5]

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. For the Value Smile PPO plan there is a three-month waiting period for minor restorative services.

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)[6]	Blue Shield Dental PPO member out-of-pocket costs ($41.40 x12months)	Blue Shield Value Smile PPO* member out-of-pocket costs ($23.50 x 12 months)	Blue Shield Dental HMO member out-of-pocket costs ($19.80 x 12 months)
Annual individual premium	$ 0.00	$ 496.80	$ 282.00	$ 237.60
Annual dental exam, teeth cleaning, and X-rays	$ 404.00	$ 0.00	$ 0.00	$ 0.00
6-month follow-up	$ 219.00	$ 0.00	$ 0.00	$ 0.00
Your total cost	**$ 623.00[6]**	**$ 496.80**	**$ 282.00**	**$ 237.60**
Your first-year savings		**$ 126.20**	**$ 341.00**	**$ 385.40**

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)[6]	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	$ 213.00	$ 37.00	$ 37.00	$ 18.00
Root canal	$ 1,336.00	$ 234.00	Not covered	$ 290.00
High noble metal porcelain crown	$ 1,439.00	$ 320.00	Not covered	$ 300.00[8]
Charges above the calendar-year benefit maximum[7]	N/A	$ 0.00	$ 0.00	$ 0.00
Your total costs	**$ 2,988.00[6]**	**$ 641.00**	**$ 62.00**	**$ 608.00**
Your savings if you have dental coverage		**$ 2,347.00**	**$ 2,926.00**	**$ 2,380.00**

Orthodontic savings

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

Description	Patients without coverage (standard list price)[6]	Blue Shield Dental PPO member out-of-pocket costs ($41.40 x 24 months)	Blue Shield Dental HMO member out-of-pocket costs ($19.80 x 24 months)
24-month individual rates	N/A	$ 993.60	$ 475.20
Calendar-year deductible	N/A	$ 50.00	$ 0.00
Braces (ages 19-64)	$ 6,642.00	$ 2,650.00	$ 2,650.00
Your total cost	**$ 6,642.00[6]**	**$ 3,693.60**	**$ 3,125.20**
Your savings if you have dental coverage		**44%**	**53%**

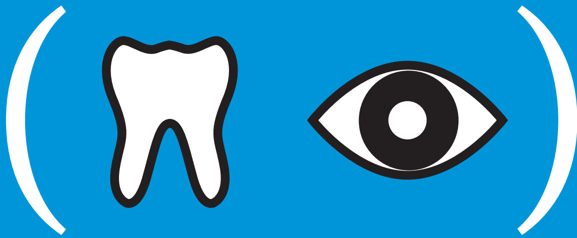
* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval.

6 The dental rates are based on a 90% average of fees charged in San Francisco as reported in 2012 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[6]	Specialty Duo* package member out-of-pocket costs ($54.10 x 12 months)
Annual individual premium	$ 0.00	$ 649.20
Annual dental exam, teeth cleaning, and X-rays	$ 404.00	$ 0.00
6-month dental care follow-up	$ 219.00	$ 0.00
Vision exam	$ 73.00	$ 0.00
Lenses	$ 75.00	$ 25.00
Frames	$ 100.00	$ 0.00
Your total cost	**$ 871.00[6]**	**$ 674.20**
Your first-year savings		**$ 196.80**

* 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 2012 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 contracted general care and specialty dentists in more than 26,000 provider locations in California[4]
- 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[10]
- 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[11]

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.

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.

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)[11]

Description	**With network dentists, you pay:**	**With non-network dentists, we pay up to:**[12]
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[13]	$ 0.00	100% of charge

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

Major services[10]
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:**[12]
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[10]
Keep your teeth healthy.

Description	With network dentists, you pay:	With non-network dentists, we pay up to:[12]
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[10,14]
For straighter teeth and a winning smile.

Description	With network dentists, you pay:	With non-network dentists:[12]
Fully banded (two-year) case – child	$ 2,350.00[15]	Not covered
Fully banded (two-year) case – adult	$ 2,650.00[15]	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 6,000 contracted vision care provider locations in California,[4] including retail chains open on evenings and weekends, plus access to eyewear online 24/7 at My2020EyesDirect.com
- No copayment for eye exams
- Choice of network or non-network vision providers
- A $25 copayment for materials
- 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.

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.

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
Comprehensive examination – every 12 months		
Ophthalmologic	100%	Up to a maximum of $60
Optometric	100%	Up to a maximum of $50
Lenses[16,17] – every 24 months (or 12 months with a prescription change)		
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
Frame – every 24 months	Up to a maximum of $100[18]	Up to a maximum of $40
Contact lenses[17,19] – every 24 months (or 12 months with a prescription change)		
Non-elective (medically necessary)[20]		
• 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
Plano (non-prescription) sunglasses[19,21]	Up to a maximum of $100[18]	Not covered
Diabetes management referral[22]	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*,[23]

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 contracted general care and specialty dentists in more than 26,000 provider locations California[4]
- 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 for diagnostic and preventive serivces; there is a three-month waiting period for minor restorative 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
- No coverage for major services
- A $25 deductible per member, per calendar year
- A $500 per member, per calendar-year benefit maximum[11]

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

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.

