

Regence Life and Health Insurance Company

# Dental coverage for the way you live

**Discover two new dental plans:**  
Individual Dollar-Based Dental  
Individual Incentive Dental

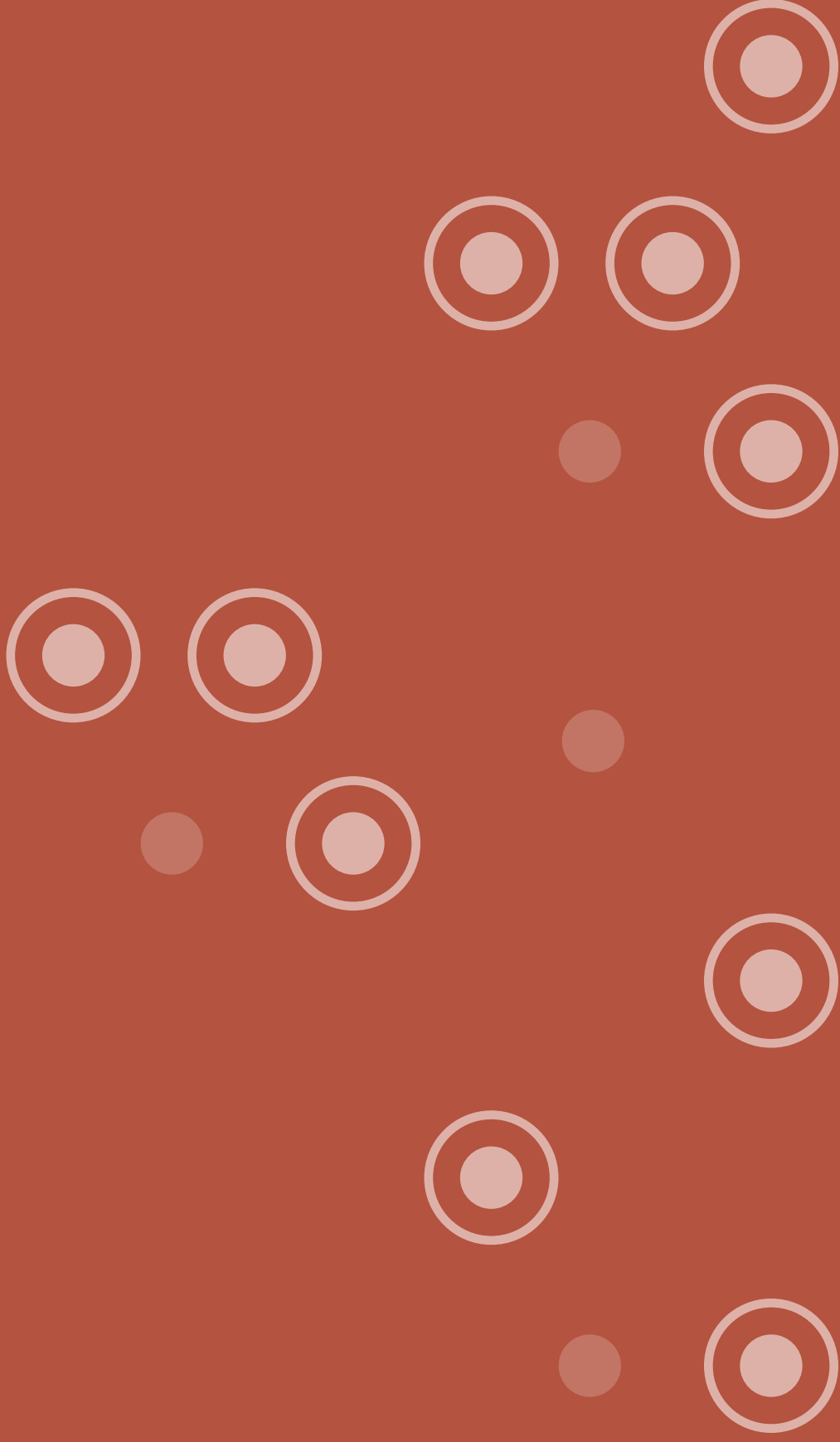


**Regence**

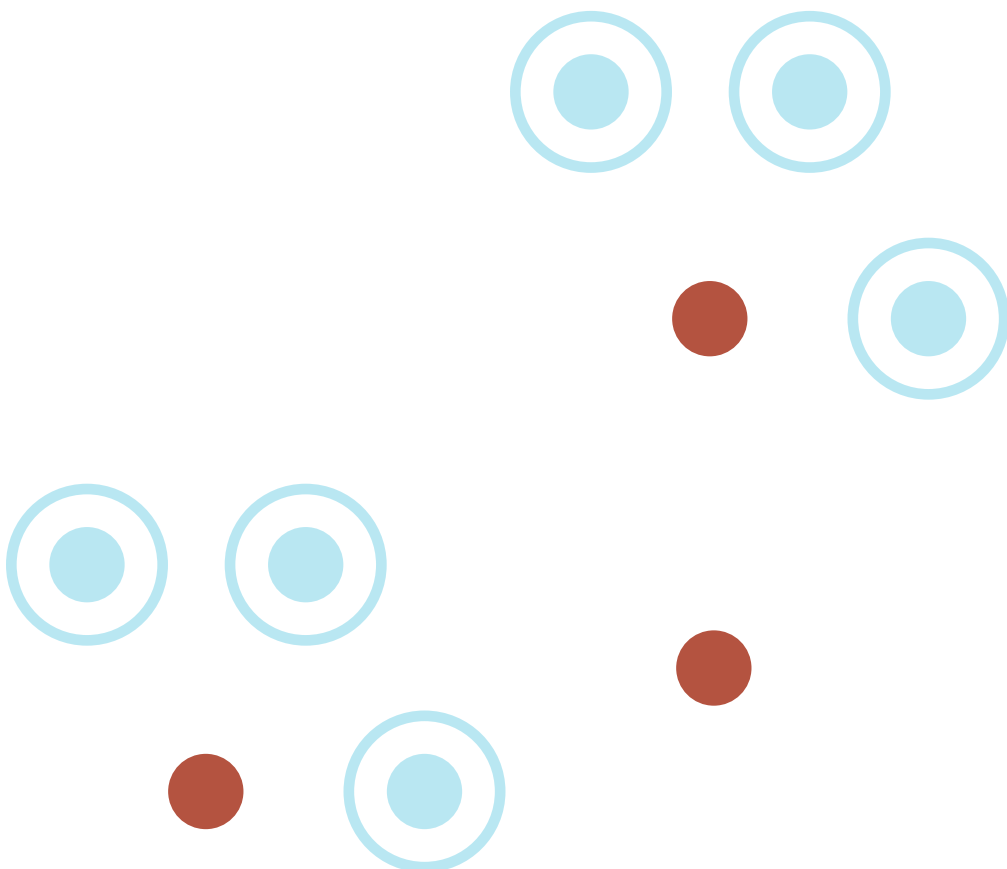
*Life and Health Insurance Company*

Independent Licensee of the Blue Cross and Blue Shield Association

**Dental health is essential to  
maintaining overall health.**



**You know it's important to receive an annual dental checkup and cleaning, but you also want the freedom to make choices about your care. That's the inspiration behind two new, innovative dental plans. As you are proactive with your health, you are rewarded with increased dental coverage.**





