



An Independent Licensee of the Blue Cross Blue Shield Association



BlueDentalSM DHMO

BENEFIT BOOK

BlueDental DHMO Classic
Individual & Family Plan

azblue.com

23452 0620

BlueDental DHMO Classic – Individual DHMO Summary of Benefits and Member Copayments

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.

ADA Code	Description	Member Copayment
DIAGNOSTIC/PREVENTIVE		
D9439	Office visit	10
D0120	Periodic oral eval - established patient	0
D0140	Limited oral eval - problem focused	0
D0145	Oral eval for a patient under 3 years of age	0
D0150	Comprehensive oral eval - new or established patient	0
D0160	Detailed and extensive oral eval - problem focused	0
D0170	Re-evaluation - limited, problem focused	0
D0180	Comp. periodontal eval - new or established patient	29
D0210	Intraoral - complete series (including bitewings)	23
D0220	Intraoral - periapical first radiographic image	0
D0230	Intraoral - periapical each add. radiographic image	0
D0240	Intraoral - occlusal radiographic image	0
D0250	Extra-oral - 2D projection radiographic image	0
D0270	Bitewing - single radiographic image	0
D0272	Bitewings - two radiographic images	0
D0273	Bitewings - three radiographic images	0
D0274	Bitewings - four radiographic images	0
D0277	Vertical bitewings - 7 to 8 radiographic images	0
D0330	Panoramic radiographic image	23
D0340	2D cephalometric radiographic image	0
D0350	2D oral/facial photographic images (intraoral/extraoral)	0

ADA Code	Description	Member Copayment
D0431	Adjunctive pre-diagnostic	51
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
D1110	Prophylaxis (cleaning) - adult	12
D1110*	Extra cleaning for diabetics and expectant mothers	40
D1120	Prophylaxis (cleaning) - child	12
D1206	Topical fluoride varnish for mod/high risk caries patients	0
D1208	Topical application of fluoride	0
D1310	Nutritional counseling for control of dental disease	0
D1320	Tobacco counseling for control and prev. oral disease	0
D1330	Oral hygiene instructions	0
D1351	Sealant - per tooth	23
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	23
D1354	Interim Caries Arresting Medicament Application	17
SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral	209
D1516	Space Maintainer - Fixed - Bilateral, Maxillary	212
D1517	Space Maintainer - Fixed - Bilateral, Mandibular	224
D1520	Space maintainer - removable - unilateral	237
D1526	Space Maintainer - Removable - Bilateral, Maxillary	30
D1527	Space Maintainer - Removable - Bilateral, Mandibular	45
D1550	Re-cementation of space maintainer	30
D1555	Removal of fixed space maintainer, by non-originating dentist	45
D1575	Distal shoe space maintainer - fixed - unilateral	209
RESTORATIVE DENTISTRY (FILLINGS)		
AMALGAM RESTORATIONS (SILVER)		
D2140	Amalgam - one surface, prim. or perm.	25
D2150	Amalgam - two surfaces, prim. or perm.	35
D2160	Amalgam - three surfaces, prim. or perm.	45
D2161	Amalgam - >=4 surfaces, prim. or perm.	58
COMPOSITE RESTORATIONS (TOOTH COLORED)		
D2330	Resin-based composite - one surface, anterior	45
D2331	Resin-based composite - two surfaces, anterior	60
D2332	Resin-based composite - three surfaces, anterior	70
D2335	Resin-based composite - >=4 surfaces, anterior	85

