DELTA DENTAL®

Delta Dental of Arizona
deltadentalaz.com/asrs

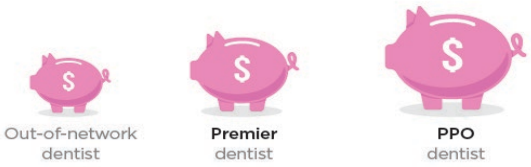
DELTA DENTAL PPO PLUS PREMIER®

ARIZONA STATE RETIREMENT SYSTEM

LOW PLAN OPTION

Why Go PPO

You may visit any licensed dentist, but you will save the most money by visiting a PPO dentist. That's because PPO dentists agree to accept lower reimbursements for services.



Find A Dentist

It's easy to find a Delta Dental dentist near you with our provider search tool at **deltadentalaz.com** or in the Delta Dental Mobile App.

Easy Benefits Coordination

If you're covered under two plans, please refer to the Delta Dental Benefit Booklet or the Arizona State Retirement System Health Plan WRAP PLAN DOCUMENT for eligibility rules and restrictions.

No ID Card Necessary

Just give your dental office your name and member ID. Don't know your member ID? Pull up an electronic ID card on your smartphone at the dentist's office by logging in to the Delta Dental Mobile App.

Download The Mobile App

Access your benefits and view your ID card on-the-go with the Delta Dental Mobile App. It's free for Android and iOS!

Know Your Coverage

New to the Delta Dental PPO plan? This plan covers treatment started and completed after your plan's effective date of coverage.[1] Your benefit summary and benefit booklet have specific details about covered treatments.

Register Online

Sign up for the member portal at **deltadentalaz.com/member** to view benefits, eligibility and claims status or to check average dental costs in your area. You can also update your delivery preference for dental benefits statements (EOBs) and go paperless!

Understand Common Dental Terms

It's our goal to make your benefits simple to use and easy to understand. Here are some common terms defined:

- **Annual Maximum** – The maximum dollar amount Delta Dental will pay toward the cost of dental care within a specific benefit period.
- **Deductible** – The amount you pay for covered dental services before Delta Dental begins to pay.
- **Coinsurance** – The percentage of dental care expenses you pay after your deductible.
- **Predetermination** – A pre-treatment estimate that helps determine the cost of a recommended dental treatment.

[1] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier will be responsible for any costs. Group-specific and other exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment. Refer to your benefit booklet for specific details about your plan.

DELTA DENTAL®

ARIZONA STATE RETIREMENT SYSTEM
Effective Date: 01/01/2025
Group 88888
Delta Dental Low Plan Option
Your benefits are based on a Calendar Year

DELTA DENTAL PPO PLUS PREMIER®

Covered Services	PPO Dentist, Premier® Dentist and Out-of-Network Dentist [1]
Calendar Year Maximum Benefit (Combination of in and out-of-network)	$1,000
Calendar Year Deductible (per covered person/maximum per family) (Combination of in and out-of-network)	$50/150
Preventive Services (Does not apply toward the Annual Maximum Benefit)	*Delta Dental Pays*
Exams	100%
Routine Cleanings	
Fluoride: Up to Age 14	
Sealants: Up to Age 16	
X-rays: Bitewing	
Harmful Habit Appliance	
Basic Services	*Delta Dental Pays*
X-rays: Full mouth and periapical	80% [2]
Fillings	
Emergency Treatment	
Minor Periodontics: Scaling and Root Planing.	
Periodontal Maintenance	
Occlusal Adjustment	

[1] Members may incur higher out-of-pocket costs when seeing a Premier or out-of-network dentist. See Covered Dental Services sheet.
[2] Deductible applies to these services.

BENEFITS ARE SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE GROUP PLAN DOCUMENTS
See deltadentalaz.com/asrs for more information

Dependent Age Limit: 26 | Predetermination recommended for services over $250.

How Can We Help You?

Member Portal
deltadentalaz.com/member

Find A Dentist
deltadentalaz.com/provider-search

Customer Service
833.335.8201

DELTA DENTAL®

ARIZONA STATE RETIREMENT SYSTEM
Effective Date: 01/01/2025
Group 88888
Delta Dental Low Plan Option
Your benefits are based on a Calendar Year

COVERED DENTAL SERVICES

PREVENTIVE SERVICES (Does not apply toward the Annual Maximum Benefit)

- Oral evaluations: Two in a benefit year.
- Routine Cleanings: Limited to two in a benefit year. (Frequencies Combined with periodontal maintenance.)
- Topical Application of Fluoride: For children to age 14 - One in a benefit year.
- Sealants: For children up to age 16 – No more than 1 time per tooth per person for permanent molars.
- Bitewing X-rays: One in a benefit year.
- Space Maintainers: For missing posterior primary (baby) teeth up to age 18. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.
- Harmful Habit Appliance: Not covered if orthodontic related. Once per person. Only for children under age 16 years.

BASIC SERVICES (Deductible applies to these services.)

- Full mouth/Panorex or vertical bitewings X-rays: Once in a 5-year period.
- Periapical X-rays: Four in a benefit year.
- Fillings: Silver amalgam and synthetic tooth color fillings. One per surface every two years.
- Emergency (Palliative Treatment): Treatment for the relief of pain.
- Minor Periodontics: Scaling and Root Planing. No more than 1 time per area of the mouth in two years.
- Periodontal Maintenance: No more than 2 times per calendar year. Frequencies combined with routine cleanings.
- Occlusal Adjustment: No more than 1 full mouth treatment in a benefit year.
- Oral Surgery: Simple extractions.

DENTIST PAYMENTS

The **Delta Dental PPO plus Premier plan** leverages the PPO and Premier networks. This provides all the benefits of Delta Dental PPO plan with a plus-members that visit a dentist in the Premier network still receive the benefit of that dentist's contracted fee.