# Dental done your way

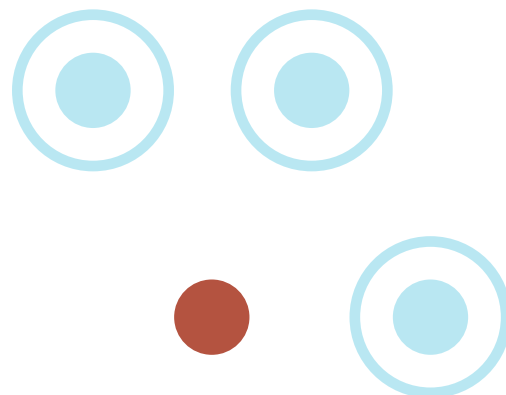
Take care of yourself and watch your benefits grow

## Individual Dollar-Based Dental

puts you in control of your dental health dollars. The plan is *dollar-based*. This means you can use your coverage almost any way you choose, with few exclusions and limitations. Each year you visit the dentist for an exam and cleaning, you are rewarded with a benefit increase the following year.

## Individual Incentive Dental

is a more traditional plan, but unlike traditional dental plans you are rewarded for receiving routine preventive care. Each year that you visit the dentist for a checkup and cleaning, means greater benefits and less out-of-pocket expenses the next year.



# Choose the plan that's right for you and your family

## Individual Dollar-Based Dental

Spend your benefit dollars on care that's important to you and your family. Include a routine exam and cleaning and watch your benefits grow in the next year.

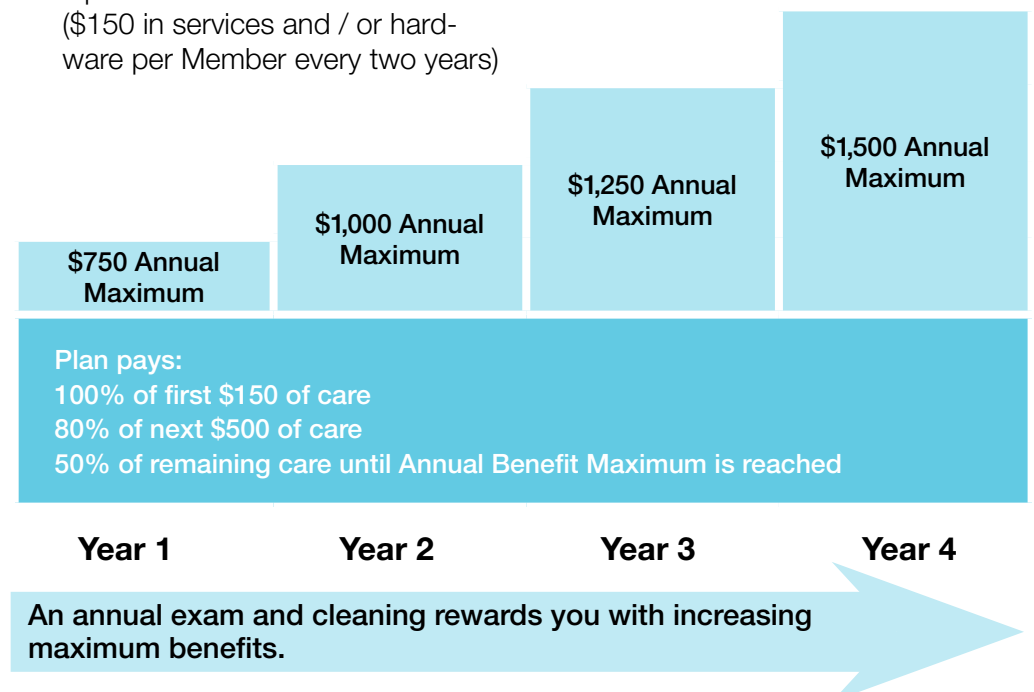
### Plan features:

- You decide how to spend your benefit dollars
- No deductibles
- No limitations or exclusions for covered services (orthodontia, teeth bleaching and veneers are not covered services)\*
- Choose any dentist, but save even more by using one of our network providers
- Optional Vision rider available (\$150 in services and / or hardware per Member every two years)

### Here's how it works:

Each year that you take advantage of an annual checkup and cleaning, the benefit dollars available to you increase. The goal is to reach \$1,500 in available benefits by year four. Every year the plan pays: 100% of the first \$150 of care, 80% of the next \$500 of care, and 50% of remaining care until you reach your annual maximum benefit. There is a six month waiting period for all covered services on this plan.

