A Family of Individual Dental Plans

We know oral health is important to you. That’s why we’re excited to offer Healthy Smiles, a family of individual dental plans that are flexible and affordable.

Each Healthy Smiles plan (Preventive, Plus, and Preferred) has something unique to offer. Here are a few items to keep in mind as you choose the plan that is best for you.

The Healthy Smiles Advantage

Healthy Smiles plans are preferred provider organization (PPO) plans, giving you the flexibility to choose your provider and a chance to save money by selecting from Blue Cross of Idaho’s network of contracting PPO dentists.

Blue Cross of Idaho’s PPO network includes dental providers in Idaho who agree to offer covered services at costs that are at or below established maximum allowances. In other words, visiting a dental provider in the Blue Cross of Idaho PPO network stretches your benefits dollars and saves you money!

If you choose a dental provider outside our PPO network, you may pay the difference between the provider’s charge and our maximum allowance, as well as any applicable copayment, deductible, and coinsurance.

Benefit Period Coverage Limit

Healthy Smiles Plus and Preferred plans provide coverage for up to $1,000 per member, per benefit period*. Healthy Smiles Preventive plan has no benefit period coverage limit!

*A benefit period is the twelve months following your coverage effective date.

Copayment

All Healthy Smiles dental plans cover 100% of the maximum allowance for in-network preventive dental services after a $20 copayment per visit.

Deductible

There is an individual deductible of $50 per member per benefit period. The deductible does not apply to in-network preventive dental services. The benefit period family deductible is satisfied after three family members meet their individual deductible.

Healthy Smiles Preventive

Healthy Smiles Preventive covers preventive dental services with no maximum limits, no in-network deductibles and no waiting periods. Because Blue Cross of Idaho covers 100 percent of in-network preventive services after a $20 copayment, this plan is the best option if you’re looking for a low premium dental plan that encourages good oral habits that help maintain a healthy smile.
Healthy Smiles Preventive benefits include:
- Oral examinations – once in a six-month period
- Emergency oral examination
- Panoramic X-ray or full mouth series X-ray – one time in any five consecutive years
- Bitewing X-rays – once per benefit period
- Periapical X-rays
- Cleanings – regular cleaning or periodontal maintenance – once in a six-month period
- Fluoride treatment – one application per benefit period for eligible dependent children

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>$50 per member, per benefit period</td>
</tr>
</tbody>
</table>

Preventive Dental Services (oral exams, cleanings, x-rays, fluoride for eligible dependent children)
- 100% of maximum allowance after $20 copayment per visit
- 50% of maximum allowance after deductible

Healthy Smiles Plus
Healthy Smiles Plus fits most budgets while providing the same coverage as Healthy Smiles Preventive, plus the following basic dental services after satisfying a six-month waiting period and $50 deductible (in-network preventive services don't apply to deductible).
- Sealants – limited to permanent posterior un-restored teeth for eligible dependent children under age 16; one time per tooth in any three consecutive benefit periods
- Fillings – same tooth surface restoration covered once in a two-year period
- Extractions

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<tr>
<td>Deductible</td>
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<tr>
<td>Benefit Period Maximum</td>
<td>$1,000 per member, per benefit period</td>
</tr>
<tr>
<td>Preventive Dental Services (oral exams, cleanings, x-rays, fluoride for eligible dependent children)</td>
<td>100% of maximum allowance after $20 copayment per visit</td>
</tr>
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<td></td>
<td>50% of maximum allowance after deductible</td>
</tr>
<tr>
<td>Basic Dental Services (sealants, fillings, extractions)</td>
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Healthy Smiles Preferred
If dental care is a top priority for you and your family, Healthy Smiles Preferred is the most comprehensive plan available. Healthy Smiles Preferred provides coverage for preventive, basic and major dental services, including the opportunity to carry over unused dental benefit dollars from one year to the next (dental maximum carryover). Copayments, deductibles, waiting periods and maximum limits apply.

Healthy Smiles Preferred includes the same preventive and basic dental services as Healthy Smiles Preventive and Plus, and the following major dental services after satisfying a 12-month waiting period and $50 deductible:
- Crowns, bridges, dentures – five-year replacement
- Root canals
- Periodontics (treatment of gum disease)
- Implants

Dental Maximum Carryover
With Healthy Smiles Preferred, you can carry over unused benefit dollars (up to $250) from one benefit period to the next. You may carry over a total of $1,000. When you visit your dentist at least once, and use $500 or less for dental claims in a benefit period, we carry over up to $250 for future use. You can use carryover dollars to pay for covered dental services after reaching the benefit period maximum, saving you out-of-pocket expenses.

