BlueDental℠ PPO

BENEFIT BOOK

BlueDental PPO Classic
Individual & Family Plan

azblue.com

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BlueDental PPO Classic
BlueDental PPO – Individual
Summary of Benefits Dental Base Book

IMPORTANT NOTICE: Please read this book, which is part of your contract with Blue Cross Blue Shield of Arizona (BCBSAZ) and all accompanying documents when you receive them. If this BlueDental benefit plan is unsatisfactory for any reason, you may cancel your policy by sending BCBSAZ written notice of cancellation within ten (10) days following receipt of this book. You may also contact BCBSAZ to discuss your options for obtaining coverage through another BCBSAZ plan. If you choose to cancel and you prepaid any premium, BCBSAZ will refund that premium and cancel the contract for your benefit plan as though it was never in effect.

Plan Benefit Structure	
Benefit Maximum per Member per Calendar Year[1] All covered services count toward the maximum except Type I for Preventive, Classic and Plus plans.	$1,000 per member year one / $1,250 per member year two / $1,500 per member year three
Annual Deductible[1] Deductible waived for Type I services **Individual** **Family**	 $50 $150

Benefit Category	**In-Network**		**Out-of-Network**	
	Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
Type I	100%	0%	90%	10%
	Type I services do not count toward the calendar-year maximum Deductible does not apply			
Type II	Plan pays 50% after deductible in year one. Plan pays 60% after deductible in year two. Plan pays 80% after deductible in year three.	You pay 50% after deductible in year one. You pay 40% after deductible in year two. You pay 20% after deductible in year three.	Plan pays 30% after deductible in year one. Plan pays 50% after deductible in year two. Plan pays 70% after deductible in year three.	You pay 70% after deductible in year one. You pay 50% after deductible in year two. You pay 30% after deductible in year three.
	After meeting deductible			
Type III	Plan pays 25% after deductible in	You pay 75% after deductible in year	Plan pays 10% after deductible in	You pay 90% after deductible in year

	year one. Plan pays 35% after deductible in year two. Plan pays 50% after deductible in year three.	one. You pay 65% after deductible in year two. You pay 50% after deductible in year three.	year one. Plan pays 20% after deductible in year two. Plan pays 40% after deductible in year three.	one. You pay 80% after deductible in year two. You pay 60% after deductible in year three.
	After meeting deductible			
Type IV	0%	100%	0%	100%
	Lifetime Max **Not Applicable**			

Type I Covered Services[1]	
Oral exams	Two per year[2] in any combination of periodic, limited, or comprehensive exams
Prophylaxis – Cleanings	Two per year – Type III periodontal maintenance <u>does not</u> count toward max of two cleanings
Bitewing X-rays[3]	Two sets per year
Periapical X-rays[3]	Four films per year
Full Mouth X-rays[3]	One per five-year period
Topical Fluoride	Through age 15 – One per year
Sealants	Through age 15 – permanent molars and bicuspids only, once per lifetime
Space Maintainers	Through age 15
Type II Covered Services[1]	
Amalgam Fillings	One treatment per tooth in any two-year period (limit based on amalgam and composite fillings combined)
Composite Fillings – Anterior (Front) Teeth	One treatment per tooth in any two-year period; (limit based on amalgam and composite fillings combined)
Composite Fillings – Posterior/Bicuspid (all except front) Teeth	Not covered.
Emergency Palliative Treatment	Covered for emergency treatment of dental pain
Simple Extractions	Surgical extractions also covered under Type III
Type III Covered Services[1]	
Prosthodontics – Bridges & Dentures	Seven-year replacement limit

