DELTA DENTAL

# DELTA DENTAL INDIVIDUAL AND FAMILY™ DENTAL COVERAGE BOOKLET
## We do dental, better.

## A Simple Explanation of Your Dental Insurance

People with dental benefits are twice as likely to visit the dentist and have better oral and overall health. Thank you for recognizing the value of dental benefits and choosing coverage from Delta Dental.

Dental benefits are important, and so is this document. That's why it's essential you read it, start to finish. We'll try to make it as painless as possible. Also, please hold onto this document. It can answer many questions you may have later about your dental coverage.

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

Your effective date is [xx/xx/xxxx].

The rates per member per month for the plan you selected are listed below and are billed [monthly, annually].

| Age Band | Agave Plan-764* |
|---|---|
| Age 0-2 | $0.00 |
| Age 3-19 | $21.83 |
| Age 20 – 54 | $22.66 |
| Age 55 + | $33.22 |

## Key Terms and Fine Print You Need to Know

"You" refers to the person who bought this policy. Any information about this policy will come to you. If you did not buy this policy, you will not receive any information from Delta Dental about this policy.

This Dental Coverage Booklet in conjunction with the Summary of Benefits, and appeals packet constitute the complete Dental Coverage Policy This Dental Coverage Booklet, which describes the benefit provisions, takes the place of any other Dental Coverage Booklet issued to you on a prior date.

This Dental Coverage Booklet should be read in conjunction with the Summary of Benefits. The Summary of Benefits is an outline of the benefits for your policy with Delta Dental. The benefits are subject to all provisions, terms and conditions of the policy.

This policy from Delta Dental of Arizona only covers Arizona residents and is governed by the State of Arizona and applicable to federal law. If you're not an Arizona resident, this policy doesn't cover you. However, if you tell us what state you live in, we may be able to refer you to a different Delta Dental.

This policy covers only what it says it covers. Even if your dentist has prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits. This is true even if the service is not expressly excluded in this Dental Coverage Booklet. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits. This policy outlines covered services; everything else is not covered, whether or not it is listed as "not covered."

Delta Dental settles claims based on a payment system that may be less than what you are billed by the dentist. Please see the "Choosing A Dentist" section for more details.

**Important Notice:**

**If you're not satisfied with this policy, you can return it anytime within 10 days of the day you received it. We'll void the policy and refund your money, less any payment for claims you incurred.**

***Renewal Subject to Consent of Company***

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## Common Questions About Your Policy

**When does my coverage start?**
At the earliest, your coverage starts the first day of the month *after* your application is approved. Your effective date is shown on page 1.

**How do I renew my coverage?**
Your coverage renews every 12 months on the policy anniversary date, unless we choose not to renew your coverage or you tell us you no longer want the coverage. If you would like to keep this coverage, all you need to do is pay the premium.

**What if I have other dental insurance?**
If you have other dental insurance, you can't buy this dental insurance.

**What about coverage for my children and spouse?**
Your children and spouse can be covered under this policy as long as they are eligible. If they are no longer eligible, but are Arizona residents, they can purchase their own policy. Please see the "Who Is Eligible For Coverage" section for details.

**Where do I go online to learn about my dental insurance, and what can I do there?**
At www.deltadentalaz.com/member, you can make address or payment changes.. You can also verify your premium and effective date and see or print information about your benefits and claims status.

## Choosing a Dentist

You can choose any licensed dentist to provide dental services. However, you will save the most money if you choose a Delta Dental PPO dentist.

Please keep in mind that the network status of the dentist you choose will affect the total amount you pay for services under this policy. To find a listing of in-network dentists in Arizona and nationwide, please visit www.deltadentalaz.com/find or call 800-894-2961.

Here is what you need to know about how the network status of the dentist you choose affects your coverage:

***Delta Dental PPO Dentists***
On the date of service, if the dentist is a **Delta Dental PPO** contracted dentist:

A. The dental office has agreed to accept the Delta Dental PPO contracted allowance for covered procedures.
B. You pay for the applicable co-insurance, deductible, optional procedures and any services not covered by this policy.
C. The dental office will complete the claim forms and submit to Delta Dental for payment, pre-determination or coordination of benefits.

