This is Your
PREPAID DENTAL PLAN ORGANIZATION
CERTIFICATE OF COVERAGE
Issued by

SOLSTICE HEALTHPLANS OF ARIZONA, INC.

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Solstice Healthplans of Arizona, Inc. (hereinafter referred to as "We", "Solstice", "Us" or "Our") and the State of Arizona (hereinafter referred to as "Group"). This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers who are located within Our Service Area. Except for Emergency Dental Care described in the Dental Care section of this Certificate, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of Arizona.

The insurance evidenced by this Certificate provides DENTAL insurance ONLY.

Solstice Healthplans of Arizona, Inc.
7901 SW 6th Court, Suite 400,
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www.smilestateofaz.com

Kenneth Sheldon
President

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Attachment:
Schedule of Benefits
Health Care Insurer Appeals Process Information Packet

SECTION I

Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Adverse Determination: A decision by Solstice not to authorize payment for general dentistry and specialty services and referrals on the basis of necessity of appropriateness of care.

Allowed Amount: Means the maximum amount determined by Solstice to be eligible for consideration for payment for a particular service supply or procedure. The allowable amount pertains to covered services on which Our payment is based for Covered Services.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Certificate: This Certificate issued by Solstice Healthplans of Arizona, Inc., including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Contract.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, specific grandchildren as described in the Who is Covered section of this Certificate, or any other Children as described in the Who is Covered section of this Certificate/shall mean a person who falls within one or more of the following categories:

1. A natural child, adopted child, or stepchild of the member who is younger than age 26;
2. A child who is younger than age 26 for whom the member has court-ordered guardianship;
3. A foster child of the member who is younger than age 26;
4. A child who is younger than age 26 and placed in the member's home by court order pending adoption; or
5. A natural child, adopted child, or stepchild of the member who has a disability prior to age 26 and continues to have a disability under 42 U.S.C. 1382c and for whom the member had custody prior to age 26.

Clinically Necessary/Clinically Appropriate: To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements:

- It must be consistent with the symptoms, diagnosis or treatment of the condition present.
- It must conform to commonly accepted standards throughout the dental field.
- It must not be used primarily for the convenience of the member or provider of care.
- It must not exceed the scope duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Request for payment authorizations that are declined by Solstice based upon the above will be the responsibility of the member at the Dentist's usual fees. A licensed Dentist will make any such denial.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate; explicitly listed in Your *Schedule of Benefits*.

Dental office: Your selected office of network general dentist(s).

Dental Plan: Managed dental care plan offered through the group contract between Solstice and Your group.

Dental Service Area: The geographical area/counties, designated by Us within which We provide coverage.

Eligible Dependents: The Subscriber's Spouse and Children. Please see "Who is Covered Section," for further description.

Eligible Employee: Shall mean an individual who is hired by the State, including the Universities, and is regularly scheduled to work at least 20 hours per week for at least 90 days. Eligible employee does not include:

1. A patient or inmate employed at a state institution
2. A non-state employee, officer or enlisted personnel of the National Guard of Arizona
3. A seasonal or temporary employee, unless they are determined to have been paid for an average of at least 30
hours per week using a 12-month measurement period
4. A variable hour employee, unless they are determined to have been paid for an average of at
least 30 hours per week using a 12-month measurement period

Persons working for participating political subdivisions may also be considered eligible employees under the respective political subdivision's personnel rules.

Eligible Former Elected Official: Shall mean an elected official as defined in A.R.S. § 38-801(3) who is no longer in office and who falls into one of the following categories:

1. Has at least five years of credited service in the Elected Officials' Retirement Plan;
2. Was covered under a group health or group health and accident plan at the time of leaving
office;
3. Served as an elected official on or after January 1, 1983; and
4. Applies for enrollment within 31 days of leaving office or retiring.

Eligible Retiree: Shall mean a person who retired under a state-sponsored retirement plan and has been continuously enrolled in the Plan since time of retirement or a person who receives long-term disability benefits under a state-sponsored plan.

Emergency Dental Care: Means dental services administered in a Dentist's facility, emergency dental clinic or another comparable facility intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain, and includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the dentist.