Oral Surgery - Extractions	Limited Coverage
General Anesthesia	Limited Coverage per BCBSAZ dental coverage guidelines[4]
Endodontics – Root Canal	One treatment per tooth in any two-year period
Endodontics – Pulpal Therapy	One treatment per tooth in any two-year period
Crowns/Inlays/Onlays	Seven-year replacement limit
Periodontics – Non-surgical	One per two-year period – Periodontal maintenance procedures are not included in this limit.
Periodontics – Surgical	One procedure per three-year period
Type IV Covered Services	
Orthodontics	Not applicable
Out of Network Reimbursement	MAC (Maximum Allowable Charge)
Maximum Rollover Benefit	Not applicable.
Provider Network	Includes both BlueDental PPO and BlueDental PPO Prime

[1] Only the allowed amount, (and not billed charges) counts to satisfy the deductible. Only the BCBSAZ portion of the allowed amount counts toward the calendar year benefit maximum. Any services in excess of a benefit limit or provided after you reach the calendar year benefit maximum are not covered.
[2]All "per year" benefits mean per calendar year.
[3]Any combination of x-rays billed on the same date of treatment cannot exceed the allowed amount for a full mouth x-ray benefit.
[4] BCBSAZ Dental Coverage Guidelines are available upon request. Not all dentally necessary services are covered benefits.

In-Network Providers

"In-network" dental providers have either a BlueDental PPO or BlueDental PPO Prime contract with Blue Cross Blue Shield of Arizona (BCBSAZ) or with BCBSAZ's independent dental network vendors. In-network providers accept negotiated fees as payment in full for covered dental services, and file a member's claims with BCBSAZ. Members usually have lower out-of-pocket costs with in-network providers.

Out-of-Network Providers

"Out-of-network" providers have no contract with BCBSAZ or with BCBSAZ's independent dental network vendors. Out-of-network providers set their own rates, can collect up to full billed charges from members, and have no obligation to file members' claims.

For out-of-network providers within Arizona, BCBSAZ reimburses the member based on the lesser of BCBSAZ's established in-network fee schedule amount or the dentist's actual billed charge. If the provider is located outside Arizona, reimbursement is based on the lesser of billed charges or the fee schedule of the independent dental network vendor.

Example

The following example shows how use of an in-network provider may save you money. This example assumes:

- you have already met your annual deductible
- you have 80% coinsurance for in-network providers
- you have 80% coinsurance for out-of-network providers
- your dentist's billed charge is $150
- BCBSAZ's established in-network fee is $100

In-Network Provider		Out-of-Network Provider	
Billed charge	$150	Billed charge	$150
BCBSAZ in-network fee	$100	BCBSAZ in-network fee	$100
BCBSAZ pays (80% x $100)	$80	BCBSAZ pays (80% x $100)	$80
You pay (20% x $100)	$20	You pay (20% x $100)	$20
		Plus difference of billed charge	$50

	Your Out-of-Pocket Cost: *$20* *Your Out-of-Pocket Cost:* *$70* While your actual expenses will vary, in this example you would have saved $50 by using an in-network provider.
Optional Pre-determination	If your dentist has recommended services and you are concerned about coverage or costs, your dentist can ask BCBSAZ for a pre-treatment estimate, called a "pre-determination." BCBSAZ will review your dentist's proposed treatment and send your dentist information explaining what services will be covered and your estimated out-of- pocket costs for these services. A pre-determination can help you better understand what will be covered and the amount you will need to pay. A pre-determination does not guarantee coverage or the amount.
Prevention + 1 Program	All diabetic and pregnant members are eligible for coverage of one additional dental cleaning procedure or one additional periodontal maintenance procedure. For members who have enrolled in the program, extended preventive benefits will remain available for the duration of these conditions.

