AAA Dental

Plan 2

SUMMARY OF BENEFITS – PLAN 2

Delta Dental of Arizona, Inc.

Dental Coverage Policy

Summary Effective Date: 1/1/2009

Group : 8201

Group Name : Plan 2 – AAA

Effective Date : First of the month following the receipt of your completed enrollment form and down payment.

Contract Year : Twelve month period, beginning on your Effective date.
This is the twelve (12) month period for which these Contract benefits apply

Benefit Year : Twelve month period, beginning on your Effective date.
Benefit Year means the annual period specified in the Dental Coverage Policy for calculation of benefits, co-payment, and deductibles under This Contract.

Age Limits : Child: 19 Student: 23

Deductible : $50.00 per person, $150.00 per family

Annual Benefit Year Maximum: $1000.00

REFER TO THE DENTAL COVERAGE POLICY'S DESCRIPTION OF SERVICES FOR A MORE DETAILED DESCRIPTION INCLUDING LIMITATIONS AND EXCLUSIONS. BENEFITS SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE DENTAL COVERAGE POLICY.

Predetermination recommended for services over $250.

Routine 80%

****Deductible does not apply to these services**

****No waiting period**

Diagnostic

- Exams, evaluations or consultations (Twice in a Benefit Year)
- X-rays Full Mouth/Panorex (Once in a five (5) year period) Bitewings(Once in a Benefit Year) Periapical - (six (6) per calendar year).

Preventive

- Topical Application of Fluoride (children to the age of eighteen (18) - twice in a benefit year)
- Routine Cleanings (limited to twice in a benefit year), or one (1) difficult cleaning may be exchanged for one (1) routine cleaning, however, the difficult cleaning is limited to not more than once in a five (5) year period.
- Space Maintainers - Once in a three (3) year period for missing posterior primary (baby) teeth up to age fourteen (14).

Basic 80%

****Deductible does apply to these services**

****Becomes a benefit following 6 (six) months of continuous coverage of the Individual under this plan**

Restorative

- Fillings consisting of silver amalgam; and in the case of front teeth only, composite tooth color fillings - Once per tooth surface in a two (2) year period.
- Stainless Steel Crowns (For primary (baby) teeth only)

Oral Surgery

- Simple Extractions only.

Emergency (Palliative Treatment)

- Emergency treatment for the relief of pain

Major 50%

****Deductible does apply to these services**

****Becomes a benefit following 12 (twelve) months of continuous coverage of the Individual under this plan**

Restorative

- Cast Crowns - Onlays Once in a seven (7) year waiting period. Not available to children under age twelve (12)

Periodontics

- Treatment of Gum Disease: Non-surgical - Once every two (2) years. Surgical - Once every three (3) years. Limited to a Seven Hundred and Fifty dollar ($750.00) Lifetime Maximum.

Endodontics

- Root Canal Treatment (Permanent Teeth); Pulpotomy (Primary (baby) Teeth) Once per tooth per Lifetime.

Prosthodontics

- Bridges - Does not provide for lost, misplaced or stolen bridges or dentures. Seven (7) year waiting period for replacement last performed.
- Complete Dentures - Does not provide for lost, misplaced or stolen bridges or dentures. Seven (7) year waiting period for replacement last performed.
- Implants are only a benefit to replace a single missing tooth, bounded by teeth on each side. Limited to $1,000.00 per tooth, per lifetime and is applied to the patient's benefit year maximum.
- Partial Dentures - Does not provide for lost, misplaced or stolen bridges or dentures. Seven (7) year waiting period for replacement last performed.

Bridge and Denture Repair

- Repair of such appliances to their original condition including relining of dentures.

Humanitarian Services

A dependent child who is engaged in documented humanitarian services, such as the Peace Corps or a religious mission is covered with the same age limitations as students. Authorized proof of this status will be required. The Humanitarian Services must satisfy the following: 1) the organization must be exempt from Federal Income Tax and 2) contributions to the organization qualify for charitable deduction.

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IMPORTANT INFORMATION ABOUT YOUR POLICY

This Dental Coverage Policy 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 policy with Delta Dental of Arizona (DDAZ). The benefits are subject to all provisions, terms and conditions of the policy.

This Dental Coverage Policy is underwritten by Delta Dental of Arizona, an Arizona dental and optometric service corporation. This policy is administered, at least in part, by Renaissance Life & Health Insurance Company of America

This Dental Coverage Policy in conjunction with the Appeals Packet and application for coverage constitutes the complete document of insurance. This Dental Coverage Policy, which describes the benefit provisions, takes the place of any other Dental Coverage Policy 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 Coverage Policy. 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 DENTAL COVERAGE POLICY

Who is the Policyholder?