*\* This plan excludes aesthetic and orthodontic dental services.*





## Outline of Coverage

### Individual Dollar-Based Dental

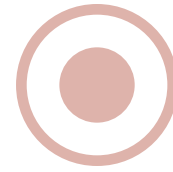
#### Covered Services

Covered Services are those services or supplies that are required to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues and are Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of his or her license.

#### Exclusions

Your policy does not cover:

- Bleaching of teeth
- Labial veneers
- Orthodontic services, including craniomandibular orthopedic treatment; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures; and other orthodontic treatment.
- Expenses payable by motor vehicle insurance or other liability insurance coverage
- Work-related injuries



## Individual Incentive Dental

Imagine dental coverage that increases as you are proactive about visiting the dentist. That's the idea behind Individual Incentive Dental—offering financial rewards for an annual checkup and cleaning.

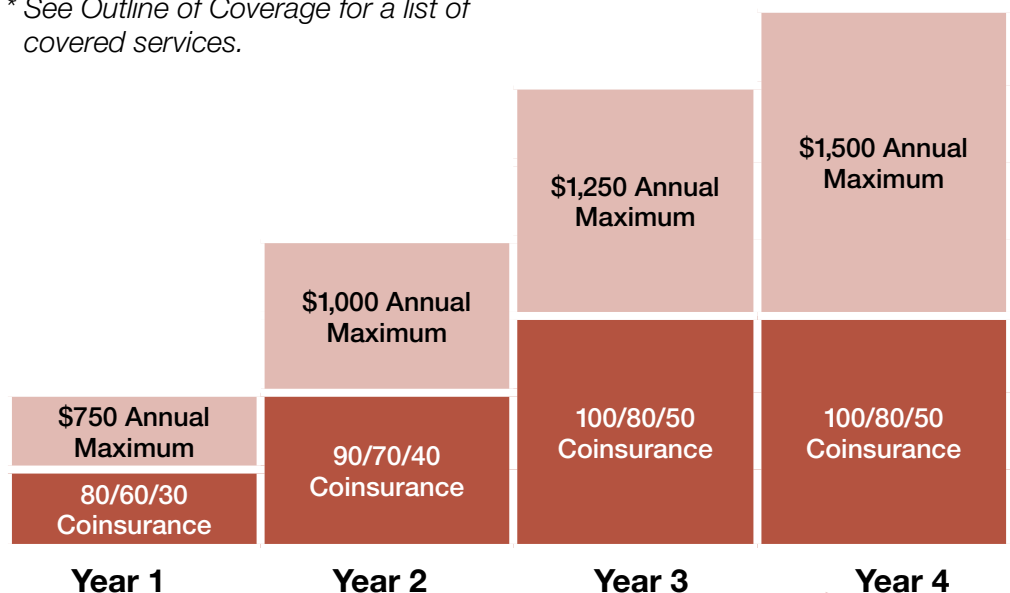
### Plan features:

- No waiting period
- Deductible waived for exams and cleanings
- \$50 deductible for other covered services\*
- Choose any dentist, but save even more by using one of our network providers
- Optional Vision rider available (\$150 in services and / or hardware per Member every two years)

