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

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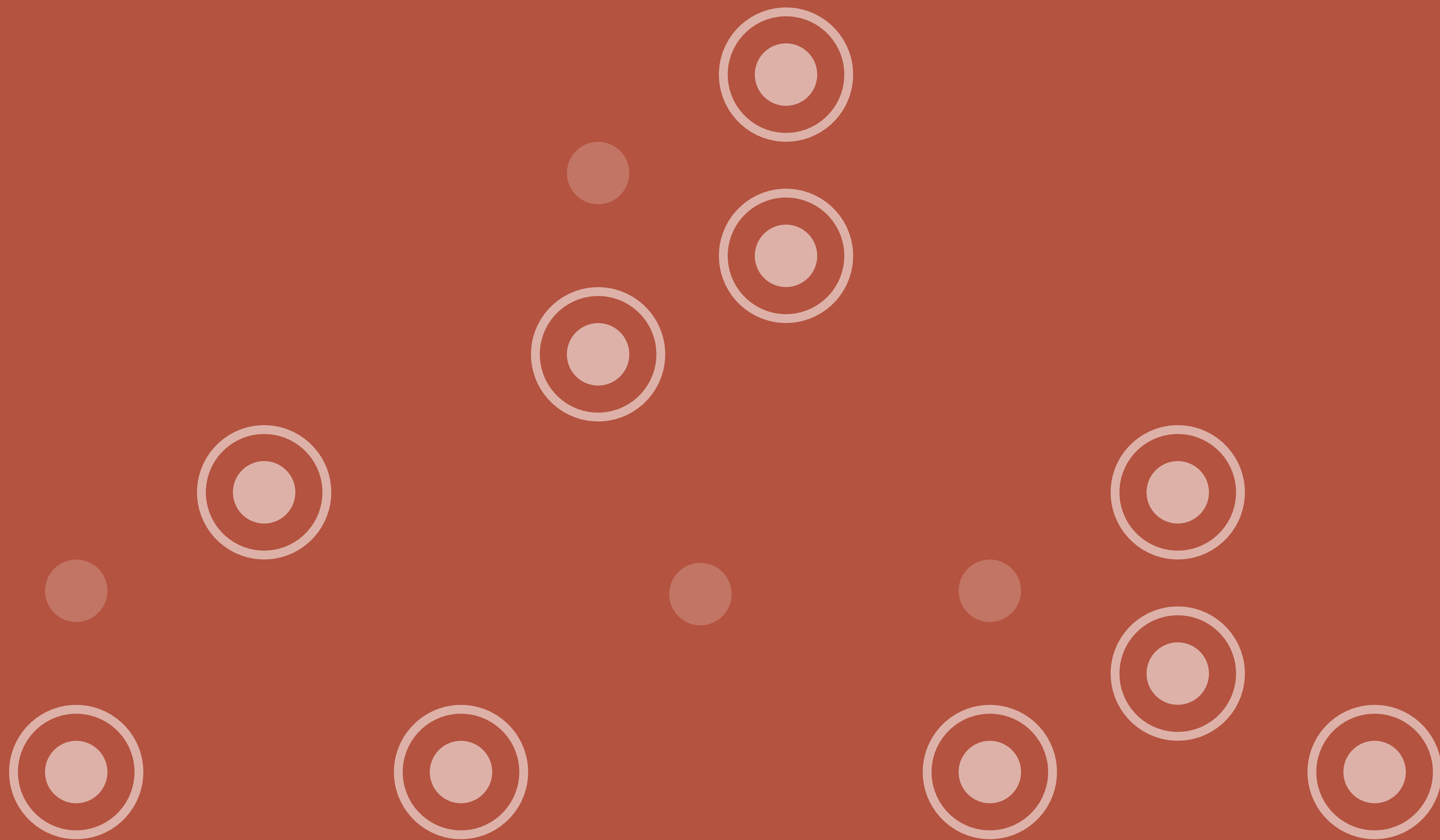
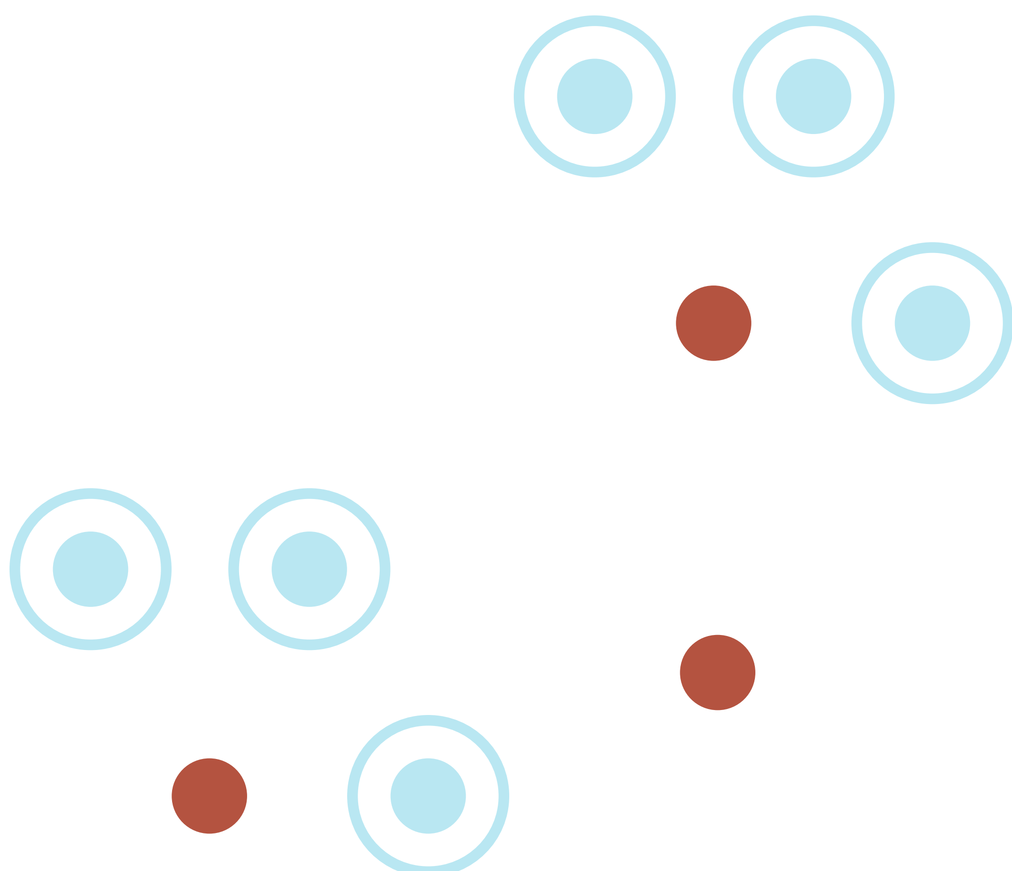
Dental health is essential to maintaining overall health.



