Blue Cross of Idaho District Offices

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Meridian, ID 83642-5995
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208-666-1495

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2116 East 25th Street
Mailing Address
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Idaho Falls, ID 83403
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Lewiston
1010 17th Street
Mailing Address
P.O. Box 1468
Lewiston, ID 83501
208-746-0531

Pocatello
275 South 5th Avenue, Suite 150
Mailing Address
P.O. Box 2578
Pocatello, ID 83206
208-232-6206

Twin Falls
1431 N. Fillmore Street, Suite 200
Mailing Address
P.O. Box 5025
Twin Falls, ID 83303
208-733-7258

bcidaho.com

Blue Cross of Idaho

one TO one

HealthySmiles℠

A family of individual dental plans

Form No. 3-052 (06-10)

HealthySmiles℠

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 over 900 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.

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

	In-Network	Out-of-Network
Deductible	$0	$50 per member, per benefit period
Benefit Period Maximum	None	
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

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

	In-Network	Out-of-Network
Deductible	$50 per member, per benefit period	
Benefit Period Maximum	$1,000 per member, per benefit period	
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
Basic Dental Services *(sealants, fillings, extractions)*	80% of the maximum allowance after deductible	50% of maximum allowance after deductible

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, implants – five-year replacement
- Root canals
- Periodontics (treatment of gum disease)

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.

	In-Network	Out-of-Network
Individual Deductible	$50 per member, per benefit period	
Benefit Period Maximum	$1,000 per member, per benefit period	
Preventive Dental Services *(oral exams, cleanings, x-rays, fluoride for eligible dependent children)*	100% of maximum allowance after $20 copayment per visit	50% of the maximum allowance after deductible
Basic Dental Services *(sealants, fillings, extractions)*	80% of the maximum allowance after deductible	50% of the maximum allowance after deductible
Major Dental Services *(crowns, bridges, dentures, implants)*	50% of the maximum allowance after deductible	50% of the maximum allowance after deductible
Dental Maximum Carryover	$250 per member, per benefit period (up to a maximum of $1,000, per insured)	

Enrollment

To enroll in a Healthy Smiles dental plan, you must be an Idaho resident.

Changing Plans

If you are enrolled in one Healthy Smiles plan and change to another, **all waiting periods start over**—we will not credit waiting periods if you move from Healthy Smiles Preventive or Plus to Preferred, or vice versa. We don't credit time enrolled on one plan toward another.

General Exclusions and Limitations

This brochure describes the general features of the Healthy Smiles plans; it is not a contract.

For a complete list of exclusions and limitations, please see the policy.

Policy 3-073P-10/10, Policy 3-074P-10/10, or Policy 3-075P-10/10 is the actual contract. All of the provisions of the policy apply. The benefits of the policy are governed by the laws of the state of Idaho.

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 Sates, 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.

HEALTHY SMILES℠
INDIVIDUAL ENROLLMENT APPLICATION

Blue Cross of Idaho

Applicant Information

Your Name *(first, initial, last)*	Date of Birth *(mm/dd/yy)* / /	Social Security Number / /	Business Phone	Home Phone
Mailing Address *(street or route)*	City, State, Zip Code			County
Billing Address *(if different from mailing address)*	City, State, Zip Code			County
Idaho resident? ❑ Yes ❑ No If yes, how long? _____	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed			❑ Male ❑ Female

Program Information – Healthy Smiles

❑ Preventive ❑ Plus ❑ Preferred *(six-month waiting period for Basic Dental Services/12-month waiting period for Major Dental Services)*

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

Change Request

Change current enrollment because of:

❑ Marriage ❑ Divorce ❑ Birth ❑ Death ❑ Court Order *(copy required)* ❑ Other Date of event _____/_____/_____

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).

Family Member's Name *(first, initial, last)*	Relationship to Applicant *(spouse, child, stepchild, etc.)*	Date of Birth *(mm/dd/yy)* / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❑ Male ❑ Female

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.

Signature	Print Name	Date

Independent Producer's Name _____ BCI _____

Office Use Only

Program No.	Enrollee ID	Effective Date	Class	Plan
Reason Code	Bill Mode	Payment Received	Receipt ID	Auditor

Street Address: 3000 E. Pine Ave., Meridian, ID 83642-5995 • *Mailing Address:* P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550

Form No. 3-052a (06-10)

Payment Options (1st month's premium required with application – No $2 service fee required on first month)

❒ Automatic monthly bank withdrawal *(complete authorization below)* ❒ Monthly – direct coupon (*payment must include $2 monthly service fee*)

Authorization Agreement for Bank Withdrawal

I or we, meaning my spouse if applicable, authorize and request Blue Cross of Idaho (hereafter called BCI) to affect payment for premiums I or we owe to BCI as they become due by initiating debit entries (hereafter called deductions) to my or our account in the institution named (hereafter called the bank). I or we authorize and request the bank to accept any deductions initiated by BCI to my or our account. BCI assumes full responsibility for correctly informing the bank of the specific amount of each deduction. I or we may terminate this agreement at any time by notifying BCI or the bank in writing. Termination will take effect after BCI or the bank has received the written notice and had a reasonable amount of time to act on it.

Bank Name _____

Bank Address *(city, state)* _____

Customer Bank Account No._____ Company I.D. No. 0000500005

Signed _____ Date _____

Signed _____ Date _____

Transit Routing No. Account Number

:									:																

Transit ABA

❒ Checking ❒ Savings

Please attach voided check for automatic bank withdrawal.

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.bcidaho.com.

- ***I affirm the answers given in this Healthy Smiles dental application are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, deny coverage retroactively and/or take any other legal action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in this application incomplete or incorrect. I understand and agree no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the insurance carrier.***

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*

For Independent Producers Only

Independent Producer Checklist

❒ Is the application completed in ink and signed by the applicant, and spouse, if applicable? (A dependent's signature is not acceptable.)
❒ Are all questions regarding other coverage information completed?
❒ Is all the legal paperwork to add special dependents, including the Judge's signature in the case of adoptions, attached to the application?
❒ Is the requested effective date on the first page filled in?
❒ Is the Authorization Agreement for Bank Withdrawal section filled out and signed, and a voided check attached, if monthly automatic bank withdrawal is requested in the Payment Option section?
❒ Are all payments attached to the front of the application?
❒ If one check is written for split applications, is a breakdown of amounts that apply to each application included?

Independent Producer Certification

1. Who actually completed this application? ❒ Applicant ❒ Independent Producer ❒ Other
   If Independent Producer or Other, please explain _____
2. Were you present at the time the application was filled out? ❒ YES ❒ NO
   If NO, please explain _____
3. Was money collected from the applicant? ❒ YES ❒ NO Amount $ _____

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions, or limitations of the policy except through written material furnished by Blue Cross of Idaho. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

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

Type of Company Appointment ❒ *Personal* ❒ *Agency (Name)* _____