The policyholder is the person in whose name the policy is written. Any other person approved for coverage under this policy is a dependent.

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 unmarried children under age nineteen (19) (or according to the maximum age limits stated in the Summary of benefits included in this Dental Coverage Policy) or those 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.

Student Status A dependent child will be eligible for coverage until age nineteen (19) or to age twenty-three (23) if a full-time student in an accredited school enrolled in a minimum number of credit hours in accordance with the school's full-time student status. Student status will be verified. Written verification of full-time student status should be submitted at each policy anniversary date. It shall be valid until the next periodic update. If verification is not received at initial enrollment, verification will occur when the first claim is received.

Handicapped Status Dependent children over the age of nineteen (19) may continue to be eligible as dependents if they are incapable of self-sustaining employment because of physical or mental incapacity that began before age nineteen (19), and are dependent on you for their support and maintenance. Proof of incapacity must be provided to DDAZ within thirty-one (31) days of a request, but not more frequently than once per year following the child reaching the applicable limiting age.

Military Status No children who are on active duty in military service are eligible for coverage under this Dental Coverage Policy.

WHEN DOES COVERAGE BEGIN?

Effective Dates

The policyholder is covered under this program:

A. When you complete the application for coverage and send the form to DDAZ with the required premium amount.
B. After the Benefit Waiting Periods have been satisfied as outlined in the Summary of benefits.

Eligible Dependents are covered under this program:

A. On the date the Policyholder's coverage is effective; or
B. At an anniversary date allowing the policyholder to make coverage changes. Coverage is effective on the anniversary date.
C. On the date the dependent is acquired, meaning: the birth, adoption, placement for foster care, placement for adoption with the Policyholder 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.
D. After the Benefit Waiting Periods have been satisfied as outlined in the Summary of benefits.

ADDITIONAL INFORMATION ON EFFECTIVE DATES OF ENROLLMENT

If a Policyholder does not enroll his/her dependents when they are first eligible and later 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 Policyholder 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 Policyholder must submit a completed DDAZ approved enrollment form 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 adjusted back to the effective month of the change.

B. If a Policyholder 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 Policyholder must complete and sign a DDAZ approved enrollment form within thirty-one (31) days. 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 Policyholder, the effective date of coverage for this Covered Person will be the first billing date after DDAZ receives the approved enrollment form. The Policyholder must submit a completed DDAZ approved enrollment form within thirty-one (31) days after the court order is issued. However, the effective date of coverage may be different if required by court order or applicable law.

Anniversary date

This policy is written for a period of 12 months from the policyholder's effective date. A Policyholder may elect to continue coverage or dis-enroll at any anniversary date

WHEN DOES COVERAGE END?

LOSS OF ELIGIBILITY

Coverage for the eligible Policyholder and/or eligible dependent will terminate on the last day of the month, or as designated by the Summary of benefits included in this Dental Coverage Policy. Examples of events that would trigger loss of eligibility include but are not limited to the following:

A. Eligible Policyholders' eligibility ceases upon:
   1. Failure to satisfy any eligibility requirements listed in the Summary of benefits included in this Booklet;
   2. The date the Policyholder enters active duty in the military service;
   3. The date of death of the eligible employee;
   4. Termination of the Dental Coverage Policy.

B. Eligible Dependents' eligibility ceases upon:
   1. The date the Policyholder no longer meets the eligibility criteria under the Dental Coverage Policy;
   2. The dependent spouse is no longer an eligible dependent as a result of a divorce decree;
   3. The date a self-sustaining, employable, dependent child between the ages of nineteen (19) and the limiting age is no longer a full-time student;
   4. The date a dependent child under the limiting age is no longer engaged in full-time humanitarian services (if included as an eligible dependent in the Dental Coverage Policy);
   5. The date of a dependent child's marriage;
   6. The date the dependent enters active duty in the military service;
   7. The date of the Policyholder's death;
   8. The date the Dental Coverage Policy terminates.

Rescission 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.

Cancellation of the Dental Coverage Policy

DDAZ may cancel the Dental Coverage Policy as follows:

A. On an anniversary of the effective date; or
B. If the monthly premiums are not paid; or
C. Upon a minimum of forty-five (45) days prior written notice to you for any other reason as outlined in the Dental Coverage Policy.

Claims Payment After policy Termination DDAZ will not pay for any claim prior to the termination date but submitted by you or your dentist more than twelve (12) months after the date of termination of the Dental Coverage Policy. DDAZ is not required to pay benefits for dental services provided after the cancellation date.

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 Dental Coverage Policy.