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.

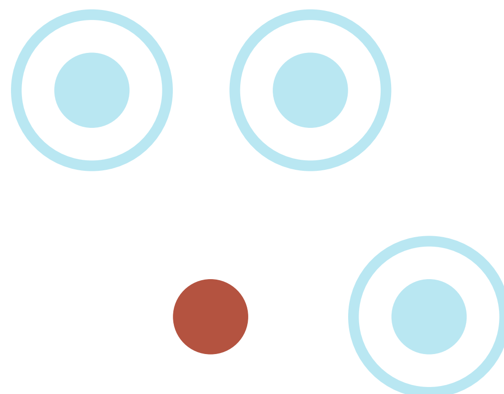


Dental done your way

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

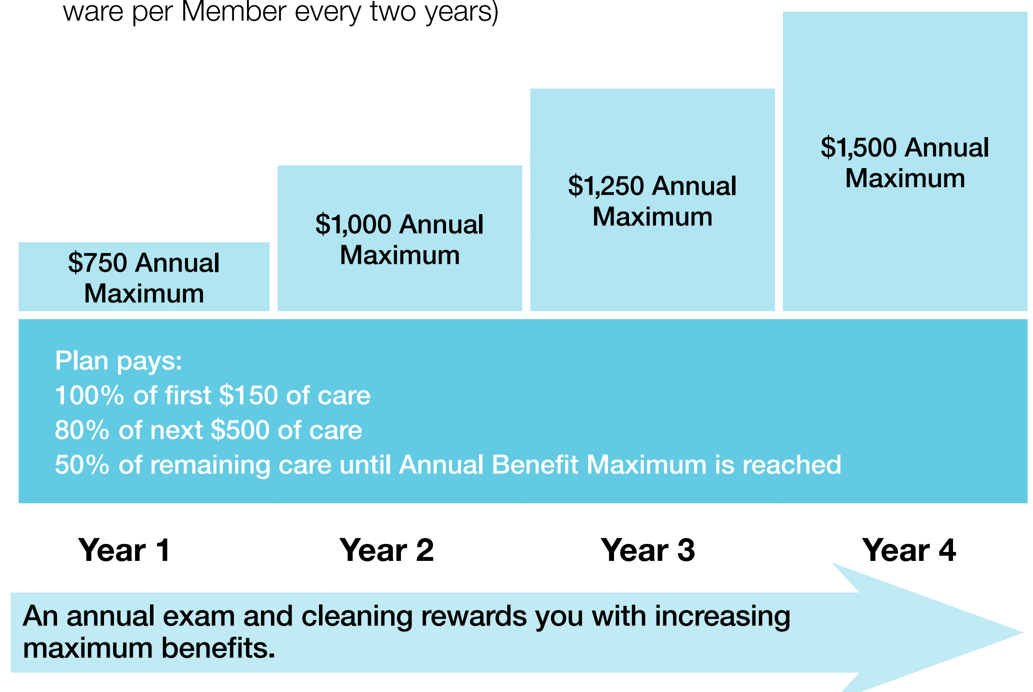
Spend your benefit dollars on care that's important to you and your family. Include a routine exam and cleaning and watch your benefits grow in the next year.

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 hard-ware 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.*



Individual Dollar-Based Dental

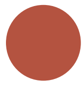
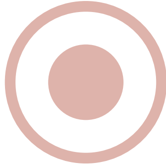
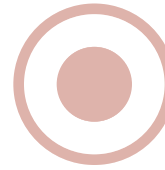
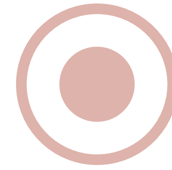
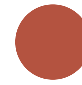
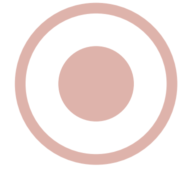
Covered Services

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

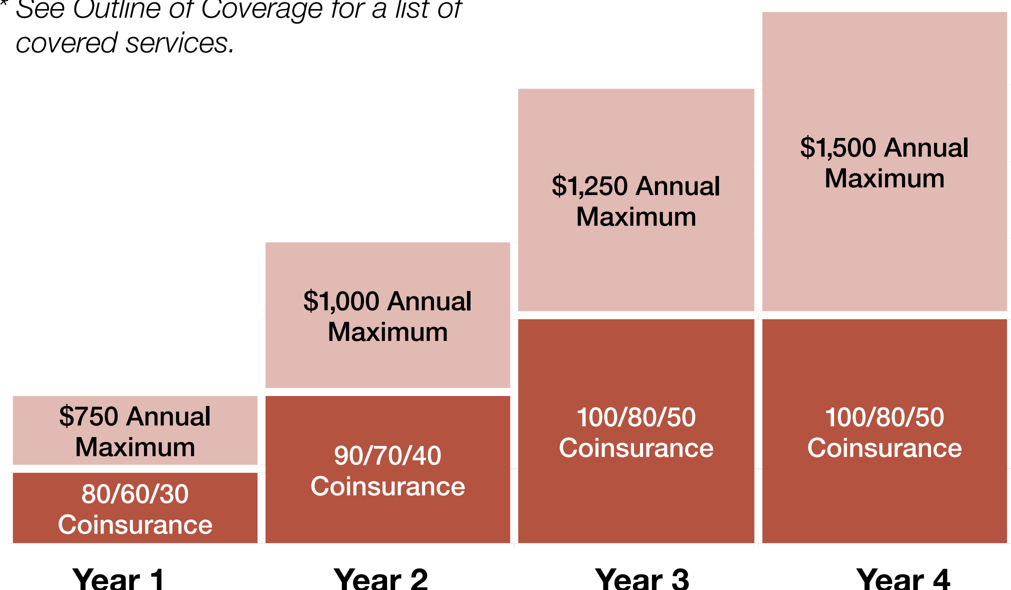
Imagine dental coverage that increases as you are proactive about visiting the dentist. That's the idea behind Individual Incentive Dental—offering financial rewards for an annual checkup and cleaning.