***Delta Dental Premier Dentists who are not Delta Dental PPO Dentists***
On the date of service, if the dentist is a **Delta Dental Premier** contracted dentist:

A. The dental office has agreed to accept the Delta Dental Premier contracted allowance for covered procedures.
B. This plan bases payment for covered procedures on the Delta Dental PPO contracted allowance.
C. You are responsible for the difference between the Delta Dental PPO contracted allowance and the Delta Dental Premier contracted allowance.
D. You pay for the applicable co-insurance, deductible, optional procedures and any services not covered by this policy.
E. The dental office will complete the claim forms and submit to Delta Dental for payment, pre-determination or coordination of benefits.
F. In most instances, treatment from a Delta Dental Premier dentist will result in a reduced benefit when compared to a Delta Dental PPO dentist.

***Out-of-Network Dentists who are not Delta Dental PPO or Delta Dental Premier Dentists***
On the date of service, if the dentist is NOT a **Delta Dental PPO** or **Delta Dental Premier** contracted dentist:

A. The dental office has NOT agreed to accept Delta Dental's allowance as payment in full.
B. You are responsible for the difference between Delta Dental's allowance and the full cost of treatment.
C. You pay for the applicable co-insurance, deductible, optional procedures and any services not covered by this policy.

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D. You are responsible for the submission of the claim forms or the predetermination of benefits form to Delta Dental unless you assign your benefits payable to your dentist.
E. Delta Dental will pay you directly for the amount of benefits payable unless you assign your benefits payable to your dentist.
F. In most instances, treatment from an Out-of-Network dentist will result in a reduced benefit when compared to a Delta Dental PPO dentist or Delta Dental Premier dentist.

***Out-of-Network Dentists who are outside the United States:***
On the date of service, if the dentist is NOT a **Delta Dental PPO** or **Delta Dental Premier** contracted dentist and is outside of the United States:

A. You are responsible for the submission of the claim forms or the predetermination of benefits form to Delta Dental.
B. The claim forms must include the billed charges in that country's currency and a conversion fee into United States dollars.
C. You are responsible for the submission of a copy of that dentist's license to practice dentistry in the county where services were rendered.
D. You are responsible to the Out-of-Network dentist for the full cost of treatment. Delta Dental will reimburse you for the amount of benefits payable by the plan. The benefits in this Dental Coverage Policy may not be assigned.
E. The payment for services rendered is based on the lesser of the billed charges or Delta Dental's Foreign Non-Participating Dentist Table of Allowance. You will be required to pay the difference between any amount billed by the dentist and Delta Dental's Foreign Non-Participating Dentist Table of Allowance. In most instances, this payment results in a reduced benefit when compared to the benefit paid for the same service to an in-network or Out-of-Network dentist within the United States.

## What Is Covered and What You Pay

Refer to your Summary of Benefits for details about what your plan covers.

A deductible (the amount you pay for covered dental services before Delta Dental begins to pay) will be set for you and for each covered dependent. The deductible period starts when your policy starts and continues for 12 months after that. This time period is also called the "benefit accumulation period." You are responsible for paying the deductible in each benefit accumulation period.

An annual maximum benefit for the benefit accumulation period will apply for each person covered under the policy.

This policy does not include an orthodontic benefit.

This policy provides benefits according to the coverage percentage listed on Summary of Benefits, after the deductible is paid. As an example, if the coverage percentage shown is 80%, Delta Dental will pay 80% of the allowable amount after any deductibles are paid. In this case, the coinsurance, or the amount you pay toward covered services, is 20%.

Benefit waiting periods noted on the Summary of Benefits may be reduced for the number of months you were covered under another dental insurance plan, but only if there was no more than a 63-day gap between your previous plan and this plan. (You may have to supply information about your previous plan to make sure you qualify for credit to the waiting periods.) Benefit waiting periods may be reduced for new members added to this policy if they were covered under another dental insurance plan, and if there was no more than a 63-day gap between their previous plan and this plan.

*The following covered dental services are subject to the age, frequency and time limitations as stated on the Summary of Benefits document for your plan. General Limitations and Exclusions apply. The date of service is the date the procedure was performed unless otherwise noted below.*

**Examinations, Evaluations or Consultations**

Any combination of examinations, evaluations, or consultations during a benefit accumulation period. Includes those performed by a general dentist or specialist.

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### Diagnostic X-Ray Services

This includes:

A. Complete (full-mouth) X-ray series/panoramic film.
B. Bitewing and Vertical Bitewing X-rays.
C. Periapical X-rays.

### Routine Cleanings

Routine cleanings and periodontal maintenance are considered to be interchangeable services (Either a routine cleaning or periodontal maintenance is allowed at the indicated frequency). 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.

