



Regence Life and Health

DENTAL PLANS

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

share the wellSM
 **Regence**
Life and Health Insurance Company

GOOD HEALTH ISN'T COMPLETE without good dental care.

That's where dental coverage from Regence Life and Health comes in.

Total wellness requires a healthy mouth. That's why we're pleased to offer a variety of affordable dental programs for individuals and families.

We offer a range of dental plan options to meet your needs.

If you choose a managed care plan, you'll work with a participating provider who can combine the best available scientific evidence with clinical experience to develop a personalized oral health plan for you.

You can also choose one of our innovative open-access plans. They give you greater choice over your dental care while rewarding you for being proactive about your oral health.

Individual Incentive 10 Dental

Take care of yourself and watch your benefits grow

Individual Incentive 10 Dental rewards you for receiving routine preventive care. Each year that you visit the dentist for an annual exam and cleaning means greater benefits and fewer out-of-pocket expenses the next year.

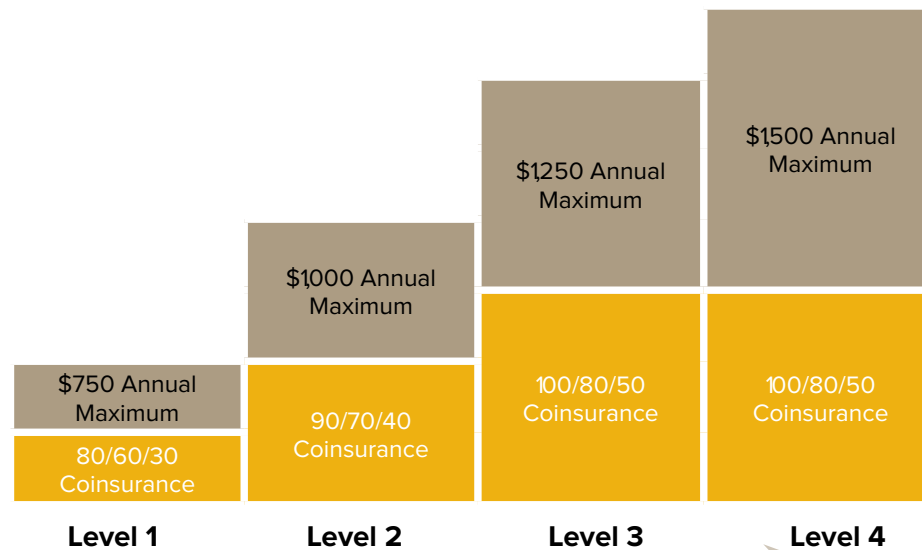
This plan features:

- Six-month waiting period for restorative services and 12-month waiting period for major services
- Deductible waived for exams and cleanings covered under Preventive Services
- \$50 deductible for other covered services
- The ability to choose any dentist but save even more by using one of our network providers (find a network provider at regence.com)
- Optional vision rider available (reimburses up to \$150 in vision services and/or hardware per member every two years)

Here's how it works

When you get your teeth cleaned and examined every year, you're rewarded with greater benefits the next year. Watch your annual benefits increase and your out-of-pocket coinsurance decrease.

By year four, you can reach a maximum annual benefit of \$1,500. And the percentage the plan pays in coinsurance can increase to 100/80/50 by year three. This means we'll 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 a cleaning reward you with lower costs for dental care and increasing maximum benefits.

Outline of coverage: Individual Incentive 10 Dental

Covered services are those dentally appropriate services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and supporting tissues. 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 services

- Cleanings, limited to two per benefit year, whether they're considered cleanings or periodontal maintenance (periodontal maintenance covered under major services)
- Oral exams allowed, two per benefit year
- Fluoride treatment: two applications per benefit year for members age 17 and under
- X-ray bitewings: 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 surgical extractions of teeth and for members age six and under
- Direct pulp capping

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 limited to four per lifetime per member
- Endodontics, including root canal treatment, pulpotomy and apicoectomy
- Periodontal maintenance, limited to two 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.