Employee - An Employee of the Group who meets eligibility rules of Solstice as set out in the Group Contract, as prescribed by the Group (specifically including any minimum number of hours worked during a week and waiting period) and as set out in the Group enrollment application.

Employee Waiting Period - The time period in which an Employee must wait before being eligible for benefits.

Exchange: The Arizona Health Benefit Exchange.

Exclusions: Dental care services that We do not pay for or Cover.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: An employer, labor union, association or other organization that has entered into a Group Contract with Solstice for managed dental services on your behalf.

Group Contract/Policy: The entire Group Contract/Policy consists of the following:
Part A - General Contract Provisions.
Part B - Member Certificate/Benefit Provisions.
Part C - Schedule of Benefits.
Part D - Any endorsements, amendments and/or riders to any or all of the above.

Medically/Dentally Necessary: See the How Your Coverage Works section in this Certificate.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Participating Dentist/Provider: A licensed Dentist who has a contract with Us to provide general dentistry or specialty care services to You. The term includes both Network General Dentists and Network Specialty Dentists. A list of Participating Providers and their locations is available on Our website at www.smilestateofaz.com or upon Your request to Us. The list will be revised from time to time by Us.

Participating General Dentist/Provider - A licensed Dentist who has signed an agreement with Solstice under which he or she agrees to provide general dental care services to you.

Participating Specialty Dentist/Provider - A licensed Dentist who has signed an agreement with Solstice under which he or she agrees to provide specialized dental care services upon payment authorization by Solstice. These dentists focus on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Non-Participating Dentist/Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Dental Care or when authorized by Us.

Patient Copayment/Contract Fees: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service from a contract dentist or contract specialty care dentist. The amount can vary by the type of Covered Service.

Plan: Referred to in this document shall mean a period of twelve (12) consecutive months. For active employees, retirees, long term disability (LTD) recipients, former elected officials, surviving spouses of participating retirees, and employees eligible for normal retirement, this period commences on January 1 and ending on December 31. Any and all provisions revised in the Plan document will become effective January 1 unless specified otherwise.

Plan Year: A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Premium/Prepayment Fees: Fees that your Group remits to Solstice, on your behalf, during the term of your Group Contract.

Referral: An authorization given by Solstice to one of its Participating Providers in order to arrange for additional and/or specialty care for a Member.

Schedule of Benefits: List of services covered under your dental plan and how much they cost you.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate is issued.

Usual and Customary Fee: The customary fee that an individual Dentist most frequently charges for a given dental service.

UCR (Usual, Customary and Reasonable): The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar dental service.

Us, We, Our: Solstice Healthplans of Arizona, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has purchased a Group dental insurance Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You

should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate and
- Received while Your Contract is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.smilestateofaz.com .

D. The Role of Primary Care Dentists.

This Certificate does not have a gatekeeper, usually known as a Primary Care Dentist ("PCD"). You do not need a written Referral from a PCD before receiving Specialist care from a Participating Provider. Your general dentist can make specialist recommendations and when appropriate, Solstice can authorize specialty care treatment for you.

1. **Access to Providers and Changing Providers.** Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

E. Services Subject to Preauthorization.

Our Preauthorization is not required before You receive certain Covered Services at a Participating Provider General Dentist.

Our Preauthorization is required before You receive certain Covered Services at a Participating Provider Specialist. Should you require the services of a Specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist), you may receive this care by obtaining written authorization from Solstice and then receive specialty treatment by an approved Participating Specialist at the listed Copayments.

You are responsible for requesting Preauthorization for any Covered Services that require such Preauthorization, as listed in the Schedule of Benefits section of this Certificate.

F. Preauthorization Procedure.

If You seek coverage for services that require Preauthorization, You must call Us at the number on Your ID card.

You must contact Us as soon as possible to request Preauthorization prior to planned service.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if these services are covered as well as if they are appropriate. Criteria will be based on multiple sources which

may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

G. Dental Management.

The benefits available to You under this Certificate are subject to preauthorization, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective dental care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

H. Medical Necessity.

We Cover benefits described in this Certificate as long as the dental service, procedure, treatment, test, device or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed dental literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are Clinically Appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

If medically necessary covered services are not available through network Physicians or Providers, We, on the request of a network Physician or Provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, will allow a referral to a non-network physician or provider and will fully reimburse the non-network provider at the usual and customary or an agreed rate.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal

and external appeal of Our determination that a service is not Medically Necessary.