### Fluoride Treatment

Fluoride treatment performed in a dental office and includes the topical application of fluoride varnish or gel.

### Space Maintainers

Space maintainers due to the premature loss of diseased posterior primary (baby) teeth. *Anterior space maintainers are not a covered benefit.*

### Sealants

Sealants are a benefit for the occlusal surface (free from caries or restorations) on permanent bicuspids and first and second molars.

### Fillings

Fillings consisting of silver amalgam and composite tooth-color fillings.

### Crowns and Onlays

*The date of service for crowns and onlays is on the permanent placement date.*

Crowns and onlays are covered 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 loss of tooth structure, fractures, and damage to either hard or soft tissues due to attrition, erosion, abrasion (wear), bruxism and/or as a result of a device worn in a tongue or lip piercing. Crowns and onlays are a benefit when provided for patients 12 years of age or older.* An allowance of a pre-formed crown will be benefited for patients under 12 years of age.

A. Crowns and onlays are a benefit from the previous date of service 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 at the interval stated in the schedule of benefits from the date this procedure was last performed on the same tooth.
E. Post and core buildups are not a benefit under an onlay.
F. Veneers are not a covered benefit unless noted on the Summary of Benefits. If veneers are not included, an alternate benefit of a crown will be provided if the above criteria are met.
G. Inlays are not a covered benefit unless noted on the Summary of Benefits. If inlays are not included, an alternate benefit of a filling will be provided.

### Pre-formed Crowns

This includes:

A. Pre-formed crowns for primary (baby) teeth.
B. Pre-formed crowns are a benefit for permanent teeth.

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### 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. Benefits for additional endodontic procedures, such as retreatment, are a benefit at the interval stated in the schedule of benefits from the date of the last procedure for that tooth.
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). Benefits are provided at the interval stated in the Summary of Benefits from the date the procedure was last performed.

A. Full Mouth Debridement - may be exchanged for one routine cleaning, however, the difficult cleaning is limited to it's own frequency limitation.
B. Periodontal Maintenance (following active periodontal treatment) – Frequency interchangeable with Routine Cleanings (Either a routine cleaning or periodontal maintenance is allowed at the indicated frequency)
C. Periodontal Scaling and Root Planing and other non-surgical treatments of gum disease are a benefit at the interval stated in the schedule of benefits from the date this procedure was last performed on specific teeth or quadrants.
D. Surgical periodontal treatment is a benefit at the interval stated in the schedule of benefits from the date this procedure was last performed on those specific teeth or quadrants.

### 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 seat date.**

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 2 adjustments per denture, per 12 months (after 6 months has elapsed since initial placement of the denture).
B. Dentures, removable partials and fixed bridges are a benefit from the date this procedure was last performed at the interval listed in the schedule of benefits.
C. Relines and rebases are a benefit from the date this procedure was last performed.
D. Temporary partial denture (flipper) for replacement of any of the permanent anterior teeth is a benefit once in a lifetime, per arch.
E. A fixed prosthesis is not a benefit under the age of 16.
F. Implant benefits
    1. Implant procedures (implant body and abutment) will be benefited to replace a single missing tooth.

    *The implant supported crown is subject to the frequency limitation of crowns.*
    See "Crowns and Onlays" section of this booklet.

### Oral and Maxillofacial Surgery Procedures

Benefits will be provided for extractions.

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

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### General Anesthesia and Intravenous Sedation/Analgesia

Benefits for general anesthesia and intravenous sedation/analgesia will be provided only if the following conditions are met. That is:

A. Performed by a dentist licensed to perform general anesthesia;
B. Administered in a dental office;
C. When performed in conjunction with covered surgical extractions (excluding routine extractions and removal of coronal remnants);
D. Necessary due to medically concurrent conditions, (i.e., neurological motor control problems) and documented by a medical physician.
E. Not for general anxiety or behavioral management.

### 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 Booklet, or selects specialized techniques rather than standard dental services, Delta Dental 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 Delta Dental 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 policy.
E. If a covered person transfers from the care of one dentist to that of another dentist during a course of treatment, Delta Dental will not pay for more than the amount it would have paid for had only one dentist rendered all the dental services during each course of treatment. Delta Dental 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 Coverage 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, Delta Dental 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. 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.
J. Sterilization fees are considered a component of any procedure in which it is used.
K. If a covered service is subject to a benefit waiting period and the treatment begins prior to the completion of the benefit waiting period, no benefit is allowed.

