BLUE SPRINGS SMILES DENTAL PLAN

WHAT IS THE BLUE SPRINGS SMILES GOLD PLAN?

The **BLUE SPRINGS SMILES GOLD PLAN** is an annual plan with reduced fees that has been developed to deliver quality dental care service to families like yours that do not have access to dental insurance. Our office offers the convenience of extended hours, plus the individualized attention of private care.

WHERE ARE SERVICES OBTAINED?
Services for this plan are offered at our office only, which is located at 5944 Stetson Hills Blvd, #100 Colorado Springs, CO 80923

HOW DO I RECEIVE CARE?
After your membership is effective, simply call our office for an appointment. All treatment completed during regular business hours will be eligible for the discount covered under this plan.

WHO IS ELIGIBLE?
You, your spouse and any dependent children under the age of 18 or full-time students up to age 23 years of age (proof must be provided).

WHEN WILL BENEFITS BEGIN?
Benefits will begin immediately. This is an annual plan members will remain in the plan for a minimum of 12 months.

WHAT IS THE ANNUAL COST?

1 Member	$285.00
2 Members	$515.00
3 Members	$675.00
4+ Members	+$150.00/person

WHAT ARE THE BENEFITS?
Unlike a conventional insurance plan there are no deductibles and no yearly maximums. You will receive:

- 2 Healthy dental cleanings* per year - **NO ADDITIONAL CHARGE**
- 2 Routine dental examinations per year - **NO ADDITIONAL CHARGE**
- Routine x-rays as prescribed by the doctor - **NO ADDITIONAL CHARGE**

- A reduction of 20% off the regular office fee for any additional treatment needed.
- A $20 fee for problem oriented office visits

*A dental prophylaxis performed on transitional or permanent dentition that includes scaling and/or polishing procedures to remove plaque, calculus, and stains from the coronal (crown) of the tooth.

Patient Payments

The **BLUE SPRINGS SMILES GOLD PLAN** is **NOT** a dental insurance policy and does not make payments directly to the provider. It is the responsibility of the members to pay for all dental services from their provider based on the reduced fee schedule. All payments are made directly to the dental office at the time treatment is performed. You should discuss all future payments and costs before future appointments are made.

How To Join

Fill out the attached enrollment form; and the number of any eligible family members that will be joining the plan. Coverage will become effective on the date payment is received.

Term and Termination of Services

The plan will be considered effective on the date payment is completed. You and your family's right to receive services will continue for one (1) calendar year after the enrollment fee is processed. If the plan is not renewed, this will be the termination date.

Auto-Renewal

In order to provide continuity of care, this plan in set to auto-renew yearly on the anniversary date of enrollment. You can opt out for future renewal at any time, by providing written notice to Blue Springs Family Dental. By opting out of future renewal, you will continue to receive the included services and reduced fee schedule for any treatment completed before the termination date.

Cancellation of Services

You will have forty-five (45) days after the payment date to cancel your eligibility and receive a full refund of your enrollment fee (excluding a 3% processing fee of the total amount billable). However, no cancellation will be permitted if you or any eligible family member received services from Blue Springs Family Dental during this 45- day period.

LIMITATIONS & EXCLUSIONS

1. Demonstrated non-compliance with the recommended course of treatment.
2. Services, which in the opinion of the attending dentist are neither necessary nor recommended for the patient's health.
3. Restorations, splints or other appliances used to increase vertical dimension or to restore occlusion.

4. Any service you are referred out of the office for, to include; Periodontics, endodontics, and oral surgery.
5. Congenital malformations, except congenital anomaly of a tooth or teeth covered from birth.
6. Dispensing of drugs not normally supplied in the dental office.
7. Hospital benefits for any other dental procedure.
8. Loss or theft of dentures, bridges or crowns.
9. Services for injuries or conditions, which are covered under Workers' Compensation or Employer's Liability Laws.
10. Services that cannot be performed because of general health, physical or psychological limitations of the patient.
11. If patient should become covered by a traditional dental plan this plan becomes null & void with no refund of the fees.

SERVICE FOR THIS PLAN AVAILABLE AT:

Blue Springs Family Dental
5944 Stetson Hills Blvd
Ste. #100
Colorado Springs, CO 80923

PROVIDERS FOR THIS PLAN ARE:
Michael Coughlin, DDS
Top of Form

Bottom of Form
Enrollment Form

Last Name ___________________________First____________________________ MI ______

Home Address ____

City _____________________________ State _________________ Zip _________________

Home Phone ____________________________ Work Phone ___________________________

Birth date _____/_____/_____ Employer ____

<u>List Covered Dependents</u>

Name	**Birth date**	**Relationship**

Please read and sign below:

I understand the benefits, limitations, exclusions and requirements of the Blue Springs Smiles Dental Plan and I agree to the following.

1. I will remain in the plan and pay membership fees for a minimum of 12 months.
2. Payment of less than 12 months membership fees may cause me to be charged the usual and customary fees for all services (including those already provided) and my being charged for the remaining months fees in lump sum.
3. Fees for dental services are due when services are rendered.
4. Fees for prosthodontic and cast restorations are due at the preparation/impression visit. Failure to comply may result in my being charged usual and customary fees for such services.
5. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs.

Signature ____ Date___/___/____

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To enroll by mail complete the above form, select your payment type below and and return to the office.

Annual Payment Amount enclosed $_____________

__________Check enclosed
______Visa / MasterCard / Discover / American Express

Authorized Cardoholder Signature____