Personal Dental

Dental Insurance for Individuals and Families in California

- **Coverage for Preventive, Diagnostic, Basic and Major services**
- **Freedom to use any dentist**
- **Optional access to a PPO network**
- **Discounts on vision care**

Sponsored by

www.beassoc.org/personaldental

Underwritten by BEST Life and Health Insurance Co.

BL-PD-MR-011312

Affordable Dental Coverage for Maintaining Healthy Teeth

Having dental coverage can save you money and more - it can help keep your mouth healthy and promote overall good health. With a Personal Dental Plan you can:

- Use any dentist in the country, or
- Save more money when accessing care through our PPO network
- Receive preventive care at little to no cost

Preventive dental care is the best way to maintain healthy teeth and Personal Dental is the insurance plan to make it affordable for you.

Begin applying for coverage today! To start, follow these five easy steps:

Step 1.

Determine who needs coverage.

Our plans provide coverage for preventive, basic and major services, including sealants, fluoride treatment and space maintainers for children.

You* may enroll your spouse, and/or your dependents. Dependent children are eligible for coverage up to age 26, regardless of student status.

* You and your spouse must be between 18 and 64 to be eligible to purchase this plan.

Step 2.

Learn how these plans work.

Progressive Indemnity Plans: Personal Dental 100 and Personal Dental 80

These plans are progressive indemnity plans. Coverage for basic and major services will increase for every year you stay on the plan, up to the third year.

Using a First Dental Health ("FDH") or DenteMax PPO network dentist is optional and wil help you save on out-of-pocket costs.
Network dentists are contracted to accept discounted fees as payment in full. When you use a FDH or DenteMax dentist, the percentage payable is applied to the discounted fee for the services performed in your area. To locate a provider, visit the Personal Dental website and select the FDH or DenteMax network.

When you use a non-network provider, the percentage payable is applied to the usual and customary charge for those services in your area.

Scheduled Plans: Personal Value 40 and Personal Value 36

Looking for simplicity? Consider a Personal Value plan! These scheduled plans provide a list of the amount we reimburse for each procedure. There is no guesswork.

Using the FDH or DenteMax PPO network is optional. You have the freedom to go to any licensed dentist in the country or to save on out-of-pocket costs when you use a network dentist.

Step 3.

Review the plans.

Choose the plan that provides the coverage you need. The Personal Value plans provide the maximum amount we will reimburse for each procedure. The progressive indemnity plans, Personal Dental 100 and Personal 80, provide the Percentage Payable we will apply to each category of services.

Waiting Periods apply for the initial time period only; after they are satisfied, there are no more waiting periods for the duration of your enrollment on the plan.

Plan Type	Personal 100	Personal 80	Personal Value 40	Personal Value 36
Calendar Year Maximum	$1,500	$1,000	$1,500	$1,000
Calendar Year Deductible	$50 per person / $150 per family Deductible does not apply to Preventive Care Services			
	Percentage Payable		Amount Reimbursed	
Preventive Care Services	No waiting period	After initial 60 day waiting period		
Periodic oral evaluation	100%	80%	$40	$36
Comprehensive oral evaluation			$62	$56
Bitewings – two films			$35	$31
Adult cleanings (prophylaxis)			$76	$69
Child cleanings (prophylaxis)			$56	$50
Topical application of fluoride (including prophylaxis) – child			$79	$71
Basic Services	After initial 6 month waiting period			
Sealant – per tooth	1st Year: 80% 2nd Year: 80% 3rd Year: 90%	80%	$44	$39
Amalgam – one surface			$86	$54
Resin-based composite – one surface, anterior			$97	$61
Complete series x-rays			$106	$95
Major Services	After initial 12 month waiting period			
Crown – porcelain fused to noble metal	1st Year: 50% 2nd Year: 60% 3rd Year: 70%	1st Year: 50% 2nd Year: 60%	$427	$342
Space maintainer – fixed – unilateral			$220	$137
Complete upper denture			$527	$421
Upper partial denture			$581	$465
Root canal therapy – bicuspid			$343	$274
Periodontal scaling & root planing – 4 or more teeth, per quadrant			$101	$80
Removal of impacted tooth – partially bony			$281	$176
Orthodontic Services, teeth whitening and other non-covered services	Not covered by plan. Network discount may apply, refer to network provider for more details.			