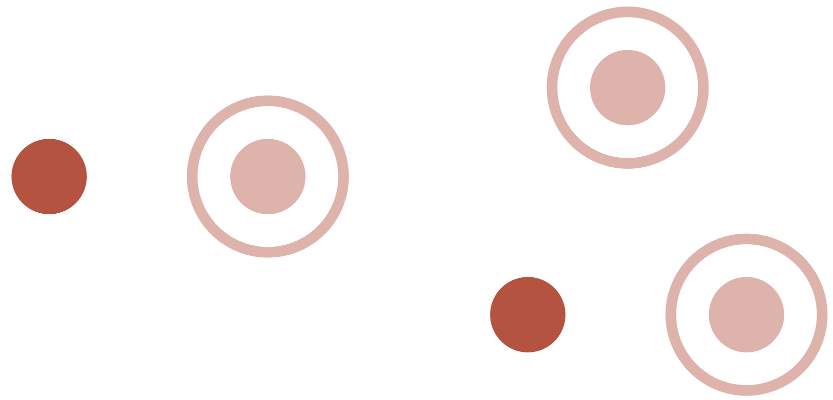
Plan features:

- 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.





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:

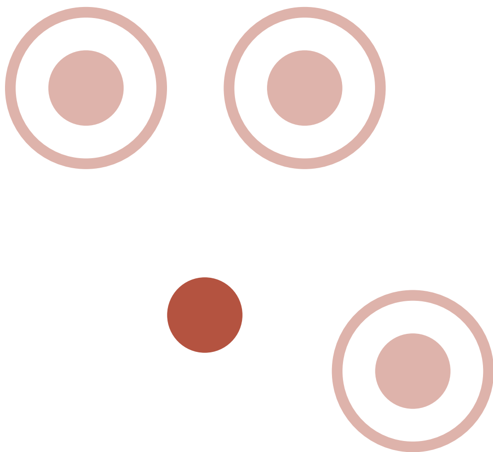
Preventive and Diagnostic Services

- Cleanings, limited to 2 per benefit year in lieu of periodontal maintenance. Periodontal mantenance are 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 bicuspids 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 members age 6 and under or members who are physically or developmentally disabled.
- Direct pulp capping

Outline of Coverage cont.

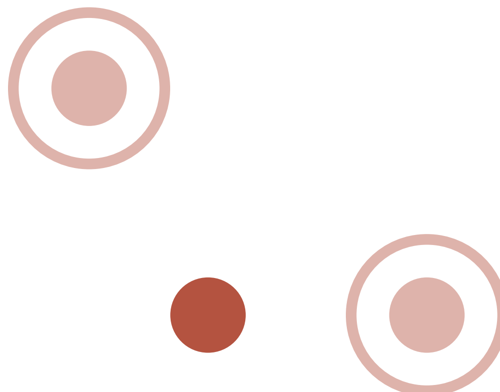


Individual Incentive Dental

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

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

www.regencelife.com

Regence

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association

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.

PREMIUM RATES FOR INCENTIVE DENTAL

MONTHLY PREMIUM PER MEMBER

	Dental Only	Dental & Vision
Under Age 18	$32.30	$34.91
18 through 64	$39.35	$43.97
65 and over	$42.60	$48.52

QUARTERLY PREMIUM PER MEMBER

	Dental Only	Dental & Vision
Under Age 18	$96.90	$104.73
18 through 64	$118.05	$131.91
65 and over	$127.80	$145.56

PREMIUM RATES FOR DOLLAR-BASED DENTAL

MONTHLY PREMIUM PER MEMBER

	Dental Only	Dental & Vision
Under Age 18	$25.40	$28.01
18 through 64	$46.05	$50.67
65 and over	$58.31	$64.22

QUARTERLY PREMIUM PER MEMBER

	Dental Only	Dental & Vision
Under Age 18	$76.20	$84.03
18 through 64	$138.15	$152.01
65 and over	$174.93	$192.66

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 registered 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. An additional ten percent penalty will be added to any premium refund due that is not paid within 30 days of return of the Policy to the insurer or agent.

