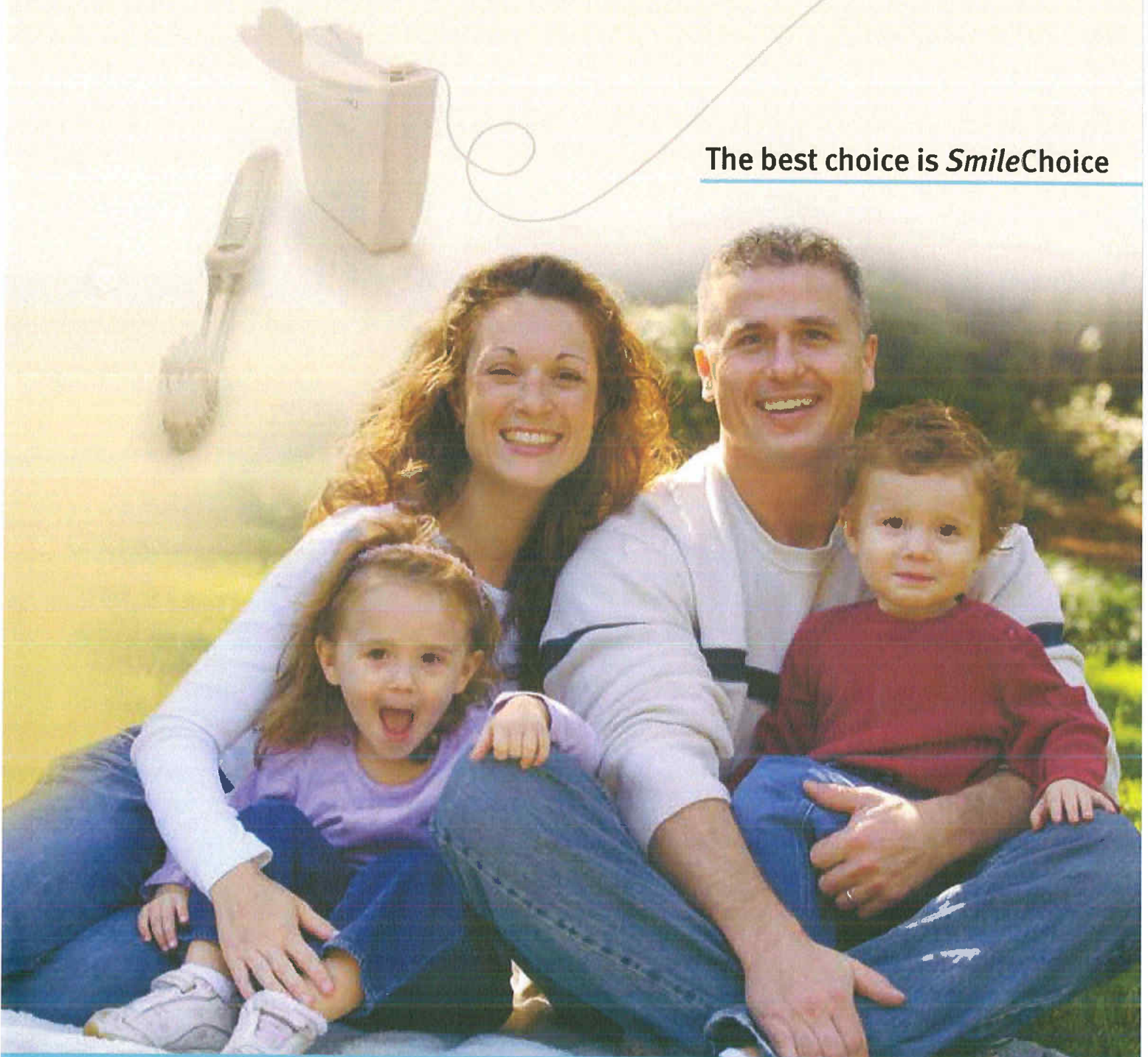


 DELTA DENTAL

# *Smile*Choice<sup>SM</sup>

The best choice is *SmileChoice*



An individual dental benefits plan just right for you and your family



## Enjoy Quality, Affordable Dental Coverage from the Dental Benefits Leader.

### You Deserve a Healthy Smile

There are good reasons for you to have dental benefits and to protect your healthy smile.

- People with dental benefits are more than twice as likely as those without benefits to have regular dental care.
- Every dollar that you invest in preventive care saves you money on restorative and major care down the road.
- Your oral health is an important part of your overall health and well-being, and good oral health may help reduce complications from some health conditions, such as diabetes and cardiovascular disease.

