BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

BlueDental℠ Prime PPO

BENEFIT BOOK

BlueDental Prime PPO Plus

azblue.com

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BlueDental Prime PPO Plus
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.

Annual Deductible	**In-Network | Out-of-Network**	Deductible is combined for all services for each calendar year per Member – maximum $75 per family in-network and $150 out-of-network
Amount	$25 | $50	
Max Per Family	$75 | $150	
Applies to All Benefits	No, waived on Class I	
Maximums		Annual maximum applies to Class II and Class III Benefits.
Annual	$1,500 | $750	
Lifetime Ortho	N/A	
Waiting Periods	None	

- If course of treatment is to exceed $300, prior review is requested

ADA Code	**Description**	**In-Network Member Copayment**	**Out-of-Network Plan Allowance**
CLASS I – DIAGNOSTIC/PREVENTIVE			
D0120	Periodic Oral Evaluation - Established Patient	0	13
D0140	Limited Oral Evaluation - Problem Focused	0	17
D0145	Oral Eval For A Patient Under 3 Years Of Age And Counseling W/Primary Caregiver	0	23
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0	19
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0	34
D0170	Re-Evaluation - Limited, Problem Focused (Est Patient; Not Post-Operative Visit)	0	16
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	0	25
D0210	Intraoral - Complete Series Of Radiographic Images	0	36
D0220	Intraoral - Periapical First Radiographic Image	0	7
D0230	Intraoral - Periapical Each Additional Radiographic Image	0	5
D0240	Intraoral - Occlusal Radiographic Image	0	9

D23342 01/20

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D0251	Extra-Oral Posterior Dental Radiographic Image	5	14
D0270	Bitewing - Single Radiographic Image	0	8
D0272	Bitewings - Two Radiographic Images	0	11
D0273	Bitewings - Three Radiographic Images	0	13
D0274	Bitewings - Four Radiographic Images	0	15
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	27	24
D0330	Panoramic Radiographic Image	45	30
D0340	2D Cephalometric Radiographic Image-Acquisition, Measurement And Analysis	47	24
D0350	Oral/Facial Photographic 2D Imaging Obtained Intraorally Or Extraorally	20	14
D1110	Prophylaxis; Adult	0	26
D1110	Extra cleaning for diabetics and expectant mothers	0	26
D1120	Prophylaxis; Child	0	20
D1206	Topical Application Of Fluoride Varnish;	10	14
D1208	Topical Application Of Fluoride - excluding varnish	10	10
D1351	Sealant - Per Tooth	0	14
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	0	14
D1354	Interim Caries Arresting Medicament Application	10	16
D1510	Space Maintainer-Fixed Unilateral	95	83
D1516	Space Maintainer - Fixed - Bilateral, Maxillary	105	111
D1517	Space Maintainer - Fixed - Bilateral, Mandibular	105	111
D1520	Space Maintainer - Removable - Unilateral	95	80
D1526	Space Maintainer - Removable - Bilateral, Maxillary	105	175
D1527	Space Maintainer - Removable - Bilateral, Mandibular	105	175
D1550	Re-Cement Or Re-Bond Space Maintainer	25	22
D1555	Removal Of Fixed Space Maintainer	25	21
D1575	Distal Shoe Space Maintainer – Fixed Unilateral	95	82
CLASS II – RESTORATIVE (FILLINGS)			
D2140	Amalgam - One Surface, Primary Or Permanent	27	13
D2150	Amalgam - Two Surfaces, Primary Or Permanent	32	16
D2160	Amalgam - Three Surfaces, Primary Or Permanent	42	19
D2161	Amalgam-Four Or More Surfaces Primary Or Permanent	52	23
D2330	Resin-Based Composite - One Surface, Anterior	32	15
D2331	Resin-Based Composite - Two Surfaces, Anterior	38	20
D2332	Resin-Based Composite - Three Surfaces, Anterior	47	23
D2335	Resin-Based Composite - 4 Or More Surfaces Or Involving Incisal Angle (Anterior)	75	28
D2390	Resin-Based Composite Crown Anterior	110	33
D2391	Resin-Based Composite - One Surface, Posterior	38	17
D2392	Resin-Based Composite - 2 Surfaces, Posterior	45	22