BCBSAZ Standard PPO Exclusions and Limitations

Type I. Diagnostic and Preventive Services (Not covered on BlueDental PPO Select)**:**

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. One topical fluoride per Calendar Year, to age 16
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)
9. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Type II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
4. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
5. Antibiotic injections administered by a dentist

Type III. Major Services: (Not covered with BlueDental PPO Preventive)

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
   d. Alveolectomy, alveoplasty, and frenectomy
   e. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   f. Tooth reimplantation and/or stabilization; tooth transplantation
   g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years
   d. Occlusal adjustment performed with covered surgery
   e. Gingivectomy
   f. Osseous surgery including flap entry and closure
   g. One pedicle or free soft tissue graft per site per lifetime
   h. One appliance (night guards) per 5 years within 6 months of osseous surgery
   i. One full mouth debridement per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced
   c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
   d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
11. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Type IV. Orthodontia Services Not Covered:

Diagnostic services, active and retention treatment to include removable, fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:

1. Services which are covered under Medicare, worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function (except with BlueDental PPO Plus).
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. **Implants and related services** (except with BlueDental PPO Plus); replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

Dental Policy – Individual

This policy is renewable subject to timely payment of premiums. Premiums are subject to change on a uniform basis for all subscribers covered under this policy form.

Blue Cross and Blue Shield of Arizona, Inc., an independent licensee of the Blue Cross and Blue Shield Association, (herein referred to as "Plan" or BCBSAZ) certifies that the Subscriber is covered under and subject to all the provisions, definitions, limitations and conditions of this Individual Dental Policy for the benefits approved herein, and is eligible for benefits stated in the attachments hereto (Coverage Schedule) as of the date indicated in the letter accompanying the Membership Identification Card.

“Dental Benefits Administrator” (DBA) means Dominion Dental Services USA, Inc., the independent company that administers dental benefits for BCBSAZ. The DBA processes dental claims, determines dental necessity and handles utilization management, grievances and appeals related to dental services.

[Member Services Contact (change mail address, add or remove dependents, termination of coverage)
Blue Cross and Blue Shield of Arizona
Attn: Membership Services
Mail Stop: A102
Blue Cross Blue Shield of Arizona
PO Box 13466
Phoenix, AZ 85002-3466]

[888-271-7806]

IMPORTANT NOTICE: Please read this book, which is part of your contract with Blue Cross Blue Shield of Arizona (BCBSAZ) and all accompanying documents when you receive them. If this benefit plan is unsatisfactory for any reason, you may cancel your policy by sending BCBSAZ written notice of cancellation within ten (10) days following receipt of this book. You may also contact BCBSAZ to discuss your options for obtaining coverage through another BCBSAZ plan. If you choose to cancel and you prepaid any premium, BCBSAZ will refund that premium and cancel the contract for your benefit plan as though it was never in effect.

Part I. DEFINITIONS

A. **Annual Deductible** shall mean the amount set forth in the Coverage Schedule which each Member must pay each Calendar Year before Benefits will be paid by the Plan.
B. **Annual Maximum** shall mean the total amount of Benefits set forth in the Coverage Schedule that will be paid to the Member in a Calendar Year.
C. **Benefits** shall mean the amount payable by the Plan, as set forth in the Coverage Schedule, for a Covered Service.
D. **Calendar Year** shall mean January 1st through December 31st.
E. **Covered Service** shall mean a procedure listed in the Coverage Schedule.
F. **Dependent** shall mean lawful spouse of Subscriber and/or unmarried natural, step or adopted children, or children under the Subscriber's legal guardianship, from and after birth up to his/her 26th birthday. A child is automatically eligible for coverage for the first 31 days beginning on the date of birth, adoption, placement for adoption, or placement in foster care (“qualifying date”), if the parent or guardian covered under this plan remains eligible for coverage during that period and the child is otherwise an eligible dependent under this plan. Coverage will continue for the child after the 31-day period and you will be responsible for any additional premium, unless you provide notice in writing to remove the child from the Plan. The additional premium is prorated. Even if no additional premium is required (for example, you already have family coverage), you must provide notice in writing if you wish to remove the child from the plan.
   When a child has been placed with a Subscriber for the purpose of adoption, that child is eligible for Dependent coverage from the date of such adoptive or parental placement. However, application for coverage must be submitted within 31 days from date of eligibility, along with proof that the adoption is pending. If a newborn infant is placed for adoption with Subscriber within 31 days of birth, such child shall be considered a newborn child of the Subscriber to the same extent as if that child had been a newborn natural child of the Subscriber. Upon the attainment of limiting age, coverage as a Dependent shall be extended if the child is and continues to be both (1) incapable of self-sustaining employment by reason of intellectual or physical disability and (2) chiefly dependent upon the Subscriber for support and maintenance, provided proof of such disability and dependency is furnished to Plan by Subscriber within 31 days of the child's attainment of limiting age and subsequently as may be required by the Plan, but not more than annually after the two-year period following the child's attainment of limiting age.
G. **Eligible Expenses** shall mean covered dental services and procedures described in this Contract.
H. **Maximum Allowable Charge** shall mean a limitation on the billed charge as determined by the Plan by geographic area where the expenses are incurred.
I. **Member** shall mean any individual Subscriber or eligible family Dependent entitled to receive services by reason of the Contract.
J. **Participating Dentist** shall mean those independent licensed dentists who have contracted with the Plan to provide dental services at negotiated fees for Members of the Plan. Participating Dentists are not employees of, nor supervised by the Plan.
K. **Premiums** shall mean amounts payable on a regular prepayment basis by or for the Subscriber to the Plan.