- **PPO Dentist** -- These in-network dentists agreed to accept lower reimbursement for services so members save the most money.
- **Premier Dentist** -- These in-network dentists also accept discounted reimbursement for services, but their discount is not as steep.
- **Out-of-Network Dentist** -- These dentists have not agreed to discount their rates for service, so members who see an out-of-network dentist will have the highest out-of-pocket costs. Members are responsible for paying the full fee charged by the dentist and can submit for reimbursement at the non-participating table of allowance.

TABLE OF CONTENTS

This Dental Benefits Booklet should be read in conjunction with the Summary of Benefits. The Summary of Benefits included in this booklet is an outline of the benefits for your ASRS Group Dental Contract with Delta Dental of Arizona (DDAZ). The benefits are subject to all provisions, terms and conditions of the ASRS Group Dental Contract.

This Dental Benefits Booklet in conjunction with the Appeals Packet and the ASRS Group Dental Contract issued to your Group constitutes the complete document of insurance. This Dental Benefits Booklet, which describes the benefit provisions, takes the place of any other Dental Benefits Booklet issued to you on a prior date.

Even if your dentist has prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits even though the service is not expressly excluded in this Dental Benefits Booklet. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.

WHO CAN BE COVERED UNDER THIS ASRS GROUP DENTAL CONTRACT?

ELIGIBLE PARTICIPANTS

Your eligibility to participate in the ASRS Group Dental plans is determined by ASRS.

ELIGIBLE DEPENDENTS

If you are enrolled for family coverage, the following dependents may be covered under this program:

A. Your lawful spouse; and
B. Your children under the age limits noted in the Summary of Benefits included in this Dental Benefits Booklet or those of your lawful spouse, including newborn children, stepchildren, persons under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption with you in accordance with applicable state or federal law.

A dependent child will be eligible for coverage until the limiting age as noted in the Summary of Benefits or according to the terms of your ASRS Group Dental Contract.

Children with Disabilities
Dependent children over the limiting age as noted in the Summary of Benefits may continue to be eligible as dependents if they are incapable of self-sustaining employment because of intellectual or physical disability that began before the limiting age, and are dependent on you for their support and maintenance. Proof of incapacity and dependency must be provided to DDAZ within thirty-one (31) days of the child's attainment of the limiting age and subsequently furnished to DDAZ upon request, but not more frequently than once per year after the two-year period following the child's attainment of the limiting age.

Military Status
No children who are on active duty in military service are eligible for coverage under this ASRS Group Dental Contract.

Dual Coverage
Dual Coverage eligibility is determined by the Arizona State Retirement System and applicable State of Arizona law. Before relying on the following dual coverage descriptions, participants should first make a determination whether dual coverage eligibility exists. Contact the Arizona State Retirement System for assistance.

ASRS provides the opportunity for its members to enroll in a plan, but there are eligibility restrictions for individuals enrolled in other health plans. This is known as "dual enrollment." It is important that you understand those limitations as it may affect your (and your dependents') eligibility to enroll in or remain enrolled in ASRS health plans.

Individuals who are ASRS retirees, disabled ASRS members, surviving dependents of ASRS members, and their dependents may not be enrolled in the ASRS health plan at the same time they are covered, or enrolled in another group health and accident plan or program. Similarly, retired members of the Public Safety Personnel Retirement System (PSPRS), the Elected Officials' Retirement System (EORP DB Plan or EORP DC Plan), the Correction Officer Retirement Plan (CORP), the Optional Retirement Plan (ORP), or other retirement plans that might be offered by the community college districts, and their dependents may not be

enrolled in an ASRS health plan while also enrolled in a health plan offered by the Arizona Department of Administration.

Some members may have more than one source of eligibility, however, individuals are limited to one enrollment at a time. For example, you may be eligible to enroll in a plan due to your participation in the ASRS and another eligible retirement plan, but you may only be enrolled in a plan in one capacity at a time—either as a member or dependent.

Additionally, if you and your spouse are both eligible to enroll in a plan, you cannot enroll each other as dependents, nor have your children enrolled twice.

One spouse may elect coverage for the entire family, or each spouse may elect their own coverage.

Dependent children can be on one spouse's policy or divided between spouses.

If ASRS determines a participant has prohibited dual coverage, enrollment in the ASRS plan will be terminated and no refunds for any premiums you paid will be issued.

WHEN DOES COVERAGE BEGIN?

EFFECTIVE DATES

Subscribers are eligible participants who are covered under this program:

A. When you complete the DDAZ approved enrollment form and your ASRS Group sends the form to DDAZ with the required monthly payment.

Eligible Dependents are covered under this program:

A. On the date the Subscriber's coverage is effective; or
B. After an Open Enrollment period allowing Subscribers to make coverage changes. The effective date of coverage will be the renewal date immediately following that Open Enrollment period; or
C. On the date the dependent is acquired, meaning: the birth, adoption, placement for foster care, placement for adoption with the Subscriber and for whom the application and approval procedures for adoption have been completed, a marriage that results in the spouse and stepchildren being added to coverage, and persons required to be covered by court order.

ADDITIONAL INFORMATION ON EFFECTIVE DATES OF ENROLLMENT

Eligible Participants and Dependents who do not enroll for coverage when first eligible, or during an Open Enrollment period, may qualify to enroll if they incur a qualifying life event which affects eligibility for dental coverage. ASRS has sole discretion to determine eligibility and enrollment relating to qualifying life events for Eligible Participants and Dependents. For detailed information regarding what constitutes a qualified life event, eligibility and enrollment, visit the ASRS website.

If a Subscriber newly acquires a dependent as a result of marriage, birth, adoption, placement for foster care or placement for adoption, the dependent(s) may enroll for coverage at that time.

A. If a Subscriber acquires a dependent due to marriage, the effective date of coverage of the eligible dependents(s) will be the first of the month following the event as long as DDAZ receives the enrollment form. The Subscriber must complete, sign and return a DDAZ approved enrollment form to ASRS within thirty-one (31) days from the date of marriage. If there is a change in premium, it will be included in the first billing date after the change is received by DDAZ, and premium will be adjusted back to the first date of the eligible dependent's coverage.

