Dental Benefits

Conversion Coverage Policy
Plan 2

Delta Dental of Arizona

CONVOL02(Rev0921)

Delta Dental of Arizona
Attn: Individual Plan Unit
PO Box 1950
Indianapolis, IN 46206
800-894-2961

An Arizona Not For Profit Dental Service Plan

Conversion Coverage Policy

Plan 2

Conversion Coverage Policy and Amendments

This Conversion Coverage Policy henceforth referred to as this Policy, with the application for Conversion Coverage, all Amendments, and the Appeals Booklet constitute the Entire Policy between the parties. Delta Dental of Arizona will, henceforth, be referred to in this document as DDAZ.

This dental 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.

CONVERSION COVERAGE

WHO IS ELIGIBLE FOR CONVERSION COVERAGE?

1. A Covered Employee (Subscriber) may enroll in Conversion Coverage upon loss of employment or a change in benefits eligible status after COBRA coverage ends as long as the Employer Group Dental Contract with Delta Dental of Arizona (DDAZ) is still in force. If the Covered Employee is not eligible for COBRA Coverage due to the size or type of the Employer Group, Conversion Coverage will apply upon termination of employment or loss of coverage due to a change in benefits eligible status.

2. A Covered Dependent may enroll in Conversion Coverage upon the death of a Covered Employee (Subscriber), divorce, or termination of employment of the Covered Employee (Subscriber) after COBRA Coverage ends. If the Covered Employee is not eligible for COBRA Coverage due to the size or type of the Employer Group, Conversion Coverage will also apply to dependents upon the same conditions as for COBRA continuation. The Conversion Coverage may include covered dependent children for whom the spouse has responsibility for care and/or support.

WHO IS THE POLICYHOLDER?

The Policyholder is the person in whose name the Conversion Coverage Policy is written. Any other person approved for coverage under this Policy is a dependent. If the only person covered under this Policy is a minor child, the parent or legal guardian in whose name the Policy is written is considered the Policyholder. In this case, as a parent or other legal guardian, you have contracted on behalf of your child for the benefits described in this Conversion Coverage Policy. It is your responsibility to assure your child's compliance with any terms and conditions outlined in this Policy. This includes consent requirements necessary to provide Conversion Coverage Policy benefits, premium payments, deductibles, coinsurance and any other additional requirements of the Policy.

There will be no evidence of insurability requirement; however, all waiting periods under the Conversion Coverage Policy must be satisfied before Conversion Coverage begins.

WHO ARE COVERED DEPENDENTS?

Covered Dependents may include:

A. A Policyholder's lawful spouse; and
B. A Policyholder's unmarried children under age nineteen (19) or those of his or her spouse, including newborn children, step-children, persons under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption with the Policyholder 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 once a year during the student's birthday month.

Handicapped Dependents Unmarried 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 the Policyholder 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 Dependent children who are on active duty in military service are not eligible for coverage under this Policy.

WHEN IS CONVERSION COVERAGE EFFECTIVE?

You are covered under this Policy on the first day following the termination of insurance under the existing Employer Group Dental Contract, provided that:

1. A completed written application on an approved enrollment form.

2. The first premium payment for this Policy.

Are submitted to DDAZ within thirty-one (31) days following termination of coverage under the existing Employer Group Dental Contract.

WHO WOULD NOT BE ELIGIBLE FOR CONVERSION COVERAGE?

You are not eligible for Conversion Coverage:

1. If you are eligible for Medicare or covered by other dental benefits, which together with this Conversion Coverage would constitute duplicate insurance.

2. If you have failed to pay the required premium under the Employer Group Dental Contract.

3. If your Employer Group terminates the Employer Group Dental Contract as a result of a change to another insurance carrier.

4. If your Employer Group has failed to pay the required premium to DDAZ as per the Employer Group Dental Contract.

CAN DEPENDENTS BE ADDED AT A LATER DATE?

Except as noted below, only your dependents that were covered under the prior Employer Group Dental Contract with DDAZ are eligible to be enrolled under this Policy. Eligible dependents covered under the prior Employer Group Dental Contract who are not enrolled at the time the Policyholder applies for this coverage, or within 31 days of the termination date under the Employer Group Dental Contract, may not be added to this Policy at a later date.