L. **Subscriber** shall mean an individual in good standing who has paid the Premiums for services of the Plan prior to the period of eligibility, including payments for Dependents as hereinafter defined.

Part II. EFFECTIVE DATE OF BENEFITS

A. All persons, who have enrolled in the Plan and paid the appropriate Premium on or before the 17th day of the month, shall be eligible for benefits commencing on the 1st day of the following month or on any date mutually agreed upon by Plan and Subscriber.
B. All persons who have enrolled in the Plan and paid the appropriate Premium between the 17th day of the month and the last day of the month shall be eligible for benefits commencing on the 1st day of the second month or on any date mutually agreed upon by Plan and Subscriber.
C. All Subscribers and enrolled Dependents become eligible for services on the effective date indicated in the letter accompanying their Membership Identification Card. Coverage is effective for dependent children on the date of birth, adoption or placement for adoption.

Part III. TERMINATION OR CANCELLATION

Benefits shall cease upon the earliest of the following events:

A. On the last day of the grace period. If payment is not made in full on or prior to the date due, as specified in Part IV, a grace period of 31 days from the last date of coverage shall be granted to the Subscriber for the payment of Subscription Dues falling due after the first payment. If payment is not received within the 31 days, coverage may be cancelled after the 31st day and the Subscriber may be held liable for the payment of the Premium for the period of time coverage remained in effect during the grace period. The Contract shall remain in full force and effect during the grace period.
B. Upon the date of Dependents attaining the age of 26. (Subject to Part I-F).
C. Upon Member performing an act, practice or omission that constitutes fraud, or intentional misrepresentation of material fact, coverage will be rescinded 30 days after written notice is provided to the Subscriber by the Plan. The rescission will only extend back to the date on which fraud or intentional misrepresentation of material fact occurred.
D. Upon the 46th day prior written notice is mailed to the Subscriber stating the reason for cancelation.

If this BlueDental Plan is unsatisfactory for any reason, you may cancel your policy by sending BCBSAZ written notice of cancellation within ten (10) days following receipt of this book. You may also contact BCBSAZ to discuss your options for obtaining coverage through another BCBSAZ Plan. If you choose to cancel and you prepaid any premium, BCBSAZ will refund that premium and cancel the contract for your Benefit Plan as though it was never in effect.