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<tr>
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</tr>
<tr>
<td>Dental Maximum Carryover</td>
<td>$250 per member, per benefit period (up to a maximum of $1,000, per insured)</td>
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General Exclusions and Limitations
In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to dental services:

- There are no benefits for services, supplies, or other charges that are procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of an Insured’s covered dental condition; or that do not have uniform professional endorsement.

- Charges incurred for services that were started prior to the Insured’s Effective Date. The following guidelines will be used to determine the date on which a service shall be deemed to have been started:
  - For full dentures or partial dentures on the date the final impression is taken.
  - For fixed bridges, crowns, inlays or onlays on the date the teeth are first prepared.
  - For root canal therapy on the later of the date the pulp chamber is opened or the date canals are explored to the apex.
  - For periodontal surgery on the date the surgery is actually performed.
  - For all other services on the date the service is performed.

- A service furnished to an Insured for cosmetic purposes, unless necessitated as a result of Accidental Injuries received while the Insured was covered by Blue Cross of Idaho.

- In excess of the Maximum Allowance.

- Any procedure, service or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.

- Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable.

- Any service, procedure or supply for which the prognosis for success is not reasonably favorable.

- For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.

- Not prescribed by or upon the direction of a Provider.

- Investigational in nature.

- Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through an employer under state or federal Workers’ Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.

- Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefor would vary, or are or would be affected by the existence of coverage under this Policy; or for which payment has been made under Medicare Part A and/or Part B.

- Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

- Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured’s household.

- Received from a dental, vision or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

- For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.

- For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses, or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.

- For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.

- For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

- Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.

- Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in Eligibility status which occurs during the Policy term.

- Provided outside the United States, which if had been provided in the United States, would not be Covered Services under this Policy.

- Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
## Applicant Information

<table>
<thead>
<tr>
<th>(first, initial, last)</th>
<th>Date of Birth (mm/dd/yy)</th>
<th>Social Security Number</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address (street or route)</td>
<td>City, State, Zip Code</td>
<td>County</td>
<td></td>
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</tr>
<tr>
<td>Billing Address (if different from mailing address)</td>
<td>City, State, Zip Code</td>
<td>County</td>
<td></td>
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</tr>
<tr>
<td>Idaho resident?</td>
<td>Male</td>
<td>Female</td>
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<tr>
<td>If yes, how long?</td>
<td>Marital Status: Single</td>
<td>Married</td>
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<tr>
<td>Preferred Phone</td>
<td>Alternate Phone</td>
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(1st month's premium required with application - No $2 service fee required on first month)

- Preventive
- Plus
- Preferred

Requested Effective Date / / (Earliest effective date will be the 1st of the month following approval.)

## Other Coverage Information

Is any person listed on this application now covered or has he or she been covered by any other dental insurance?  

- YES
- NO

If YES:
- Name(s) of other dental insurance carrier(s) ____________________________
- Policy number(s) ____________________________
- City/State ____________________________
- Person(s) covered under the policy ____________________________
- Effective Date ____________________________

Is any person on the application covered by a medical health insurance policy?  

- Applicant  
  - YES
  - NO
- Family Member  
  - YES
  - NO

## Additional Family Member Information – premiums are calculated on a per person basis

List additional enrolling family members including any child who is under age 26, or who is medically certified as disabled and dependent upon you for support (copy of certification required).

<table>
<thead>
<tr>
<th>Family Member’s Name (first, initial, last)</th>
<th>Relationship to Applicant (spouse, child, stepchild, etc.)</th>
<th>Date of Birth (mm/dd/yy)</th>
<th>Age</th>
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<th>Female</th>
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## Parental or Guardian Consent to Application (Only if applicant is under age 18)

I represent that the person listed as the applicant on this application is under 18 years of age and is applying for Blue Cross of Idaho dental coverage with my full knowledge and consent. I accept full responsibility for the payment of premiums and the information provided on this application.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print Name</th>
<th>Date</th>
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Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief and that I understand and agree to the following conditions:

• No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
• The insurance carrier may terminate or rescind an insured’s coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier’s acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
• If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
• I understand that this application will become part of the contract between the insurance carrier and me.
• I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.
• Healthy Smiles Plus and Healthy Smiles Preferred include waiting periods. Preventive and diagnostic dental services do not have a waiting period. Basic dental services have a six month waiting period. Major dental services have a 12 month waiting period.
• I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at www.bcيدaho.com.

X __________________________   __________________________ 
Applicant’s Signature    Date
( Parent or Guardian’s signature if applicant is under age 18)

X __________________________ 
Spouse’s Signature (if listed on application)    Date

Independent Producer’s Printed Name   Independent Producer’s Signature   Date   Blue Cross of Idaho No.