### Your Smile Deserves Delta Dental!

Delta Dental is the leader in dental benefits. One in four families with dental benefits chooses Delta Dental, and now you can, too.

- Rates are very affordable.
- You can choose any dentist you want. Your benefits are greater for preventive and basic care, and your out-of-pocket expenses will be lower when you select a Delta Dental PPO dentist. However, you still get great coverage when you choose a Delta Dental Premier dentist or a non-participating dentist.
- Your Delta Dental PPO dentist or Delta Dental Premier dentist will file claims for you. This reduces your paperwork.
- With Delta Dental, you get the best in personal service from a recognized leader in customer service.
- With the *Benefit24* toll-free line and *Benefit24 Online*, you also receive 24/7 self-service access to your claims history, claims status, description of benefits and eligibility status.

### There's No Better Choice for Quality and Affordable Dental Coverage.

For more information, call Delta Dental's *Benefit24* line at (866) 991-7345 (press "4" for prospective members) or visit our web site at [www.deltadentalmo.com](http://www.deltadentalmo.com).



# SmileChoice<sup>SM</sup>

## Benefit Summary

Services Covered	Delta Dental PPO Dentists	Delta Dental Premier Dentists <sup>1</sup>	Non-Participating Dentists <sup>1</sup>
<b>Diagnostic and Preventive</b> (no deductible, no waiting period)			
<b>Exams and cleanings</b> (2 per year <sup>2</sup> ) <b>X-rays</b> (once in any 36-month period; 1 set of bitewings every year) <b>Space maintainers for dependents under age 16</b> <b>Emergency palliative treatment</b> (for dental pain) <b>Fluoride for dependents under age 18</b> (once per year) <b>Sealants for dependents under age 18</b> (on cavity-free first and second permanent molars, once every five years)	<b>100%</b>	<b>80%</b>	<b>80%</b>
<b>Basic Services</b> (six-month waiting period for fillings) <sup>3</sup>			
<b>Fillings</b> (basic restorative) <b>Periodontal maintenance cleanings</b> (2 per year*) <b>Scaling and root planing</b> <b>Non-surgical extractions</b> <b>Pulpotomy and pulp capping</b>	<b>80%</b>	<b>60%</b>	<b>60%</b>
<b>Major Services</b> (twelve-month waiting period) <sup>3</sup>			
<b>Root canals, apicoectomy, root amputation</b> <b>Oral surgery – including surgical extractions</b> <b>Periodontics</b> (surgical) <b>Crown and cast restorations</b> (once every 5 years) <b>Prosthodontics<sup>4</sup></b> (bridges, dentures, once every 5 years) <b>Denture repair, rebase and relining</b> <b>General anesthesia</b> (with surgical procedures only)	<b>50%</b>	<b>50%</b>	<b>50%</b>
<b>Deductibles and Maximums per Enrollee</b>			
Deductible (basic, major only)	<b>\$50</b>	<b>\$50</b>	<b>\$50</b>
Annual maximum benefit	<b>\$1,000</b>	<b>\$1,000</b>	<b>\$1,000</b>

<sup>1</sup> Coverage based on Delta Dental PPO fee schedule.

<sup>2</sup> Only two cleanings of any type per year.

<sup>3</sup> Delta Dental will waive waiting periods with proof of twelve months continuous coverage for basic and major services immediately preceding enrollment in this plan.

<sup>4</sup> Pre-existing conditions apply to prosthodontics. Charges for services related to teeth missing prior to the membership effective date will not be covered.

**This is a summary of your benefits. For a complete description, please refer to the Membership Certificate and Schedule of Benefits online at [www.deltadentalmo.com](http://www.deltadentalmo.com) or in your new member packet.**

# Oral Health Solutions for You

SmileChoice from Delta Dental of Missouri for individuals and families has it all. You receive comprehensive coverage, the freedom to select your own dentist, quality dental care and affordable rates. Plus, the outstanding customer service that you receive with Delta Dental means we are there with solutions when and where you need them.

## Easy Enrollment

Great dental coverage is just a few easy steps away. Just detach and mail the enclosed application. Or, simply visit [www.deltadentalmo.com](http://www.deltadentalmo.com), click on "Welcome to SmileChoice," download the enrollment application and then mail it in. You must enroll for a minimum of one year. Mail your application to:

*Kevin J. Guss  
The Daniel & Henry Company  
1001 Highlands Plaza Drive West, Suite 500  
Saint Louis, MO 63110*

## Convenient Payment Options

You have the option to pay a one-time premium for a full year by check or ACH payment. You can also set up an automatic, recurring monthly ACH payment from your checking or savings account. If you enroll online (Delta Dental expects online enrollment to be available in the spring of 2010), you can submit your account information and set up payments online.

