BlueDental℠ Optimum PPO

BENEFIT BOOK

azblue.com

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BlueDental 10+ PPO 50 1500 A2 O MAC
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BLUEDENTAL PPO
SUMMARY OF BENEFITS
50 - $1500 A2 O MAC

Plan Benefit Structure		
Benefit Maximum per Member per Calendar Year[1] All services, except Type I	**In-Network (INN)** $1,500	**Out-of-Network (OON)** $1,500
Annual Deductible[1] Deductible waived for Type I services **Individual** **Family**	**In-Network (INN)** $50 $150	**Out-of-Network (OON)** $50 $150

Benefit Category	In-Network (INN)		Out-of-Network (OON)	
	Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
Type I: Preventive Covered Services[2]	100%	0%	80%	20%
Oral Exams				
Prophylaxis				
Bitewing X-rays[3]				
Periapical X-rays[3]				
Full Mouth X-rays[3]				
Topical Fluoride				
Sealants				
Space Maintainers				
Type II: Basic Covered Services[2] (after meeting deductible)	80%	20%	60%	40%
Fillings - Composite and Amalgam				
Emergency Palliative Treatment				
Oral Surgery - Simple Extractions				
Oral Appliances for Treatment of Bruxism				
Root Canals / Pulpal Therapy				
Non-Surgical / Surgical (Root Planing and Therapy)				
Extraction of Impacted Teeth				
Type III: Major Covered Services[2] (after meeting deductible)	50%	50%	40%	60%
Prosthodontics - Bridges and Dentures				
General Anesthesia				
Crowns / Inlays / Onlays				
Implants				
Type IV: Orthodontia	For orthodontia benefits, if any, please see the separate orthodontia benefit summary. Orthodontia is subject to certain additional limitations.			

Plan Benefit Structure	
OON Reimbursement	MAC (Maximum Allowable Charge)
Provider Network	BlueDental PPO Network
Roll-over Benefits	Included: • Rollover Threshold (50% of Annual Max Less Benefits Paid) = $750 • Rollover Maximum (125% of Annual Max) = $1,875
1. All per year benefits mean calendar year. 2. 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. 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. 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.	
In-Network Providers (INN)	"In-network" dental providers have contracts with Blue Cross Blue Shield of Arizona (BCBSAZ) or with BCBSAZ's independent dental network vendor. 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 (OON)	"Out-of-network" providers have no contract with BCBSAZ or with BCBSAZ's independent dental network vendor. 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.
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.
Preventive Rewards	Primary subscriber will receive a $20 payment from BCBSAZ for each family member who receives two cleanings during the plan year from a participating network dentist.
Prevention Plus	All diabetic and expecting mothers 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.

AZ BLUE STANDARD PLAN LIMITATIONS

1. Two evaluations per calendar year in any combination of periodic, limited, comprehensive, or problem focused.
2. Two prophylaxis (cleaning, scaling and polishing teeth) per calendar year.
    a. One additional cleaning is covered during pregnancy and for diabetic patients (If applicable).
3. One topical fluoride per calendar year to age 16.
4. Bitewing x-rays, two per calendar year.
5. Periapical x-rays
6. One diagnostic x-ray, full or panoramic per 60 months
7. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).
8. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars).
9. Simple extraction of teeth.
10. Composite and amalgam fillings per tooth per surface every 24 months (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)
11. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin).
12. Antibiotic injections administered by a dentist.
13. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
14. 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. Reimplantation or transplantation of a natural tooth.
    g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
15. 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.
16. 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.
17. One study model per 36 months.
18. Crown build-up for non-vital teeth.
19. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter.
20. One repair of dentures or fixed bridgework per 24 months.
21. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery, or implant placement procedures (if applicable).
22. Restoration services, limited to:
    a. Cast metal, resin-based, gold or porcelain 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 placed 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.
23. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridgework.
    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.
24. Teledentistry, synchronous (D9995) or asynchronous (D9996). Must be accompanied by a covered procedure
25. Implants and related services (if applicable).
26. Type IV. Orthodontia services. Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy (if applicable).

AZ BLUE STANDARD 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 (if applicable).
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony (except for D7880).
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
14. 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.
15. Treatment of cleft palate, malignancies or neoplasms.
16. Implants and related services (if applicable); replacement of lost, stolen, or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.

DENTAL POLICY – GROUP PPO

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 AZ Blue) certifies that the Subscriber is covered under and subject to all the provisions, definitions, limitations and conditions of this Group 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.

Member Services Contact (change mail address, add or remove dependents, termination of coverage)

Blue Cross Blue Shield of Arizona

Attn: Membership Services
Mail Stop: A102
Blue Cross Blue Shield of Arizona
PO Box 13466
Phoenix, AZ 85002-3466

1-888-271-7806

PART I. DEFINITIONS

A. Annual Deductible shall mean the amount set forth in the Coverage Schedule which each Member must pay each Benefit Year or 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 Benefit Year or Calendar Year.