Listed below are the circumstances in which you may add dependents at a later date:

A. If the Policyholder acquires a dependent as a result of birth, adoption 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 or placement for adoption. The Policyholder must complete and sign a DDAZ approved enrollment form send it to DDAZ within thirty-one (31) days from the date of acquisition. If there is a change in premium, it will be included in the

premium due date after the change adjusted back to the effective month of the change.

If you already have family coverage, please notify DDAZ of the new child dependent as soon as possible so that the necessary changes to your enrollment record can be made.

B. If a court of law orders that coverage be provided by the 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 complete and sign the DDAZ enrollment form and send it to DDAZ 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.

HOW DOES THE PROGRAM WORK?

USING YOUR DENTAL BENEFITS

Visit the dentist of your choice. If you do not have a dentist, visit the web site at www.deltadentalaz.com/member

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 Conversion Coverage Policy and specify whether it is Conversion Coverage Policy Plan 1 or Plan 2. Give the dentist your Social Security Number. (or the Policyholder I.D. number if you do not use your Social Security Number). Covered Dependents must use the Policyholder's Social Security number or Policyholder I.D. 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 predetermination of benefits and submit the form to:

Delta Dental of Arizona, Inc.
Attn: Individual Plan Unit
PO Box 1950, Indianapolis, IN 46206

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 Conversion Coverage Policy, the dental treatment estimated in the pre-determination explanation of benefits must begin prior to the termination of coverage and be completed within thirty-one (31) days after the termination of coverage.

Pre-determinations are only valid for the procedure approved and not transferable to another participating dentist. All fee information is confidential. To estimate your out of pocket expenses ask your dentist to submit a pre-determination.

NOTICE TO SUBSCRIBERS AND DEPENDENTS

All notices and correspondence regarding claims will be sent to the Covered Person by ordinary mail to the last address in DDAZ's enrollment records. The Covered Person should notify DDAZ of any change of name and/or address.

NETWORK OF MEMBER DENTISTS

PARTICIPATING DENTIST

If your dentist is a participating dentist (a dentist who has signed an agreement with DDAZ):

A. The dental office will complete the claim forms and submit to DDAZ for payment, pre-determination or coordination of benefits.
B. You are required to pay only your co-insurance/co-payment/patient portion (if any) and/or deductible (if any) for covered benefits.
C. Payment will be based upon the lesser of the Participating Dentist's submitted or usual and customary fee, or DDAZ's allowable fee for services rendered. The Participating Dentist will not bill fees higher than the allowable fees to you.
D. The dentist agrees to abide by DDAZ's benefit determination and administration policies, and agrees to accept payment directly from DDAZ.

NON-PARTICIPATING DENTIST

If your dentist is a non-participating dentist (a dentist who has not signed an agreement with DDAZ, 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 the Conversion Coverage 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 billed charges, or DDAZ's Non-Participating Dentists Table of Allowance. You will be required to pay the difference between any amount billed by the dentist and DDAZ's "allowable " fee. The Non Participating Table of Allowance results, in most instances, in a reduced benefit when compared to the benefit paid for the same service to a Participating Dentist.

OUT-OF-STATE DENTIST

Participating Dentist

If the dentist you see outside Arizona is a member of that state's Delta Dental network, benefits will be based on DDAZ's participating dentist's allowable fees. The patient is responsible for the difference in the billed charges and DDAZ's allowable fee.

Non-Participating Dentist

If the dentist you see outside of Arizona is not a member of a Delta Dental organization, benefits will be based on the lesser of billed charges or DDAZ's Non-Participating Dentists Table of Allowance. The Subscriber is responsible for the full amount of the billed charges by the Dentist. DDAZ will reimburse the Covered Person for the amount of benefits payable by the Conversion Coverage Policy unless the Covered Person assigns their benefits payable to the non-participating dentist. Claim forms are available from our DDAZ website at www.deltadentalaz.com/member.

OUTSIDE THE UNITED STATES OF AMERICA

If the dentist you see is outside of the United States, benefits will be based on the lesser of billed charges, or DDAZ's non-participating dentists Table of Allowance. The Covered Person is responsible for the full amount of the billed charges by the dentist. The claim form must include the billed charges in that country's currency and a conversion fee into United States dollars. DDAZ will reimburse the Covered Person for the amount payable by the Conversion Coverage Policy. The benefits in this Conversion Coverage Policy cannot be assigned.