CONVERSION COVERAGE

Who is Eligible for Conversion Coverage?

A Covered Dependent may enroll in conversion coverage upon the divorce or death of the Policyholder. The conversion coverage may include covered dependent children for whom the spouse has responsibility for care and/or support. A Covered Dependent child may also enroll in conversion coverage upon reaching the limiting age, it no longer a full-time student, or on the date of the dependent child's marriage.

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 coverage. 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 Policyholder terminates the Dental Coverage Policy 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, you may obtain a participating dentist directory by visiting our web site at www.deltadentalaz.com.

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.

A Pre-determination or Pre-estimate Protects the Patient from Unanticipated Charges.

During your first appointment, advise your dentist that you are covered by DDAZ under the Dental Coverage Policy number indicated on the Summary of benefits included in this booklet. Give the dentist your member identification number. Dependents must use the Policyholder's member identification number.

After an examination, your dentist will establish the treatment to be performed. If dental services over two hundred fifty dollars ($250) are needed, ask your dentist to complete a pre-determination of benefits and submit the form to:

Delta Dental of Arizona, Inc.
225 S. East Street, Indianapolis, IN 46202

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 unless you assign the amount of benefits payable to your Non-participating dentist. The amount of the allowable fee, the amount of benefits payable by Delta Dental 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 Dental Plan, the date ofservice 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 Policyholders and Dependents

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

Notice of changes to the benefit plan will be provided to you forty five (45) days prior to the policyholder's anniversary date.

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:
    - 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.
    - 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 a Delta Dental Member Company, or who has terminated as a Participating Dentist):

A. You will be responsible for the submission of the claim form and the predetermination of benefits form to DDAZ unless you assign your benefits payable to the non-participating dentist.
B. You will be responsible to the non-participating dentist for the full cost of treatment. DDAZ will reimburse you for the amount of benefits payable by your plan, unless you assign your benefits payable to the non-participating provider.
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 a Delta Dental Member Company, 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 county 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

You may not assign or transfer the rights to receive any portion of your benefits to any person or entity except as provided in this subsection. If you validly assign the amount of your benefits payable for covered services under this policy to your non-participating dentist who performed the services, and your dentist delivers that assignment to DDAZ, payment for the covered services may not be made to you, and may be made only to the dentist to whom the payment has been assigned. If Delta Dental makes a payment that is inaccurate or makes an overpayment to you or your dentist on your behalf, Delta Dental is entitled to reimbursement from you or the provider of your dental services or may offset the amount owed against a future claim. Inaccurate payments are not a waiver of any future rights of Delta Dental 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. DDAZ assumes no 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. Policyholders who have questions concerning the services received either personally or by their dependents, should direct those questions to:

Professional Services Department
Delta Dental of Arizona
225 S. East Street
Indianapolis, IN 46202
Email: service@smilepoweraz.com

WHAT IS COVERED?

Benefit Payment Definitions

A. Policy Year

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

B. Benefit Year

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 can be either a

calendar year or a policy year. Please refer to the Summary of benefits included in this Dental Coverage Policy to determine the benefit period for your policy.

C. Deductibles

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

(Applies only if noted in the Summary of benefits included in this Dental Coverage Policy) 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 Specific Deductibles

Your benefit plan may include other deductibles that are in addition to your Benefit Year deductible. Examples of benefits which may require an additional deductible are TMJ and orthodontics. Refer to your Summary of benefits included in this Dental Coverage Policy.

F. Benefit Year Maximum

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 Dental Coverage Policy. 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.

The Benefit Year Maximum available to the Policyholder 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 Policyholder or any dependent has been covered both as an employee 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.

G. Specific Benefit Maximum

Some benefits may have a specific lifetime maximum. No benefits will be paid over the maximum amount specified in this benefit provision. The lifetime maximum amount is usually a separate benefit maximum and, as such, does not apply toward the annual maximum. The types of benefits, which may have a separate benefit maximum, include periodontics and orthodontics and temporomandibular joint (TMJ) procedures. Please refer to your Summary of benefits included in this Dental Coverage Policy for any procedures that have a Specific Benefit Maximum.

H. Benefit Waiting Periods

Some procedures may have a Benefit Waiting Period. The Summary of benefits included in this Dental Coverage Policy states the length of Benefit Waiting Periods and which dental services are subject to

Benefit Waiting Period. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the deductible.

I. Dental Services

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.

J. Alternate Treatment

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. 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 Policyholder is responsible for the additional charges beyond those paid or allowed by DDAZ.

K. Date of Service

The date of service is indicated in the Covered Dental Services in this Dental Coverage Policy 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 Coverage Policy or the Dental Coverage Policy.