C. Benefits shall mean the amount payable by the Plan, as set forth in the Coverage Schedule, for a Covered Service.

D. Benefit Year shall mean the 12 months following the effective date of the Contract.

E. Calendar Year shall mean January 1st through December 31st.

F. Covered Service shall mean a procedure listed in the Coverage Schedule.

G. 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. At the Group's request, Dependent coverage may include a Domestic Partner of Subscriber and/or children of a Domestic Partner. 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. An unmarried child who is 26 years, but less than 27, whose time is principally devoted to attending school, and who is dependent upon his parents for primary support, is eligible to be covered as a Dependent. If a Dependent child is enrolled as a full-time student and is unable due to medical condition to continue as a full-time student, coverage for such child shall continue in force for a period of 12 months from the date the child ceases to be a full-time student, or until such child attains age 26, whichever first occurs. The child's treating physician must certify at the time the child withdraws as a fulltime student that the child's absence is medically necessary. 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 mental or physical incapacity and (2) chiefly dependent upon the Subscriber for support and maintenance, provided proof of such incapacity 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.

H. Domestic Partner shall mean a person who is at least 18 years old, is not related to Subscriber by blood or marriage within four degrees of consanguinity under civil law rule, is not married or in a civil union or domestic partnership with another individual, has been financially interdependent with Subscriber for at least 6 consecutive months prior to enrollment in Plan in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship

indefinitely, and shares a primary residence with Subscriber. In order to obtain coverage for a

Domestic Partner, Subscriber must sign an Affidavit of Domestic Partnership form provided by the Plan.

I. **Eligible Expenses** shall mean covered dental services and procedures described in this Contract.

J. **Group** shall mean the organization or employing unit with which the Subscriber is associated and which has executed the Group Dental Service Contract.

K. **Maximum Allowable Charge** shall mean a limitation on the billed charge as determined by the Plan by geographic area where the expenses are incurred.

L. **Member** shall mean any individual Subscriber or eligible family Dependent entitled to receive services by reason of the Contract.

M. **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.

N. **Premiums** shall mean amounts payable on a regular prepayment basis by or for the Subscriber to the Plan.

O. **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 Group.

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 Group.

C. All Subscribers and enrolled Dependents become eligible for services on the effective date indicated in the letter accompanying their Membership Identification Card.

PART III. TERMINATION OR CANCELLATION

Benefits shall cease upon the earliest of the following events:

A. On the date of expiration of the period for which the last payment of Premium was made to Plan. If payment is not made in full by the Group on or prior to the date due, as specified in Part IV-A, a grace period of 31 days from the last date of coverage shall be granted to the Group after the first payment. If payment is not received within the 31 days, coverage may be cancelled after the 31st day and the Group 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 years or marriage prior to that date (Subject to Part I-G).

C. Upon violation of the terms of this Contract, fraud or deception in the use of services, or termination of the Group Contract under which the Member is covered. Coverage will be canceled after the 31st day after written notice is mailed to the Subscriber.

Group coverage will renew for one (1) year periods in the absence of written termination notification by Group at least thirty (30) days in advance of expiration of the term of the Contract.

PART IV. PREMIUMS

A. All Premiums are payable on or before the 17th day of the month preceding the month in which services may be rendered.

B. Premiums must be received in the administrative office of the Plan no later than the 17th day of the month before eligibility is desired. 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.

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 and is considered valid for 180 days.

ALTERNATE BENEFIT: 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.

COORDINATION OF BENEFITS: All Benefits covered under this Contract are subject to coordination.

The following definitions apply only to this Coordination of Benefits section:

A. Plan shall mean coverage providing hospital, medical or dental benefits or services by: i) group or blanket insurance coverage except school accident coverage; ii) group Blue Cross and Blue Shield, group practice or other pre-payment coverage on a group basis; or iii) labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans. Plan will be construed separately for a policy, contract, or other arrangement for benefits or services that reserves the right to take the benefits or services of their Plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.

B. Eligible Expenses shall mean any necessary, reasonable and customary item of expense all or part of which is covered under one of the Plans. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Eligible Expense and a benefit paid.

C. Claim Period shall mean a Calendar Year or portion of a Calendar Year for a claim on a Member covered under this Plan.

If Member is also covered under one or more other Plans, the Benefits under this Plan will be coordinated with benefits payable under all other Plans. The coordination will apply in determining the benefits payable for any Claim Period if the sum of: i) the benefits that would be payable under this Plan in absence of the coordination; and ii) the benefits that would be payable under all other Plans without provisions for coordination in those Plans, would exceed such benefits.

