Dental Prime for Individuals and Families

BlueCross BlueShield of Georgia

Good health starts with a healthy mouth.

Taking care of your teeth and making regular visits to your dentist can help you stay healthy. How? The germs in an unhealthy mouth can affect the rest of the body. And regular dental checkups can help find early warning signs of health issues. That's one reason why it's so important to take good care of your teeth and gums.

Dental Prime can help you get the care you need.

When you have the right dental benefits, you can have a better handle on your total health. That's why our Dental Prime plan offers:

- Exams, cleanings and X-rays covered 100%
- No waiting period for diagnostic and preventive services
- A benefit for a brush biopsy which helps detect oral cancer
- An extra cleaning each year for those who are pregnant or living with diabetes

Get a dental plan for as little as **$25 a month.**

Choose the plan that's right for you.

Our plans can help you get routine dental care and help you manage your health care costs. And with three options, you're bound to find the Dental Prime plan that's right for you and your family.

	Plan A		*Plan B*		*Plan C*	
Deductible *(The amount you pay before we pay for any services)*	None		$50 per person		$50 per person	
Annual maximum *(The most we will pay in one calendar year)*	$500 per person		$1,000 per person		$1,250 per person	
Diagnostic and preventive care *(Such as cleanings, exams and X-rays)*	100% covered		100% covered		100% covered	
Extra cleanings	Available to those who are pregnant or living with diabetes.					
Basic treatment *(Such as fillings and simple tooth extractions)*	Not covered		80% covered for fillings and simple tooth extractions.		80% covered for fillings and simple tooth extractions.	
Brush biopsy	Not covered		80% covered		80% covered	
Major treatment *(Such as root canals, scaling, root planing, crowns, dentures and bridges)*	Not covered		50% covered for root canals, scaling, root planing and complex surgical extractions. Crowns, dentures, bridges and orthodontics not covered.		50% covered for root canals, scaling, root planing, complex surgical extractions, crowns, dentures and bridges. Orthodontics not covered.	
Waiting periods	Diagnostic and preventive care: No waiting period		Diagnostic and preventive care: No waiting period Basic treatment: 6 months Brush biopsy: 6 months Major treatment: 12 months		Diagnostic and preventive care: No waiting period Basic treatment: 6 months Brush biopsy: 6 months Major treatment: 12 months	
Monthly/annual premiums (get a 5% discount when you pay your premium annually)	*Monthly*	*Annual*	*Monthly*	*Annual*	*Monthly*	*Annual*
Individual	$24.55	$279.85	$36.20	$412.70	$44.90	$511.85
Individual + 1	$47.75	$544.35	$70.35	$802.00	$87.30	$995.20
Family	$76.45	$871.55	$112.55	$1,283.05	$139.65	$1,592.00

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To find a dentist near you, go to bcbsgadentaladmin.com and click on Enroll Now. Enter ZIP code, coverage type and date of birth, then click Dentist Search.

Save time and money with smart dentist choices.

While all three plans allow you to go to any dentist and receive the same benefits, you can save money by choosing a participating dentist.

	Participating dentist	*Non-participating dentist*
What you pay the dentist	• Your deductible. • The percentage that's not covered by your insurance.	• The total cost of your services.
Claims paperwork	• Your dentist submits claims to us. • We pay the dentist directly.	• You submit your claims to us. • We pay you back for covered expenses.

You may pay more for dental care if you choose a non-participating dentist. Here's why:

- **Participating dentists** have agreed to payment rates for services and cannot charge you more.
- **Non-participating dentists** don't have a contract with us. They can charge you the difference between the total amount we allow to be paid for a service and the amount they normally charge for a service.

Get started with Dental Prime.

It's easy to sign up. You can either fill out a form online or by hand.

- Go to **bcbsgadentaladmin.com**.
- Or fill out and sign the Dental Prime application form. Then give your completed form to your agent or mail it to us at:

  Dental Enrollment Department
  P. O. Box 1193
  Minneapolis, MN 55440-1193

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 877-567-1807.