B. If a Subscriber acquires a dependent as a result of birth, adoption, placement foster care or placement for adoption, the effective date of coverage for the newly acquired dependent and any other eligible dependent(s), will be the date of birth, adoption, placement for foster care or placement for adoption. The Subscriber must complete, sign and return a DDAZ approved enrollment form to ASRS within thirty-one (31) days from the date of birth, adoption, placement for foster care or placement for adoption. If there is a change in premium, it will be included in the first billing date after the change adjusted back to the effective month of the change.

   An approved enrollment form must be submitted to add newborn or any adopted children, even if no additional premium is required. DDAZ's claim payment system tracks deductibles, maximums and benefit information individually for each Covered Person. The name and other pertinent information, as included on the enrollment form, are required to process claims. Therefore, although it is not required that an enrollment form be completed for anyone under age three (3), it is prudent to address this as soon as possible. The claims payment may be delayed and/or possibly denied if DDAZ does not have the data on this dependent in the claims paying system and if premium has not been paid for this dependent.

C. If a court orders that coverage be provided by a Subscriber, the effective date of coverage for this Covered Person will be the first billing date after DDAZ receives the approved enrollment form. The Subscriber must complete, sign and return the approved DDAZ enrollment form to ASRS within thirty-one (31) days from the date the court order is issued. However, the effective date of coverage may be different if required by court order or applicable law.

OPEN ENROLLMENT

An eligible participant may enroll for coverage for the eligible participant and any eligible dependents during any annual Open Enrollment period. The effective date of coverage will be the renewal date immediately following that Open Enrollment period, as long as the approved DDAZ enrollment form is completed, signed and returned to ASRS within thirty-one (31) days.

WHEN DOES COVERAGE END?

LOSS OF COVERAGE

Coverage for the eligible Subscriber and/or eligible dependent will terminate on the last day of the month in which loss of eligibility is triggered, or as designated by ASRS and outlined in the Summary of Benefits included in this Dental Benefits Booklet. Examples of events that would trigger loss of eligibility or coverage include but are not limited to the following:

1. The date the policy ends.
2. The policy is changed to end the insurance for the subscriber's eligible class, or with respect to a dependent, the subscriber or dependent's eligible class.

3. The subscriber is no longer in an eligible class, or with respect to a dependent, the subscriber or dependent is no longer in an eligible class.
4. A required contribution was not paid.
5. You become covered under an optional dental plan, which is sponsored by ASRS, or your policyholder, or an associated company and provided through a dental maintenance organization.
6. For a dependent, the day the policy is changed to end dependent insurance.
7. For a dependent, the day the subscriber's coverage under the policy ends.
8. The date the ASRS Group Dental Contract terminates.

RESCISSON OF COVERAGE

If there is fraud or a material misrepresentation on an enrollment form for coverage for any person ineligible to be covered by the dental plan, the coverage will be rescinded and will be considered as never having been in effect. Any premiums paid for coverage for the ineligible person will be refunded minus any claims paid for that person. DDAZ is entitled to recover the claim payments that exceed the amount of premium paid. The other persons on the benefit plan who remain eligible will not be affected by the rescinded coverage of the ineligible person.

CAN COVERAGE BE EXTENDED AFTER TERMINATION?

COVERAGE AFTER TERMINATION

Benefits will not be paid for dental services provided after your coverage ends, including pre-determined services, except for multiple appointment procedures with a date of service before the termination of coverage which were completed within thirty (30) days from the date your coverage ended. Such benefits will be subject to all conditions specified in the ASRS Group Dental Contract.

DDAZ will not pay any claim received more than twelve (12) months after the earlier of (i) the date of termination of the ASRS Group Dental Contract or (ii) the date of service under the policy.

CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or continuation coverage provided by state or other federal continuation law, you and your covered dependents may have the right to continue dental insurance coverage beyond the date the insurance would otherwise terminate. Please contact ASRS concerning any right to continuation coverage.

CONVERSION COVERAGE

WHO IS ELIGIBLE FOR CONVERSION COVERAGE?

A Subscriber may enroll in conversion coverage upon a termination or loss of coverage due to a change in benefits eligible status after any applicable continuation coverage ends if the ASRS Group Dental Contract with DDAZ is still in force. If the Subscriber is not eligible for continuation coverage due to the size or type of the Group, conversion coverage will apply upon termination or loss of coverage due to a change in benefits eligible status.

A Covered Dependent may enroll in conversion coverage upon the death of a Subscriber, divorce, or change in benefits eligible status of the subscriber. Conversion coverage will also apply to dependents upon the loss of coverage due to reaching the limiting age. The conversion coverage may include covered dependent children for whom the spouse has responsibility for care and/or support.

DDAZ requires a DDAZ approved enrollment form and the first premium payment within thirty-one (31) days for the conversion contract to become effective. The effective date of the conversion contract will be the day following termination of active group coverage or if applicable, the day after continuation coverage ceases provided that this Contract continues to be in force. There will be no evidence of insurability requirement.

WHO WOULD NOT BE ELIGIBLE FOR CONVERSION COVERAGE?

This conversion coverage is not available to a person covered by other dental benefits, which together with this conversion coverage would constitute duplicate insurance. This coverage also does not apply if the Group terminates the Group Dental Contract as a result of a change to another insurance carrier.

HOW DOES THE PROGRAM WORK?

USING YOUR DENTAL BENEFITS

Visit the dentist of your choice. If you do not have a dentist, speak with your benefits administrator to obtain a participating dentist directory or visit our web site at www.deltadentalaz.com/asrs.

The contract between DDAZ and your dentist may have changed. To maximize the value of your dental benefits, when making an appointment, confirm that your dentist is contracted with Delta Dental of Arizona.

PRE-DETERMINATION OR PRE-ESTIMATE

During your first appointment, advise your dentist that you are covered by DDAZ under the ASRS Contract number indicated on the Summary of Benefits included in this booklet. Give the dentist your member identification number. Dependents must use the Subscriber's member identification number.

