BlueChoice Dental for Individuals and Families

BlueCross BlueShield of Georgia

For dental benefits you can smile about

Why dental care is important to your overall health

You've probably heard that dental health is an important part of overall health. But consider this: if a patient is suffering from periodontal disease, they are twice as likely to have heart disease or a stroke.[1] And there's also research linking poor oral health to diabetes, lung disease and premature births.[2]

Fortunately, regular dental check-ups can help detect the early warning signs of certain health-related issues. That's just one reason why it's so important to take good care of your teeth and gums. And a BlueChoice Dental plan from Blue Cross and Blue Shield of Georgia can help make it easy and affordable.

[1] American Academy of Periodontology: Gum Disease Links to Heart Disease and Stroke, perio.org, 2008.
[2] National Institute of Dental and Craniofacial Research: Oral Health in America, 2008

What BlueChoice Dental coverage helps pay for

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

BlueChoice Dental benefits-at-a-glance

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

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

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

*Subject to change

DIAGNOSTIC AND PREVENTIVE CARE

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

Notes for Diagnostic and Preventive Care

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

BASIC DENTAL CARE

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

Notes for Basic Dental Care

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

MAJOR DENTAL CARE

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

Notes for Major Dental Care

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

How to apply for coverage

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

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

Mail your completed application to:

Blue Cross and Blue Shield of Georgia
3350 Peachtree Road, N.E.
GAG008-0005
Atlanta, GA 30326

If you have any questions or need help with your application, talk to your Blue Cross and Blue Shield of Georgia representative or call us at 888-209-7852.

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

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

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BlueCross BlueShield of Georgia

Individual/Family Dental Plan Enrollment Application

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

MEMBER ID NO.

FOR BCBSGA USE ONLY:

DCN #

Billing Type

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

Applicant Information - Applicant must complete this section.

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

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

Home Address (*Must be complete. P.O. Box not acceptable)*

City | State | Zip Code

Billing Address (*If different or P.O. Box)*

City | State | Zip Code

Spouse to Be Insured - Signature required below.

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

Children to Be Insured - Signature required below.

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

Signatures (Required)

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

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

Agent Information

Name of Agent (Print)	Agent Number	Signature of Agent	Today's Date
Steven McClelland	408175	X	

Rep No. 11696

FOR BCBSGA USE ONLY

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

Area	By	Date

Checking Account Automatic Premium Payment for Individual Plans

As a Blue Cross and Blue Shield of Georgia member, you have the opportunity to pay your premiums directly form your checking account.

This service provides you the following advantages:

- No bills to pay or checks to write
- Avoid cancellation of coverage for non-payment of premiums

NOTE: Your premium will be automatically deducted between the 5th and 10th of each month from the checking account provided below.

Instructions

Please complete the information below and FAX it to us at **800-327-9255**. Or, if you prefer, mail it to us at the following address:

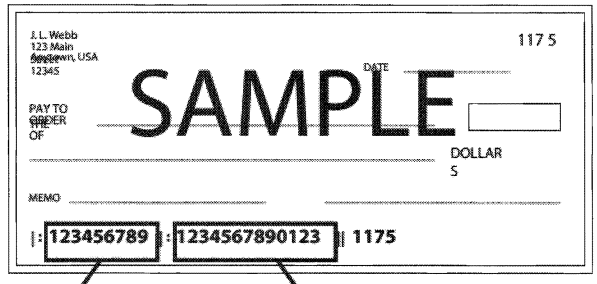
Blue Cross and Blue Shield of Georgia
P.O. Box 4445, Atlanta GA 30302, Attn: GAG008-0005

NOTE: We need 30 days advance notice to change or delete the automatic withdrawal information.
We value this opportunity to serve you. If you have any questions, please call Customer Service at the number listed on the back of your card.

Monthly Checking Account Automatic Premium Payment Authorization

By providing your check information below, you authorize Blue Cross and Blue Shield of Georgia to electronically debit your bank account.

Name of Policyholder	Member's ID or Social Security No.
Contact Phone Number Daytime phone ( )	
Evening phone ( )	



NOTE: We do not accept Savings Account as a form of Automatic Payment.

Provide your Bank Name, Routing and Account numbers here

Bank Name	Bank Routing No.	Bank Account No.

As a convenience to me, I request and authorize Blue Cross and Blue Shield of Georgia to pay and charge to my account checks drawn on that account by and payable to the order of Blue Cross and Blue Shield of Georgia provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. I agree that Blue Cross and Blue Shield of Georgia's right in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Blue Cross and Blue Shield of Georgia to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross and Blue Shield of Georgia premiums. This authority is to remain in effect until revoked by me by providing a 30-day written notice. I agree that Blue Cross and Blue Shield of Georgia shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, where with or without cause and whether intentionally or inadvertently, Blue Cross and Blue Shield of Georgia shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed monthly. You may incur a service charge for any withdrawal not honored.

Authorized Signature (as is appears in the financial institution's records	Account Holder Name PRINT	Date
X		

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Fax Cover Sheet

To: Health Plans of Georgia

Fax #: 770-271-4012

Please accept my completed application and contact me to confirm receipt.

Name: _____

Email: _____

Phone: _____