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 Relations Department

Delta Dental of Arizona
Attn: Individual Product Unit
PO Box 1950
Indianapolis, IN 46206
Email: service@smilepoweraz.com

WHAT IS COVERED?

BENEFIT PAYMENT DEFINITIONS

CalendarYear – January through December

A Calendar 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.

Deductibles – $50 per person/$150 per family per calendar year

Deductible is the amount of covered dental expenses that you pay before the dental benefits are payable and applies to each Covered Person per Calendar 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 Calendar Year and is calculated by the date received not the date of service. The lesser of the DDAZ's allowance or billed charges for covered services will count toward the deductible
5. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the Deductible.

Annual Maximum Benefit – $1000 per person per calendar year
Annual Maximum Benefit is the total dollar amount that DDAZ will pay for dental services rendered during any one Calendar Year as per this Conversion Coverage Policy. This Annual Maximum Benefit applies to each covered person per Calendar Year. You cannot transfer all or any portion of your Annual Maximum Benefit from person to person or year to year. All covered dental services including those with a separate lifetime maximum will apply to the Annual Maximum Benefit regardless of coinsurance level.

Specific Benefit Maximum – $750 per person per lifetime periodontics – $1000 per person per lifetime orthodontics
Orthodontic and Periodontic Services each have a specific lifetime maximum. No benefits will be paid over the maximum amount specified in this benefit provision. The lifetime maximum does not apply to the calendar year maximum.

Benefit Waiting Periods
Some procedures have a Benefit Waiting Period. The Covered Dental Services Section states the length of Benefit Waiting Period and which dental services are subject to a Benefit Waiting Period. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the deductible.

Dental Services
Expenses submitted to DDAZ should 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. The sum of the fees for temporary and permanent services will be used to determine whether the charges are usual, customary, and reasonable.

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 Conversion Coverage Booklet or the Conversion Coverage Policy, unless we agree to accept such dental service as a covered dental expense. If DDAZ does accept a dental service that is not listed, we will determine benefits on the same basis as a dental service that is included on the list.

The program covers the following 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. Dental services covered are subject to the Limitations and Exclusions described within this Policy. Even if your dentist has furnished, prescribed, ordered, recommended or approved the dental service, it does not make it a dental or medical necessity or make the charge eligible for benefits even though it is not expressly excluded in this Policy.

COVERED DENTAL SERVICES

DIAGNOSTIC AND PREVENTATIVE SERVICES – Covered at 80%
The Deductible DOES NOT apply to these services

Benefits are available for the following services to diagnose or to prevent tooth decay and other forms of oral disease:

Examinations or consultations

LIMITATION: Examinations or consultations are limited to twice in a Calendar Year whether performed by a general dentist or specialist.

Diagnostic X-Ray Services

LIMITATIONS:
A. One full mouth x-ray series (panorex, or seven (7) or more films at one time) in a five (5) year interval from the date this procedure was last performed.
B. Bitewing x-rays (x-rays of the crown of the teeth) once in a Calendar Year.
C. Single tooth x-rays as needed.

Routine prophylaxis (scaling and polishing of teeth)

LIMITATION: Routine prophylaxis is limited to twice in a Calendar Year.

Difficult Prophylaxis (full mouth debridement)

Difficult prophylaxis (full mouth debridement) is limited to once in a two (2) year interval from the date this procedure was last performed.

LIMITATIONS:
A. One difficult prophylaxis may be exchanged for two routine prophylaxis. However, the difficult prophylaxis is limited to not more than once in a two (2) year interval from the date this procedure was last performed.
B. A patient must have documented periodontal treatment history to receive a periodontal maintenance benefit (excluding difficult prophylaxis).

Fluoride treatment

LIMITATIONS:
A. Fluoride treatment is limited to not more than twice in a Calendar Year.
B. Fluoride treatment is limited up to the age of eighteen (18) years for a Covered Person.

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

LIMITATIONS:
A. Space Maintainers for posterior primary (baby) teeth are for covered individuals under fourteen (14) years of age.
B. Anterior space maintainers are not a covered benefit.
C. Space maintainers are not a benefit in conjunction with orthodontic services, and are covered once in a three (3) year interval from the date the procedure was last performed.

BASIC SERVICES – Covered at 80%
The Deductible DOES apply to these services

These services are subject to a six months waiting period before benefits begin.