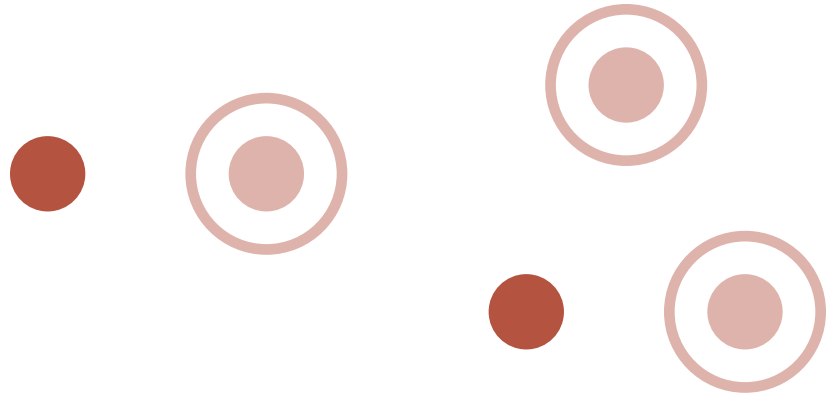
\* See *Outline of Coverage* for a list of covered services.

### Here's how it works:

Have your teeth cleaned and examined every year and get rewarded with greater benefits the next year. Watch your annual benefits increase and your out-of-pocket expenses for co-insurance decrease. By year four, you can reach a maximum annual benefit of \$1,500. And the percentage the plan pays in coinsurance increases to 100/80/50 by year three. This means we will pay 100% of preventive care, such as routine cleanings; 80% of restorative care, such as fillings; and 50% of major dental care like crowns or root canals.



An annual exam and cleaning rewards you with lower costs for dental care and increasing maximum benefits.



## Outline of Coverage

### Individual Incentive Dental

#### Covered Services

Covered Services are those services or supplies that are required to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues and are Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of his or her license.

Subject to the limitations and conditions described in the policy, the following will be considered covered services under your policy:

#### Preventive and Diagnostic Services

- Cleanings, limited to 2 per benefit year in lieu of periodontal maintenance. Periodontal maintenance is covered under major services.
- Oral exams allowed, two per benefit year
- Fluoride Treatment allowed two applications per benefit year for members age 17 and under
- X-ray bitewings: allowed one set limited to twice per benefit year, panoramic and full mouth series: limited to once every three years

- Sealants allowed for permanent bicuspid and molars for members age 17 and under
- Space Maintainers allowed for members age 11 and under

#### Restorative Services

- Fillings, composite and amalgam
- Emergency treatment for pain relief only
- Oral surgery including surgical extractions, removal of teeth, biopsies and incision and drainage
- General anesthesia or intravenous sedation allowed for surgical extractions of teeth and for members age 6 and under
- Direct pulp capping

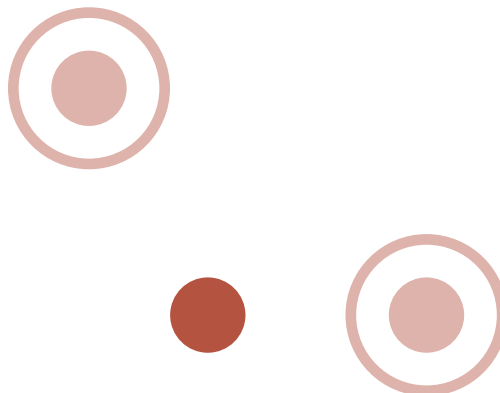
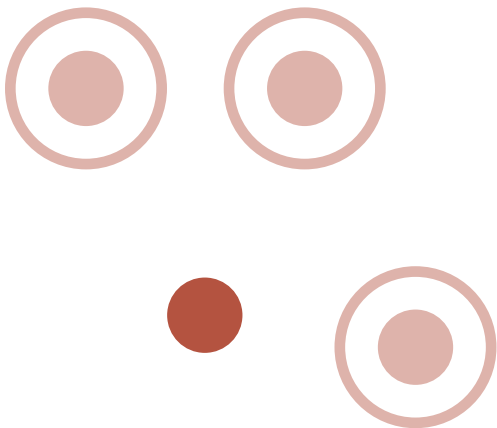
## Outline of Coverage cont.