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D2393	Resin-Based Composite - 3 Surfaces, Posterior	57	28
D2394	Resin-Based Composite - 4 Or More Surfaces, Posterior	100	33
CLASS III – CROWN & BRIDGE*			
D2510	Inlay-Metallic-One Surface	85	87
D2520	Inlay-Metallic-Two Surfaces	96	98
D2530	Inlay - Metallic - Three Or More Surfaces	120	112
D2542	Onlay Metallic Two Surfaces	290	112
D2543	Onlay - Metallic- Three Surfaces	300	117
D2544	Onlay - Metallic- Four Or More Surfaces	330	120
D2610	Inlay - Porcelain/Ceramic - One Surface	370	101
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	390	109
D2630	Inlay - Porcelain/Ceramic - Three Or More Surfaces	410	116
D2642	Onlay- Porcelain/Ceramic - Two Surfaces	400	110
D2643	Onlay- Porcelain/Ceramic - Three Surfaces	410	119
D2644	Onlay- Porcelain/Ceramic - Four Or More Surfaces	430	129
D2650	Inlay - Resin-Based Composite - One Surface	195	68
D2651	Inlay - Resin-Based Composite - Two Surfaces	220	79
D2652	Inlay - Resin-Based Composite - Three Or More Surfaces	255	85
D2662	Onlay - Resin-Based Composite - Two Surfaces	230	77
D2663	Onlay - Resin-Based Composite - Three Surfaces	250	87
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	280	93
D2710	Crown - Resin-Based Composite (Indirect)	220	57
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	220	55
D2740	Crown-Porcelain/Ceramic Substrate	340	149
D2750	Crown - Porcelain Fused To High Noble Metal	380	153
D2751	Crown - Porcelain Fused To Predominantly Base Metal	330	140
D2752	Crown - Porcelain Fused To Noble Metal	360	144
D2780	Crown 3/4 Cast High Noble Metal	360	135
D2781	Crown 3/4 Cast Predominately Base Metal	340	131
D2782	Crown 3/4 Cast Noble Metal	310	149
D2783	Crown 3/4 Porcelain/Ceramic	360	135
D2790	Crown - Full Cast High Noble Metal	360	144
D2791	Crown-Full Cast Predominantly Base	320	126
D2792	Crown-Full Cast Noble Metal	340	140
D2794	Crown-titanium	415	131
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	15	10
D2915	Re-Cement Or Re-Bond Indirectly Fabricated Or Prefabricated Post And Core	15	10
D2920	Re-Cement Or Re-Bond Crown	15	10
D2929	Prefabricated Porcelain/Ceramic Crown - Primary Tooth	175	40
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	45	29
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	50	32

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D2932	Prefabricated Resin Crown	85	36
D2933	Prefabricated Stainless Steel Crown With Resin Window	130	40
D2934	Prefab Esthetic Coated Stainless Steel Crown Primary Tooth	200	40
D2940	Protective Restoration	20	11
D2950	Core Buildup, Including Any Pins When Required	50	28
D2951	Pin Retention - Per Tooth, In Addition To Restoration	14	6
D2952	Post And Core In Addition To Crown Indirectly Fabricated	85	43
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	95	21
D2954	Prefabricated Post And Core In Addition To Crown	80	34
D2957	Each Additional Prefabricated Post - Same Tooth	30	18
D2960	Labial Veneer (Resin Laminate) - Chairside	230	50
D2961	Labial Veneer (Resin Laminate) - Laboratory	250	97
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	290	105
D2971	Addtl Procedures To Construct New Crown Under Existing Partial Denture Framework	50	14
D2980	Crown Repair Necessitated By Restorative Material Failure	48	10
D2981	Inlay repair necessitated by restorative material failure	95	20
D2982	Onlay repair necessitated by restorative material failure	95	20
D2983	Veneer repair necessitated by restorative material failure	95	20
CLASS III – ENDODONTICS			
D3110	Pulp Cap - Direct (Excluding Final Restoration)	15	7
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	15	5
D3220	Therapeutic Pulpotomy (Excl Final Restoration)-Removal Of Pulp Coronal	25	16
D3221	Pulpal Debridement Primary And Permanent Teeth	88	18
D3230	Pulpal Therapy (Resorbable)-Anterior, Primary Tooth (Excl Final Restoration)	45	20
D3240	Pulpal Therapy (Resorbable)-Posterior, Primary Tooth (Excl Final Restoration)	40	22
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	150	97
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	210	108
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	350	126
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	75	39
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	280	107
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	305	127
D3348	Retreatment Of Previous Root Canal Therapy - Molar	380	135
D3351	Apexification/Recalcification- Initial Visit	90	29
D3352	Apexification/Recalcification - Interim Medication Replacement	90	20