After an examination, your dentist will establish the treatment to be performed. We strongly encourage you to obtain a pre-determination of benefits for any dental treatment plan that is expected to exceed three hundred dollars ($300) in cost. Ask your dentist to complete a pre-determination of benefits and submit the form to:

Delta Dental of Arizona
PO Box 43026
Phoenix, AZ 85080-3026

Delta Dental will verify your eligibility and determine the amount of benefits payable by your Plan. The pre-determination voucher will be returned by DDAZ to the Participating Dentist with a copy to you. If you see a Non-participating Dentist, the pre-determination voucher will be returned by DDAZ ONLY to you. The amount of the allowable fee, the amount of benefits

payable by DDAZ and the portion you are required to pay will be shown on the voucher and should be discussed with the dentist before extensive treatment is begun.

In order to be considered for coverage under this ASRS Group Dental Plan, the date of service for the dental treatment estimated in the pre-determination explanation of benefits must occur before the termination of coverage and be completed within thirty (30) days after the termination of coverage.

Pre-determinations are only valid for the procedure and for the dentist who submitted the pre-determination request and may not be transferred to any other dentist. All fee information is confidential. To estimate your out-of-pocket expenses ask your dentist to submit a pre-determination.

NOTICE TO SUBSCRIBERS AND DEPENDENTS

All notices and correspondence regarding claims will be sent to the Subscriber by ordinary mail to the last address in DDAZ's enrollment records. It is recommended that the Subscriber notify ASRS of any change of name and/or address.

Notice of changes to the benefit plan will be provided to ASRS. ASRS is responsible for notifying you of these changes.

NETWORK OF MEMBER DENTISTS

Dentist: A natural person licensed to practice dentistry within the jurisdiction in which the service was provided.

NETWORK PROVISIONS

Participating Dentist;

On the date of service, if the dentist is a participating dentist (a dentist who has signed an agreement with Delta Dental):

A. The dental office will complete the claim forms and submit to DDAZ for payment, pre-determination or coordination of benefits.
B. The Subscriber is required to pay only the co-insurance (if any) and/or deductible (if any) for covered benefits.
C. Participating Dentist reimbursement:
    I. Payment to a dentist participating in the Delta Dental PPO network will not exceed the Table of Allowance for the state in which services are rendered.
    II. Payment to a dentist exclusively participating in the Delta Dental Premier network will not exceed the Maximum Reimbursable Amount for the state in which services are rendered.

Non-Participating Dentist;

Within the United States;

On the date of service, if the dentist is a non-participating dentist (a dentist who has not signed an agreement with Delta Dental, or who has terminated as a Participating Dentist):

A. The Subscriber will be responsible for the submission of the claim form or the predetermination of benefits form to DDAZ.
B. The Subscriber will be responsible to the non-participating dentist for the full cost of treatment and DDAZ will reimburse the Subscriber for the amount of benefits payable

by the Group's plan. The benefits in this Contract may not be assigned.

C. The payment for the treatment will be based on the lesser of the billed charges or the Non-Participating Dentist Table of Allowance for the state in which services are rendered. You will be required to pay the difference between any amount billed by the dentist and that states Non-Participating Dentist Table of Allowance. This payment results, in most instances, in a reduced benefit when compared to the benefit paid for the same service to a Participating Dentist.

Non-Participating Dentist;

Outside the United States;

On the date of service, if the dentist is a non-participating dentist (a dentist who has not signed an agreement with Delta Dental, or who has terminated as a Participating Dentist):

A. The Subscriber will be responsible for the submission of the claim form or the predetermination of benefits form to DDAZ.
B. The claim form must include the billed charges in that country's currency and a conversion fee into United States dollars.
C. The Subscriber will be responsible for the submission of a copy of that dentist's license to practice dentistry in the country services were rendered.
D. The Subscriber will be responsible to the non-participating dentist for the full cost of treatment and DDAZ will reimburse the Subscriber for the amount of benefits payable by the Group's plan. The benefits in this Contract may not be assigned.
E. The payment for the treatment will be based on the lesser of the billed charges or DDAZ's Foreign Non-Participating Dentist Table of Allowance. You will be required to pay the difference between any amount billed by the dentist and DDAZ's Foreign Non-Participating Dentist Table of Allowance. This payment results, in most instances, in a reduced benefit when compared to the benefit paid for the same service to a Participating Dentist or Non-Participating Dentist within the United States.

NON-ASSIGNABILITY OF BENEFITS

The benefits of this ASRS Group Dental Contract are not assignable. You may not assign or transfer the rights to receive any portion of your benefits to any person or entity. If DDAZ makes a payment that is inaccurate to you or makes an overpayment to you or on your behalf, DDAZ is entitled to reimbursement from you or the provider of dental services or may offset the amount owed against a future claim. Inaccurate payments are not a waiver of any future rights of DDAZ to deny payment for noncovered benefits.

COMPLAINTS ABOUT DENTAL SERVICES

This dental program recognizes the right of each Covered Person to select a dentist of his or her own choosing. Neither ASRS nor DDAZ assumes any responsibility for the selection of dentists or for the quality of services received. However, all these parties are vitally interested in resolving questions that may arise concerning availability or quality of dental care. In fact, DDAZ is committed to assuring, to the degree possible, that the professional services provided under this program do meet professionally established standards of dental health care. DDAZ will, on its own or in consultation with a review committee of either the local and/or state dental society, thoroughly review the facts in each case and make a recommendation with regard to the issues brought to our attention. Subscribers who have questions concerning the services received either personally or by their dependents, should direct those questions to:

Professional Relations Department

Delta Dental of Arizona
PO Box 43000
Phoenix, Arizona 85080-3000

WHAT IS COVERED?

BENEFIT PAYMENT DEFINITIONS

A. Contract Year

I. The Contract Year is the twelve (12) month period beginning on the effective date of the Contract and each yearly period thereafter. The ASRS Group Dental Contract is for one (1) year renewable terms. At any renewal period any portion of The ASRS Group Dental Contract may be amended, particularly the benefit provisions and rates. The twelve (12) month period for each Contract Year is outlined in the Summary of Benefits included in this Dental Benefits Booklet.