Need more information? For a full listing of scheduled reimbursements, or exclusions and limitations, download Plan Details at www.beassoc.org/personaldental, on the "Dental Plans" and "Quote Now" web pages.

Step 4.

Review Personal Dental rates.

Rates vary by ZIP code. To find the rates for your area, locate the first three digits of your ZIP Code below. Then compare the price for each plan.

Area		Personal Dental 100	Personal Dental 80	Personal Value 40	Personal Value 36
Area A 917-925, 932-939, 952-961	Member Only	$47.00	$36.50	$31.50	$28.00
	With Spouse	$93.50	$72.50	$62.50	$56.00
	With Child	$74.50	$58.00	$50.00	$44.50
	With Children	$111.50	$86.50	$74.50	$66.50
	With Family	$152.50	$118.50	$102.00	$91.00
Area B 900-916, 926-931	Member Only	$48.50	$37.50	$32.00	$28.50
	With Spouse	$97.00	$74.50	$63.50	$57.00
	With Child	$77.50	$59.50	$51.00	$45.50
	With Children	$115.50	$89.00	$76.00	$68.00
	With Family	$158.50	$122.00	$104.00	$93.00
Area C 945-951	Member Only	$50.50	$38.50	$32.50	$29.00
	With Spouse	$100.50	$77.00	$65.00	$58.00
	With Child	$80.50	$61.50	$51.50	$46.50
	With Children	$120.00	$91.50	$77.00	$69.00
	With Family	$164.50	$125.50	$105.50	$94.50
Area D 940-944	Member Only	$52.50	$39.50	$33.00	$29.50
	With Spouse	$104.50	$79.00	$66.00	$59.00
	With Child	$83.50	$63.00	$52.50	$47.00
	With Children	$124.50	$94.00	$78.50	$70.50
	With Family	$170.50	$129.00	$107.50	$96.50

Expires June 2012. Rates may change at any time.

Rates do not include an additional $1 monthly BEA Membership Fee, $5 Billing Fee, and a $10 one-time non-refundable Initial Enrollment Fee. Billing fees are charged for processing payment, based on the billing option selected.

Step 5.

Complete the enclosed application.

To enroll, mail a completed enrollment application and payment for the first month's premium, including any applicable fees, to: **Personal Dental New Enrollments,** BEST Life and Health Insurance Co., PO Box 19721, Irvine, CA 92623-9721.

BEST Employers Association and Membership

Personal Dental is offered to members of the BEST Employers Association ("BEA"). Anyone can join BEA to purchase a Personal Dental plan. Membership dues are added to the premium and membership information is provided along with the Personal Dental ID card and plan documents.

Join BEA!

As an association member, you can save with the following BEA discount programs:

- Eye exams and eyewear through EyeMed
- LASIK eye surgery through QualSight
- Lab results through HealthScreen
- Purchases through Sears Commercial
- Avis car rentals
- International medical services

To learn more visit www.beassoc.org.

Go to www.beassoc.org/personaldental for:

- Answers to frequently asked questions
- Plan Details
- Locating a network dentist
- A summary of plans details

Distributed by:

Pacific Brokers
Greg Albin
AIC Branch Office
2010 Crow Canyon Place # 100
San Ramon, CA 94583
Phone: 925.551.7600 | Fax: 925.551.5232
Email: greg@pacbrokers.com

This brochure highlights the features of the Personal Dental plans. Complete details are available in the Certificate of Insurance issued to enrolled members of the BEST Employers Association.