Your membership will automatically renew each year. We will notify you 31 days in advance of your renewal date of any change in your premium rates. If you choose to discontinue your membership, you must notify us 15 days prior to your annual renewal date. You may notify us by mail or online at [www.deltadentalmo.com](http://www.deltadentalmo.com). If your coverage lapses, there is a twelve-month waiting period to re-enroll.

## SmileChoice<sup>SM</sup> Answers

### **Q Who is eligible to enroll in Delta Dental of Missouri's SmileChoice plan?**

**A** The Delta Dental SmileChoice plan is available to all permanent residents of Missouri, age 18 or older. Coverage is also available for your spouse, and/or dependent children until the end of the month in which they turn 18. Coverage types are: individual, individual and spouse, individual and children, or family coverage (individual, spouse and children).

### **Q What are the advantages of visiting a Delta Dental PPO dentist?**

**A** While enrolled in SmileChoice, you can visit any dentist anywhere in the country regardless of whether the dentist participates in one of our networks. However, you will have the lowest out-of-

pocket expense by using a Delta Dental PPO dentist. When you visit a Delta Dental PPO dentist, your benefits will be greater for preventive and basic services and your out-of-pocket expenses lower. A Delta Dental PPO dentist accepts the PPO maximum plan allowance as payment-in-full for covered charges. You are only responsible for non-covered charges, coinsurance amounts and deductibles.

### **Q What if I visit a Delta Dental Premier dentist?**

**A** With SmileChoice, you also have access to the Delta Dental Premier network. This network is the largest network of dentists in Missouri and the nation. If you visit a Delta Dental Premier dentist, you receive the advantages of negotiated fees (the Delta Dental Premier fee schedule), great service and having the dentist file your claim for you. However, your benefits will be lower for preventive and basic services and your out-of-pocket expenses will be higher than they would be if you received care from a Delta Dental PPO dentist.

In addition, the Delta Dental Premier dentist can bill you for the difference between the Delta Dental Premier fee schedule amount and the Delta Dental PPO maximum plan allowance. The Delta Dental Premier fee schedule is typically higher than the PPO maximum plan allowance. Delta Dental Premier dentists cannot bill you for the remainder of their billed (retail) charge, which is typically higher than the Delta Dental Premier fee schedule amount.

### **Q Can I visit a dentist who does not participate in a Delta Dental network?**

**A** You may choose to visit a non-participating dentist (a dentist who does not participate in one of our Delta Dental networks). If you do, you will not have the advantage of negotiated fees and could be billed for the difference between the dentist's billed (retail) charge and what Delta Dental pays for a covered service. Also, the dentist may request full payment prior to service.

You may also have to file your own claim. Claim forms are available on our web site at [www.deltadentalmo.com](http://www.deltadentalmo.com) in the Subscribers section. You may also obtain a claim form by calling our Customer Service Department at (866) 991-7345, or online at [www.deltadentalmo.com](http://www.deltadentalmo.com).

### **Q What will be the difference in my out-of-pocket expenses when I use a Delta Dental PPO dentist, Delta Dental Premier dentist or non-participating dentist?**

**A** Here's an example of how your out-of-pocket expenses might be different depending on the dentist you visit. Hypothetically, let's say the Delta Dental PPO maximum plan allowance for a crown is \$500, the Delta Dental Premier fee schedule amount is \$600, the dentist's billed (retail) charge for a crown is \$700. Under your SmileChoice plan, this is considered a major service, and we'll assume your deductible has been met. Your coinsurance





# SmileChoice<sup>SM</sup> ENROLLMENT/CHANGE APPLICATION

Your SmileChoice plan has a commitment period of 12 months.

If you are accepted, your SmileChoice plan is issued by Delta Dental of Missouri. In order to be eligible to enroll, you must be a Missouri resident. The effective date for coverage under your SmileChoice plan is always the 1<sup>st</sup> of the month. An application must be received by the 15<sup>th</sup> of the month and accepted for coverage to be effective the first of the following month. For example, if the application is received on 1/14 and accepted, your coverage is effective on 2/1. If it is received on 1/16 and accepted, your coverage is effective on 3/1.

Please print clearly or type. Complete this form in full to ensure timely processing.