B. Benefit Year

I. Benefit Year is the time period for which benefits are paid; certain time limitations are tracked and the deductibles and maximum benefits described below are applied. A Benefit Year for this ASRS Group Dental Contract is based on a calendar year.

C. Deductibles

I. Deductible is the amount of covered dental expenses that you pay before the dental benefits are payable and applies to each Covered Person per Benefit Year. Only fees charged for covered dental services will be used toward the deductible. Please refer to the Summary of Benefits included in this booklet for the dental services for which the deductible is applied.

How the deductible works:

1. When covered dental expenses equal to the deductible amount have been incurred and submitted to DDAZ, the deductible will be satisfied.
2. DDAZ will not pay benefits for covered dental services applied to the deductible.
3. There is one common deductible amount for the Participating and Non-participating Dentists.
4. The deductible is for a Benefit Year and is calculated on the date of service.
5. The lesser of the DDAZ's allowance or billed charges for covered services will count toward the deductible.
6. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the deductible.

D. Family Deductible Maximum

I. (Applies only if noted in the Summary of Benefits included in this Dental Benefits Booklet and ASRS Group Dental Contract). Any amount applied to each Covered Person's deductible will count toward a family deductible maximum. Once the family deductible maximum is met, no further, deductible(s) is required. No family member may contribute more than the individual deductible amount toward the family maximum.

E. Benefit Year Maximum

I. The Benefit Year Maximum is the total dollar amount that DDAZ will pay for dental services rendered during any one (1) Benefit Year as per the ASRS Group Dental Contract. This Benefit Year Maximum applies to each Covered Person per Benefit Year. Please refer to the Summary of Benefits for the dental services that are included in the Benefit Year Maximum.

II. The Benefit Year Maximum available to the Subscriber or covered dependent during a Benefit Year is shown in the Summary of Benefits included in this booklet. This maximum will apply even if coverage is interrupted or if the Subscriber or any dependent has been covered both as a participant and a dependent. You cannot transfer all or any portion of your Benefit Year Maximum from person to person or year to year. All covered dental services that do not have a separate lifetime maximum will apply to the Benefit Year Maximum regardless of coinsurance level.

F. Benefit Waiting Periods

I. Some procedures may have a Benefit Waiting Period. The Summary of Benefits included in this Dental Benefits Booklet states the length of Benefit Waiting Periods and which dental services are subject to a Benefit Waiting Period. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the deductible.

G. Dental Services

I. Expenses submitted to DDAZ must identify the dental services performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature by narrative description. DDAZ reserves the right to request x-rays, narratives and other diagnostic information, as needed, to determine benefits. We consider a temporary service to be an integral part of the final service.

H. Alternate Treatment

I. Occasionally, there are several professionally accepted methods to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced with either a fixed bridge or a partial denture. In addition, several different types of appliances can be used for orthodontia with either metal brackets, ceramic brackets or sublingual brackets chosen. DDAZ will make payment based on the allowance for the less expensive procedure provided that the less expensive procedure meets the accepted standards of dental treatment. DDAZ's decision does not commit the patient to the less expensive procedure. However, if the patient and the dentist choose the more expensive procedure, the Subscriber is responsible for the additional charges beyond those paid or allowed by DDAZ.

I. Date of Service

I. The date of service is indicated in the Covered Dental Services in this Dental Benefits Booklet by type of procedure.

DESCRIPTION OF SERVICES

The following is a complete list of covered dental services. DDAZ will not pay benefits for expenses incurred for any service not listed in this Dental Benefits Booklet or the ASRS Group Dental Contract.

Only those services indicated as covered benefits on the Summary of Benefits included in this Dental Benefits Booklet are covered. Also noted in the Summary Benefits are the following:

A. Deductibles and maximum benefits;
B. The Benefit Year (calendar year or an ASRS Group Contract year);
C. The Contract Year for ASRS;
D. The categories of expenses indicating the coinsurance level at which these dental services will be covered (Routine, Basic or Major);
E. The Benefit Waiting Period for each category of expense (if applicable).

The program includes these covered dental services when they are performed and completed by a licensed dentist in a dental office and when necessary and appropriate as determined by the standards of generally accepted dental practice. Covered dental services covered are subject to the Limitations and Exclusions described within this Dental Benefits Booklet and in accordance with the ASRS Group Dental Contract

As deemed necessary on an individual basis, Delta Dental of Arizona may request radiographs and additional information for consultant review to determine if any procedures or services submitted for predetermination or for payment are:

A. A covered benefit under the group contract
B. Within the guidelines generally accepted by the American Dental Association and Delta Dental of Arizona's Processing Policies

Even if your dentist has prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits even though the service is not expressly excluded in this Dental Benefits Booklet. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.

REPLACEMENT OF PRIOR ASRS GROUP DENTAL CONTRACT

If this plan replaces another carrier's group dental contract for the same Policyholder, the No Loss/No Gain Provisions as outlined in this paragraph apply. In applying the deductible provisions of this ASRS Group Dental Contract, DDAZ will give credit for expenses incurred during the same Benefit Year applied in satisfaction or partial satisfaction of any deductible under the prior contract. DDAZ will reduce lifetime and annual maximums under This ASRS Group Dental Contract by any allowable amounts applied towards comparable lifetime or annual maximum amounts in the prior carrier's group dental contract for the same benefit year. To administer these provisions, DDAZ must have knowledge of these deductibles and maximum amounts whether supplied through ASRS, by an Explanation of Benefits through the Subscriber or by the dental history records on a Covered Person as maintained by DDAZ.

COVERED DENTAL SERVICES

The date of service is the date the procedure was performed unless otherwise noted below.

Examinations, evaluations or consultations

A. Two (2) of any combination of examinations, evaluations, or consultations during a Benefit Year. Includes those performed by a general dentist or specialist.