Individual Dollar-Based Dental

Dental done your way

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 annual exam and cleaning, you're rewarded with a benefit increase the following year.

You decide how to spend your benefit dollars.

This plan features:

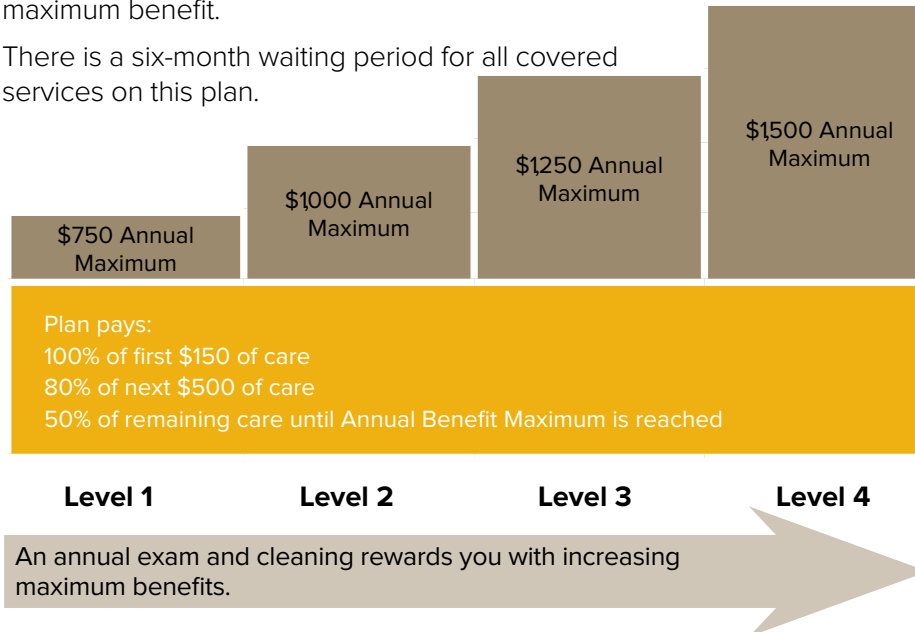
- No deductibles
- No limitations or exclusions for covered services (orthodontia, teeth bleaching and veneers are not covered services)
- The ability to choose any dentist but save even more by using one of our network providers (find a network provider at regence.com)
- Optional vision rider available (reimburses up to \$150 in vision services and/or hardware per member every two years)

Here's how it works

Each year that you take advantage of an annual exam 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.



Outline of coverage: Individual Dollar-Based Dental

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

Managed Care Dental

Coverage that keeps your teeth healthy and your costs down

With Managed Care Dental, you get a variety of services covered at predictable copays. You'll work with a participating provider to maintain your oral health and enhance your overall health through routine exams and other preventive care.

This plan features:

- No deductibles
- No annual maximums
- Routine exams, teeth cleanings, periodontal screenings and evaluations provided for just a \$15 visit charge
- X-rays, fillings and a variety of other dental services provided at a low copay
- Orthodontia coverage regardless of age
- Emergency dental care coverage
- Orthodontic and some major services covered after a six-month waiting period
- Optional vision rider available (reimburses up to \$150 in vision services and/or hardware per member every two years)

Please refer to the summary of benefits, included in this brochure, for an overview of the plan and a list of limitations and exclusions.

Friendly offices are nearby

Services must be rendered by a participating provider. For the purposes of this plan, participating providers are Willamette Dental Group, P.C., and the providers who are employed by or are under contract with Willamette Dental Group, P.C. or any of its affiliates.

Participating provider offices are conveniently located throughout the area. You can find addresses and directions at **WillametteDental.com**.

Care is just a call away

After you sign up for Individual Managed Care Dental, you should call 1 (800) 461-8994 to schedule your first appointment with a participating provider. You can see a dentist in as soon as three to six weeks.

