BlueCross BlueShield Nebraska

PO Box 3248
Omaha, Nebraska 68180-0001

DentalEssentials Application
(For direct mail use only)

To enroll in the DentalEssentials option of your choice, please check the appropriate box in the chart and sign and date the application below. Please return this form in the enclosed postage-paid envelope. **If you DO NOT wish to purchase optional dental coverage, you DO NOT need to complete and return this form.**

DentalEssentials Options and Premium Rates

I want to enroll in the following DentalEssentials plan (select one):	Preventive Plus	Enhanced	Premier
	☐	☐	☐
Monthly Premium	**[$$$$]**	**[$$$$]**	**[$$$$]**

	Preventive Plus	Enhanced	Premier
Deductible (per person per calendar year)	[$50]	[$100]	[$100]
Annual Benefit Maximum (per person per calendar year)	[$1,000]	[$1,500]	[$2,000]

Coinsurance (what you pay)

	Preventive Plus		Enhanced		Premier	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Coverage A Services (deductible waived for in-network services)	[0%]	[20%]	[0%]	[20%]	[0%]	[20%]
Coverage B Services (6-month waiting period)	[20%]	[30%]	[20%]	[30%]	[20%]	[30%]
Coverage C Services (12-month waiting period)	[50%]	[50%]	[50%]	[50%]	[50%]	[50%]

Coverage A Services Preventive and Diagnostic Dentistry	[Two] preventive oral examinations per calendar year Medically necessary dental consultations Cleaning, scaling and polishing of teeth, [two] per calendar year Dental X-rays
Coverage B Services Maintenance and Simple Restorative Dentistry and Oral Surgery	Fillings Oral surgery including extractions and removal of dental cysts and tumors Simple and impacted extractions General anesthesia Palliative treatment Problem focused and/or emergency oral examinations
Coverage C Services Complex Restorative Dentistry, Periodontic and Endodontics	Crowns, including repairs Installation of permanent bridges, including repairs Dentures - full and partial, including adjustments Up to [four] periodontic cleanings per calendar year Root canals Vital pulpotomy

IMPORTANT: PLEASE READ THE FOLLOWING INFORMATION BEFORE YOU SIGN.

1. I certify that I am a resident of the State of Nebraska.
2. I understand that no insurance is effective until this application is approved, the policy is issued and the first full premium has been received by Blue Cross and Blue Shield of Nebraska (BCBSNE).
3. All benefits are subject to the terms of the contract. I understand that this contract includes a 6-month waiting period for Coverage B services and a 12-month waiting period for Coverage C services (if applicable).
4. The effective date will be the first of the month following receipt of the application.
5. The same billing method will be used for the DentalEssentials coverage as for my health coverage (same billing schedule and bank account).

Signature _____ Date _____

[Name] [Member ID]

For internal use only: LSA Name:_____ LSA Number:_____