### Individual Incentive Dental

#### Major Services

- Crowns or onlays and related services
- Bridges (fixed partial dentures)
- Dentures (full or partial) and related services
- Endosteal Implants and related services; implants are limited to four per lifetime per member
- Endodontics including root canal treatment, pulpotomy, apicoectomy
- Periodontal maintenance, limited to 2 per benefit year in lieu of preventive cleaning.
- Scaling and root planing allowed once every two years per quadrant
- Debridement allowed once every three years
- Gingivectomy and gingivoplasty allowed once every three years per quadrant
- Osseous and mucogingival surgery allowed once every five years per quadrant

Replacement of prosthetics is limited to replacements made at least seven years from the most recent placement; limited to once in a seven year period.



## Exclusions for Individual Incentive Dental Only.

Your policy does not cover:

- Additional procedures to construct new crown under existing partial denture framework
- Application of desensitizing resin for cervical and/or root surface
- Bleaching of teeth
- Collection of cultures and specimens
- Connector bar or stress breaker
- Cosmetic/Reconstructive Services and Supplies (certain exceptions apply)
- Diagnostic casts or study models
- Duplicate x-rays
- Endodontic endosseous implants
- Exfoliate cytology sample collection or brush biopsy
- Expenses payable by motor vehicle insurance or other liability insurance coverage
- Fees, Taxes, Interest
- Gold foil restorations
- Hospitalization for dentistry
- Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis
- Incision and drainage of abscess extraoral soft tissue, complicated or non-complicated
- Indirect pulp capping
- Interim partial or complete dentures
- Labial veneers
- Local anesthesia, sterilization, and supplies billed as separate charges (these procedures are considered inclusive of billed procedures)
- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue per tooth
- Maxillofacial prosthetic procedures
- Military Service Related Conditions: any condition resulting from military service in the armed forces of any country
- Modification of removable prosthesis following implant surgery
- Nitrous oxide
- Occlusal analysis and adjustments
- Occlusal guards
- Oral hygiene instructions
- Oral/facial photographic images
- Orthodontic services, including craniomandibularorthopedic treatment; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures; and other orthodontic treatment
- Pediatric dentures
- Pin retention in addition to restoration
- Precision attachments
- Prescription drugs, including take home prescription drugs, pre-medications, therapeutic drug injections, or supplies
- Provisional splinting
- Pulp vitality tests
- Radical resection of maxilla or mandible
- Radiographic/surgical implant index
- Removal of nonodontogenic cyst, tumor or lesion
- Replacement of lost, stolen or broken dental appliances
- Self-Help, Non Dental Self Care, Training, or Instructional Programs
- Services and Supplies provided by a Family Member: services and supplies provided to a member by an immediate family member
- Surgical procedures for isolation of a tooth with rubber dam
- Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
- Treatment of simple or compound fractures of the mandible
- Treatment of Temporomandibular Joint Dysfunction
- Unspecified implant procedures
- Work related injuries

**For quick, easy enrollment, visit our Web site:  
[www.regencelife.com](http://www.regencelife.com)**

**To learn more, call toll-free:  
1-888-REGENCE (1-888-734-3623)**



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**To choose the plan that's right for you, please see the following premium rates and applications for the *Incentive and Dollar-Based* dental plans.**

## INDIVIDUAL DENTAL RATES

**You may enroll for Dental Only Coverage or Dental with Vision Coverage.  
All members must be enrolled for the same coverage and premium payment schedule.**

<b>PREMIUM RATES FOR INCENTIVE DENTAL</b>		
<b>MONTHLY PREMIUM PER MEMBER</b>		
	<u>Dental Only</u>	<u>Dental &amp; Vision</u>
Under Age 18	\$27.94	\$30.55
18 through 64	\$33.66	\$38.28
65 and over	\$35.88	\$41.79
<b>QUARTERLY PREMIUM PER MEMBER</b>		
	<u>Dental Only</u>	<u>Dental &amp; Vision</u>
Under Age 18	\$83.82	\$91.65
18 through 64	\$100.98	\$114.84
65 and over	\$107.64	\$125.37