Reasons for Termination of Coverage

Unless coverage is earlier terminated by request of the Contract Holder and/or any Dependent(s) or due to the death of the Contract Holder and/or or any Dependents, BCBSAZ will notify the Contract Holder and Dependent(s) of any termination dates of coverage for the Contract Holder and/or any Dependent(s) a minimum of thirty (30) days prior to the last day of coverage. The Contract Holder and/or any Dependents' coverage under this Benefit Plan may terminate for the following reasons, including but not limited to:

A. The Contract Holder and/or any Dependent(s) die
B. The Contract Holder and/or Dependent(s) request termination of coverage
C. Non-payment of premiums by the Contract Holder, after expiration of any grace period available under applicable law
D. Coverage for the Contract Holder and/or Dependents is rescinded

Termination Date of Coverage

Termination dates are generally the following, subject to changes in applicable federal and state law:

A. The last day of coverage allowed by applicable law for a grace period for non-payment of premium.
B. If the Contract Holder gets divorced, the termination date for the Contract Holder's spouse is the date of the final divorce decree.
C. When an adult Dependent turns age 30 and does not qualify as a disabled Dependent, the termination date is the adult Dependent's 30th birthday.
D. When an adult Dependent's disability ends, the termination date is the date disability or incapacity ends.
E. When a Dependent child covered by a qualified medical support order is no longer eligible under the court order or administrative order, the termination date is the last day of the time period specified in the court order or administrative order.
F. When a Contract Holder dies, BCBSAZ terminates the Contract Holder's policy on the date of death and transfers any Dependents to a new policy on the date of death.
G. Any other termination date allowed under applicable law.

BCBSAZ does not automatically terminate a Contract Holder or Dependent when that person turns age 65 or becomes eligible for Medicare for some other reason. For persons who are eligible for Medicare and at least age 65, BCBSAZ has other coverage

options that may offer lower premium rates. Please call us for additional information. If you continue your coverage under this Plan, BCBSAZ will not duplicate benefits for covered Services paid by Medicare as primary payer.

Voluntary Termination of Coverage
Except as provided in this section for Dependents subject to court order or administrative order, the Contract Holder may voluntarily cancel coverage at any time for the Contract Holder and all Dependents by notifying BCBSAZ. BCBSAZ will terminate the Plan on the 1st day of the month following BCBSAZ's receipt of the request.

Part IV. PREMIUMS

A. Monthly Premiums are payable a monthly basis each month that this Contract is in effect.
B. Premiums must be received in the administrative office of the Plan no later than the first day on which the coverage period begins. If Electronic Funds Transfers is not utilized, payments should be mailed to: [Blue Cross Blue Shield of Arizona, Inc P.O. Box 52563 Phoenix, AZ 85072-2563]. Monthly Premiums must be debited from either a bank or credit card account.

Part V. BENEFITS AND COVERAGES

ELIGIBLE EXPENSES: Plan will pay for Eligible Expenses incurred for Subscribers or on behalf of their covered Dependents. Expenses must be incurred while the policy is in force. The description of Eligible Expenses is shown in the Coverage Schedule. All Benefits will be paid to the Subscriber unless otherwise designated by the claimant. Benefits will be paid after the Member complies with any Waiting Periods, Deductibles and Annual Maximums as specified in the Coverage Schedule. All Benefits are subject to Plan Exclusions as set forth in the Coverage Schedule. Benefit amounts will vary depending on whether the Member obtains services from a Participating Dentist or a non-participating dentist. To be considered an Eligible Expense, the service must be performed by a dentist, a physician, or a dental hygienist, and be deemed by the treating dentist to be necessary for the patient's dental health.

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates:

a) Dentures - on the date the final impression is taken.
b) Fixed bridges, crowns, inlays and onlays - on the date the teeth are initially prepared.
c) Root canal therapy - on the date the pulp chamber is opened.
d) Periodontal surgery - on the date surgery is performed.
e) All other services - on the date the service is performed.

IN-NETWORK BENEFITS: Plan will pay a percentage of the Participating Dentist's charge for each Covered Service up to the Participating Dentist's negotiated fee. The percentage of payment by Plan is determined by procedure classification as set forth in the Coverage Schedule. For example, if a procedure is covered at 80%, the Plan will pay 80% and the Member will pay the remaining balance of 20%, up to the Participating Dentist's negotiated fee. The Member may be required to remit payment for the remaining balance at the time of service. Billing arrangements are between the Member and the Participating Dentist. Participating Dentists are listed in the Dentist Directory. Members should confirm continued participation of a Participating Dentist prior to receiving treatment.