Exclusions

This is a partial list of plan exclusions. Please see the individual dental plan contract for a complete list.

New or unproven dental techniques or services · Dental services performed for cosmetic purposes · Dental services completed prior to the date the covered person became eligible for coverage · Services of anesthesiologists · Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care · Dental services performed other than by a licensed dentist, licensed physician, his or her employees · Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration · Orthodontic treatment services · Case presentations, office visits and consultations · Incomplete, interim or temporary services · Corrections of congenital conditions during the first 24 months of continuous coverage under this policy · Athletic mouth guards, enamel microabrasion and odontoplasty · Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening · Bacteriologic tests · Separate services billed when they are an inherent component of a dental service · Pediatric removable or fixed prosthetic appliances · Services for the replacement of an existing partial denture with a bridge · Oral hygiene instruction · Diagnostic casts · Incomplete root canals · Sinus augmentation · Recement space maintainers · Consultations · Orthodontic services

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.

BlueCross BlueShield of Georgia

Dental Prime Individual Enrollment Form

Blue Cross and Blue Shield of Georgia
Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193

Please complete in blue or black ink only. For information or assistance in completing this form, call Customer Service at 1-877-567-1807.

Applicant Information - Applicants must be at least 18 years of age and not currently covered by another Blue Cross Blue Shield of Georgia (BCBSGa) group or individual dental plan.

Last Name	First Name	Middle Initial	Social Security Number

Gender ☐ M ☐ F	Day Phone Number	Evening Phone Number	E-mail Address	Date of Birth / /

Address	City	State	ZIP Code

Agent Name	Agent ID	Agent Tax ID	Agent License ID	Agent Paid ID
Holly G. Conley	13140	58-2176207	416743	58-2176207

Select One Plan Option

Dental Prime: ☐ **Plan A** No Deductible/$500 Maximum ☐ **Plan B** $50 Deductible/$1000 Maximum ☐ **Plan C** $50 Deductible/$1250 Maximum

You can submit this application up to three months in advance of when you would like coverage to start. Coverage starts on the first day of the Requested Start Month. If you do not provide a start month, coverage will begin the first of the month after we receive your completed application.
Requested Start Month _____.

Select Who Is To Be Enrolled: ☐ Applicant Only ☐ Applicant + One Dependent ☐ Family (Three or More Family Members)

Complete this section if you want to enroll family members. Dependent children under age 26 can be enrolled.

Relationship to Applicant	First Name, Middle Initial, Last Name	Gender		Date of Birth (mm/dd/yyyy)
☐Spouse ☐Domestic Partner		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

Select One Payment Option and Billing Frequency The first premium is charged immediately. Future premiums are deducted/charged around the 20th business day of each coverage period.

☐ **A. Direct Withdrawal from Checking/Savings Account:** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual**
Name on Checking Account _____ Bank Name _____
Routing Number _____ Checking Account Number _____

☐ **B. Credit Card or Debit Card:** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual** ☐ MasterCard ® ☐ Visa ®
Credit/Debit Card Number _____ Exp. Date ____/____ Security Code _____ (3 or 4 digits on back of card)
Name As It Appears On Credit/Debit Card _____

AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I have read the information contained in the application and choose to enroll. I understand the benefits and restrictions of this plan as stated in the material provided with the application. I certify the information contained in this application is true and complete. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages. I understand my enrollment is subject to approval and receipt of payment and verification of funds. The start and cancellation dates of my insurance coverage will be determined by BCBSGa. I authorize BCBSGa to withdraw funds from my bank account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made on time I will no longer be eligible for coverage. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of 24 months.

Applicant Signature: **Date:**

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES PRIVACY ACT. Georgia state law establishes standards for the collection use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals. **ALL DATA CONFIDENTIAL.** O.C.G.A. section 33-39-5,subsection (c) (1 through 4) requires that: 1. Personal information may be collected from persons other than the individual or individuals proposed for coverage; 2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be discussed to third parties without authorizations; 3. A right of access and correction exists with respect to all personal information collected; 4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.