Except as provided in the following paragraph, when Coordination of Benefits applied to the benefits payable for any Claim Period, the benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Eligible Expenses under all other Plans will not exceed the total of those Eligible Expenses. Benefits payable under all other Plans include the benefits that would have been payable had a claim been properly made for them.

The rules establishing the order of benefit determination are:

1. The benefits of a plan covering a person for whom claim is made other than as a dependent will be determined before the benefits of a plan covering such person as a dependent.
2. Except as stated in (3) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":
   a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
   b. if both parents have the same birthday, the benefits of the Plan covering the parent longer are determined before benefits of the Plan covering the other parent for the shorter period of time. However, if the other Plan does not have the rule described in a. above, but instead uses a different method, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
3. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for such child are determined in this order:
   a. first, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse of the parent with custody of the child; and
   c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of such parent has actual knowledge of those terms, the benefits of that Plan are determined first. This does not apply with respect to any Claim Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. The benefits of a Plan covering a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as the employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule 4. is ignored.
5. If none of the above rules determines the order of benefits, the benefits of a Plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a Plan covering the person the shorter period of time.

If this Plan is responsible for secondary coverage for Eligible Expenses, this Plan will not deny coverage or payment of the amount it owes as secondary payer solely on the basis of the failure of another group contract, which is responsible as the primary payer, to pay for such Eligible Expenses. This Plan will not be required to pay the obligations of the primary payer.

For the purposes of administering the above provisions of this Contract or any similar provisions of other Plans, this Plan may, without consent or notice to any person, release to or obtain from any other insurance company, organizations or person, any information concerning any individual which is considered necessary. Any person claiming Benefit will furnish the Plan with any information necessary.

Whenever payments which should have been made under this Contract in accordance with the above provisions have been made under any other Plans, this Plan has the right, at its sole discretion, to pay any organizations making these payments any amount this Plan determines to be due. Amounts paid in this manner will be considered to be Benefits paid under this Contract and, to the extent of these payments, Plan will be fully discharged from liability under this Contract.

Whenever payments have been made by this Plan, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, this Plan will have the right to recover the excess from one or more of the following: (i) other insurance companies; (ii) other organizations; or (iii) persons to or for whom payments were made.

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 Group forty-five (45) days prior written notice.

PART VIII. CONVERSION OF COVERAGE

Plan coverage will terminate for Group Subscribers and their Dependents when Subscriber is no longer associated with the Group. Thereafter, Subscriber may convert by enrolling in the Plan on an individual basis (Subject to Part III-A and B only). In such case, payment shall be on either a monthly or annual basis.

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: In the absence of fraud, all statements made by a Subscriber shall be considered representations and not warranties and no statement shall be the basis for voiding coverage or denying a claim after the Contract has been in force for two years from its effective date, unless the statement was material to the risk and was contained in a written application.

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.

PART X. APPEALS AND GRIEVANCES

Members may participate in AZ Blue's appeal and grievance processes, which are described in detail in the AZ Blue Appeal and Grievance Guidelines, a separate document provided to you. You may ask AZ Blue 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 Group Dental Service Contract, executed on behalf of Subscribers, and this Certificate of Coverage (including any attachments thereto) constitute the entire Contract between the parties. No portion of the charter, bylaws, or other corporate documents of AZ Blue 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.

ATTACHMENTS

Coverage Schedule
Notice of Privacy Practices

These attachments contain other terms, including important exclusions and limitations. Subscribers may request additional copies by contacting Member Services at 1-888-271-7806.

NOTICE OF NONDISCRIMINATION

Blue Cross® Blue Shield® of Arizona (AZ Blue) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). **AZ Blue** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

AZ Blue:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that **AZ Blue** 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:

Section 1557 Coordinator
P.O. Box 13466
Phoenix, AZ 85002-3466; Call 602-864-2288; TTY 711
or email us at crc@azblue.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **AZ Blue Section 1557 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
This notice is available at AZ Blue's website: http://www.azblue.com/nondiscrimination-notice

PRIVACY NOTICE
Your Right to Information and Availability of Notice of Privacy Practices

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

The AZ Blue "Notice of Privacy Practices" describes how AZ Blue may use and disclose your information to administer your health plan. It also describes some of your individual rights and AZ Blue's responsibilities under federal privacy regulations. You can view the "Notice of Privacy Practices" by visiting the AZ Blue website, www.azblue.com, and clicking on the "Privacy & Legal" link under the Resources heading at the bottom of the home page. If you would like AZ Blue to mail you a 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.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

Navajo: Diné bee yániłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-877-475-4799.

Chinese Simplified: 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-475-4799 。

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-475-4799。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

Korean: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-475-4799 ।

Farsi (Persian)

توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-877-475-4799.

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799 หรือปรึกษาผู้ให้บริการของคุณ"

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799 。