ADA Code	Description	Member Copayment
CROWN & BRIDGE*		
D2390	Resin-based composite crown, anterior	115
D2391	Resin-based composite - one surface, posterior	65
D2392	Resin-based composite - two surfaces, posterior	85
D2393	Resin-based composite - three surfaces, posterior	100
D2394	Resin-based composite - >=4 surfaces, posterior	120
D2510	Inlay- metallic - one surface	453
D2520	Inlay- metallic - two surfaces	460
D2530	Inlay - metallic - three or more surfaces	468
D2542	Onlay - metallic-two surfaces	828
D2543	Onlay - metallic - three surfaces	851
D2544	Onlay - metallic - four or more surfaces	822
D2610	Inlay - porcelain/ceramic - one surface	454
D2620	Inlay - porcelain/ceramic - two surfaces	481
D2630	Inlay - porcelain/ceramic - >=3 surfaces	511
D2642	Onlay - porcelain/ceramic - two surfaces	497
D2643	Onlay - porcelain/ceramic - three surfaces	535
D2644	Onlay - porcelain/ceramic - >=4 surfaces	569
D2650	Inlay - resin-based composite - one surface	299
D2651	Inlay - resin-based composite - two surfaces	348
D2652	Inlay - resin-based composite - >=3 surfaces	374
D2662	Onlay - resin-based composite - two surfaces	342
D2663	Onlay - resin-based composite - three surfaces	385
D2664	Onlay - resin-based composite - >=4 surfaces	409
D2710	Crown - resin based composite (indirect)	316
D2712	Crown - 3/4 resin-based composite (indirect)	244
D2720	Crown - resin with high noble metal	569
D2721	Crown - resin with predominantly base metal	591
D2722	Crown - resin with noble metal	569
D2740	Crown - porcelain/ceramic	621
D2750	Crown - porcelain fused to high noble metal	595
D2751	Crown - porcelain fused to predominantly base metal	575
D2752	Crown - porcelain fused to noble metal	598
D2780	Crown - 3/4 cast high noble metal	598
D2781	Crown - 3/4 cast predominantly base metal	621

ADA Code	Description	Member Copayment
D2782	Crown - 3/4 cast noble metal	598
D2783	Crown - 3/4 porcelain/ceramic	621
D2790	Crown - full cast high noble metal	598
D2791	Crown - full cast predominately base metal	621
D2792	Crown - full cast noble metal	598
D2794	Crown - titanium	621
D2799	Provisional crown	100
D2910	Recement inlay	45
D2920	Recement crown	46
D2930	Prefab. stainless steel crown - prim. tooth	121
D2931	Prefab. stainless steel crown - perm. tooth	114
D2932	Prefabricated resin crown	164
D2933	Prefab. stainless steel crown w/ resin window	176
D2934	Prefab. esthetic coated primary tooth	198
D2940	Protective restoration	39
D2950	Core buildup, including any pins	115
D2951	Pin retention - per tooth, in addition to restoration	39
D2952	Cast post and core in addition to crown	199
D2954	Prefab. post and core in addition to crown	167
D2955	Post removal (not in conj. with endo. therapy)	116
D2960	Labial veneer (resin laminate) - chairside	392
D2961	Labial veneer (resin laminate) - lab	690
D2962	Labial veneer porcelain laminate) - lab	776
D2980	Crown repair, by report	190
ENDODONTICS¹		
D3110	Pulp cap - direct (excl. final restoration)	25
D3120	Pulp cap - indirect (excl. final restoration)	25
D3220	Therapeutic pulpotomy (excl. final restor.)	86
D3221	Pulpal debridement, prim. and perm. teeth	90
D3310	Endodontic therapy, anterior tooth	380
D3320	Endodontic therapy, premolar tooth	460
D3330	Endodontic therapy, molar	595
D3331	Treatment of root canal obstr. non-surgical	176
D3332	Incomp. endo. therapy-inop. or fractured tooth	156
D3333	Internal root repair of perforation defects	175

ADA Code	Description	Member Copayment
D3346	Retreat of prev. root canal therapy, anterior	495
D3347	Retreat of prev. root canal therapy, premolar	575
D3348	Retreat of prev. root canal therapy, molar	715
D3351	Apexification/recalcification - initial visit	121
D3352	Apexification/recalcification - interim med. repl.	121
D3353	Apexification/recalcification - final visit	121
D3410	Apicoectomy - anterior	375
D3421	Apicoectomy - premolar (first root)	414
D3425	Apicoectomy - molar (first root)	454
D3426	Apicoectomy - (each add. root)	206
D3430	Retrograde filling - per root	114
D3450	Root amputation - per root	127
D3920	Hemisection, not inc. root canal therapy	117
PERIODONTICS¹		
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	291
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	162
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	371
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	202
D4249	Clinical crown lengthening - hard tissue	406
D4260	Osseous surgery - >3 cont. teeth, per quad	557
D4261	Osseous surgery - <=3 cont. teeth, per quad	336
D4263	Bone replacement graft – First site in quadrant	404
D4264	Bone replacement graft – Each additional site in quadrant	313
D4266	Guided tissue regen. - resorb. barrier, per site	529
D4274	Mesial/distal or proximal wedge procedure, single tooth	354
D4320	Provisional splinting - intracoronal	101
D4321	Provisional splinting - extracoronal	108
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	132
D4342	Perio scaling and root planing - <= 3 teeth, per quad	86
D4346	Scaling in presence of generalized moderate/severe gingival inflammation	61
D4355	Full mouth debridement	110
D4381	Localized delivery of chemotherapeutic agents	69
D4910	Periodontal maintenance	81
PROSTHETICS (DENTURES)		
D5110	Complete denture - maxillary	755