I. Important Telephone Numbers and Addresses.

- CLAIMS
  Refer to the address on Your ID card; PO Box 2057, Farmington Hills, MI 48333
  (Submit claim forms to this address.)
  claims@solsticebenefits.com
  (Submit electronic claim forms to this email address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Call the number on Your ID card

- MEMBER SERVICES
  Call the number on Your ID card
  (Member Services Representatives are available Monday - Friday, 6:00 a.m. – 6:00 p.m.)

- PREAUTHORIZATION
  Call the number on Your ID card

- OUR WEBSITE
  www.smilestateofaz.com

SECTION III

Access to Care and Transitional Care

A. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates.

In order for You to continue to receive Covered Services for up to 90 days, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

B. New Members In a Course of Treatment.

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease.

In order for You to continue to receive Covered Services for up to 60 days, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

SECTION IV

Who is Covered

A. Eligibility

The Plan is administered in accordance with Section 125 Regulations of the Internal Revenue Code and the Arizona Administrative Code.

Please see Section 1 for definitions of the terms used below.

Benefit Services will provide potential members reasonable notification of their eligibility to participate in the Plan as well as the terms of participation. Both Benefit Services and Solstice have the right to request information needed to determine an individual's eligibility for participation in the Plan.

B. Member Eligibility

Eligible employees, eligible retirees, and eligible former elected officials may participate in the Plan. The individual should enroll either as a member or as a dependent but never both. In certain situations, an individual may be eligible to enroll as both a member and a dependent. Such situations are:

-Spouses who are both State and/or a State University employees and/or retirees must have either one spouse elect coverage for the entire family, or each spouse may elect their own individual coverage.

- A Child who is a State and/or State University employee whose parents are also State and/or a State University employees and/or retirees must either elect dependent coverage under a parent's policy, or they may elect their own individual coverage.

C. Dependent Eligibility

Member's legal spouse and eligible child(ren) until the age of 26 may participate in the Plan. An Eligible Dependent may not participate in the Plan unless an Eligible Employee, Eligible Retiree, or Eligible Former Elected Official is also enrolled.

This individual should be enrolled as the dependent of only one member. In certain situations, an individual may be eligible to participate as a dependent of more than one member. Such as when Spouses are both State and/or a State University employees and/or retirees. They cannot have the same child enrolled as a dependent under both member's coverage. Dependent children can be on one spouse's policy or divided between spouses.

D. Continuing Eligibility through COBRA

See Section VI for more information.

E. Non-COBRA Continuing Eligibility

The following individuals are eligible for continuing coverage under the Plan.

Surviving Dependent(s) of Covered Retiree

Upon the death of a retiree covered under the Plan, the surviving dependents are eligible to continue coverage under the Plan, provided each was covered at the time of the member's death, by payment of the retiree premium.

If the spouse survives, he/she, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under subsection C. above. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

In the case where children, who are eligible dependents of the surviving spouse, survive, they may continue participation in the Plan if enrolled by the surviving spouse as allowed under subsection C. above.

In the case where children survive but no spouse survives or the children are not eligible dependents of the spouse, each child, for purposes of Plan administration, will be reclassified as a member. As such, each child may enroll dependents as allowed under subsection C. above. In this circumstance, coverage for each surviving child may be continued indefinitely provided the appropriate premium is paid.

Please note that a dependent not enrolled at the time of the member's death may not enroll as a surviving dependent.

Surviving Spouse/Child of Covered Employee Eligible for Retirement under the Arizona State Retirement System (ASRS)
Upon the death of a covered employee meeting the criteria for retirement under the ASRS, the surviving spouse and children, provided each was enrolled at the time of the member's death, are eligible to continue participation in the Plan by payment of the retiree premium.

If the covered spouse survives, he/she, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under subsection C. above. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

In the case where covered children, who are eligible dependents of the surviving spouse, survive, they may continue participation in the Plan if enrolled by the surviving spouse as allowed under subsection C. above.