## Exclusions

A. Any service or procedure that is not described as a benefit of the Summary of Benefits or included in the Dental Coverage Booklet, including orthodontia.
B. Injuries or conditions covered under Workers' Compensation or Employer's Liability laws; services provided by any government agency; or any services that are provided free except as pursuant to Title XIX of the Social Security Act.
C. Any dental services to treat injuries or diseases caused by any form of civil disobedience or criminal act, or any injuries intentionally inflicted.
D. Dental and surgical services with respect to cosmetic surgery or dentistry for purely cosmetic reasons, including cosmetic work done on dentures.

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E. A service or procedure that is not generally accepted by the American Dental Association and Delta Dental's processing policies or not performed in accordance with the laws of the State of Arizona; services provided by someone other than a dentist or licensed hygienist employed by a dentist; or services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition as explained. This includes anything determined (by Delta Dental) not to be necessary for treating a dental condition, disease or injury.

F. A method of treatment more costly than is customarily provided. Benefits will be based on the least expensive professionally accepted method of treatment. You must pay the rest of the dentist's fee if a more expensive dental procedure is selected.

G. 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.

H. Charges for any health care not specifically covered under this plan including hospital charges, prescription drug charges, and laboratory charges or fees.

I. Pain relievers like nitrous oxide, conscious sedation, euphoric drugs or injections.

J. 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.

K. Temporary dentures, other than those noted in the Summary of Benefits.

L. Direct diagnostic or surgical and non-surgical treatment procedure applied to body joints or muscles, temporal mandibular joint (TMJ) or temporal mandibular disturbances (TMD).

M. Delta Dental will not pay for the following: any claim submitted more than 12 months from the date of service or 12 months after the termination of the policy, whichever comes first, or any adjustments to previously received claims, including submissions of additional information, submitted more than 12 months from the initial payment date or initial date issue date of the requested information.

N. Experimental or transitional procedures or other treatments that are still under investigation or observation.

O. Second opinions.

P. Charges for missed appointments.

Q. Patient management problems.

R. Charges for completing claim forms.

S. Brushing and flossing instructions, tobacco and nutritional counseling.

T. Any dental services performed or started before this policy took effect.

U. Any dental services performed or started after this policy ends.

V. Duplicate or replacement of a lost, stolen or damaged dental appliances including, but not limited to, full or partial dentures, space maintainers, crowns or fixed partial dentures (bridges).

## Who Is Eligible For Coverage

If you are an Arizona resident age 18 and older, with no other active individual insurance covering dental procedures, you may buy this policy.

You can also include the following people under your policy:

A. Your legal spouse;

B. Your legal dependents, married or unmarried, up to the end of the month when they turn age 26. Dependents include 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.

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**Handicapped Dependents**
Your dependent children over age 25 may continue coverage if they are incapable of self-sustaining employment because of physical or intellectual disability that began before the limiting age, and are dependent on you for their support and maintenance. Proof of incapacity must be provided to Delta Dental within 31 days of of the child reaching the limiting age and subsequently as may be required by Delta Dental, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

**Coverage for A Newborn/Adopted Child**
If you enroll and have family coverage, a newborn child is covered at birth. If you adopt a child, coverage begins the first of the month following the date the child is adopted, placed for adoption, or on the day of the final order granting adoption, whichever comes first.

If you do not have family coverage and have any new dependents because of birth, adoption, placement for foster care or placement for adoption, you must complete an application within 31 days for them to be added to the policy on the day they became your dependent. Other dependents not already covered on the policy may also be added. If there is a change in premium, you will be billed for the added dependent(s) as of the effective date.

**Adding or Removing Dependents**
If you did not include your spouse or dependents at the time you enrolled, they may be added on the policy anniversary date and you must notify us of any necessary change. You will be billed for the added dependent(s) on the bill immediately following the policy anniversary date.

If you have any new dependents because of marriage, you must notify us within 31 days for them to be added to the policy on the first day of the month following the day they became your dependent. Other dependents not already covered on the policy may also be added. If there is a change in premium, you will be billed for the added dependent(s) as of the effective date.

If you wish to remove your spouse or dependents, they may be removed from your policy on the anniversary date. You must notify us of any changes within your renewal period. You may also remove your spouse or dependents within 31 days of a qualifying event. You must notify us of any changes within this time period.