ADA Code	Description	Member Copayment
D5120	Complete denture - mandibular	755
D5130	Immediate denture - maxillary	794
D5140	Immediate denture - mandibular	794
D5211	Maxillary partial denture - resin base	670
D5212	Mandibular partial denture - resin base	670
D5213	Maxillary partial denture - cast metal	791
D5214	Mandibular partial denture - cast metal	791
D5221	Immediate maxillary partial denture - resin base	647
D5222	Immediate mandibular partial denture - resin base	647
D5223	Immediate maxillary partial denture - cast metal	705
D5224	Immediate mandibular partial denture - cast metal	705
D5225	Maxillary partial denture - flexible base	705
D5226	Mandibular partial denture - flexible base	705
D5282	Removable Unilateral Partial Denture -One Piece Cast Metal, Maxillary (Incl Clasps & Teeth)	439
D5283	Removable Unilateral Partial Denture -One Piece Cast Metal, Mandibular (Incl Clasps & Teeth)	439
D5410	Adjust complete denture - maxillary	46
D5411	Adjust complete denture - mandibular	46
D5421	Adjust partial denture - maxillary	46
D5422	Adjust partial denture - mandibular	46
D5511	Repair broken complete denture base, mandibular	83
D5512	Repair broken complete denture base, maxillary	83
D5520	Replace missing or broken teeth - complete denture	83
D5611	Repair resin partial denture base, mandibular	83
D5612	Repair resin partial denture base, maxillary	83
D5621	Repair cast partial framework, mandibular	83
D5622	Repair cast partial framework, maxillary	83
D5630	Repair or replace broken clasp	83
D5640	Replace broken teeth - per tooth	83
D5650	Add tooth to existing partial denture	83
D5660	Add clasp to existing partial denture	83
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	492
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	492
D5710	Rebase complete maxillary denture	242

ADA Code	Description	Member Copayment
D5711	Rebase complete mandibular denture	242
D5720	Rebase maxillary partial denture	242
D5721	Rebase mandibular partial denture	242
D5730	Reline complete maxillary denture (chairside)	164
D5731	Reline complete mandibular denture (chairside)	164
D5740	Reline maxillary partial denture (chairside)	164
D5741	Reline mandibular partial denture (chairside)	164
D5750	Reline complete maxillary denture (lab)	259
D5751	Reline complete mandibular denture (lab)	259
D5760	Reline maxillary partial denture (lab)	259
D5761	Reline mandibular partial denture (lab)	259
D5810	Interim complete denture - maxillary	383
D5811	Interim complete denture - mandibular	383
D5820	Interim partial denture - maxillary	443
D5821	Interim partial denture - mandibular	443
D5850	Tissue conditioning - maxillary	38
D5851	Tissue conditioning - mandibular	38
BRIDGE & PONTICS*		
D6210	Pontic - cast high noble metal	576
D6211	Pontic - cast predominately base metal	591
D6212	Pontic - cast noble metal	576
D6240	Pontic - porcelain fused to high noble metal	627
D6241	Pontic - porcelain fused to predominately base metal	616
D6242	Pontic - porcelain fused to noble metal	627
D6245	Pontic - porcelain/ceramic	620
D6250	Pontic - resin with high noble metal	627
D6251	Pontic - resin with predominately base metal	620
D6252	Pontic - resin with noble metal	627
D6545	Ret. - cast metal for resin bonded fixed prosthesis	367
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	202
D6549	Resin retainer - for resin bonded fixed prosthesis	758
D6600	Inlay - porc./ceramic, two surfaces	472
D6601	Inlay - porc./ceramic, >=3 surfaces	491
D6602	Inlay - cast high noble metal, two surfaces	634
D6603	Inlay - cast high noble metal, >=3 surfaces	654