OUT-OF-NETWORK BENEFITS: A Member may choose to receive treatment from a non-participating dentist. Benefit percentages for out-of-network Benefits, if applicable, are listed in the Coverage Schedule according to procedure classification. Benefits are calculated using a Maximum Allowable Charge. Members are responsible for any amount charged which exceeds the Maximum Allowable Charge per procedure. Billing arrangements are between the Member and the non-participating dentist. If a Member receives treatment from a nonparticipating dentist, the Member may be required to make payment in full at the time of service. The Member may then submit a claim to the Plan for Benefit payment.

PRE-DETERMINATION OF BENEFITS: If the charge for treatment is expected to exceed $300, the Plan strongly advises the treating dentist to submit a treatment plan prior to initiating services. The Plan may request x-rays, periodontal charting or other dental records, prior to issuing the pre-determination. The proposed services will be reviewed and a pre-determination will be issued to the Member or dentist, specifying coverage. The pre-determination is not a guarantee of coverage or the amount.

LESS EXPENSIVE ALTERNATE TREATMENT: If: 1) Plan determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and 2) the alternate treatment will produce a professionally satisfactory result; then the maximum the Plan will allow will be the charge for the less expensive treatment.

Part VI. DENTAL RECORDS
The dental records of all Members concerning services performed hereunder shall remain the property of the treating dentist. Information related to the number, cost, and delivery of services provided under the Plan to Members may be made available to the Plan by dentists for purposes of review, investigation, or evaluation of care.

Part VII. CHANGE IN SERVICE
Plan reserves the right to change the Premiums or Benefits after completion of the term of the Contract. No change will be made without giving the Subscriber thirty (30) days prior written notice.

Part IX. CLAIMS

PAYMENT OF CLAIMS: If Plan provides coverage of a Member as a Dependent of a parent who has legal responsibility for the Dependent's dental care, and such parent does not have custody of the Dependent, the Plan may, upon request of the custodial parent, make the payments directly to the treating dentist. Any payments so made will release Plan from all further liability to the Member to the extent of the payments made. Benefits for other losses are paid to the Member. However, the Plan has the right to pay all or part of the benefits due to the treating dentist. This is true whether or not the Member is alive. If the Member has died and the Plan does not pay accrued benefits to the treating dentist, benefits will be paid to the Member's estate.

CLAIM FORMS/NOTICE OF CLAIM: If Plan receives a notice of claim, it will provide claim forms for filing proof of loss. If such forms are not sent within 15 days after notice of claim is received, the claimant will be deemed to have complied with the requirements of this Contract as to proof of loss. Instructions for submitting notice of claim to Plan can be found on the Membership Identification Card.

PROOF OF LOSS: Plan must receive written proof of loss within 180 days of treatment. Failure to provide proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one year from the time proof is otherwise required. Instructions for submitting proof of loss to Plan can be found on the Membership Identification Card.

TIME OF PAYMENT OF CLAIM: Benefits payable under this Contract for any loss will be paid immediately or within the time required by state regulations. If Plan fails to pay claim within the time required by state regulations, it will pay interest from the date on which payment is required to the date the claim is paid. INCONTESTABILTY CLAUSE: After 2 years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy commencing after the expiration of such 2-year period. **LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Contract. No such action will be brought after the expiration of three years after written proof of loss is required to be furnished. This contract is governed by, construed and enforced in accordance with the laws of the state of Arizona without regard to conflict of law principles. Maricopa County, Arizona shall be the site of jurisdiction and venue for any legal action or other proceeding arising out of or relating to this contract.

Part X. APPEALS AND GRIEVANCES
Members may participate in BCBSAZ's appeal and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You may ask BCBSAZ for another copy of the Guidelines at any time by visiting us at www.azblue.com or by calling the customer service telephone number listed in the front of this booklet.