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

A. Deductibles and maximum benefits;
B. The Benefit Year (calendar year or policy year);
C. The Policy Year
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 Coverage Policy and in accordance with the Dental Coverage Policy

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:

1. a covered benefit under the Dental Coverage Policy
2. 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 Coverage

Policy. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.

COVERED DENTAL SERVICES

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

Examinations, evaluations or consultations

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 x-ray series/ panoramic film, vertical bitewings is a benefit once in a five (5) year interval from the date this procedure was last performed.

B. Bitewing x-rays are a benefit once in a Benefit Year.

C. Single x-rays (periapical) are limited to not more than six (6) in a Benefit Year.

Routine prophylaxis (scaling and polishing of teeth)

A. Routine prophylaxis is a benefit twice 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 twice in a Benefit Year.

B. Fluoride treatment is a benefit up to the age as stated in the Summary of Benefits.

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

A. Space maintainers for posterior primary (baby) teeth are covered up to the age as stated in the Summary of Benefits.

B. Anterior space maintainers are not a covered benefit.

Sealants are not a covered benefit.

Fillings
Fillings consisting of silver amalgam and, in the case of front teeth, composite tooth color fillings. (Composite tooth color fillings are a benefit on all teeth only if included in the Summary of Benefits in this Dental Coverage Policy.)

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 five (5) year interval from the date this procedure was last performed on specific primary (baby) teeth.

B. Pre-formed crowns are a benefit once in a seven (7) year interval from the date is procedure was last performed on specific permanent teeth.

Crowns and Onlays
The date of service for crowns and onlays is on the preparation date.

Crowns and onlays as follows, but only when the teeth cannot be restored with fillings due to severe loss of hard tooth structure as a result of decay or fracture. This excludes fractures or loss of tooth structure due to attrition, erosion, abrasion (wear), bruxism and damage to either hard or soft tissues as a result of a device worn in a tongue or lip piercing.

A. Crowns and onlays are a benefit once in a seven (7) year interval from the date this procedure was last performed on the same tooth.

B. Crowns and onlays are a benefit only when no other professionally acceptable form of treatment can be performed.

C. Crown build-ups are a benefit only when necessary to retain a cast restoration due to extensive loss of tooth structure.

D. Crown build-ups (pin, bonded, or post and core) are a benefit once in a seven (7) year interval from the date this procedure was last performed on the same tooth.

E. Crowns and onlays are a benefit when provided for patients twelve (12) years of age or older. An allowance of a pre-formed crown will be benefited for patients under 12 years of age.

F. Post and core buildups are not a benefit under an onlay.

Endodontics
Benefits will be provided for necessary procedures for pulpal therapy in primary (baby) teeth (pulpotomy) and root canal treatment of infected tooth pulp (nerve) in permanent teeth.

A. Endodontic benefits as described above are benefited once per tooth.

B. Additional endodontic procedures, such as retreatment, are not a covered benefit.

C. The date of service is the date the Root canal is completed.

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 Planing is a benefit once in a two (2) year interval from the date this procedure was last performed on specific teeth or quadrants.

B. Surgical periodontal treatment is a benefit once in a three (3) year interval from the date this procedure was last performed on those specific teeth or quadrants.

C. Full Mouth Debridement (difficult prophylaxis) is a benefit once in a five (5) year interval from the date this procedure was last performed.

Prosthetic Services

Removable and Fixed Appliances

The date of service for **a removable appliance is the delivery date.**
The date of service for a **fixed appliance is the date of preparation.**

Provides bridges, partial dentures and full dentures for replacement of fully extracted or missing teeth.

A. Adjustments to complete or partial dentures are limited to two (2) adjustments per denture, per twelve (12) months (after six months has elapsed since initial placement of the denture).

B. Implant benefits
   1. Unless otherwise stated in the Summary of Benefits, implants are subject to both the benefit year allowance and a life time limitation.

   2. Implant procedures (surgical placement and connecting rod) will be benefited to replace a single missing tooth, bounded by teeth on both sides, when the implant would be performed in place of a 3-unit bridge or as stated in the Summary of Benefits.

   3. Implant supported crown/denture:

      a. If the Summary of Benefits states that implants are a covered benefit, your implant supported crown/denture will be benefited as submitted.
      b. Whether or not your implant procedure was given a benefit, your implant supported crown/denture will be eligible for an alternate benefit of a crown/denture. This alternate benefit is subject to prosthetic coverage; the time limitations and guidelines of the procedure allowed and must be reviewed by the dental consultant.

C. Dentures, removable partials and fixed bridges are a benefit once in a seven (7) year interval from the date this procedure was last performed.