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D3353	Apexification/Recalcification - Final Visit	180	64
D3355	Pulpal Regeneration - Initial Visit	90	29
D3356	Pulpal Regeneration - Interim Medication Replacement	90	20
D3357	Pulpal Regeneration - Completion Of Treatment	180	64
D3410	Apicoectomy - Anterior	270	91
D3421	Apicoectomy - Bicuspid (First Root)	330	108
D3425	Apicoectomy - Molar (First Root)	365	113
D3426	Apicoectomy (Each Additional Root)	95	33
D3427	Periradicular Surgery Without Apicoectomy	100	28
D3430	Retrograde Filling-Per Root	60	28
D3450	Root Amputation-Per Root	100	57
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	85	44
CLASS III – PERIODONTICS			
D4210	Gingivectomy Or Gingivoplasty - 4 Or More Contiguous Teeth, Per Quadrant	200	56
D4211	Gingivectomy Or Gingivoplasty - 1 To 3 Contiguous Teeth, Per Quadrant	75	32
D4240	Gingival Flap Procedure, Incl Root Planing-4 Or More Contiguous Teeth, Per Quad	300	93
D4241	Gingival Flap Procedure, Incl Root Planing -1-3 Contiguous Teeth, Per Quadrant	200	43
D4245	Apically Positioned Flap	150	69
D4249	Clinical Crown Lengthening - Hard Tissue	200	92
D4260	Osseous Surg (Incl Elev Of A Full Thickness Flap/Closure)-4 Or More Contig Teeth	380	150
D4261	Osseous Surgery - One To Three Contiguous Teeth Or Tooth	350	92
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	233	47
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Addtl Site In Quadrant	188	38
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	243	49
D4267	Guided Tissue Regeneration - Non-Resorbable Barrier, Per Site	335	70
D4270	Pedicle Soft Tissue Graft Procedure	240	88
D4273	Autogenous Connective Tissue Graft Procedure (Incl Donor & Recipient Surg Sites)	325	113
D4274	Mesial/Distal Wedge Proc, Single Tooth (W/Surgical Procs In The Same Anat Area)	125	51
D4275	Non-Autogenous Connective Tissue Graft (Incl Recip Site & Donor Material)	341	68

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D4276	Combined Connective Tissue And Double Pedicle Graft Per Tooth	65	84
D4277	Free Soft Tissue Graft Proc (Incl Recipient & Donor Surgical Sites) First Tooth	215	114
D4278	Free Soft Tissue Graft Procedure (Incl Recipient & Donor Surgical Sites)	75	114
D4283	Autogenous Connective Tissue Graft Procedure (Incl Donor & Recipient Surg Sites)	268	114
D4285	Non-Autogenous Connective Tissue Graft Proc (Incl Recip Surg Site & Donor Matl)	392	114
D4320	Provisional Splinting-Intracoronal	115	50
D4321	Provisional Splinting-Extracoronal	105	45
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	40	26
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	45	17
D4346	Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation - Full Mouth, after oral Evaluation	30	16
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	40	18
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle	42	18
D4910	Periodontal Maintenance	60	15
CLASS III – PROSTHETICS (DENTURES)			
D5110	Complete Denture; Maxillary	420	163
D5120	Complete Denture - Mandibular	420	163
D5130	Immediate Denture - Maxillary	425	176
D5140	Immediate Denture - Mandibular	425	176
D5211	Maxillary Partial Denture - Resin Base	275	143
D5212	Mandibular Partial Denture-Resin Base	275	143
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases	480	154
D5214	Mandibular Partial Denture - Cast Metal Framework W/Resin Denture Bases	480	154
D5221	Immediate Maxillary Partial Denture-Resin Base (Incl Any Conv Clasp/Rests/Teeth)	440	123
D5222	Immediate Mandibular Partial Denture-Resin Base (Incl Any Conv Clasp/Rest/Teeth)	440	143
D5223	Immediate Maxillary Partial Denture -Cast Metal Framework W/Resin Denture Bases	445	161
D5224	Immediate Mandibular Partial Denture-Cast Metal Framework W/Resin Denture Bases	445	161