<b>PREMIUM RATES FOR DOLLAR-BASED DENTAL</b>		
<b>MONTHLY PREMIUM PER MEMBER</b>		
	<u>Dental Only</u>	<u>Dental &amp; Vision</u>
Under Age 18	\$24.66	\$27.27
18 through 64	\$44.99	\$49.61
65 and over	\$56.98	\$62.89
<b>QUARTERLY PREMIUM PER MEMBER</b>		
	<u>Dental Only</u>	<u>Dental &amp; Vision</u>
Under Age 18	\$73.98	\$81.81
18 through 64	\$134.97	\$148.83
65 and over	\$170.94	\$188.67

### HOW TO APPLY

- Choose the dental insurance plan that best meets your needs.
- Complete the application in full. Missing information may cause your effective date to be delayed. If you have more than four children, please attach a separate list.
- If you are enrolling a non-state certified domestic partner, please complete the attached affidavit.
- Calculate the premium. Indicate if you are enrolling for the Optional Vision coverage. Be sure to select a monthly or quarterly payment schedule. Include the applicable payment for the first month or quarter of coverage, according to the payment schedule you have selected.
- You may enroll for Child Only coverage. If you are enrolling children only, a separate application must be completed and submitted for each child.
- If you have any questions, please call 503-721-7161 or toll-free 1-800-794-5390.
- Send the application and your check or money order made payable to Regence Life and Health Insurance Company to:

Regence Life and Health Insurance Company  
PO Box 1271, MS E-3A  
Portland, OR 97207-1271

- Keep this brochure for your records.

### REFUNDS

If you are not satisfied with this Policy, you may return the policy within 10 days of delivery for a full refund of premium.

**Please note:** The policy fee of \$25 is non-refundable.

**Please read your policy carefully and keep it available for future reference.**



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100 SW Market Street  
 P.O. Box 1271 E-3A  
 Portland, OR 97207-1271  
 (503) 721-7161 • (800) 794-5390

## RENEWABLE INDIVIDUAL DENTAL INSURANCE APPLICATION (WITH OPTIONAL VISION RIDER)

**Please complete all information on this page and on Page 2.**

Applicant's Last Name*	Applicant's First Name	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Married / Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Single	Telephone Number (    )		Email Address
Home Address & Apt. No./Mailing Address			City	State    Zip

We are always searching for ways to better serve your needs. You can help us by answering the following questions.

1. Are you : <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	
2. How would you describe yourself in terms of your racial heritage? <input type="checkbox"/> African-American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Two or More Races	
You may choose to not answer this question	

<b>Requested Effective Date:</b> (Your requested effective date must be after your application date and within 60 days from the date the application is signed or a new application will be required.) <input type="checkbox"/> 1 <sup>st</sup> OR <input type="checkbox"/> 15 <sup>th</sup> of _____ (month) _____ (year)	
<b>Premium Payment Schedule:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<b>Amount of Payment Remitted With This Application</b> \$

**Dependents to be enrolled:** Dependent children must be under 23 years of age and primarily dependent on you for support.

Last Name	First Name	M	SS#	Birth Date	Sex	Relationship (Spouse or Child)
Same as above			Same as above	Same as above	M / F	Self
					M / F	
					M / F	
					M / F	
					M / F	

**Please list names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.**

**Other coverage information (This is not a waiver of coverage. This information is required for payment of claims.) Do you or any family members enrolling have other dental coverage?**  Yes  No

**If yes, provide the information regarding other coverage requested below.**

Name of Family Member with other coverage		Relationship	
Name of Insurance Carrier	Policy No.	ID No.	Carrier Phone No. (    )
Address of Other Carrier	City	State	Zip Code

Is the coverage of any dependent affected by a divorce decree/court order?  
 Yes  No If yes, please include portion of decree that shows responsibility for health expenses.