ADA Code	Description	Member Copayment
D6604	Inlay - cast predominantly base metal, two surfaces	553
D6605	Inlay - cast predominantly base metal, >=3 surfaces	567
D6606	Inlay - cast noble metal, two surfaces	588
D6607	Inlay - cast noble metal, >=3 surfaces	601
D6608	Onlay -porc./ceramic, two surfaces	505
D6609	Onlay - porc./ceramic, three or more surfaces	528
D6610	Onlay - cast high noble metal, two surfaces	627
D6611	Onlay - cast high noble metal, >=3 surfaces	653
D6612	Onlay - cast predominantly base metal, two surfaces	553
D6613	Onlay - cast predominantly base metal, >=3 surfaces	567
D6614	Onlay - cast noble metal, two surfaces	588
D6615	Onlay - cast noble metal, >=3 surfaces	615
D6720	Crown - resin with high noble metal	354
D6721	Crown - resin with predominantly base metal	484
D6722	Crown - resin with noble metal	354
D6740	Crown - porcelain/ceramic	620
D6750	Crown - porcelain fused to high noble metal	627
D6751	Crown - porcelain fused to predominately base metal	620
D6752	Crown - porcelain fused to noble metal	627
D6780	Crown - 3/4 cast high noble metal	627
D6781	Crown - 3/4 cast predominantly base metal	620
D6782	Crown - 3/4 cast noble metal	627
D6783	Crown - 3/4 porc./ceramic	620
D6790	Crown - full cast high noble metal	627
D6791	Crown - full cast predominately base metal	620
D6792	Crown - full cast noble metal	627
D6920	Connector bar	95
D6930	Recement fixed partial denture	77
D6940	Stress breaker	190
D6950	Precision attachment	276
D6980	Fixed partial denture repair, by report	114
ORAL SURGERY¹		
D7111	Extraction, coronal remnants - primary tooth	50
D7140	Extraction, erupted tooth or exposed root	65
D7210	Surg. removal of Extraction, erupted tooth req elev, etc	104

ADA Code	Description	Member Copayment
D7220	Removal of impacted tooth - soft tissue	121
D7230	Removal of impacted tooth - partially bony	161
D7240	Removal of impacted tooth - completely bony	213
D7241	Removal of imp. tooth - completely bony, with unusual surg. complications	258
D7250	Surgical Removal of residual tooth roots	147
D7251	Coronectomy – Intentional partial tooth removal	258
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	190
D7280	Surgical access Exposure of an unerupted tooth	181
D7286	Biopsy of oral tissue - soft (all others)	159
D7310	Alveoloplasty in conj. w/ extractions, >=4 per quad.	127
D7311	Alveoloplasty in conj. w/ extractions, 1-3 per quad.	121
D7320	Alveoloplasty not in conj. w/ extractions, >=4 per quad.	193
D7321	Alveoloplasty not in conj. w/ extractions, 1-3 per quad.	159
D7471	Removal of lateral exostosis	450
D7510	Incision and drainage of abscess - intraoral soft tissue	101
D7960	Frenulectomy (frenectomy/frenotomy) - separate proc.	146
D7979	Non-surgical sialolithotomy	23
ORTHODONTICS		
D8050	Interceptive ortho. treatment of the primary dentition	3010
D8060	Interceptive ortho. treatment - transitional dentition	3010
D8070	Comp. ortho. treatment - transitional dentition	3515
D8080	Comp. ortho. treatment - adolescent dentition	3852
D8090	Comp. ortho. treatment - adult dentition	4049
D8660	Pre-orthodontic treatment visit	77
D8670	Periodic ortho. treatment visit (as part of contract)	135
D8680	Orthodontic retainer (rem. of appl./placement of retainer(s))	314
D8999	Unspecified orthodontic procedure, by report	218
D9110	Palliative (emergency) treatment of dental pain	23
D9210	Local anesthesia not in conj. w/ operative/surg. procedures	22
D9211	Regional block anesthesia	28
D9212	Trigeminal division block anesthesia	55
D9215	Local anesthesia in conj. w/ operative/surg. procedures	22
D9222	Deep sedation/general anesthesia – first 15 minutes	104
D9223	Deep sedation/general anesthesia - each 15 minute increment	104
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	45

ADA Code	Description	Member Copayment
D9239	Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	104
D9243	Intravenous moderate (conscious) sedation/analgesia - each additional 15 minute increment	104
D9310	Consultation (diagnostic service by nontreating dentist)	40
D9450	Case pres, detailed/ext treatment planning	0
D9940	Occlusal guard, by report	245
D9944	Occlusal Guard – Hard Appliance, Full Arch	67
D9945	Occlusal Guard – Soft Appliance, Full Arch	67
D9946	Occlusal Guard – Hard Appliance, Partial Arch	67
D9951	Occlusal adjustment - limited	58
D9952	Occlusal adjustment - complete	265
D9995	Teledentistry – synchronous; real-time encounter	20
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	20

¹ As performed by a Participating General Dentist. See Plan Exclusions #13 for additional details

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

In-Network Providers

“In-network” dental providers have a BlueDental DHMO network 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. If you visit an “In-Network dental provider”, you will be responsible for the amount listed in the member copayment column.