In the case where covered children survive but no spouse survives, each child, for purposes of Plan administration, will be reclassified as a member. As such, each child may enroll dependents as allowed under subsection C. above. In this circumstance, coverage for each surviving child may be continued indefinitely provided the appropriate premium is paid.

Please note that a child/spouse not enrolled as a dependent at the time of the member's death may not enroll as a surviving child/spouse.

Surviving Spouse of Elected Official or Covered Former Elected Official (EORP)
Upon the death of a former elected official covered under the Plan, the surviving spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the member's death, by payment of the retiree premium. The surviving spouse, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under subsection C. above. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

Please note that a spouse not enrolled at the time of the former elected official's death may not enroll as a surviving spouse.

Upon the death of an elected official who would have become eligible for coverage upon completion of his/her term, the surviving spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the elected official's death, by payment of the retiree premium. The surviving spouse, for purposes of Plan administration, will be reclassified as a member. As such, he/she may enroll dependents as allowed under subsection C. above. Coverage for the surviving spouse may be continued indefinitely provided the appropriate premium is paid.

Please note that a spouse not enrolled at the time of the elected official's death may not enroll as a surviving spouse.

Surviving Spouse or Dependent of a Law Enforcement Officer Killed in the Line of Duty
Upon the death of an insured Employee meeting the criteria under A.R.S. § 38-1114, the Surviving Spouse and/or Dependent are eligible to participate in the Plan.

F. Children Covered Under this Certificate.
If You selected parent and child/children or family coverage, Children covered under this Certificate include: natural, adopted, step, foster, Children under court-ordered placement pending adoption or guardianship, and a disabled Child over age 26 who continues to be disabled as defined by 42 U.S.C. 1382c before age 26. Coverage lasts until the end of the birth month in which the Child turns 26 years of age.

Any dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

G. When Coverage Begins.
Coverage under this Certificate will begin as described in the following circumstances:

Initial Enrollment
Once Eligible for coverage, potential Members have 31 calendar days to enroll and provide required documentation for themselves and their Dependents in the Plan. Coverage begins only after an individual has successfully completed the enrollment process by submitting a completed election and providing any required documentation within 31 days. Benefits will be effective as referenced on the following table.

Category	Must enroll within 31 days	Enrollment contact	Coverage begins on the:
Eligible state Employee	Date of hire	Agency liaison	First day of the first pay period after completion of enrollment process

Eligible university Employee	Date of hire	University Human Resources Office	First day of the first pay period after completion of enrollment process
Eligible participating political subdivision Employee	Date of hire	The appropriate Human Resources Office	*Please contact the appropriate Human Resources Office*
Eligible Retiree	Date of retirement	ADOA Human Resources-Benefits	First day of the first month after completion of enrollment process
Eligible Former Elected Official	Date of leaving office or retiring	ADOA Human Resources-Benefits	First day of the first month after completion of enrollment process

Open Enrollment

Before the start of a new Plan Year, Members are given a certain amount of time during which they may change coverage options. Potential Members may also elect coverage at this time. This period is called Open Enrollment.

In general, Open Enrollment for Eligible Employees, Retirees and Former Elected Officials is held in October or November of each year.

At the beginning of each year's Open Enrollment period, enrollment information is made available to those Eligible for coverage under the Plan. This information provides details regarding changes in benefits as well as whether a current Member is required to re-elect his/her coverage during Open Enrollment (called a "positive" Open Enrollment).

Elections must be made before the end of Open Enrollment. Those elections – or the current elections, if no changes were made and it was not a positive Open Enrollment – will be in effect during the subsequent Plan Year.

Coverage for all groups begins on the first day of the new Plan Year.

It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election form and providing any required documentation within 31 days of the end of the Open Enrollment period.

Qualified Life Event Enrollment

If a qualified life event occurs, Members have 31 days to enroll or change coverage options.

Changes made as a result of a qualified life event must be consistent with the event itself, except in the case of HIPAA Special Enrollment.

It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election form and providing any required documentation within 31 days of the qualifying event.

State Employees should contact the appropriate agency liaison when they choose to change coverage options

as a result of a qualified life event. University and political subdivision Employees should contact the appropriate human resources office. Retirees and Former Elected Officials should contact ADOA Human Resources-Benefits.