This plan covers:  Self     Spouse /Domestic Partner     Child(ren)     Stepchild(ren)     Other  
 Please list names:



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PREMIUM CALCULATION

You may enroll for Dental Only Coverage or Dental with Vision Coverage.

All members must be enrolled for the same coverage and premium payment schedule.

I am making application for: Incentive Dental Insurance [ ] Dollar-Based Dental Insurance [ ]
Add Vision Rider [ ] Yes [ ] No
Number enrolling in Dental Only: Under Age 18, Age 18 through age 64, Age 65 and over
Enter Monthly or Quarterly Dental Only Premium Rate
Number enrolling in Dental & Vision: Under Age 18, Age 18 through age 64, Age 65 and over
Enter Monthly or Quarterly Dental & Vision Premium Rate
Total Dental Only Premium \$ OR Total Dental & Vision Premium \$
PLUS Policy Fee of \$ 25.00 = Total Due \$ Enclosed With Application

I hereby apply for enrollment with Regence Life and Health Insurance Company under the Individual Dental Insurance plan.

I acknowledge and understand Regence Life and Health Insurance Company may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
a clinic, hospital, long-term care or other medical facility;
any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

DISCLOSURE: If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence Life and Health Insurance Company. Incentives may be based on any of several factors including the size of group business, the products you buy, your broker or agent's volume of business with Regence Life and Health Insurance Company and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

INSURANCE FRAUD WARNING: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date.

Insured's Signature, Parent's or Guardian's Signature, Date Signed, Agent Number, Licensed Agent's Name (Please Print)



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## AFFIDAVIT OF NON-STATE CERTIFIED DOMESTIC PARTNERSHIP

An Affidavit of Non-State Certified Domestic Partnership is required before any domestic partner benefits may be granted for non-state certified domestic partners. One affidavit may be used for any of the insurance benefits available to domestic partners.

**Name of Policyholder:** \_\_\_\_\_ **Policy & ID #:** \_\_\_\_\_

**Domestic Partner's Name:** \_\_\_\_\_ **Date Domestic Partnership Began** \_\_\_\_\_

I certify that \_\_\_\_\_ and I are domestic partners and that we meet the following criteria:  
Name of Domestic Partner

- We are each 18 years of age or older;
- We share a close personal relationship and are responsible for each other's common welfare;
- We are each other's sole domestic partner;
- We share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
- We are jointly financially responsible for "basic living expenses" including food, shelter, and medical expenses;
- We are not legally married to anyone, nor have had another domestic partner within the previous 30 days;
- We are not related by blood closer than would bar marriage in our state of residence; and
- We were both mentally competent to contract when our domestic partnership began.

### **CHANGE IN DOMESTIC PARTNERSHIP:**

I \_\_\_\_\_ agree to inform Regence Life and Health Insurance Company within 30 days  
Name of Policyholder  
of any change in our domestic partnership status that would make the domestic partner no longer eligible for benefits by filing a *Termination of Non-State Certified Domestic Partnership Statement*.

Upon termination or dissolution of this domestic partnership, the policyholder named herein agrees that he/she cannot file another affidavit for a minimum of 90 days from the date of termination.

### **ACKNOWLEDGEMENT:**

We understand that this information will be held confidential and will be subject to disclosure only upon express written authorization, in any action involving the enrollment or eligibility of the domestic partner, or if otherwise required by law. We understand that this declaration of responsibility for our common welfare may have legal implications under State law. We further understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from false or misleading statements contained in the Affidavit of Non-State Certified Domestic Partnership. We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct.

Policyholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Domestic Partner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Policyholder and Domestic Partner's Home Address:

\_\_\_\_\_ Address

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip

Return your signed Affidavit of Non-State Certified Domestic Partnership to Regence Life and Health Insurance Company. Your completed affidavit should accompany any necessary applications.