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

23 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.

Calendar-year deductible (per member)	$25 per person
Calendar-year benefit maximum	$500[11]

Description	**With network dentists, you pay:**	**With non-network dentists, we pay up to:[24]**
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[25]	$ 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:[24]**
One-surface composite (filling)	$ 37.00	$ 30.00
Two-surface composite (filling)	$ 56.00	$ 44.00

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

24 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.

25 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.** 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 to over 10,000 contracted dental provider locations in California[4]
- 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[26]
- Virtually no claim forms

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.

26 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:[27]
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:[27]
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:[27]
Crown (porcelain fused to noble metal)	$ 300.00[29]
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[29]
Bridge retainer – porcelain fused to high noble metal (per unit)	$ 300.00[29]
Complete denture (upper or lower)	$ 400.00
Removal of impacted tooth (complete bony)	$ 125.00

Orthodontics[26,28]
For straighter teeth and a winning smile.

Description	You pay:[27]
Fully banded (two- year) case – child	$ 2,350.00[15]
Fully banded (two- year) case – adult	$ 2,650.00[15]

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

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

27 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.

28 Orthodontic services have a fixed patient copayment.

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

Apply today

Effective March 1, 2013

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	$ 54.10	$ 41.40	$ 23.50	$ 19.80
Adult and spouse/ domestic partner	$ 112.20	$ 83.90	$ 46.30	$ 39.30
Adult and child	$ 82.10	$ 62.70	$ 35.50	$ 34.80
Adult and children	$ 122.00	$ 93.40	$ 53.10	$ 40.60
Family	$ 190.20	$ 145.60	$ 82.60	$ 76.50

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

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 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.
Please include first month's dues/premium to avoid a return of the application.

You are eligible for any Individual and Family Plan (IFP) dental plan or the dental + vision package if you are a California resident at the time of enrollment. If you had a Blue Shield IFP 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 the Blue Shield dental plans. Blue Shield will not approve concurrent enrollment in two Blue Shield IFP dental plans. If you enroll in any HIPAA guaranteed-issue plan, you are not eligible for a dental plan or the dental + vision package.

Part 1 – Coverage, plan, and applicant information

Reason for application: ☐ New enrollment ☐ Plan transfer ☐ Add dependent family member to existing coverage

Dental plan or dental + vision package: (please check one below)
☐ Value Smile PPO*† ☐ Specialty Duo (dental + vision) package*† ☐ Dental PPO ☐ Dental HMO
Requested effective date: ____________________ **Dental HMO applicants only** – please choose a dentist from the Provider Directory at **blueshieldca.com**, or call **(800) 431-2809** for assistance.
Dental HMO provider name: ____ Dental HMO provider number: ____________________________________

Applicant information

Applicant Social Security number	Gender: ☐ Male ☐ Female	Date of birth (mo/day/yr) / /	Married: ☐ Yes ☐ No Domestic partnership: ☐ Yes ☐ No
First name	MI	Last name	
Do you currently have dental coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Dental subscriber number (if applicable)	
Do you currently have medical coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Medical subscriber number (if applicable)	
Do you currently have vision coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Vision subscriber number (if applicable)	
Applicant business phone number	Applicant home phone number	Applicant fax number	Applicant cell number
Applicant home address (NO P.O. box)		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	
Email address	Best time to contact by phone ☐ AM ☐ PM		

Preferred method of contact (check one): ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other ________________________________

Part 2 – Dependent information

List all dependent family members you wish to cover (dependent children must be under age 26).

1. ☐ Spouse ☐ Domestic partner (check 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) / /

* Pending regulatory approval.
† Underwritten by Blue Shield of California Life & Health Insurance Company.

An independent licensee of the Blue Shield Association C36143-FF (7/12)

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/package. 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 month's dues/premium:** Blue Shield requires first month's dues/premium at the time of application submission. Find your estimated monthly dues/premium in the rate book provided to you. Refer to part 4 and 5 for details on payment options. Failure to submit full payment of dues/premium will result in a return of your application. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If your application is not approved, the dues/premium you submit with your application will not be processed. If you include a check, it will be destroyed. If you complete the payment authorization form, your credit card or checking account will not be debited.
3. **Dues/premium:** Dues/premium are to be paid by the due date. Coverage will be terminated for failure to pay dues/premium in a timely manner as set forth in the *Evidence of Coverage* and Health Service Agreement/Policy.
4. **Effective date of coverage:** If your application is approved, Blue Shield will notify you in writing of your effective date of coverage. If Blue Shield cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible. If additional dues/premium are owed, payment must be received within the time specified in the notice from Blue Shield to be enrolled. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of application:** You understand that only Blue Shield can accept your application and approve coverage. Your agent or broker cannot approve this application for coverage or change any terms or conditions of coverage.
6. **Parents/guardians:** If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 3. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premium payments and for the following terms and conditions for coverage. If you are not the parent of the applicant, please attach court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):

☐ Parent or legal guardian ______________________________ (include name and relationship); or
☐ My designee ______________________________ (include name and relationship); or
☐ Qualified medical child support order designee ______________________________ (include name and relationship); or
☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.