## Premiums: The Price You Pay

Your premium rates will be shown on page one of this dental policy. The first month of premium is due with your completed application. You can pay premiums monthly or annually. That time is called a "premium period." Monthly premiums must be set up to pay via Electronic Funds Transfer (EFT) or credit card and will be automatically drawn from your account on the 5th day of each month. If your charge is declined, you have a 31-day grace period to make a payment. If, at the end of the grace period, your account is still overdue, we will cancel your coverage. Annual payments may also be made via paper check.

Any change in premium due to age-band changes will be adjusted on your policy's renewal date.
Delta Dental may change the rates and/or benefits under this policy on this policy's renewal date. Notice of changes to the benefit plan and rates will be provided to you 45 days prior to the policy anniversary date.

This policy is valid for 12 months. When you buy this policy, you are committing to keeping it in force for at least 12 months, starting with the policy's effective date as shown on the declaration page. After that, you can renew this policy for another 12-month period under the following circumstances: if we agree, if you remain eligible, and if premiums are paid according to the procedure described above.

**Premium Grace Period**
You have a 31-day grace period to pay your premium. You are still covered during the grace period. If you don't pay your premium within the grace period, you will lose coverage on the last day of the grace period. You must pay for coverage provided during the grace period.

**Policy Reinstatement**
If we terminate this policy for nonpayment of premium and we accept a premium payment from you within 6 months after the date the policy was terminated, we will reinstate this policy. The effective date will be the date we accepted the premium.

Once we reinstate this policy, we will not cover any dental services performed between the date the policy was terminated and the date it was reinstated. In all other respects, we will treat your reinstated policy as if it never was terminated, unless we disclose to you any special provisions in connection with the reinstatement.

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**Estimate of Payment and Treatment Plans**
After an exam, your dentist may recommend a treatment plan. If the plan includes crowns, implants, fixed bridges, or partial or complete dentures, and you are wondering what the treatment will cost, ask your dentist to send the treatment plan, with X-rays, to Delta Dental.

After we receive the treatment plan, we will estimate how much each of us will pay, and we will send you and your dentist an estimate. If you have any questions about the estimate, just call us at 800-894-2961.

Before you begin the treatment plan, you and your dentist should discuss the plan, the amount Delta Dental will pay, and how you will pay the remainder.

**Coordination of Benefits**
Delta Dental coordinates the benefits under this program with you or your dependents' benefits under any other managed care program or insurance policy. Benefits under one of these programs may be reduced so that your combined coverage does not exceed the maximum reimbursable amount or out-of-network dentist allowable fee for the covered service. If this Individual plan is determined to be the "primary" program, Delta Dental will not reduce benefit amount, but if the other program is primary, Delta Dental may reduce benefit amount. The reduction will be the amount paid under the terms of the primary program if it exceeds Delta Dental's maximum reimbursable amount. Refer to Summary of Benefits for covered services.

## Filing Claims

To file a claim with Delta Dental, show your ID card or give your ID number to your dentist's office. You or your dentist should file your claim with us within 90 days of seeing the dentist.

We'll tell you what we paid -- called an Explanation of Benefits -- within 30 days of receiving your claim, unless special circumstances require more time. If we need more information, we will send you a notice within 15 working days of receiving your claim to let you know. If we deny a claim, the Explanation of Benefits will tell you the reason and shows any additional information we may need. Claims need to be filed within 12 months after a procedure is incurred for Delta Dental to consider them for payment.

**Dental Procedure Incurred**
A dental procedure is incurred on the date it is completed. Delta Dental pays upon completion of a procedure. Removable dentures and bridges are considered completed when they are placed in a patient's mouth. Fixed partial dentures and crowns are considered completed when they are cemented in. Root canals are completed on the date the canals are permanently filled. The completion date must be listed on the claim.

**Provisions Required by Law**
Before approving a claim, Delta Dental may receive any information and records for a covered person allowed by law which may be needed to process the claim and will keep such information and records confidential. The release of information is made only to facilitate coverage and in accordance with state and federal laws. If you wish to authorize someone to have access to information, you must give us a written request by sending an Authorization to Disclose Information form. Please call 800-894-2961 to request a form.

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, Delta Dental provides equal parental access to information.

## If We Deny Your Claim

If anyone covered under this policy makes a claim and we deny some or all of it, we'll give written notice to you, or the person who made the claim, or the dentist who provided treatment. Our claim decision will be provided on an Explanation of Benefits form.