© 2012 BEST Life and Health Insurance Company

BEST Life and Health Insurance Company

BEST Employers Association Sponsored Personal Dental Insurance Application

Mail to: Personal Dental Enrollments
BEST Life and Health Insurance Co.
PO Box 19721
Irvine, CA 92623-9721

Home Office Endorsement	☐ New Application ☐ Dependent Add On
Case No.: ______	Payment Method ☐ Bank Draft ☐ Credit Card ☐ Check Credit Card Type: ☐ MasterCard ☐ Visa ☐ Discover
Eff. Date: ______	Account / Routing Number: ______
Other: ______	Credit Card Expiration Date: ______
Approved By: ______	CV2 Number: ______
	Signature: ______

Instructions: (Please print in blue or black ink. Corrections should be lined through and initialed by the applicant. Do not use white out.)

A. General Information

1. a. Applicant's Name (First, M.I., Last) ______
b. Resident Street Address (PO Box not acceptable) ______
c. City, State, Zip ______

2. a. Applicant's Billing Name (if different) ______
b. Billing Address ☐ Same as Resident Address ______
c. City, State, Zip ______

3. a. Applicant's Daytime Phone: ______
b. Email address: ______

4. Applicant's Marital Status:
☐ Married ☐ Single ☐ Divorced ☐ Widowed
☐ Legally Separated ☐ Domestic Partner

5.

List All Applicants Applying For Coverage (First, M.I., Last)	Relationship to Applicant	Birth date mo/day/yr.	Sex M/F	Social Security Number
	Applicant			
	Spouse/Domestic Partner			
	Dependent Child			
	Dependent Child			
	Dependent Child			
	Dependent Child			
	Dependent Child			

6. Effective Date (subject to approval)
Your plan's effective date will be the first of the month following receipt of payment and the approval of your enrollment application.
If the Company is unable to approve the application within 60 days of the application date, a new, currently dated application may be required.

DO NOT CANCEL ANY EXISTING DENTAL INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL

Total Amount Submitted $ ______ (Include one month's insurance premiums, $1 monthly Association Membership fee, $5 billing fee, and $10 one-time non-refundable initial enrollment fee.) Make check payable to BEST Life and Health Insurance Company. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

B. Type of Coverage Requested

Select a dental plan – all enrollees must be on same plan	☐ Plan A Personal 100	☐ Plan B Personal 80	☐ Plan C Personal Value 40	☐ Plan D Personal Value 36
Calendar Year Deductible (Applies to Basic and Major Services)	$50 per person $150 per family	$50 per person $150 per family	$50 per person $150 per family	$50 per person $150 per family
Maximum Benefit Limit	$1,500	$1,000	$1,500	$1,000
Preventive Care Services Exams once per 6 months, cleanings (prophylaxis) once per 6 months, fluoride (under age 15), bitewing X-rays once per 6 months	100% No waiting period	80% 60 day waiting period	Scheduled Amounts 60 day waiting period	Scheduled Amounts 60 day waiting period
Basic Services Fillings (amalgam, porcelain & plastic), emergency treatment, all other X-rays once per 3 years, simple extractions, sealants under age 15	1st & 2nd Year: 80% 3rd Year: 90% 6 month waiting period	80% 6 month waiting period	Scheduled Amounts 6 month waiting period	Scheduled Amounts 6 month waiting period
Major Services Crowns, inlays, onlays, installation of bridges & crowns, space maintainers under age 15, endodontics, periodontics, surgical extractions, dentures & bridge repair, general anesthesia, oral surgery	1st Year: 50% 2nd Year: 60% 3rd Year: 70% 12 month waiting period	1st Year: 50% 2nd Year: 60% 12 month waiting period	Scheduled Amounts 12 month waiting period	Scheduled Amounts 12 month waiting period

C. Certification and signature

By signing below:

I have reviewed and understand the Policy's benefits, limitations and exclusions.

I understand that I must be a member of BEST Employers Association ("BEA") to be eligible for this insurance. I agree and understand that by signing this Application, I become a member of BEA and a $1 monthly due will be charged along with the insurance premium for the plan I select. I understand that this insurance is not designed nor marketed as employer provided insurance.