Diagnostic X-Ray Services

A. Full mouth/Panorex or vertical bitewings X-rays: Once in a five (5)-year period.
B. Bitewing x-rays are a benefit once in a Benefit Year.

Routine prophylaxis (scaling and polishing of teeth)

A. Routine prophylaxis: Limited to two (2) in a benefit year.
B. Routine prophylaxis and periodontal prophylaxis are considered to be interchangeable services. A patient must have documented periodontal history to receive a periodontal maintenance benefit (excluding full mouth debridement).

Please refer to Periodontics for full mouth debridement (difficult prophylaxis).

Fluoride treatment

A. Fluoride treatment is a benefit once (1) in a Benefit Year.
B. Fluoride treatment is a benefit up to the age fourteen (14).

Space maintainers due to the premature loss of diseased posterior primary (baby) teeth.

A. Space Maintainers: For missing posterior primary (baby) teeth up to age eighteen (18). Service is deemed to include all adjustments made, or recementing done, within six (6) months of installation.
B. Anterior space maintainers are not a covered benefit.

Sealants

A. Sealants: For children up to age sixteen (16) – No more than one (1) time per tooth per person for permanent molars.

Fillings

A. Fillings are a benefit once for each tooth surface in a twenty-four (24) month interval from the date this service was last performed on that specific tooth surface.

Pre-formed crowns

A. Pre-formed crowns are a benefit once in a three (3) year interval from the date this procedure was last performed on specific primary (baby) teeth up to age sixteen (16).

Periodontics

Benefits will be provided for treatment of diseases of the tissues supporting the teeth (gingival and/or alveolar bone).

A. Periodontal Scaling and Root Planning is a benefit once in a two (2) year interval from the date this procedure was last performed on specific teeth or quadrants.
B. Full Mouth Debridement (difficult prophylaxis) - one (1) difficult cleaning may be exchanged for one routine cleaning, however, the difficult cleaning is limited to not more than once in a five (5) year period.
C. Occlusal adjustment No more than one (1) full mouth treatment in any twelve (12) months. Only when performed with periodontal surgery.

Oral and Maxillofacial Surgery Procedures

Benefits will be provided for extractions as shown in the summary of benefits, except when subject to the Limitations and Exclusions described within this Dental Benefits Booklet.

Post-treatment care for extractions and surgical procedures is considered to be part of the procedure performed and a separate benefit is not provided.

Emergency Palliative Treatment

Emergency treatment for the relief of pain.

Palliative treatment is not covered if definitive treatment is performed for the same problem on the same date. Examination and x-rays are not considered a relief of pain.

GENERAL LIMITATIONS – ALL SERVICES

A. If an eligible person with a covered condition selects a service that is not provided for under the terms of This ASRS Group Dental Contract, or selects specialized techniques rather than standard dental services, DDAZ will pay the applicable percentage of the allowable fee for the standard covered dental service and the patient is responsible for the difference between what DDAZ paid and the dentist's fee.
B. Pre- and post-operative procedures are considered part of any associated covered service. Benefit will be limited to the covered amount for the covered services.
C. Local anesthesia is considered a component of any procedure in which it is used.
D. A temporary dental service will be considered an integral part of a complete service rather than a separate service, and separate payment will not be made for a temporary service unless otherwise included as a covered service of this Contract.
E. If a Covered Person transfers from the care of one (1) dentist to that of another dentist during a course of treatment, DDAZ will not pay for more than the amount it would have paid for had only one (1) dentist rendered all the dental services during each course of treatment. DDAZ will not pay for duplication of dental services.
F. Even if your dentist has: prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits even though it is not expressly excluded in this Dental Benefits Booklet. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.
G. If you or any of your dependents have received free services by or through a public program, DDAZ will coordinate benefits based on submitted documentation.
H. When a procedure is benefited, and then a new service is performed on the same tooth, it is subject to the time limitations of the prior service; therefore, benefits will be reduced on the new service.
I. Sterilization fees are considered a component of any procedure in which it is used.
J. If a covered service is subject to a benefit waiting period and the treatment begins prior to the completion of the waiting period, no benefit is allowed.

EXCLUSIONS

A. Services for injuries or conditions which are compensable under Workman's Compensation or Employer's Liability Law, services which are provided the Covered Person by any Federal or State Government Agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or community agency.
B. A service or procedure that is not generally accepted by the American Dental Association and DDAZ's processing policies.
C. A service or procedure that is not described as a benefit of This ASRS Group Dental Contract and included in the Summary of Benefits in this Dental Benefits Booklet.
D. A method of treatment more costly than is customarily provided without prior approval. Benefits will be based on the least expensive professionally accepted method of treatment.
E. Dental and surgical services with respect to cosmetic surgery, dentistry for purely cosmetic reasons or orthognathic surgery.
F. Specialized techniques including but not limited to precious metal for removable appliances, precision attachments for partials or bridges, overdentures, overlays, implantology, ceramic or sublingual brackets for orthodontia as well as procedures

and appliances associated with the preceding procedures in addition to personalization and characterization.