Benefits listed below are available for the following dental services to: (1) treat loss of hard tooth structure due to decay or fracture; (2) remove diseased or damaged teeth.

Fillings
Fillings consisting of silver amalgam and, in the case of front teeth, composite tooth color fillings.

LIMITATION: Benefits for restorations are limited to one restoration for each tooth surface in a twenty-four (24) month interval from the date this service was last performed for that specific tooth surface.

Pre-formed crowns

LIMITATIONS:
A. Pre-formed crowns will be a benefit once in a two (2) year interval from the date this procedure was last performed on specific primary (baby) teeth.
B. Pre-formed crowns will be a benefit once in a five (5) year interval from the date the procedure was last performed for specific permanent teeth.

Oral Surgery
Benefits will be provided for single (routine) extractions.

LIMITATIONS:
A. Post-treatment care is considered to be part of the surgical procedure performed and a separate benefit is not provided.
B. There is no benefit for other oral surgery.

General Anesthesia
Benefits for general anesthesia will be provided only if the following conditions are met. That it is:

1. Performed by a Dentist licensed to perform general anesthesia
2. Administered in a dental office.
3. Necessary due to medically concurrent conditions, i.e., neurological motor control problems and documented by a medical physician.
4. Not for an anxiety, behavioral or management problem.

LIMITATION: Analgesia (nitrous oxide) is not a covered benefit. Local anesthesia is considered a component of any procedure in which it is used.

Emergency Palliative Treatment
Emergency treatment for the relief of pain.

LIMITATION: 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.

MAJOR SERVICES – Covered at 50%
The Deductible DOES apply to these services

These services are subject to a 12 month waiting period before benefits begin.

Benefits are available for the following dental services: 1) initial placement or replacement of wholly extracted natural teeth with artificial teeth; 2) onlays or crowns when teeth are severely decayed or severely fractured and cannot be restored by any other means; 3) partial dentures, full dentures, fixed bridges and crown repair and 4) treat oral diseases of the supporting tissues (gingival and/or alveolar bone).

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

LIMITATIONS:
A. Non-surgical periodontal treatment is limited to once in a two (2) year interval from the date that procedure was last performed for specific teeth or quadrants.
B. Surgical periodontal treatment is limited to once in a three (3) year interval from the date that procedure was last performed for those specific teeth or quadrants.
C. Crown lengthening or single tooth gingivectomy procedures necessary for crown preparation are allowed only if done as a separate procedure and not done

on the same day as crown preparation.

D. Limited to seven hundred and fifty dollar ($750) lifetime maximum.

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.

LIMITATIONS: A. Endodontic benefits as described above are limited to once per lifetime per tooth.

B. Benefits for additional endodontic procedures are limited to once in a three (3) year interval from the date of the last procedure for that tooth.

C. Retreatment is a benefit when unusual morphological or pathological conditions exist and requires review by the dental consultant.

D. Root canals are benefited on the date of completion, not including the final restoration.

Removable and Fixed Appliances

A removable appliance is benefited on the delivery date.
A fixed appliance is benefited on the date of preparation.

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

LIMITATIONS: A. Repairs and adding teeth to existing dentures, partial dentures or to fixed bridges

B. Temporary partial denture (flipper) for replacement of any of the permanent anterior teeth, but only if it is installed immediately following the loss of teeth during the period of healing.

C. A temporary partial denture (flipper) will be considered to be a permanent appliance if not replaced within six (6) months and all time limitations for a permanent partial denture will apply.

D. Includes services to measure, fit and adjust appliances up to three (3) months after placement

E. Implants are not a covered benefit.

F. Partial dentures, full dentures and fixed bridges are limited to once in a seven (7) year interval in the same arch from the date this procedure was last performed.

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

H. Temporary partial dentures are available as the replacement of permanent teeth only for a Covered Person under sixteen (16) years of age.

I. A fixed bridge is not a benefit for a covered person under sixteen (16) years of age.

Crowns and Onlays

Crowns and Onlays are benefited on the preparation date.

Crowns and onlays as follows, but only when the teeth cannot be restored with fillings due to severe decay or severe loss of hard tooth structure.

LIMITATIONS: A. Crowns and onlays are a benefit only once in a seven (7) year interval from the date of the previous procedure for 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 three (3) or more of the five (5) tooth surfaces are destroyed or missing.