To the best of my knowledge and belief, all statements contained herein and on any attachments or amendments are true, complete and correct and that no material information has been withheld or omitted. Furthermore, I UNDERSTAND THAT:

- BEST Life and Health Insurance Company (Insurer) will individually underwrite my application;
- The responses contained herein and on any attachments or amendments will be relied upon by the Insurer in the issuance of insurance coverage;
- Any incomplete, incorrect or misleading answers or misrepresentation of material facts on this application, made with actual intent to deceive or which materially affected the Insurer's acceptance of the risk or hazard assumed by the Insurer, may give the Insurer the right to deny benefits, or increase the premium payable for coverage under the Policy, in accordance with the provisions of the certificate for which I am applying.
- No agent has authority to advise me to omit or inaccurately report any information requested herein, make or alter any Insurer contract or waive any of the Insurer's other rights or requirements and I represent that such has not occurred;
- No representation by an agent or any other person shall be binding on the Insurer unless the representation is reduced to writing and signed by an officer of the Insurer; (NOT APPLICABLE TO MISSOURI RESIDENTS)
- The insurance hereby applied for will not be considered in force until an insurance certificate is issued and full first premium paid and other conditions remain as described in this application. No insurance will be effective until the date specified by the Insurer in the certificate. The actual effective date may not be the requested effective date.
- If this application is declined or withdrawn or if an insurance certificate is not issued or accepted, the only obligation of Insurer will be to return any premium paid. The nonrefundable processing fee, if any, will not be returned.
- This application shall be deemed to have been declined if it has not been approved by the Insurer within days of the date of the application.
- I must initial or otherwise give my written consent to any corrections, additions or changes made by the Insurer to this application.
- I understand that an electronic signature on this application and/or any Endorsement Riders is legal and enforceable.
- The insurance hereby applied for includes a BINDING ARBITRATION PROVISION to settle disputes. Judicial review and enforcement of awards (or dismissals) is available as provided in California code of Civil Procedure, Sections 1281 and 1294, et. seq.

I represent that the information contained in the application for insurance are correct and true to the best of my knowledge. I understand that providing false information or omission of relevant information on this form which materially affects either the acceptance of risk or hazard assumed by BEST Life and Health Insurance Company and may result in denial of claims, retroactive cancellation of coverage, or an increase in premiums, and may be considered insurance fraud. I understand that, subject to the terms and conditions of the contract under which I am enrolling for coverage, I may be subject to a pre-existing condition limitation. I understand that no insurance will be effective unless approved in writing by BEST Life and Health Insurance Company.

X ______________________ ______________ ______________________

Signature of Applicant | Date | Print full name

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Producing Agent Information and Statement

Producing Agent's Name (please print) Greg Albin Agency Name Pacific Brokers

Producing Agent's GA or MGA Name (please print) ______________________ Agent No. 60560

Street Address 2010 Crow Canyon Place #100 City San Ramon State CA Zip 94583

Daytime Phone Number (925) 551-7600 Fax Number (925) 551-5232 E-Mail Address greg@pacbrokers.com

The following statements are true and complete to the best of my knowledge and belief: • that the application was completely filled out by the applicant, or I have truly, accurately and completely recorded all the information given to me by the applicant and the applicant has personally reviewed the completed application; • I know of no other dental information about those persons applying for coverage other than that contained on this application; • I have witnessed the signing of this application by the applicant; • I have explained all the policy benefits, maximums, exclusions and waiting periods; • I have not advised the applicant to omit or inaccurately report any information requested on the application or on any attachments or amendments, and I represent that such has not occurred; • I understand I have no right to bind coverage and I have advised the applicant that no insurance will be effective unless approved in writing by the Insurer and have instructed the applicant not to terminate any existing dental coverage prior to receiving the Insurer's written notice of approval.

Producing Agent's Signature X ______________________ State License ID Number 0479535 Date ______________

© 2012 BEST Life and Health Insurance Company