7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**
8. **HIV or genetic testing prohibited:** No genetic information, including family medical history, and no information related to HIV testing should be provided. 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/parent or legal guardian	___/___/___ Today's date (required)	Print name (and your relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	___/___/___ Today's date (required)	Print name
Signature of family member age 18 or over (if applying)	___/___/___ Today's date (required)	Print name
Signature of family member age 18 or over (if applying)	___/___/___ Today's date (required)	Print name
Signature of family member age 18 or over (if applying)	___/___/___ Today's date (required)	Print name

Producer information

Producer number	Telephone number	Fax number
Email address		
Producer address		
City	State	ZIP code
Super producer name	Super producer number	

Do you want the *Evidence of Coverage* and Health Service Agreement/Policy sent directly to the subscriber? ☐ Yes ☐ No

Producer signature (required)	/ / Today's date (required)	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:

Installation and Membership
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: **(209) 367-6490**

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

Part 4 – Billing and payment information

Calculate estimated monthly dues/premium

- Using the rate book provided to you, calculate your estimated rates or talk to your agent to get estimated rates.
- First month's dues/premium are required at the time of application submission. You can enroll in Easy$Pay[SM] where automatic payments are handled via electronic transfer through your checking or savings account for the first month's dues/premium and for ongoing payments. You can also pay the first month's dues/premium via electronic check by completing section C on the Payment Authorization form or you can staple a personal check or money order to your application in an amount equal to the dues/premium for one month, payable to Blue Shield. If paying first month's dues/premium by credit card, please fill out section B of the Payment Authorization form.

Easy$Pay automatic payment option

To sign up for automatic payments, complete section A of the Payment Authorization form and return it with your application. You must provide the routing/transit number of your financial institution or staple a deposit slip or blank check marked "VOID CHECK" to your authorization form.

Mary Jane Blue
123 First St.
Anytown, CA 99999
3025
20___
Pay to Order of
VOID CHECK
Dollars
Any Bank
San Francisco Main Office
P.O. Box 8944
San Francisco, CA 94126
Memo
032056884 9 8707228001 0233
Bank account number
Bank routing/transit number

Part 5 –Payment Authorization form

(Dues/premium payment is required with your application. Please select Option 1 or 2.)

☐ **Option 1:** Automatic payment through checking or savings account – Easy$Pay for initial and ongoing payments (complete section A below)
☐ **Option 2:** Please choose one of the options below for both: 1) your initial payment, and 2) for ongoing payments

Initial payment with application:
☐ By check
☐ By credit card (complete section B)

Ongoing payments:
☐ By automatic payment through checking or savings account – Easy$Pay (complete section A)
☐ Monthly billing ☐ Quarterly billing

Applicant information

Applicant name		
Mailing address		Apt. No.
City	State	ZIP code
Applicant's daytime phone number		

Method of payment

A. Easy$Pay debit: ☐ Checking account ☐ Savings account

Payment date: ☐ 1st of month ☐ 15th of month (Note: If you do not select a payment date, the default will be 1st of the month. Dental HMO must use 1st of the month.)

Payment frequency: ☐ Monthly

Bank routing/transit number

Bank account number

Name(s) on bank account

Name of financial institution

Branch address

City	State	ZIP code

Branch telephone number

B. Credit card (Visa or MasterCard only) – For initial payment only

Cardholder name

Cardholder billing address	Apt. No.

City	State	ZIP code

Credit card number

Card type: ☐ Visa ☐ MasterCard	Expiration date (mm/yyyy) _____/_________

If paying first month's dues/premium by credit card, the estimated first month's payment is:* $ __________

* This is only an estimate of monthly dues/premium. Blue Shield will provide notice of actual monthly dues/premium if my application for coverage is accepted. All dues/premium must be received prior to the original effective date for coverage to be in effect.

Authorization and signature(s)

Automatic payment by debit from checking/savings account:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date (or within 2 to 3 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

Additional information if paying initial dues/premium only by credit card:
If only the first month's dues/premium box is checked, this authorization is only valid to charge the first month's dues/premium owed to Blue Shield. I understand my credit card will be charged for the estimated first month's dues/premium immediately upon receipt of my application; however, this payment does not constitute approval of my application, and if my application is accepted, a different rate may apply. If I am accepted at a different rate, the difference in dues/premium must be paid prior to the original effective date of coverage. Blue Shield will not automatically charge the difference in rate owed to the credit card without a separate authorization from the applicant.

Notice to change/cancel required:
I will continue to be debited/charged the amount of dues/premium owed until I cancel this automatic payment authorization upon at least 10 calendar days' notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 431-2809**. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form (if the bank account is a joint account, all account holders must sign) and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Cardholder/Account holder signature

Print Name

Social Security number

Date

Cardholder/Account holder signature

Print Name

Social Security number

Date