Part XI. ENTIRE CONTRACT
The Enrollment Application and this Individual Dental Policy (including any attachments thereto) constitute the entire Contract between the parties. No portion of the charter, bylaws, or other corporate documents of BCBSAZ will constitute part of the Contract. No change in this Contract shall be valid until approved by an executive officer of the Plan and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Contract or to waive any of its provisions.

Part XII. CONTINUING COVERAGE FOR TERMINATED DEPENDENTS
This individual policy may be renewed at the discretion of the Subscriber subject to Part III and IV.
Eligible dependents who are terminated for any reason other than failure to pay the premium may continue coverage on a separate plan. To continue coverage on a separate plan, the dependent must apply for such coverage within thirty-one (31) days of the date of termination; otherwise, the dependent must reapply.

Part XIII. PLAN AMENDMENT
There is no guarantee to continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed by BCBSAZ upon thirty-one (31) days' notice to the contract holder or as required to comply with state or federal laws. Please review and retain this book, any replacement books, all schedule pages, all riders and amendments and other communications concerning your coverage. BCBSAZ reserves the right to make certain retroactive amendments to this benefit plan, as may be permitted under applicable federal and state law. You will receive notice of any such amendments.

Part XIV. BLUE CROSS AND BLUE SHIELD ASSOCIATION
Subscriber, on behalf of self and all members, expressly acknowledges and agrees that:

i. This Agreement is a contract solely between Subscriber and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”), permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the State of Arizona;
ii. BCBSAZ is not contracting as the agent of the Association;
iii. Subscriber has not entered into this Agreement based on any representations by the Association or any other Blue Cross or Blue Shield plan other than BCBSAZ; **and**
iv. Subscriber and members shall not seek to hold the Association or any Blue Cross or Blue Shield plan other than BCBSAZ accountable or liable for BCBSAZ’s obligations created under this Agreement.

This Paragraph shall not create any additional obligations whatsoever on the part of BCBSAZ other than those obligations created under other provisions of this Agreement.

Your Right to Information; Availability of Notice of Privacy Practices

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

The BCBSAZ "Notice of Privacy Practices" describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ's responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ.

You can also view the "Notice of Privacy Practices" by visiting the BCBSAZ website, www.azblue.com, and clicking on the "Legal" link at the bottom of the home page.

If you would like BCBSAZ to mail you another copy of the "Notice of Privacy Practices," please call the Customer Service number on your ID card, or call [(602) 864-4400] or[(800) 232-2345] to make your request.

NONDISCRIMINATION STATEMENT

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call [(602) 864-4884] for Spanish and [(877)475-4799] for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, [P.O. Box 13466, Phoenix, AZ 85002-3466], [(602) 864-2288], TTY/TDD [(602) 864-4823], [crc@azblue.com]. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-271-7806.

Navajo: Díí kwe'é atah nílínigií Blue Cross Blue Shield of Arizona haada yit'éego bína'ídílkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló̜ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á̜ doo bá̜á̜h ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 1-888-271-7806.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 1-888-271-7806。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-271-7806.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 1-888-271-7806.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-271-7806.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-271-7806 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-271-7806.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-271-7806 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-271-7806.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-888-271-7806 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 1-888-271-7806
.تماس حاصل نمایید

Assyrian:
ܐܢ ܐܢܬܘܢ، ܝܢ ܐܢܫܐ ܕܒܥܐ ܕܗܝܪܬܘܢ ܬܠܗ، ܐܝܬܠܘܟܘܢ ܟܘܫܝܐ ܟܘܬ Blue Cross Blue Shield of Arizona، ܐܢܬܘܢ ܐܝܬܠܘܟܘܢ ܫܘܠܛܢܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܐܢܫܐ ܡܦܩ ܠܫܢܐ، ܩܪܝܐ ܬܠܦܘܢ ܥܠ ܡܢܝܢܐ 1-888-271-7806.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-888-271-7806.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-271-7806