For state Employees, most coverage changes become effective on the first day of the first pay period after completion of the enrollment process. For Retirees and Former Elected Officials, most coverage changes become effective on the first day of the first month after completion of the enrollment process. University and political subdivision Employees should contact the appropriate Human Resources Office for information regarding the effective date of coverage changes.

If you request a change due to a HIPAA special enrollment event within the 31-day timeframe, coverage for birth, adoption, or placement for adoption will become effective on the date of birth, adoption or placement for adoption. For all other HIPAA Special Enrollment events, coverage will become effective the first day of the next month following your request for enrollment.

A Surviving Spouse/Dependent must submit a completed election form and provide any required documentation within six months of the death of the insured Retiree or insured Employee eligible for retirement under the ASRS. A Surviving Spouse/Dependent of an Elected Official or Formal Elected Official has 31 days to complete the election form and provide required documentation.

The table below lists pertinent information related to the qualified life event enrollment process. It should be noted that not all qualified life events are listed below.

Type of event	Must enroll/change coverage within 31 days of:	Coverage/change in coverage begins on the:
Marriage	Date of the event	The first day of the next month
Loss of other coverage due to: - Divorce, annulment, or legal separation - Change in dependent employment status - Death of spouse	Date of the event	The first day of the next month
Employment status change (beginning employment, termination, strike, lockout, beginning/ending FMLA, full-time to part-time)	Date of the event	The first day of the first pay period
Change in residence affecting coverage availability	Date of the event	The first day of the next month
Loss/gain of Dependent eligibility (other than listed below)	Date of the event	The first day of the next month
Newborn	Date of birth	Date of birth
Adopted Child	Date of placement for adoption	Date of adoption
Child placed under legal guardianship	Date Member granted legal guardianship	Date Member granted legal guardianship
Child placed in foster care	Date of placement in foster care	Date of placement in foster care

You, Your Spouse or Child can also enroll 31 days from exhaustion of Your COBRA or continuation coverage.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child dental plan; or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child dental plan.

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

H. Renewal Terms

The Group Contract is renewable at the option of the Group and Solstice at the end of the initial term for an additional 12 months (renewal term) and each renewal term may be renewed at the Group's option for an additional 12 months, subject to Solstice's right to modify/change, or amend the coverage and/or the premium rates applicable for the renewal term. Any such changes/amendments shall be subject to the Group's acceptance and shall be made part of the Group contract. Solstice will offer renewal terms a minimum of 45 days in advance of the Group's anniversary date for signature by an authorized officer of Solstice. The agreement shall be deemed accepted and approved without the Group's signature if the first premium due for the new contract year is paid to Solstice on or before the first day of the month of the new contract year.

I. Family and Medical Leave Act of 1993

Under the Family and Medical Leave Act of 1993 (FMLA), you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for payment to your Group the portion of the premium/prepayment fees, if any, which you would have paid if you had not taken the leave. You may be entitled to FMLA leave for any of the following reasons:

- The birth of a child, and to care for such child.
- The placement of a child with You for adoption or foster care.
- To care for your seriously ill spouse, child, or parent.
- A serious health condition which makes you unable to perform your job functions.
- The Group shall be responsible for the determination of your eligibility, rights, or length of leave period for FMLA.
-

Section V

Termination of Coverage

Coverage for all Members/Dependents ends at 11:59 p.m. on the date the Plan is terminated. Failure to pay employee premiums could result in retroactive termination to the last day of the pay period which premium was paid through. The employee and their dependents will not be allowed to re-enroll until the following Open Enrollment period. Termination of coverage prior to that time is described in the table below.

Category	**Coverage ends at 11:59 p.m. on the earliest of:**
Eligible state/university Employee	-The last day of the pay period for/in which the Member: - Makes last contribution; or - Fails to meet the requirements for eligibility -The last day the Member is Eligible for extension of coverage.
Eligible participating political subdivision Employee	*Please contact the appropriate human resources office*
Eligible Retiree/Former Elected Official	The last day of the month for/in which the Member: - Makes the last premium payment; or - Fails to meet the requirements for eligibility.
Eligible long-term disability recipient	The last day of the month in which the disability benefit ends.
Eligible Dependent	-The last day of the month in which the Dependent Child reaches the limiting age of 26; -The day the Dependent: - Dies; - Loses eligibility for reason other than limiting age; or -The day the Member: - Is relieved of a court-ordered obligation to furnish coverage for a Dependent Child; or - Is no longer covered.
Eligible Employee on leave without pay	-The last day of the period in which the Member becomes Eligible for: - Long-term disability benefits for which there is eligibility to continue coverage under the Plan; or - Coverage under Medicare; or -30 months after the leave-without-pay period