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D5225	Maxillary Partial Denture - Flexible Base (Incl Any Clasps, Rests And Teeth)	470	117
D5226	Mandibular Partial Denture - Flexible Base (Incl Any Clasps, Rests And Teeth)	470	143
D5282	Removable Unilateral Partial Denture -One Piece Cast Metal, Maxillary (Incl Clasps & Teeth)	330	94
D5283	Removable Unilateral Partial Denture -One Piece Cast Metal, Mandibular (Incl Clasps & Teeth)	330	94
D5410	Adjust Complete Denture -Maxillary	20	8
D5411	Adjust Complete Denture - Mandibular	20	8
D5421	Adjust Partial Denture - Maxillary	20	8
D5422	Adjust Partial Denture - Mandibular	20	8
D5510	Repair Broken Complete Denture Base	60	15
D5511	Repair broken complete denture base, mandibular	60	15
D5512	Repair broken complete denture base, maxillary	60	15
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	65	13
D5610	Repair Resin Denture Base	60	17
D5611	Repair resin partial denture base, mandibular	60	17
D5612	Repair resin partial denture base, maxillary	60	17
D5620	Repair Cast Framework	60	19
D5621	Repair cast partial framework, mandibular	60	19
D5622	Repair cast partial framework, maxillary	60	19
D5630	Repair Or Replace Broken Clasp - Per Tooth	60	20
D5640	Replace Broken Teeth-Per Tooth	65	14
D5650	Add Tooth To Existing Partial Denture	65	19
D5660	Add Clasp To Existing Partial Denture - Per Tooth	75	21
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	270	71
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	270	71
D5710	Rebase Complete Maxillary Denture	210	59
D5711	Rebase Complete Mandibular Denture	210	55
D5720	Rebase Maxillary Partial Denture	120	49
D5721	Rebase Mandibular Partial Denture	120	53
D5730	Reline Complete Maxillary Denture (Chairside)	100	33
D5731	Reline Complete Mandibular Denture (Chairside)	100	33
D5740	Reline Maxillary Partial Denture (Chairside)	100	31
D5741	Reline Mandibular Partial Denture (Chairside)	100	31
D5750	Reline Complete Maxillary Denture (Laboratory)	140	45
D5751	Reline Complete Mandibular Denture (Laboratory)	140	45
D5760	Reline Maxillary Partial Denture (Laboratory)	140	42
D5761	Reline Mandibular Partial Denture (Laboratory)	140	44

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D5850	Tissue Conditioning, Maxillary	45	14
D5851	Tissue Conditioning, Mandibular	45	14
CLASS III – BRIDGE & PONTICS*			
D6205	Pontic - Indirect Resin Based Composite	364	73
D6210	Pontic - Cast High Noble Metal	440	144
D6211	Pontic - Cast Predominantly Base Metal	320	126
D6212	Pontic - Cast Noble Metal	340	133
D6214	Pontic - Titanium	415	131
D6240	Pontic - Porcelain Fused To High Noble Metal	380	153
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	340	140
D6242	Pontic - Porcelain Fused To Noble Metal	340	149
D6245	Pontic - Porcelain Ceramic	345	144
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	205	45
D6548	Retainer Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	257	51
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	962	192
D6600	Retainer Inlay - Porcelain/Ceramic, Two Surfaces	330	92
D6601	Retainer Inlay - Porcelain/Ceramic, Three Or More Surfaces	340	96
D6602	Retainer Inlay - Cast High Noble Metal, Two Surfaces	330	135
D6603	Retainer Inlay - Cast High Noble Metal, Three Or More Surfaces	320	108
D6604	Retainer Inlay - Cast Predominantly Base Metal, Two Surfaces	340	96
D6605	Retainer Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	330	102
D6606	Retainer Inlay - Cast Noble Metal, Two Surfaces	330	95
D6607	Retainer Inlay - Cast Noble Metal, Three Or More Surfaces	340	105
D6608	Retainer Onlay - Porcelain/Ceramic, Two Surfaces	350	101
D6609	Retainer Onlay - Porcelain/Ceramic, Three Or More Surfaces	370	104
D6610	Retainer Onlay - Cast High Noble Metal, Two Surfaces	350	106
D6611	Retainer Onlay - Cast High Noble Metal, Three Or More Surfaces	350	117
D6612	Retainer Onlay - Cast Predominantly Base Metal, Two Surfaces	350	105
D6613	Retainer Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	350	110
D6614	Retainer Onlay - Cast Noble Metal, Two Surfaces	320	104
D6615	Retainer Onlay - Cast Noble Metal, Three Or More Surfaces	330	109