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

Regence
Life and Health Insurance Company
Independent Licensee of the Blue Cross and Blue Shield Association.

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

Home Office Use Only	
ID #	
Eff. Date	
Vis. Rider ☐	EFT ☐

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.	☐ M ☐ F	Social Security Number
Date of Birth (mm/dd/yyyy)	☐ Married / Domestic Partner ☐ Divorced ☐ Single	Telephone Number ( )	E-mail 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 : ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
2. How would you describe yourself in terms of your racial heritage? ☐ African-American ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Caucasian ☐ Two or More Races

You may choose to not answer this question

Requested Effective Date: (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.) ☐ 1st OR ☐ 15th of __________ (month) _______(year) The Effective Date must be following or coinciding with the date We receive Your application. In no event may the Effective Date of this Policy be back-dated.

Premium Payment Schedule: ☐ **Monthly** ☐ **Quarterly** | **Amount of Payment Remitted With This Application** **$**

Dependents to be enrolled: Dependent children must be under 25 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:

If you are enrolling a non-state registered domestic partner, please complete the attached affidavit.

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Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

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: ☐ **Dollar-Based Dental Insurance** **NOTE:** This coverage has a **SIX (6) MONTH BENEFIT WAITING PERIOD**. The **BENEFIT WAITING PERIOD** is the continuous length of time the member must be covered under the Policy before becoming eligible for benefits.

☐ **Incentive Dental Insurance** **Add Vision Rider** ☐ Yes ☐ No

	Number enrolling in Dental Only		Enter Monthly or Quarterly Dental Only Premium Rate		
Under Age 18	___________	**Times**	$ _________________	=	$_________________
Age 18 through age 64	___________	**Times**	$ _________________	=	$_________________
Age 65 and over	___________	**Times**	$ _________________	=	$_________________

	Number enrolling in Dental & Vision		Enter Monthly or Quarterly Dental & Vision Premium Rate		
Under Age 18	___________	**Times**	$ _________________	=	$_________________
Age 18 through age 64	___________	**Times**	$ _________________	=	$_________________
Age 65 and over	___________	**Times**	$ _________________	=	$_________________

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

AFFIDAVIT OF NON-STATE REGISTERED DOMESTIC PARTNERSHIP

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

Name of Policyholder: ___________________________________ **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 Registered 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 Registered 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 Registered Domestic Partnership to Regence Life and Health Insurance Company. Your completed affidavit should accompany any necessary benefit enrollment forms.

Regence

Life and Health Insurance Company

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PRIVACY NOTICE

We, at Regence Life and Health, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. Because we endeavor to earn and keep your trust, we have long-standing privacy policies, robust training, and full-time staff dedicated to protecting privacy. We also maintain physical, administrative, and technical safeguards to protect your personal information from unauthorized access. Even if you are no longer a Regence member, we protect the confidentiality of your personal information as if you were.

Marketing

While other companies may sell or rent your contact information, Regence never sells or rents your personal information for marketing purposes. If you want Regence to share your personal information with a nonaffiliated third party so the third party can market to you, you must give us your express permission.

Your Personal Information

We collect personal information such as your name, contact information, health information, and financial information from you, your providers, and other insurers that provide coverage to you. We use this information to provide services to you and to conduct insurance transactions. You may receive a copy of your personal information by contacting us at the phone number or address below. We will not disclose your personal information unless we are permitted or required by law or you give your permission. As permitted or required by law, we may provide personal information to our affiliates and agents, reinsurers, insurance administrators, consultants, or regulatory and governmental authorities. We obligate entities receiving this information on our behalf to protect it in the same way that we protect it.

Changes to Our Practices

We may change our privacy practices in an effort to provide even better protection. If we change our privacy practices in a material way, we will notify current customers in writing.

Contact Us

If you have any questions about our privacy program, you may contact us at (800) 794-5390 or write to:

Regence Privacy Official
P.O. Box 1071, Mailstop E12B
Portland, OR 97207