For more information go to <a href="http://www.deltadentalmo.com">www.deltadentalmo.com</a>		Social Security Number	Effective Date (mm/dd/yy) ____ / 01 / ____	
Reason for Form:	<input type="checkbox"/> New Applicant <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Change in Banking Information			
<b>SECTION I</b>	Applicant Name (First, Middle Initial, Last)		Date of Birth __/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female
Complete Address – Street		City	State MO	Zip
E-mail address			Telephone ( )	<input type="checkbox"/> Single <input type="checkbox"/> Married
Please select the coverage for which you are applying: <input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & Children <input type="checkbox"/> Family				
<b>SECTION II ELIGIBLE DEPENDENTS</b>				
List eligible members of your family to be covered (submit additional page, if necessary):			Date of Birth (mm/dd/yy)	Sex
First Name	Middle Initial	Last		
Dependent Spouse			__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Child			__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Child			__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Child			__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Child			__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>SECTION III CHANGE OF COVERAGE</b>				
Please check the events requiring a change in coverage. Note: Eligibility changes as a result of a qualifying event must be reported within 31 days.				
<input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Terminate Coverage				
Name of affected person: _____			Date of event: _____	
<b>SECTION IV PRODUCER INFORMATION (to be completed when requested by your agent, if any)</b>				
Producer Name		Carolyn Bunch 314-444-1945 BunchC@DanielandHenry.com		
Company Name		The Daniel & Henry Co. Taxpayer ID 430634945		
Address		City	State	Zip
1001 Highlands Plaza Drive West, Suite 500,		Saint Louis	MO	63110

Your application must be executed in Section VII (and Section VI, if applicable) on the next page in order to process.

**SECTION V PAYMENT OPTIONS**

By signing this application, you agree to pay premiums by (check only one box below):

- Check – one payment annually for 12 months of premiums for a 4% discount
- Automatic debit – monthly withdrawal from my bank account (ACH transaction) on the 20<sup>th</sup> of the month
- Automatic debit – one payment annually for 12 months of premiums (ACH transaction) for a 4% discount

**BY CHECK** - If you elect to pay by check, please make it payable to Delta Dental of Missouri, and mail your check, along with your application, to Enrollment Services c/o CBIZ, PO Box 20, Roanoke, VA 24002. Note: your application will not be complete until we have received your check.

**BY AUTOMATIC DEBIT** - If you elect to pay by automatic debit, you must complete Section VI below.

By electing to pay by automatic debit, I authorize Delta Dental of Missouri and its representatives to initiate electronic debit entries (and corrections to previous debits) to my checking or savings account indicated below for amounts due Delta Dental and I authorize the financial institution named below to debit these entries from my account. This authority remains in effect until I revoke it by giving Delta Dental at least 31 days prior written notice of such revocation. I agree that Delta Dental and my financial institution shall be fully protected in honoring any such debit. I understand that premium rates and other charges are subject to change by Delta Dental giving at least 31 days prior written notice of any change. I understand that if my withdrawal is not honored by my financial institution, Delta Dental may remove me from the automatic debit payment program, in which case, I must pay by check.

**Date of Debit – 20th of Each Month** - SmileChoice is a pre-paid dental benefits plan. Monthly payments are required by the 20<sup>th</sup> of each month for your next month of coverage. When first enrolling, if your enrollment application is processed by the 15<sup>th</sup> of the month and accepted, your account will be debited on the 20<sup>th</sup> of that month for the following month of coverage. There are rare occurrences when applications are received by the 15<sup>th</sup>, but not accepted and processed until after the 20<sup>th</sup> when debits are initiated for the month. Should this occur, your account will be debited on the 20th of the next month, for the premiums due for both the prior and current month. **When first enrolling, be sure to reserve enough money in your bank account for two months premiums for the first payment.** If the 20th falls on a weekend or bank holiday, the withdrawal will occur on the following business day.

**SECTION VI BANKING INFORMATION**

**Banking Information:**  Initial Information  Change in Information

<b>Financial Institution</b>		<b>Branch (if applicable)</b>	
<b>Address</b>		<b>City</b>	<b>State</b> <b>Zip</b>
<b>Account Type</b> <input type="checkbox"/> Checking <input type="checkbox"/> Savings	<b>Routing Number</b>	<b>Account Number</b>	
<p>This authority is to remain in full force and effect until Delta Dental of Missouri has received at least 31 days prior written notice from the applicant of its termination.</p>			
<b>Print Name of the Applicant</b>		<b>SSN of Applicant</b>	
<b>SIGN HERE - Signature of Applicant</b>		<b>Date</b>	

**SECTION VII APPLICATION AGREEMENT AND AUTHORIZATION**

By signing this application, you (and your spouse, if the spouse is to be covered) acknowledge, agree, certify, represent and authorize, as applicable, each of the following.