We usually give written notice within 30 days. If we need more time, we'll tell you, or the person who made the claim, and the dentist. If we need more information, we will send you a notice within 15 working days of receiving your claim to let you know.

**Claims Appeal Process**
Either you or your treating provider can file an appeal on your behalf. Delta Dental provides a form you can use in 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.

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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 policyholder. You can request another copy of the Appeals Packet by visiting our website at www.deltadentalaz.com/appeals or call 800-894-2961 to request a form.

### Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has three 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.

Please read the information in your Appeals Packet for details about your rights and responsibilities during the appeals process. These will include the procedures Delta Dental 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 Delta Dental regarding your appeal.

Should you have any questions regarding the appeals process and procedures, please contact Delta Dental 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.

## Terminating This Policy

### Mid-Term Termination by Policyholder

When you buy this policy, you are committing to keeping it in force for at least 12 months. You can terminate this policy sooner only for the following reasons:

A. You become covered under a group dental plan. If anyone else covered under this policy becomes covered under a group plan, they may be terminated without terminating the entire policy.

B. You enter full-time United States military service. If a person covered under this policy other than you enters military service, their coverage may be terminated without terminating the entire policy.

If any of the above events occurred, and you want us to terminate your dental insurance, you must tell us in writing (either electronically or through the mail) at least 31 days in advance of the date you wish to terminate. If you do, we will refund your unused premium.

In the event of your death, anyone else covered under your policy who meets eligibility standards may choose to continue coverage by applying for a new policy. If a covered person other than you dies, you can terminate their coverage without terminating the entire policy.

### Mid-Term Termination by Delta Dental

We can terminate your policy before its annual renewal for the following reasons:

A. You don't pay the premium when it's due.

B. You or a covered dependent commits fraud or lies about something having to do with your dental insurance.

C. Someone other than you or a covered dependent uses your dental insurance.

D. You or a covered dependent doesn't comply with the policy or are no longer eligible.

If we terminate your dental insurance, we will refund your unused premium.

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

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**Continuation of Coverage for Dependents**
If this policy is terminated for a reason other than non-payment of premiums, the other family members covered by this policy are entitled to continue coverage under this or a similar policy, provided they meet eligibility requirements. They must submit an application to us and pay the premium within 31 days of termination.

**Non-renewal**
This policy will automatically renew on an annual basis. If you don't want to renew this policy, send us written notice (either electronically or through the mail) before the policy's renewal date. If you do, this policy will end on the last day before the renewal date. We can non-renew this policy by sending you written notice (either electronically or through the mail) at least 60 days before the renewal date. If we do, this policy will end on the last day before the renewal date.

**Effective Date of Termination**
All insurance for you and/or other people covered under this policy stops on the date this policy is terminated. That date is:

A. The day following the grace period, if the premium hasn't been paid; or
B. The last day of the month we receive a termination request from you, or any later date stated in your request (if we approve of this date); or
C. The last day before the renewal date if either we or you don't renew this policy; or
D. The last day of the month of the date of your death; or
E. The last day of the month of the date of death of a person covered under this policy other than yourself, but only for that person; or
F. The last day of your current policy period if you move out of Arizona. This applies to anyone covered under this policy.

If your coverage under this policy is terminated for any reason, and is not reinstated by us prior to the coverage expiration date, you cannot sign up for another Delta Dental individual policy for 24-months from the date of termination.

**Termination for Fraud**
If anyone covered under this policy commits fraud or lies about something having to do with your dental insurance, we may terminate your coverage back to its original effective date. If we do that, we'll give back the premium you paid us minus any claims we paid and a reasonable administration fee. If the claims we paid are more than the premium you paid, you must pay us the difference.

**Delta Dental's Liability**
We are not responsible for the actual care you receive from anyone. This policy does not give anyone any claim, right, or cause of action against us based on what a provider of dental care, services or supplies does or doesn't do.

## Notices

Any notice sent to Delta Dental must be sent in writing (either electronically or through the mail). It's considered delivered when sent to us at the email address shown below; when given in person; or when sent registered or certified United States mail, return receipt requested, proper postage prepaid, and properly addressed to:

Delta Dental
ATTN: Individual Product Unit
P.O. Box 1950
Indianapolis, IN 46206
Email: service@smilepoweraz.com

Information sent to you will be considered sufficient if sent to your last known physical address or email address.