	began. -Last day of the period for which the Member makes the last premium payment.
Surviving Child/Spouse of Eligible Retiree	-The last day of the period for which the Member makes last premium payment; or -The day the Surviving Child fails to be Eligible as a Child.
Surviving Spouse of elected official or Eligible Former Elected Official	The last day of the period for which the Member makes the last payment.

A. Groups

- The Group has failed to pay Premiums within 30 days of when Premiums are due, of which notice has been given. If payment is not received within thirty (30) days, and the subsequent 30 day Grace Period, coverage will be terminated. You will be liable for the cost of services received through the Grace Period.
- In the case of fraud on the part of the group, after 60-days written notice;
- For employer groups, for violation of participation or contribution rules;
- For employer groups on discontinuance of:
  - each of its small or large employer coverages; or
  - a particular type of small or large employer coverage;
- Where no enrollee resides, lives, or works in the service area or area for which Solstice is authorized to do business, after 60-days written notice; and
- If membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, after 60-days written notice.

Additionally, the following apply to both members and groups:

1. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the date of subscriber's death.

2. For Spouses in cases of divorce, the date of the divorce.

3. For Children, until the end of the birth month in which the Child turns 26 years of age.

4. For all other Dependents, until the end of the benefit period as determined by the Group.

5. The end of the month during which the Group or Member provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

6. The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days' prior written notice.

7. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

8. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

9. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination. See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage.

Section VI

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

COBRA: This is a federal law that applies to employers with 20 or more employees. If your employer is subject to COBRA and you are laid off, your employer is required to give you a written notice that explains your COBRA rights. You must decide whether to continue your health care coverage and notify your former employer of your decision to continue your coverage within 60 days of receiving written notice of your COBRA rights from your former employer. Under COBRA, you and your family have the right to remain on whatever health plan your former employer has for up to 18 months. You must continue paying the full premium, which includes both your former employer's share and your share plus a 2 percent administrative fee.

A. Qualifying Events.

Pursuant to federal COBRA, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:
1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.
Continued coverage under this section will terminate at the earliest of the following:
1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

Continuation Rights During Active Duty

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write Your Group to find out if You are entitled to temporary continuation of coverage under USERRA.

The Group may charge up to 102% of the Group Premium for continued coverage. This does not apply if You or Your dependents serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:
1. The 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which You or Your Dependent fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.
1. This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans

Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

2. If You or Your Dependent's coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if You or Your Dependents had become reemployed upon such termination of eligibility.

Section VII

Extension of Benefits

Coverage for a specific dental procedure (other than orthodontics) which was started before your disenrollment or your Group's termination from the Dental Plan will be extended for a maximum of 90 days from the disenrollment/termination date. Your provider, by contract, is obligated to complete any and all procedures begun during the Dental Plan coverage period at the original contracted fees. Should this treatment be considered complex dentistry (ex. full mouth rehabilitation involving 6 or more crowns to be fabricated at the same time, periodontal therapy, etc.) as determined by the Solstice dental director, a decision will be rendered as to the additional time period that the provider needs to complete the original dental treatment plan.

Coverage for orthodontic treatment which was started before Member disenrollment/Group termination will be extended to the end of the quarter or for 90 days after Member disenrollment or Group termination whichever is later, unless such action was prompted due to nonpayment of premiums in which case coverage ceases immediately.

SECTION VIII

Dental Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Please note that the network general dentist you select may not perform all procedures listed. The co-payments shown in your schedule of benefits apply only to network participating general dentists.

We Cover the following dental care services for Members:

A. Emergency Dental Care.
We Cover Emergency Dental Care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization. An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe that his or her condition requires immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. Please contact your Network General Dentist if you have an emergency in your service area.