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I acknowledge my understanding that I am applying for individual coverage offered by Delta Dental of Missouri. I agree to pay all monthly premiums due to Delta Dental for this coverage in a timely manner. If payment is not made when due, I acknowledge that my coverage may be terminated by Delta Dental. I acknowledge that if this coverage is terminated, either voluntarily or involuntarily, neither I nor any person named in this application is eligible to apply for individual coverage offered by Delta Dental for a period of 12 months from the date of termination. I acknowledge that coverage under the SmileChoice plan will not commence until after this application and the required premiums are received and accepted by Delta Dental and then only on the effective date established by Delta Dental for such coverage. If accepted for coverage, I agree to comply with the terms, conditions and restrictions of the Membership Certificate and Schedule of Benefits, including, without limitation, the obligation to notify Delta Dental of any change that would make me or any dependent ineligible for coverage. I agree that any notice required or permitted to be given by Delta Dental under the Membership Certificate and Schedule of Benefits is sufficient if it is mailed or given by electronic means to me at the address appearing on Delta Dental's records for me. Without limiting the foregoing, I agree that Delta Dental may issue the Membership Certificate and Schedule of Benefits (and amendments thereto, including notices of such amendments) by electronic means to me.

I represent that the statements, information and answers set forth in this application are true, complete and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I acknowledge that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made. Any false statement, misrepresentation or omission of any material fact found in this application may result in a denial of benefits or rescission or cancellation of my coverage.

I authorize any health care provider to release medical records to Delta Dental of Missouri when reasonably related to the dental care coverage for which I have applied. I give this authorization for and on behalf of myself and any person named herein; I am acting as their agent and representative. If an additional authorization is required and I fail to give it, I acknowledge that such failure may result in a denial of benefits.

**SIGN HERE** - You and your spouse (if the spouse is to be covered) must sign below. By signing below, you each acknowledge that you have read and understand this application, and accept and agree to be bound by all of the provisions of this application.

		____ / ____ / ____
Applicant Printed Name	Applicant Signature	Date
		____ / ____ / ____
Spouse Printed Name	Spouse Signature	Date

# SmileChoice<sup>SM</sup> Answers

(CONTINUED FROM PAGE 4)

amount is 50% of the Delta Dental PPO maximum plan allowance, and Delta Dental would pay 50% of the Delta Dental PPO maximum plan allowance.

• **Delta Dental PPO Dentist = \$250 out-of-pocket expense**

If you go to a **Delta Dental PPO dentist**, the Delta Dental PPO maximum plan allowance would be \$500. Delta Dental would pay 50% of this amount, and you would pay 50%, or **\$250 out-of-pocket**.

• **Delta Dental Premier Dentist = \$350 out-of-pocket expense**

If you go to a **Delta Dental Premier dentist**, Delta Dental would still pay 50% of the Delta Dental PPO maximum plan allowance, which would be \$250, and you would pay the other 50% of the Delta Dental PPO maximum plan allowance. In addition, the Delta Dental Premier dentist might bill you for the difference between the Delta Dental Premier fee schedule amount of \$600 and the Delta Dental PPO maximum plan allowance, which would be an additional \$100. Thus, you might pay a total of **\$350 out-of-pocket**.

• **Non-Participating Dentist = \$450 out-of-pocket expense**

If you go to a **non-participating dentist**, Delta Dental would still pay 50% of the Delta Dental PPO maximum plan allowance, or \$250. The dentist might bill you for the difference between the dentist's billed charge of \$700 and what Delta Dental pays, which could be **\$450 out-of-pocket**.

Keep in mind that a **non-participating dentist** might expect full payment for services prior to treatment, and you would need to file a claim to receive reimbursement for the covered amount from Delta Dental.

**Q How can I find a dentist or find out if my dentist participates in a Delta Dental network?**

**A** Visit our web site at [www.deltadentalmo.com](http://www.deltadentalmo.com) and click on "Looking for a Dentist?" In the search menu, you can specify "Delta Dental PPO." Or, you can call customer service at (866) 991-7345. Remember, if your dentist does not currently participate in the Delta Dental PPO network, you can encourage him or her to do so. Participation is always welcome.