Choosing a DHMO In-Network Provider

You must choose a BlueDental DHMO network provider from the BCBSAZ member portal and confirm with that provider that you are a DHMO patient when scheduling an appointment. You may also call BCBSAZ Member Services at 888-271-7806 for assistance in getting assigned to a DHMO network provider or to address any issues.

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. There is no coverage on this BlueDental DHMO plan if you visit an out-of-network provider.

BCBSAZ STANDARD EXCLUSIONS AND LIMITATIONS

Plan Limitations

Unless determined to be medically necessary, covered services are limited to:

1. Two (2) evaluations are covered per calendar year including a maximum of one (1) comprehensive evaluation.
2. One (1) problem focused exam is covered per calendar year.
3. Two (2) teeth cleanings (prophylaxis) are covered per calendar year (one additional cleaning is covered during pregnancy and for diabetic patients).
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) bitewing x-rays are covered per calendar year.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
7. One (1) sealant or preventative resin restoration per tooth is covered per lifetime, up to age 16 (limited to permanent 1st and 2nd molars).
8. Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
11. Relining and rebasing of dentures is covered once every 24 months.
12. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
13. Root planing or scaling is covered once every 24 months per quadrant.
14. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110/D1120, limited to once per two years.
15. Full mouth debridement is covered once per lifetime.
16. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater.
17. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.
19. Coronectomy - intentional partial tooth removal, once per lifetime.
20. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two (2) per calendar year (when available).

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 as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry including bleaching except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, 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 from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as covered benefits under this Plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergency dental services).
12. Services related to the treatment of TMD (Temporomandibular Disorder).
13. Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating General Dentist. Above copayments do not apply when performed by a Participating Specialist (with the exception of orthodontics). Participating Specialists, if available, have entered into an agreement with BCBSAZ to provide dental services to members at a 25% reduction from their Usual, Customary, and Reasonable (UCR) fees. This means that the member will be responsible for 25% of the lesser of a Participating Specialists UCR fee or the amount the provider has agreed to accept. Members must directly contact the Participating Specialist to obtain fees as the amount varies by provider.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
16. 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.
17. Placement of dental implants, implant-supported crowns, abutments, and prostheses.

Dental Policy – Individual

This policy is guaranteed 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. **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.
- B. **Member** shall mean any individual Subscriber or eligible family Dependent entitled to receive services by reason of the Contract.
- C. **Participating Dentist** shall mean those independent licensed dentists who have contracted with the Plan to provide dental services for Members of the Plan. Participating Dentists are not employees of, nor supervised by the Plan.
- D. **Plan Specialist Participating Dentist** shall mean those independent licensed specialists who have contracted with the Plan to provide dental services for Members of the Plan that are of such a degree of complexity as not to be normally performed by a Participating Dentist. Plan Specialists are not employees of, nor supervised by the Plan.
- E. **Subscriber** shall mean an individual in good standing who has paid the Subscription Dues for services of the Plan prior to the period of eligibility, including payments for Dependents as hereinafter defined.

- F. **Subscription Dues** shall mean amounts payable on a regular prepayment basis by or for the Subscriber to the Plan.
- G. **Usual and Customary Fees** shall mean those fees that the Participating Dentist usually charges its patients for dental services when a person is not affiliated with any dental program.

Part II. EFFECTIVE DATE OF BENEFITS

- A. All persons, who have enrolled in the Plan and paid the appropriate Subscription Dues 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 Subscription Dues 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 cancellation.

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. SUBSCRIPTION DUES AND MEMBER COPAYMENTS

Subscription Dues are payable on a monthly basis each month that this Contract is in effect. Subscription Dues 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., and P.O. Box 52563 Phoenix, AZ 85072-2563. Monthly Subscription Dues must be debited from either a bank or credit card account. Member Copayments (as listed in the attached Description of Benefits and Member Copayments) are payable to the Participating Dentist at the time services are rendered.

Part V. BENEFITS AND COVERAGES

All dental procedures listed under the attached Description of Benefits and Member Copayments will be provided if they are necessary for the patient's dental health. The fee charged will be the fee listed under Member Copayments for each procedure completed. If conflict arises regarding the quality, cost, or extent of work performed pursuant to the Plan, the case in question will be resolved pursuant to the Complaint or Quality Assurance Procedures established by the Plan.