D. Relines and rebases are a benefit once in a two (2) year interval from the date this procedure was last performed.

E. Temporary partial denture (flipper) for replacement of any of the permanent anterior teeth is a benefit once in a lifetime, per arch.

F. A fixed prosthesis is not a benefit under the age of sixteen (16).

Oral and Maxillofacial Surgery Procedures
Benefits will be provided for non-surgical (simple) extractions.

A. An alternate benefit of a simple extraction will be made for the removal of any tooth regardless of difficulty.

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

C. There is no benefit for other oral and maxillofacial surgical procedures.
Post-treatment care is considered to be part of the extraction 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 Dental Coverage Policy, or selects specialized techniques rather than standard dental services, DDPAZ 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 DDPAZ 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, DDPAZ 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. DDPAZ 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, DDPAZ will coordinate benefits based on submitted documentation.
H. When an alternate benefit allowance is given, the alternate procedure allowed is subject to the time limitations of the procedure benefited.
I. Implants, materials implanted or grafted into or onto bone or soft tissue, or removal of implants, are not a covered benefit except when covered by this Dental Coverage Policy. Refer to the Summary of Benefits included in this Dental Benefits Booklet.
J. 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.
K. Sterilization fees are considered a component of any procedure in which it is used.
L. 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 except as pursuant to title XIX of the social security act.
B. A service or procedure that is not generally accepted by the American Dental Association and DDPAZ's processing policies.

C. A service or procedure that is not described as a benefit of this Dental Coverage Policy and included in the Summary of Benefits in this Dental Benefits Booklet.
D. A method of treatment more costly than is customarily provided. Benefits will be based on the least expensive professionally accepted method of treatment.
E. Dental and surgical services with respect to cosmetic surgery or dentistry for purely cosmetic reasons.
F. Specialized techniques including but not limited to precious metal for removable appliances, precision attachments for partials or bridges, overdentures, overlays, implantology 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 Dental Coverage Policy 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 Dental Coverage Policy 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 Dental Coverage Policy.
K. Study models, casts and other ancillary services not covered in this Dental Coverage Policy 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 Dental Coverage Policy 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 Dental Coverage Policy and included in the Summary of Benefits.
O. DDPAZ will not pay for any claim submitted more than twelve (12) months from the date of service or twelve (12) months after the termination of this Dental Coverage Policy whichever comes first.
P. DDPAZ will not pay for any adjustments to previously received claims, including submissions of additional information, submitted more than twelve (12) months from the initial payment date or initial date issue 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.
X. Inlays are not a covered benefit
Y. Anesthesia and Intravenous Sedation/Analgesia is not a covered benefit

WHAT ELSE DO I NEED TO KNOW ABOUT CLAIMS PAYMENT?

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. Calls should be made to 800-894-2961.

Coordination of Benefits

DDAZ coordinates the benefits under this program with you or your dependents' benefits under any other 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 plan allowance 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 plan allowance. Refer to Covered Dental Services in the Summary of benefits included in this Dental Coverage Policy.

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 Policyholder 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 Dental Coverage Policy then this Dental Coverage Policy 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 an employee (or as that employee's dependent) is primary over the program covering the patient as a laid off or Retired Employee (or that employee's 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 policy. DDAZ will determine the existence of, or amount payable under any other program, through the eligible person claiming benefits under This Dental Coverage Policy.

Right of Recovery

DDAZ will recover any payment made that is more than the obligation determined by 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 spouses, relatives, attorneys, or others purporting to be the 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.smilepoweraz.com or call DDAZ's Customer Service Department at 800-894-2961 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 Policyholder 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 policy 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

Proof of Loss must be provided within ninety (90) days after the termination of care for which Benefits are payable. If that is not possible, it must be provided 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 filed outside these limits, the claim will be denied. These limits will not apply should the Policyholder 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 Policyholder's expense. No dental benefit will be paid until Proof of Loss is satisfied.

Documentation of Proof of Loss

At the Policyholder's expense, it is necessary to submit completed claim statements, with the Policyholder'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 Policyholder 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 Dental Coverage Policy 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 Policyholder 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 Policyholder does not receive DDAZ's decision within thirty (30) days after DDAZ receives information required to process the claim, the Policyholder 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 Policyholder 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 Policyholder'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 Policyholder. You can request another copy of this Appeals Packet by visiting our Web site at www.smilepoweraz.com or by calling 800-894-2961.

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)	**Standard Appeals** (for non-urgent services or denied claims)
Level 1: Expedited Medical Review	Informal Reconsideration[1]
Level 2: Expedited Appeal	Formal Appeal
Level 3: Expedited External Independent Review	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 Consumer Services Section.