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D6624	Retainer Inlay - Titanium	410	98
D6634	Retainer Onlay - Titanium	410	103
D6710	Retainer Crown - Indirect Resin Based Composite	380	105
D6740	Retainer Crown - Porcelain/Ceramic	360	153
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	340	153
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	310	140
D6752	Retainer Crown - Porcelain Fused To Noble Metal	360	144
D6780	Retainer Crown - 3/4 Cast High Noble Metal	360	118
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	340	118
D6782	Retainer Crown - 3/4 Cast Noble Metal	340	124
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	350	122
D6790	Retainer Crown - Full Cast High Noble Metal	360	144
D6791	Retainer Crown - Full Cast Predominantly Base Metal	350	126
D6792	Retainer Crown - Full Cast Noble Metal	360	131
D6794	Retainer Crown - Titanium	380	131
D6920	Connector Bar	306	61
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	30	14
D6940	Stress Breaker	125	28
D6950	Precision Attachment	245	50
D6980	Fixed Partial Denture Repair Necessitated By Restorative Material Failure	76	15
CLASS III – ORAL SURGERY			
D7111	Extraction Coronal Remnants Deciduous Tooth	45	10
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	25	14
D7210	Extract, Erupted Tooth Req Removal Of Bone, & Incl Elev Of Mucoperiosteal Flap	30	30
D7220	Removal Of Impacted Tooth; Soft Tissue	40	30
D7230	Removal Of Impacted Tooth; Partially Bony	65	40
D7240	Removal Of Impacted Tooth; Completely Bony	80	48
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	128	58
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	25	25
D7251	Coronectomy - Intentional Partial Tooth Removal	270	62
D7270	Tooth Reimplantation/Stabilization Of Accidentally Evulsed Or Displaced Tooth	50	51
D7280	Exposure Of An Unerupted Tooth	125	43
D7285	Incisional Biopsy Of Oral Tissue-Hard (Bone, Tooth)	115	39
D7286	Incisional Biopsy Of Oral Tissue-Soft	75	39
D7288	Brush Biopsy Transepithelial Sample Collection	25	10

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D7292	Placement Of Temp Anchorage Device Req Flap; Incl Device Removal	360	72
D7293	Placement Of Temporary Anchorage Device Requiring Flap; Includes Device Removal	229	46
D7294	Placement Of Temporary Anchorage Device Without Flap; Includes Device Removal	166	33
D7310	Alveoloplasty In Conjunction W Extractions - 4/More Teeth/Spaces Per Quad	90	30
D7311	Alveoloplasty In Conjunction W Extractions 1-3 Teeth/Spaces Per Quadrant	65	22
D7320	Alveoloplasty Not In Conjunction W Extractions - 4/More Teeth/Spaces Per Quad	90	34
D7321	Alveoloplasty Not In Conjunction W Extractions 1-3 Teeth/Spaces Per Quadrant	50	36
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	230	73
D7472	Removal Of Torus Palantinus	225	102
D7473	Removal Of Torus Mandibularis	200	107
D7485	Reduction Of Osseous Tuberosity	225	83
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	40	22
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	40	42
D7880	Occlusal Orthotic Device, By Report	0	68
D7881	Occlusal Orthotic Device Adjustment	41	8
D7960	Frenulectomy-Aka Frenectomy Or Frenotomy - Separate Procedure Not Incidental	280	65
D7963	Frenuloplasty	280	66
D7970	Excision Of Hyperplastic Tissue - Per Arch	221	44
D7971	Excision Of Pericoronal Gingiva	102	20
D7972	Surgical Reduction Of Fibrous Tuberosity	183	37
D7979	Non-surgical Sialolithotomy	48	10
CLASS IV – ORTHODONTIA			
D8010	Limited Orthodontic Treatment Of Primary Dentition	N/A	N/A
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	N/A	N/A
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	N/A	N/A
D8040	Limited Orthodontic Treatment Of The Adult Dentition	N/A	N/A
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	N/A	N/A
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	N/A	N/A
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	N/A	N/A

ADA Code	Description	In-Network Member Copayment	Out-of-Network Plan Allowance
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	N/A	N/A
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	N/A	N/A
D8210	Removable Appliance Therapy	N/A	N/A
D8220	Fixed Appliance Therapy	N/A	N/A
D8680	Orthodontic Retention (Removal Of Appliances/Construct & Placement Of Retainers)	N/A	N/A
ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	20	10
D9222	Deep Sedation/General Anesthesia-First 15 Minute Increment	50	14
D9223	Deep Sedation/General Anesthesia-Each 15 Minute Increment	50	14
D9239	Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	50	11
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia-Each 15 Minute Increment	56	11
D9310	Consult - Dx Service Provided By Dentist/Phys Other Than Requesting Dentist/Phys	25	12
D9440	Dental Office Visit - After Regularly Scheduled Hours	0	12
D9610	Therapeutic Parenteral Drug Single Administration	15	7
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	0	12
D9944	Occlusal Guard – Hard Appliance, Full Arch	220	57
D9945	Occlusal Guard – Soft Appliance, Full Arch	220	57
D9946	Occlusal Guard – Hard Appliance, Partial Arch	220	57
D9995	Teledentistry – synchronous; real-time encounter	20	4
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	20	4