PARTICIPATING REFERRAL: Referrals to a Plan Specialist must be made by the Member's Participating Dentist, except in the case of orthodontics.

NON-PARTICIPATING REFERRAL: If a Participating Dentist refers the Member to a nonparticipating specialist for dental services, which are covered under this agreement, the Plan shall be responsible for payment of the specialist's charges to the extent the charges exceed the Copayments specified in the Description of Benefits and Member Copayments.

If Plan's network does not have a geographically accessible Provider with appropriate expertise to treat a Member's dental condition, after notifying the Plan, the Member can obtain services from an out-of-network Provider. The Plan will work with the Member to identify a Provider. The Plan will pay all medically necessary covered expenses directly related to the treatment of the Member's dental condition. The Member will be responsible for the Plan's copayments and cost-sharing based on in-network benefits. The Plan may apply preauthorization and/or alternative benefit protocols that would be applied to an in-network provider. In the event that the Plan and the out-of-network Provider cannot agree upon the appropriate rate, the Provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute. The Plan will pay the benefits directly to the out-of-network Provider.

If during the term of this Contract none of the plan dentists can render necessary care and treatment to the Member due to circumstances not reasonably within the control of the Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the plan dentists, then the Member may seek treatment from an independent licensed dentist of his own choosing. The Plan will pay the Member for the expenses incurred for the dental services with the following limitations: The Plan will pay the Member for services which are listed in the Description of Benefits and Member Copayments as 'No Charge', to the extent that such fees are reasonable and customary for dentists in the same geographic area. The Plan will also pay the Member for those services for which there is a Copayment, to the extent that the reasonable and customary fees for such services exceed the Copayment for such services as set forth in the Description of Benefits and Member Copayments. The enrollee may be required to give written proof of loss.

PRE-AUTHORIZATION 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 or other dental records, prior to issuing the pre-authorization. The proposed services will be reviewed and a pre-authorization will be issued to the Member or dentist, specifying coverage. The pre-authorization 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.

Part VI. DENTAL RECORDS

The dental records of all Members concerning services performed hereunder shall remain the property of the Participating Dentist or Plan Specialist. 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 Subscription Dues or Member Copayments after completion of the term of the Contract. No change will be made without giving the Subscriber thirty (30) days prior written notice.

Part VIII. EMERGENCY SERVICES

When a member is more than 50 miles from their Participating Dentist, they may have emergency services rendered by any licensed dentist. Emergency services is defined as "palliative care of injury, toothache, or accident requiring the immediate attention of a dentist which occurs under circumstances where it is impractical for Members to present themselves to their designated Participating Dentist for care." Plan reimburses for emergency out-of-area services up to \$100 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Plan must be notified of such treatment within five (5) days of the Member's return to their area. Proof of loss must be submitted to Plan within thirty (30) days of treatment. Proof of loss should be mailed to: Blue Cross Blue Shield of Arizona, Inc., 251 18th Street South, Suite 900, Arlington, VA 22202, ATTN: Accounting Dept. When a Member has a dental emergency within the service area, but is unable to make arrangements to receive care through their Participating Dentist, treatment must be pre-authorized by contacting BCBSAZ Customer Services at 888-271-7806.

Part IX. INCONTESTABILITY 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.

Part X. HOW TO RECEIVE BENEFITS

In order to make an appointment, Members must contact their selected dental office. The first appointment scheduled will usually be for the purpose of taking a complete set of full mouth x-rays, an examination, developing a treatment plan, and providing an estimate of the cost of needed work. Members must pay the fees listed for each covered procedure performed on the Description of Benefits and Member Copayments. These fees are paid directly to the Participating Dentist who renders treatment. In the event the Participating General Dentist determines specialty care is necessary, the Participating General Dentist will provide a referral to a Plan Specialist (if available). The Participating Dentist may also refer the Member to a non-participating specialist as set forth in Part V. A Member may transfer to another dental office by contacting Plan Member Services and requesting a transfer. The transfer will be approved provided there are no outstanding balances with the current Participating Dentist.

Part XI. 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 XII. 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 XIII. GUARANTEED RENEWABILITY

This individual policy may be renewed at the discretion of the Subscriber subject to Part III and IV. A Dependent who is no longer eligible for Dependent coverage may enroll under their own separate policy.

ATTACHMENTS

Description of Benefits and Member Copayments, Membership Identification Card, Notice of Privacy Practices. These attachments contain other terms, including important exclusions and limitations. Subscribers may request additional copies by contacting Customer Services at 888-271-7806.

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>.