**Governing Law**
This policy is issued and delivered in the State of Arizona and obeys its laws and regulations. If it conflicts with any of Arizona's laws and regulations, it will automatically conform to the state's minimum requirements.

**Nonwaiver and Severability**
If we don't exercise any remedy or right under this policy, that doesn't affect our ability to exercise any remedy or right at any time in the future.

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**Entire Policy: Changes**
The entire policy of insurance between you and us consists of this Dental Coverage Booklet, the Summary of Benefits, the completed application, and any and all endorsements and riders.

No oral statements by anyone can change or affect any aspect of this policy.

**Notice of Legal Action**
No legal action can be brought against us until at least 60 days after proof of loss has been furnished. No such action may be brought more than 3 years after the earlier of:

A. The date Delta Dental receives the proof of loss, and
B. The end of the period within which proof of loss is required to be given.

**Problems With Your Insurance**
If you have problems with any insurance company or agent, contact them to resolve your problem. You can contact Delta Dental at the following address and telephone number:

Delta Dental
P.O. Box 1950
Indianapolis, IN 46206
800-894-2961

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DELTA DENTAL

# Delta Dental Individual and Family™

## Agave Plan
## 764

This plan is a Delta Dental PPO™ plan that leverages the PPO network. While members can see any licensed dentist, they'll have the lowest out-of-pocket costs when they see a PPO dentist.

- **Delta Dental PPO Dentist** – These in-network dentists agreed to accept lower reimbursement for services so members save the most money.
- **Delta Dental Premier Dentist** – These in-network dentists also accept discounted reimbursement for services, but their discount is not as steep. Members can be billed for the difference between the Delta Dental PPO dentist fee and the Delta Dental Premier dentist fee.
- **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.

## SUMMARY OF BENEFITS

| DEDUCTIBLE[1,2] | YOU PAY |
|---|---|
| Per person, per benefit year | $50 |
| **ANNUAL MAXIMUM BENEFIT[1]** | **DELTA DENTAL PAYS** |
| Per person, per benefit year | $1,000 |

| Benefits and Covered Services[2] | Co-insurance[3] | Frequencies and Limitations | |
|---|---|---|---|
| **Type 1: Preventive Services** | **Delta Dental Pays[3]** | **How Many** | **How Often** |
| Exams, Evaluations or Consultations | 90% | 2 | Benefit Year |
| Routine Cleanings | 90% | 2 | Benefit Year |
| Topical Application of Fluoride (under age 16) | 90% | 1 | Benefit Year |
| Space Maintainers for missing posterior primary (baby) teeth (under age 14) | 90% | 1 | Lifetime |
| Sealants – One treatment per tooth for permanent molars & bicuspids (under age 15) | 90% | 1 | 3-year Period[4] |
| **Type 2: Basic Services** | **Delta Dental Pays[3]** | **How Many** | **How Often** |
| Bitewing or Vertical Bitewing X-rays | 40% | 1 | Benefit Year |
| Complete Series (Full Mouth) / Panoramic X-rays | 40% | 1 | 5-year Period[4] |
| Simple Extractions | 40% | No Limit | No Limit |
| Amalgam (silver-colored) Fillings per tooth surface | 40% | 1 | 2-year Period[4] |

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| | | | |
|---|---|---|---|
| Composite (tooth-colored) Fillings per tooth surface | 40% | 1 | 2-year Period[4] |
| Emergency (Palliative) treatment for the relief of pain | 40% | No Limit | No Limit |
| Prefabricated Stainless Steel Crowns – Primary Teeth | 40% | 1 | 2-year Period[4] |
| Periodontal Maintenance (following active periodontal treatment) - Interchangeable with Routine Cleanings | 40% | 2 | Benefit Year |
| **Type 3A: Major Services (A 6-month waiting period applies to these services)[5]** | **Delta Dental Pays[3]** | **How Many** | **How Often** |
| Non-Surgical treatment of Gum Disease | 30% | 1 | 2-year Period[4] |
| Surgical treatment of Gum Disease | 30% | 1 | 3-year Period[4] |
| Root Canal Treatment per tooth (Permanent Teeth) | 30% | 1 | Lifetime |
| Pulpotomy per tooth (Primary (baby) Teeth) | 30% | 1 | Lifetime |
| Additional Endodontic procedures, such as retreatment | 30% | 1 | 3-year Period[4] |
| Surgical Extractions | 30% | No Limit | No Limit |
| General Anesthesia and Intravenous Sedation/Analgesia for surgical extractions | 30% | No Limit | No Limit |
| Denture Relines and Rebases | 30% | 2 | Benefit Year |
| Denture Adjustments | 30% | 2 | 1-year Period[4] |
| Crown, Bridge and Denture Repair – Repair of such appliances to their original condition | 30% | No Limit | No Limit |
| **Type 3B: Major Services (A 9-month waiting period applies to these services)[5]** | **Delta Dental Pays[3]** | **How Many** | **How Often** |
| Special Restorative | 30% | 1 | 5-year Period[4] |
| Implant per tooth | 30% | 1 | 5-year Period[4] |
| Cast Crowns - Onlays | 30% | 1 | 5-year Period[4] |
| Prefabricated Stainless Steel Crowns – Permanent Teeth | 30% | 1 | 5-year Period[4] |
| Bridges – Does not provide for lost, misplaced or stolen bridges | 30% | 1 | 5-year Period[4] |
| Complete Dentures – Does not provide for lost, misplaced or stolen dentures | 30% | 1 | 5-year Period[4] |
| Partial Dentures – Does not provide for lost, misplaced or stolen dentures | 30% | 1 | 5-year Period[4] |