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

same tooth.
1. If a root canal is required, a post will be benefited.
2. If a root canal therapy is required, the seven (7) year wait for post and core is waived.

E. Crowns and onlays are not a benefit when provided for children under twelve (12) years of age. An allowance will be made for a pre-formed crown.
F. Buildups are not a benefit under an onlay or 3/4 crown.
G. Veneers are not a covered benefit.
H. Inlays are not a covered benefit.

ORTHODONTIC SERVICES – Covered at 50% – $1000 Lifetime Maximum
The Deductible DOES NOT apply to these services

These services have a 24 month waiting period before benefits are begin.

Procedures using appliances (non-surgical) to treat misalignment of teeth and/or jaws which significantly interfere with their function.

Benefit payments will be distributed over the course of treatment as follows, or dictated by the Conversion Coverage Policy.

A. One-half of the pre-calculated maximum amount allowed will be paid upon insertion of the appliance/initial banding.
B. After six (6) months from the date the appliances were placed, DDAZ will make a payment for the balance of the pre-calculated maximum amount payable. (The patient must have current eligibility on this new date of service in order for this payment to be made.)

LIMITATIONS:
A. For dependent children, treatment must begin prior to their seventeenth (17) birthday and not before their eighth (8) birthday.
B. Full benefits are provided only if the first active appliance was inserted while the patient was covered for this benefit under this Conversion Coverage Policy.
C. Payments will be discontinued if treatment ceases for any reason.
D. Repair or replacement of an orthodontic appliance that is lost or broken, for any reason, is not covered
E. If orthodontic work was begun and was benefited prior to This Conversion Coverage Policy, and work is still in progress, any additional benefit payable will be prorated over a three (3) year period. The additional benefit payable will be at the appropriate coinsurance level and only up to any lifetime maximum benefit remaining for orthodontic services as outlined in the Summary of Benefits

Orthodontic records are covered (i.e., study molds, photographs, panoramic and encephalometric x-rays but included as part of the orthodontic maximum.

GENERAL LIMITATIONS

A. If an eligible person selects a service that is not provided for under the terms of This Conversion Coverage Policy or specialized techniques rather than standard dental services:
   1. DDAZ will pay the applicable percentage of the allowable fee for the standard covered dental service and the patient is responsible for the remainder of the dentist's fee.
   2. 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.
B. Local anesthesia is considered a component of any procedure in which it is used.
C. 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.

D. In the event that a Covered Person transfers from the care of one dentist to that of another dentist during a course of treatment, DDAZ will not be liable for more than the amount it would have been liable for had only one dentist rendered all the dental services during each course of treatment. DDAZ will also not be liable for duplication of dental services.
E. DDAZ may decide a service is not necessary and appropriate under the terms of This Conversion Coverage Policy even if your dentist has furnished, prescribed ordered, recommended or approved the service.
F. If you or any of your dependents have received compensation or free services by or through a public program, DDAZ may reduce or coordinate benefits based on submitted documentation.
G. 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 may be reduced on the new service.
H. Sterilization fees are not a separate covered service.
I. If a covered service is subject to a waiting period and the treatment begins prior to the completion of the waiting period, no benefit is allowed.

EXCLUSIONS

A. Services for injuries or conditions which are compensable under Workman's Compensation or Employer's Liability Law, services which are provided the covered person by any Federal or State Government Agency or are provided without cost to the covered person by any municipality, county or other political subdivision, or community agency.
B. A service or procedure that is not generally accepted by the American Dental Association and/or DDAZ
C. A service or procedure that is not described as a benefit of This Conversion Coverage Policy .
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 congenital or developmental malformations or 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. Anesthetic services, except when medically necessary and performed in the office by the dentist licensed to perform anesthesia and in conjunction with a covered oral surgery.
H. Charges for any health care not specifically covered under This Conversion Coverage Policy including hospital charges, prescription drug charges, and laboratory charges or fees.
I. Charges for dental services which are started prior to the date the person became covered under This Conversion Coverage Policy.
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 wear or bruxism, realignment of teeth, periodontal splinting, splinting, gnathologic recordings, equilibration, bite appliances or harmful habit appliances.
K. Temporary dentures, other than those provided in This Conversion Coverage Policy.
L. Study models, casts and other ancillary services not covered in This Conversion Coverage Policy
M. Travel time and related expenses.
N. Orthodontic services, except when covered by This Conversion Coverage Policy.
O. Direct diagnostic or surgical and non-surgical treatment procedure applied to body joints or muscles, temporal mandibular joint (TMJ) or temporal mandibular disturbances (TMD).
P. DDAZ 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 Conversion Coverage Policy whichever comes first.
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 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. Preparation for placement or replacement, removal or repair or any other procedure related in any way to any procedure or services not included in covered dental services. The only exception is the crown or pontic to be placed once the otherwise uncovered implant services are complete.
W. Inlays are not a covered benefit.
X. Veneer restorations are not a covered benefit.
Y. Implants, materials implanted or grafted into or onto bone or soft tissue, or removal of mplants, are not a covered benefit.
Z. Sealants are not a covered benefit.
AA. All other services not specified as covered dentist