Managed Care Dental summary of benefits

Annual maximum	None
Deductible	None
Visit charge	\$15 per visit
SUMMARY OF COVERED SERVICES AND SERVICE COPAYS	WHAT YOU PAY <i>(Please note: Service copays and coinsurance are charged per service)</i>
SERVICES COVERED WITH NO SERVICE COPAY	
Routine and emergency oral evaluations	\$15 visit charge
Teeth cleanings	
Bitewing X-rays	
Periodontal screenings	
Periodontal maintenance	
SERVICES PROVIDED WITH ADDITIONAL \$10 SERVICE COPAY	
Nitrous oxide (per visit)	\$15 visit charge plus \$10 service copay
SERVICES PROVIDED WITH ADDITIONAL \$20 SERVICE COPAY	
Panoramic X-rays	\$15 visit charge plus \$20 service copay
Sealant (per tooth)	
After-hours visit	
SERVICES PROVIDED WITH ADDITIONAL \$30 SERVICE COPAY	
Filings - amalgam, anterior composite, or posterior primary composite (per tooth)	\$15 visit charge plus \$30 service copay
Simple denture/partial repairs	
Simple extractions	
ORTHODONTIA	
Pre-orthodontic service	Pre-orthodontic service copay will be deducted from the comprehensive orthodontic copay if the member elects orthodontic treatment
Initial orthodontic exam	\$15 visit charge plus \$25 service copay
Study models and X-rays	\$15 visit charge plus \$125 service copay
Comprehensive orthodontia	\$2,600 service copay per case
OTHER	
Out-of-area emergency care (50 miles or more from a WDG office)	You pay applicable service copays and fees. Willamette Dental covers up to \$100 of covered services.
Additional services covered by this policy (Please see the Schedule of Covered Services, Copays and Coinsurance for a complete list.)	\$15 visit charge plus 80% coinsurance
OPTIONAL VISION BENEFIT RIDER	
You may elect to add vision benefits to with your dental coverage. The vision benefit reimburses up to \$150 per member for vision exams and/or hardware every 24 months.	

This is a brief summary of benefits. For full coverage provisions, including a description of limitations and exclusions, refer to your policy.

There is a six-month waiting period for all Orthodontic Services and some Major Services, including Permanent Crowns and some Prosthetic Services and Supplies.

Please note: If you cancel Individual Managed Care Dental, there is a 12-month waiting period before you can re-enroll.

The benefits of this plan are not subject to any coordination of benefits provision.

Individual Incentive 10 Dental

Exclusions

These services and supplies are not covered:

- 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
- Experimental/investigational treatments, procedures, and services and supplies
- 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
- Non-direct patient care
- 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 for an illness or injury caused by a member's unlawful instigation and/or active participation in a riot, rebellion, war or illegal act
- Treatment of simple or compound fractures of the mandible
- Treatment of Temporomandibular Joint Dysfunction
- Unspecified implant procedures
- Work-related injuries

Individual Dollar-Based Dental

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
- Treatment for an illness or injury caused by a member's unlawful instigation and/or active participation in a riot, rebellion, war or illegal act
- Work-related injuries

Managed Care Dental

Exclusions

These services and supplies are not covered:

- Aesthetic dental procedures and complications arising out of such services
- Benefits not stated
- Charges by any person other than a participating provider except as otherwise indicated in the policy
- Cosmetic/reconstructive services and supplies (certain exceptions apply)
- Coverage available under any federal, state, or other governmental program, except where required by law
- Diagnostic casts or study models
- Endodontics, bridges, crowns, and other prosthetic devices or services if treatment was started or ordered prior to the member's effective date or delivered more than 60 days after the member's coverage under this policy has terminated
- Excision of a tumor; biopsy of soft or hard tissue; removal of a cyst
- Experimental/investigational treatments, procedures, services and supplies
- Extraction of permanent teeth for tooth guidance procedures; procedures for tooth movement
- Full-mouth reconstruction
- General Anesthesia, except as specified in the Schedule of Covered Services, Copays and Coinsurance.
- Habit-breaking or stress-breaking appliances
- Hospitalization for dentistry
- Maxillofacial prosthetic services
- Medication and supply charges
- Military service-related conditions
- Motor vehicle coverage and other insurance liability
- Non-direct patient care
- Occlusal treatment including complete occlusal adjustments and occlusal guards
- Personalized restorations, precision attachments, and special techniques
- Repair or replacement of lost, stolen, or broken items
- Replacement of sound restorations
- Services and supplies for treatment of an illness or injury caused by riot, rebellion, war and illegal acts
- Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident
- Services or supplies and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved a participating provider
- Temporomandibular Joint (TMJ) dysfunction treatment
- Transseptal fiberotomy
- Treatment started prior to the member's effective date under this policy or completed after this policy terminates
- Work-related injuries