[1] Deductible and annual maximum benefit amounts represent a combination of all networks and are not cumulative.
[2] Deductible applies to all services. Delta Dental recommends asking for a predetermination (pre-treatment estimate) for any services over $250.
[3] This dental plan reimburses all procedures based on the Delta Dental PPO fee. Premier and out-of-network dentists may bill you for charges above the allowed Delta Dental PPO fee. As a result, you may incur higher out-of-pocket costs when seeing a Premier or out-of-network dentist.
[4] The interval begins with your last date of service.
[5] Waiting period may be waived if covered under a prior PPO/Indemnity plan with no more than a 63-day gap in coverage.

For additional plan information, please visit our website at

www.deltadentalaz.com/member or call us at 800-894-2961

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DELTA DENTAL

## INDIVIDUAL PLAN EXCLUSIONS, LIMITATIONS & ADDITIONAL INFORMATION

### 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, Delta Dental 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 Delta Dental 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 policy.

E. If a Covered Person transfers from the care of one (1) dentist to that of another dentist during a course of treatment, Delta Dental 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. Delta Dental 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 Coverage Policy. 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, Delta Dental 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. 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.

J. Sterilization fees are considered a component of any procedure in which it is used.

K. 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. Any service or procedure that is not described as a benefit of this Summary of Benefits or included in the Dental Coverage Booklet, including Orthodontia.

B. Injuries or conditions covered under Workers' Compensation or Employer's Liability laws; services provided by any government agency; or any services that are provided free except as pursuant to Title XIX of the Social Security Act.

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C. Any dental services to treat injuries or diseases caused by any form of civil disobedience or criminal act, or any injuries intentionally inflicted.

D. Dental and surgical services with respect to cosmetic surgery or dentistry for purely cosmetic reasons, including cosmetic work done on dentures.

E. A service or procedure that is not generally accepted by the American Dental Association and Delta Dental's processing policies or not performed in accordance with the laws of the State of Arizona; services provided by someone other than a dentist or licensed hygienist employed by a dentist; or services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition as explained. This includes anything determined (by Delta Dental) not to be necessary for treating a dental condition, disease or injury.

F. A method of treatment that is more costly than is customarily provided. Benefits will be based on the least expensive professionally accepted method of treatment. You must pay the rest of the dentist's fee if a more expensive dental procedure is selected.

G. 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.

H. Charges for any health care not specifically covered under this plan including hospital charges, prescription drug charges, and laboratory charges or fees.

I. Pain relievers like nitrous oxide, conscious sedation, euphoric drugs, or injections.

J. 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.

K. Temporary dentures, other than those provided in this Summary of Benefits.

L. Direct diagnostic or surgical and non-surgical treatment procedure applied to body joints or muscles, temporal mandibular joint (TMJ) or temporal mandibular disturbances (TMD).

M. Delta Dental will not pay for the following: any claim submitted more than twelve (12) months from the date of service or twelve (12) months after the termination of the policy, whichever comes first, or 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.

## Additional Information

A. For a full list of exclusions, please refer to the Dental Coverage Booklet.

B. The Summary of Benefits, in conjunction with your Dental Coverage Booklet, appeals packet and application for coverage constitute your full Dental Coverage Policy.

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