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.

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 may send a written request or call DDAZ's Customer Service Department to request a Confidential Information Release 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.

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 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 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 DDAZ Participating Dentists immediately after proof of loss is established. If your dentist is a DDAZ Non-Participating Dentist, DDAZ will pay all dental benefits to you immediately after proof of loss is established, unless you have assigned your benefits payable to your Non-Participating Dentist. DDAZ does not require that any covered services be provided by a specific Dentist. See the Network Provisions Section of This Conversion Coverage Policy for a complete description of how benefits are paid for Participating and Non-Participating Dentists. .

Notice of Decision on Claim
If the claim submitted does not require additional information, you will receive a written decision on your claim within a reasonable time after we receive your claim. If DDAZ must request additional information in order to process the claim, you will receive a notice of DDAZ's receipt of the claim within fifteen (15) days from the date we receive the claim. If you do not receive DDAZ's decision within ninety (90) days after DDAZ receives the required information to process the claim, you will have an immediate right to request a review as if your 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 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 at the end of the Appeals Packet. You are not required to use the form; a letter with the same information is acceptable. If you decide to appeal a decision to deny authorization or payment of a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

The process for an Appeal is described in detail in the Appeals Packet, a separate document, which is provided to you when you become a Covered Subscriber. You can request another copy of this Appeals Packet by visiting our website at www.deltadentalaz.com/appeals or by calling 800-894-2961 .

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 (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
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.

WHEN ARE PREMIUM PAYMENTS DUE?

For Conversion Coverage Plan 2

The Policyholder will make the first payment of the appropriate premium within thirty-one (31) days following the termination of coverage under the existing Employer Group Dental Contract with DDAZ.

For each Policyholder without dependents	**$41.36**
For each Policyholder and all dependents	**$138.29**

The Policyholder will submit all subsequent required monthly premium payments to DDAZ on or before the due date. Each Policyholder will be sent coupons for a twelve-month period. Regardless of whether you receive these notices, DDAZ will not continue the Policy unless payment is received within 30 days after the premium due date.

Grace Period

A Grace Period of 30 days after the due date is allowed. DDAZ is not responsible or liable for covered services provided during the grace period unless payment is received by DDAZ before the end of the grace period. A premium not paid when due and not paid within the grace period is in default. This Policy will terminate as of the premium due date that is the last day for which premium was paid.

Notice of Premium Changes

With a sixty (60) day prior notice, DDAZ may change the premium as long as the same change is made for all similar policies.

WHEN DOES THE POLICY TERMINATE?

The Policy may be terminated:

1. By the Policyholder at any time. The Policyholder must request termination in writing. The termination date of the Policy will be the first of the month following DDAZ's receipt of the request.
2. By DDAZ with regards to the Policyholder or Covered Dependents
   A. If the required premiums are not paid when due; or
   B. If a Covered Person has performed an act that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of coverage; or
   C. If a Covered Person becomes eligible for Medicare or eligible for, or covered by, other similar dental benefits; or
   D. If a Covered Dependent no longer meets the definition of eligibility outlined in this document.

The effective date of termination will be the first of the month following the date of the event that causes DDAZ to terminate coverage.

Once coverage is terminated either voluntarily by the Policyholder or by DDAZ for any of the reasons stated above, you CANNOT reapply for this coverage at a later date.

DO ANY BENEFITS CONTINUE AFTER TERMINATION?

You have no coverage on and after the date coverage terminates.