**Q When will my dental coverage begin?**

**A** All complete applications received on or before the 15th day of the month will be effective the first of the following month, provided the application for coverage is accepted. For example, a completed

application received by September 15 will be effective on October 1. An application received after September 15 will have an effective date of November 1. You can check your enrollment status by calling Enrollment Services at (800) 284-2674.

**Q When can I add a spouse or dependent?**

**A** You can add a spouse or dependent annually, on your anniversary month, or if you have a qualifying event (i.e., marriage, adoption). Effective dates for membership changes will follow the schedule stated for initial effective dates (explained in the previous question). To add or delete a spouse or dependent, call Enrollment Services at (800) 284-2674. We expect that in the spring of 2010, you will be able to do this online at [www.deltadentalmo.com](http://www.deltadentalmo.com). Just click on *SmileChoice* on the home page menu.

**Q Are there waiting periods before benefits are paid?**

**A** Yes, *SmileChoice* has a 6-month waiting period for fillings (a basic service) and a 12-month waiting period for major services including periodontal surgery, crowns, root canals, bridges and dentures. Waiting periods can be waived with proof of 12 months of continuous coverage under an insurance contract with similar dental coverage that was in effect immediately preceding your membership effective date.

**Q What is needed to prove I had 12 months of coverage for restorative and major services with my prior dental carrier?**

**A** To waive the waiting periods for fillings and major services, send Delta Dental a statement from your previous insurance carrier, stating your coverage period (effective date and termination date) and that you have had 12 months of prior continuous coverage for yourself and applicable dependents that included coverage for fillings and major services. Fax this information to Delta Dental at (314) 656-2900. Please include your name, address, phone number and "*SmileChoice*" on the front of the document.

**Q What do I do if I want to change my bank account used for the automatic withdrawal of premiums?**

**A** You can change your bank account information anytime by calling Enrollment Services at (800) 284-2674. We expect that in the spring of 2010, you will also be able to do this online at [www.deltadentalmo.com](http://www.deltadentalmo.com). Just click on

*SmileChoice* on the home page menu.

**Q If I elect to pay through ACH transactions, when will my premium be deducted from my bank account each month?**

**A** The ACH transaction will occur on or about the 20th day of the month immediately preceding the month for which the premium is due. Please note that, depending on the day of the month your *SmileChoice* application is processed and accepted, the first ACH transaction taken from your bank account may be for two months of premiums. For example, if your application is received on January 15 and processed on January 21 for a February 1 effective date, your first ACH withdrawal will occur on February 20 for both the February and March premiums. **When first enrolling, it would be a good idea to keep enough money in your account for your first two months of premiums.**

**Q When is a "pre-existing condition" not eligible for prosthodontic coverage?**

**A** A pre-existing condition in prosthodontics would occur when you have one or more missing teeth, lost before your coverage under *SmileChoice* begins. Benefits under this plan will not be available for the initial replacement of these missing teeth.

**Q Are there services that are not covered?**

**A** We provide strong coverage for common preventive, restorative and major services. However there are some services not covered. One example is orthodontics. For a complete list of non-covered services, you can review a Membership Certificate and Schedule of Benefits online at [www.deltadentalmo.com](http://www.deltadentalmo.com) or, if you enroll, in your new member packet.

**Q Do I have coverage outside of Missouri?**

**A** Yes, your Delta Dental coverage travels with you. Common examples are:

- A part-time secondary residence outside of Missouri
- Traveling outside of the state of Missouri, including international travel

**Q What if I permanently move out of Missouri?**

**A** Your coverage would terminate at the end of the month in which you change permanent residency.

## Choose *SmileChoice*<sup>SM</sup> for a lifetime of healthy smiles.

At Delta Dental of Missouri, we are passionate about oral health and advancing solutions for oral health for everyone. We believe that everyone deserves a healthy smile. Science is reinforcing how important oral health is to maintaining overall health. A small investment in regular check-ups, cleanings and x-rays may help maintain not only your oral health but your overall health as well.

If you would like more information on *SmileChoice*, please call *Benefit24* at (866) 991-7345, and press "4" for prospective members or visit our web site at [www.deltadentalmo.com](http://www.deltadentalmo.com). Just click on *SmileChoice* on the home page menu.

There's no better choice than **SmileChoice** for quality, affordable dental coverage.



**Delta Dental of Missouri**

**St. Louis headquarters**

(800) 392-1167

(314) 656-3000

**[www.deltadentalmo.com](http://www.deltadentalmo.com)**