G. Charges for any health care not specifically covered under this ASRS Group Dental Contract including hospital charges, prescription drug charges, and laboratory charges or fees.
H. Charges for dental services which are started prior to the date the person became covered under This ASRS Group Dental Contract or which are performed during the Benefit Waiting Period.
I. Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: altering vertical dimension, replacing or stabilizing tooth structure lost by attrition, erosion, abrasion wear or bruxism, realignment of teeth, periodontal splinting, splinting, gnathologic recordings, equilibration, bite appliances or harmful habit appliances and/or other damage to either hard or soft tissues as a result of a device worn in a tongue or lip piercing is not a covered benefit.
J. Temporary dentures, other than those provided in This ASRS Group Dental Contract.
K. Study models, casts and other ancillary services not covered in this ASRS Group Dental Contract unless orthodontics is included as a covered benefit in the Summary of Benefits.
L. Travel time and related expenses.
M. Orthodontic services except when covered by This ASRS Group Dental Contract and included in the Summary of Benefits.
N. Direct diagnostic or surgical and non-surgical treatment procedure applied to body joints or muscles, temporal mandibular joint (TMJ) or temporal mandibular disturbances (TMD), except when covered by This ASRS Group Dental Contract and included in the Summary of Benefits.
O. Any claim received more than twelve (12) months from the date of service or twelve (12) months after the termination of This ASRS Group Dental Contract whichever comes first.
P. Any adjustments to previously received claims, including submissions of additional information, received more than twelve (12) months from the initial payment date or initial date of the requested information.
Q. Experimental or transitional procedures or any procedure other than those covered services.
R. Myofunctional therapy or speech therapy.
S. Services not performed in accordance with the laws of the State of Arizona, services performed by any person other than a person authorized by dental license to perform such services, or services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition as explained.
T. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
U. Replacement of lost, stolen or damaged dental appliances.
V. Procedures or services performed in conjunction with uncovered dental services.
W. All other services not specified as covered dental service.

WHAT ELSE DO I NEED TO KNOW ABOUT CLAIMS PAYMENTS?

Claims Inquiry

A toll free number is available for your use in calling DDAZ to inquire about claims, claim payment status or to check on a specific dentist's status with regard to participation with DDAZ. Phoenix area calls should be made to 833-335-8201.

Coordination of Benefits

DDAZ coordinates the benefits under this program with you or your dependents' benefits under any other group managed care program or insurance policy. Benefits under one (1) of these programs may be reduced so that your combined coverage does not exceed the Maximum Reimbursable Amount or non-participating dentist allowable fee for the covered service. If this plan is the "primary" program, DDAZ will not reduce benefits, but if the other program is primary, DDAZ may reduce benefits. The reduction will be the amount paid under the terms of the primary program if it exceeds DDAZ's Maximum Reimbursable Amount. Refer to Covered Dental Services in the Summary of Benefits included in this Dental Benefits Booklet.

The ASRS provides the opportunity for its Members to enroll in the plan, but there are eligibility restrictions for individuals enrolled in other health plans (known as "Dual Enrollment"). ASRS retired Members, Members on ASRS Long Term Disability, Surviving Dependents of ASRS Members, and their Dependents may not be enrolled in the ASRS health plan at the same time they are enrolled in another group health and accident plan or program.

Similarly, retired Members of the PSPRS, the EORP Plan, the CORP, the ORP, or other retirement plans that might be offered by the community college districts, and their Dependents may not be enrolled in an ASRS health plan while also enrolled in a health plan offered by the Arizona Department of Administration (ADOA).

Some Members may have more than one source of eligibility, however, individuals are limited to one enrollment at a time. For example, you may be eligible to enroll in a plan due to your participation in the ASRS and another eligible retirement plan, but you may only be enrolled in a plan in one capacity at a time—either as a Member or Dependent.

Additionally, if you and your spouse are both eligible to enroll in a plan, you cannot enroll each other as Dependents, nor have your children enrolled twice. One spouse may elect coverage for the entire family, or each spouse may elect their own coverage. Dependent children can be on one spouse's policy or divided between spouses, but cannot be enrolled as a Dependent of both spouses.

If the ASRS determines a Participant has prohibited dual coverage, enrollment in the ASRS Plan will be terminated, no refunds for any premiums you paid will be issued, and overpayments made by the ASRS plan will be recovered.

Determination of Primary Program
If a person is eligible for benefits under two (2) or more programs and more than one (1) of the programs provides coverage for an allowable benefit, DDAZ will pay according to the Determination of the Primary Program stated below:

A. The program covering the patient as a Subscriber is primary over a program covering the patient as a Covered Dependent.
B. When the patient is a dependent child, then the birthdays of the parents determine which program is primary. The program of the parent whose birthday (month and day, not year) occurs earlier in a calendar year is primary and will pay its benefits first. The program covering the parent whose birthday occurs later in the year is secondary.

C. When the parents of a dependent child are legally separated or divorced, the program covering the parent with legal custody is primary. The program covering the spouse of the parent with custody (i.e. stepparent) is next. The program of the parent not having legal custody is last. However, if there is a court decree assigning the responsibility for healthcare expenses of the child to one (1) parent, then the program covering that parent is primary.
D. If the patient is a member of a pre-paid dental plan or other capitation plan and is also a Covered Person under this ASRS Group Dental Contract then this ASRS Group Dental Contract is primary, without regard to the existence of such other plan. DDAZ will not be obligated to pay, however, for any dental services that are covered without charge under the prepaid or other capitation plan or to pay in excess of the amount of the co-payment obligation for the particular service under the prepaid or other capitation plan.
E. The program covering the patient as a subscriber (or as that subscriber's dependent) is primary over the program covering the patient as a laid off or a Retired Subscriber (or that subscribers dependent).
F. If the above rules do not apply, or if there are two (2) "primary" coverage plans due to retirement, then the program covering the patient longer is primary.

Right to Receive and Release Necessary Information
DDAZ may release or obtain information from any insurance company or other person(s) as necessary to meet the "Coordination of Benefits" provisions of This ASRS Group Dental Contract. DDAZ will determine the existence of, or amount payable under any other program, through the eligible person claiming benefits under This ASRS Group Dental Contract.

Right of Recovery
DDAZ will recover any payment made that is more than the obligation determined by the terms and conditions of the ASRS Group Dental Contract and the rules of the Coordination of Benefits provision.

Provisions Required by Law
Before approving a claim, DDAZ will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist who is providing dental services to a Covered Person, any information and records regarding the examination and treatment of a Covered Person, as may be required to administer the claim. DDAZ will in every case hold such information and records confidential. DDAZ takes confidentiality very seriously and has various processes in place to ensure that sensitive or confidential information is safeguarded and that the release of such information is made only to facilitate coverage and in accordance with state and federal laws.