This is a brief summary of the individual dental plans available from Regence Life and Health Insurance Company. For full coverage provisions, including a complete list of Covered Services and Exclusions, please refer to your policy.

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

Enroll online today! regenceLife.com



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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 <input type="checkbox"/>	EFT <input type="checkbox"/>

RENEWABLE INDIVIDUAL DENTAL INSURANCE APPLICATION (WITH OPTIONAL VISION RIDER)

Please complete all information on this page and on Page 2. Incomplete information may result in a delayed Effective Date.

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 ()		E-mail Address	
Home Address & Apt. No./Mailing Address				City		State	Zip

Requested Effective Date

Your requested Effective Date must be following or coinciding with the date We receive your Application, after the date your Application is signed, and within 60 days from the date of your signature, or a new Application will be required.

A new Application may result in a delayed Effective Date. In no event may the Effective Date of this Policy be back-dated

For **Dollar-Based** and **Incentive 10** Dental: 1st OR 15th of _____ (month) _____ (year)

For **Managed Care** Dental: 1st of _____ (month) _____ (year)

Dependents to be enrolled: Dependent children must be under 26 years of age.

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include portion of decree that shows responsibility for health expenses.							
This plan covers: <input type="checkbox"/> Self <input type="checkbox"/> Spouse / Domestic Partner <input type="checkbox"/> Child(ren) <input type="checkbox"/> Stepchild(ren) <input type="checkbox"/> Other Please list names:							

**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 **6 MONTH BENEFIT WAITING PERIOD (BWP)*** for **ALL SERVICES**.

INCENTIVE 10 DENTAL INSURANCE

NOTE: This coverage has a **6 MONTH BWP*** for **RESTORATIVE SERVICES** and a **12 MONTH BWP*** for **MAJOR SERVICES**

MANAGED CARE DENTAL INSURANCE

NOTE: This coverage has a **6 MONTH BWP*** for **MAJOR and ORTHO SERVICES**

*The **BENEFIT WAITING PERIOD** is the continuous length of time the member must be covered under the Policy before becoming eligible for benefits.

Add Vision Rider Yes No

Premium Payment Schedule: **Monthly** **Quarterly**

Premium Calculation for Dollar Based and Incentive 10 Dental

	Number enrolling for coverage		Enter <u>Monthly</u> or <u>Quarterly</u> Dental Only or Dental with Vision Premium Rate	=	\$ _____
Under Age 18	_____	X	\$ _____	=	\$ _____
Age 18 through age 64	_____	X	\$ _____	=	\$ _____
Age 65 and over	_____	X	\$ _____	=	\$ _____
Total <u>Monthly</u> or <u>Quarterly</u> Dental or Dental with Vision Premium Rate					\$ _____

Premium Calculation for Managed Care Dental

Family Status of Member(s) enrolling:

Individual

Individual & Spouse

Enter Monthly or Quarterly **Dental or Dental with Vision**

Individual & 1 Child

Family

Premium Rate \$ _____

Your 1st premium payment must be enclosed with this Application.

Total Monthly or Quarterly Dental or Dental with Vision

Premium Rate \$ _____ **PLUS Policy Fee of \$ 25.00 = Total Due \$ _____ (Enclosed)**

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 and the Participating Provider 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 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
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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.



Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

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