[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 a BlueDental PPO Prime 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, the member is responsible for the amount listed in the "In-Network Member Copayment" column.
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. If you visit an out-of-

network provider, BCBSAZ will pay the provider the fee listed in the "Out-of-Network Plan Allowance" column and the member may be billed for any difference between the billed amount and the "Out-of-Network Plan Allowance."

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
- your dentist's billed charge is $100
- the in-network member copayment is $20
- The out-of-network plan allowance is $15

In-Network Provider		Out-of-Network Provider	
Billed charge	$100	Billed charge	$100
In-network member copayment	$20	Out-of-network plan allowance	$15
BCBSAZ pays	$80	BCBSAZ pays	$15
		Difference of billed charge	$85
Your Out-of-Pocket Cost:	*$20*	*Your Out-of-Pocket Cost:*	*$85*

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.

Rollover Benefits

A Member may be eligible for a rollover of a portion of his or her unused Annual Maximum for Class I, II and III Services. If a Member submits at least one claim for a covered cleaning during a Calendar Year and, in that Calendar Year, receives Benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Rollover Benefit Threshold, he or she may be entitled to Rollover Benefits. Rollover Benefits can accrue and are tracked by the Plan. If a Member reaches his or her Annual Maximum for Class I, II and III Services, Plan will pay Benefits up to the Rollover Maximum. The amount of Rollover Benefits may not be greater than the Rollover Maximum. A Member's Rollover Benefits may be eliminated, and the accrued benefit lost, if there is a break in coverage of any length of time, for any reason, or if the Rollover Benefit Threshold is exceeded in any given Calendar Year. Under this Contract, the Rollover Benefit Threshold and Rollover Maximum are as follows:

Rollover Benefit Threshold $750
Calculated at 50% of Annual Maximum

Rollover Maximum $1,875
Calculated at 125% of Annual Maximum

Rollover Benefit is calculated at 50% of Annual Maximum less Benefits paid.

BCBSAZ Prime PPO Limitations and Exclusions

Type I. Diagnostic and Preventive Services:

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. One full mouth or panoramic x-ray per 60 months
4. Periapical x-rays
5. Bitewing x-rays, 2 per Calendar Year
6. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients); Preventive Reward: Primary subscriber will receive a $20 payment from BCBSAZ for each family member that receives two cleanings during the plan year from a participating PPO network dentist. Contact your Benefit Administrator for details.
7. One topical fluoride per Calendar Year, to age 16
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. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
2. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)

Type III. Major Services:

1. Simple extraction of teeth
2. One study model per 36 months
3. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
4. 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
5. Crown build-up for non-vital teeth
6. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
7. 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
8. 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
    j. Antibiotic injections administered by a dentist
9. 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
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 repair of dentures or fixed bridgework per 24 months
    e. 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)
12. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery, or periodontal surgery, or implant placement procedures

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.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony (except for D7880).
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; 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

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.

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: “In-network” dental providers have contracts with BlueCross BlueShield of Arizona (BCBSAZ) or with BCBSAZ’s independent dental network vendor. In-network providers accept member’s copayment 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. 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. “Out-of-network” providers have no contract with BCBSAZ or 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. If you visit an out-of-network provider, BCBSAZ will pay the provider the fee listed in the “Out-of-Network Plan Allowance” column and the member may be billed for any difference between the billed amount and the “Out-of-Network Plan Allowance.” 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 nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ́ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą́ doo bą́ąh 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 ܚܕ ܐܢܫܐ ܕܩܐ ܡܥܕܪܝܬܘܢ ܠܗ، ܐܝܬܠܘܟܘܢ ܫܘܐܠܐ ܒܘܬ Blue Cross Blue Shield of Arizona، ܐܢܬܘܢ ܐܝܬܠܘܟܘܢ ܗܘܝܬܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܡܚܐ ܩܠܐ ܥܠ ܬܠܝܦܘܢ ܡܢܝܢ 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 หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-271-7806