The release of information is made only to facilitate coverage. DDAZ will not release information to your spouse, relative, attorney or others purporting to be your representative without your written consent. If you wish to authorize someone to have access to information, you must send a written request. You may visit our website, www.deltadentalaz.com or call DDAZ's Customer Service Department to request an Authorization to Disclose or an Authorized Representative Form. Once DDAZ receives the form, it will release information to the person you have designated. DDAZ may also limit release of information to the parent of dependent children who have reached the age of majority and are not subject to guardianship or conservatorship, even when such children are covered under the parent's policy.

When the Subscriber is not a custodial parent of a child who is covered because of a court administrative order to provide health benefits that include dental coverage to that child,

DDAZ will provide benefit information to the custodial parent, permit the custodial parent to submit claims for the child and make payments directly to the custodial parent, provider or state agency as applicable. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, DDAZ provides equal parental access to information. Whether issues relate to a court or administrative order concerning coverage or simply access to information, DDAZ is not a party to domestic disputes. Such matters must be resolved between parents of the dependent child.

Claim: A demand by an insured or another party for indemnification of a loss under an insurance contract or bond; sometimes, the actual or estimated amount of a loss.

Filing a Claim

Claims should be filed on DDAZ forms. If DDAZ does not provide the requested forms within fifteen (15) days after the request is made, the claim may be submitted in a letter which provides written proof of the claim covering the occurrence, the character and the extent of the loss. The requirements for Proof of Loss will be considered satisfied if DDAZ receives the DDAZ forms or a written statement as outlined above within the time frame as stated in the following paragraph.

Time Limits on Filing Proof of Loss

DDAZ must receive Proof of Loss within ninety (90) days after the termination of care for which Benefits are payable. If that is not possible, it must be received as soon as reasonably possible, but not later than three hundred sixty-five (365) days after the date of service. If the Proof of Loss is received outside these limits, the claim will be denied. These limits will not apply should the Subscriber lack legal capacity.

Proof of Loss

Proof of Loss means written proof that the Covered Person has incurred Dental Expenses for which Dental Benefits are payable. Proof of Loss must be provided at the Subscriber's expense. No dental benefit will be paid until Proof of Loss is satisfied.

Documentation of Proof of Loss

At the Subscriber's expense, it is necessary to submit completed claim statements, with the Subscriber's or Covered Person's signed authorization for DDAZ to obtain information, and any other items we may reasonably require in support of the claim. This information may be obtained from any provider or insurance company. DDAZ reserves the right to reject or suspend a claim based on lack of dental information or records.

Investigation of Claims

DDAZ may investigate your claims at any time. At DDAZ's expense, we may have a dental professional of our choice examine the Covered Person and/or review x-rays. DDAZ may deny or suspend payment of Dental Benefits if the Covered Person or the dentist providing care fails to cooperate with a review or examination by the Dental Professional that DDAZ selects.

Payment of Dental Benefits

DDAZ will pay all dental benefits directly to the Participating Dentists or to the Subscriber if the dentist is a Non-participating Dentist immediately after Proof of Loss is established. DDAZ does not require that any covered services be provided by a specific Dentist. See the Network of Member Dentists Section of this ASRS Group Dental Contract for a complete description of how benefits are paid for Participating and Non-participating Dentists.

Notice of Decision on Claim

If additional information is needed and, therefore, DDAZ is unable to pay the claim, the Subscriber will receive a notice of our receipt of the claim within fifteen (15) working days after DDAZ receives the claim. If DDAZ denies your claim or procedure, or reduces your payment, in whole or in part, including those due to eligibility to participate or utilization review, you will receive an Explanation of Benefits (EOB) describing your liability for services received. If you have no liability and part of your claim is denied (included in the participating dentist agreement), you will not receive an EOB. The plan provisions that are relied upon for processing are included in your benefit booklet. If the Subscriber does not receive DDAZ's decision within thirty (30) days after DDAZ receives information required to process the claim, the Subscriber will have an immediate right to request a review as if the claim had been denied.

If DDAZ denies any part of the claim, the Subscriber will receive a written notice of denial containing:

A. The reasons for the decision,
B. A description of any additional information needed to support the claim, and
C. Information concerning the Subscriber's right to appeal the decision.

Time Limits on Legal Actions

No action at law or in equity may be brought until sixty (60) days after you have given us Proof of Loss. No such action may be brought more than three (3) years after the earlier of:

A. The date DDAZ receives the Proof of Loss, and
B. The end of the period within which Proof of Loss is required to be given.

Claims Appeal Process

Either you or your treating provider can file an appeal on your behalf. DDAZ provides a form to be used for an appeal in the center of the Appeals Packet. You are not required to use the form; a letter with the same information is acceptable. If you decide to appeal a decision to deny authorization or payment of a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

The process for an appeal is described in detail in the Appeals Packet, a separate document, which is provided to you when you become a Covered Subscriber. You can request another copy of this Appeals Packet by visiting our Web site at www.deltadentalaz.com or by calling DDAZ's Customer Service Department.

Description of the Appeals Process

There are two (2) types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has three (3) levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Expedited Appeals

(for urgently needed services you have not yet received)
Level 1: Expedited Medical Review
Level 2: Expedited Appeal
Level 3: Expedited External Independent Review

Standard Appeals

(for non-urgent services or denied claims)
Level 1: Informal Reconsideration[1]
Level 2: Formal Appeal
Level 3: External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

[1]Delta Dental does not provide informal reconsideration of a denied claim; our appeals process begins at the formal appeal level.

Please read the information in your Appeals Packet for details about your rights and responsibilities during the appeals process. These will include the procedures DDAZ and you must follow when participating in the appeals process, the time period applicable at each level of appeal, whether your request for an appeal must be in writing, and notices you will receive from DDAZ regarding your appeal.

Should you have any questions regarding the appeals process and procedures, please contact DDAZ at the numbers listed in your Appeals Packet. For additional assistance with questions regarding the appeals process, you may contact the Arizona Department of Insurance and Financial Institutions (DIFI) Consumer Protection Division.

Delta Dental of Arizona
PO Box 43000
Phoenix, Arizona 85080-3000