Emergency Care Away From Home
If you have an emergency while you are out of your service area, you may receive emergency covered services as defined above from any General Dentist. Typical routine emergency services may be emergency examination, x-rays, extraction, prescription, or other palliative care to relieve immediate pain, infection and bleeding. Routine restorative procedures or definitive treatment (e.g. root canal) which might be the final therapy necessary to correct the clinical situation creating the patient symptoms are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency care there will be up to $100.00 reimbursement towards the abatement of pain.

Emergency Care After Hours
There is a patient charge listed on your Schedule of Benefits for the emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

B. Preventive Dental Care.
We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including: Dental prophylaxis where the dental prophylaxis or periodontal maintenance procedure is limited to two (2) times in any consecutive 12 month period.

C. Routine Dental Care.
We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations (excluding problem-focused), visits and consultations once within a 6-month consecutive period;
- Comprehensive exams 1 time per 36 months, if and only if the Member is considered to be a new patient;
- X-ray, full mouth x-rays or panoramic x-rays at five-year intervals, bitewing x-rays are limited to one set in any consecutive twelve month period.
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization,

including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations; and
- Cosmetic bleaching not for home use.

D. Endodontics.
We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required. Copayments for endodontic procedures do not include the cost of the final restoration.

E. Periodontics.
We cover periodontic services, including procedures for preventive, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues. The dental prophylaxis or periodontal maintenance procedure is limited to 1 time in any consecutive 6-month period.

F. Prosthodontics.
We Cover prosthodontic services as follows:

- Replacement of crowns, implants, and fixed bridges or dentures, limited to 1 time every consecutive 5 years;
- Removable complete or partial dentures, including 6 months follow-up care; and
- Additional services include insertion of identification slips, repairs, relines and rebases.
- Fixed bridges are Covered as set forth in your Schedule of Benefits.

G. Oral Surgery
Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.

H. Orthodontics. We Cover orthodontics.

I. Additional Limitations

- D0272, D0277 or D0210 are payable only when other inclusive films have not been taken (paid) within the last six (6) months.
- Copies of X-rays can be obtained for $2.00 per periapical film up to a maximum of $30.00. Panoramic X-ray can be obtained for a $15.00 fee.
- All denture adjustment fees are for dentures which were not fabricated at the present office; all denture adjustment for new dentures made within 12 months are at no fee to the Member.
- When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
- Occlusal Guard(s) is/are limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
- D0364-D0395 is limited to one (1) time per sixty (60) months, covered only in a dental setting and not in a radiographic imaging center.
- Certain dental procedures that the provider may consider and propose as an upgraded procedure may require additional costs of material and laboratory fees in addition to the stated copayment.

SECTION IX

Exclusions and Limitations

Limitations on Covered Services

Listed below are limitations on services covered by your Dental Plan:

- **Frequency/Age**: The frequency of certain covered services, specifically preventive and diagnostic procedures such as cleanings, x-rays, are limited. Your Schedule of Benefits lists these limitations on frequency and age.

  ***Please note, however, diagnostic, preventive, and restorative services will be provided more frequently if medically necessary.

- **Specialty Care**: The Schedule of Benefits applies when listed Dental Services are performed by a Participating General Dentist, unless otherwise authorized by Solstice. Procedures not covered on the Schedule of Benefits that are performed by a participating Dentist will be charged at the participating Dentist's usual and customary fee less 25%. The Participating General Dentist you select may not perform all Dental Procedures listed. The Copayments shown apply to Participating Dentists who do perform these Dental Services. Therefore, you are encouraged to secure availability of the scheduled Dental Services with your Participating General Dentist.

  Should the services of a Specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care by obtaining written authorization from Solstice and You may receive specialty treatment by an approved Participating Specialist at the listed Copayments.

  Should the services of an Orthodontist be necessary, you may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member Co-payment.

  Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.smilestateofaz.com under "Locate A Provider."

  Though it is the intent to provide easy access for Solstice members to its Network Specialty Dentists, Solstice is not obligated to provide the required dental specialist within a specific radius or geographic area. The following general limitations apply:

  - **Pediatric Dentistry**: Coverage for referral to a pediatric dentist ends on your child's 16th birthday: however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 16th birthday.
  - **Oral Surgery**: Surgical removal of impacted tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.

Orthodontics

The following definitions apply:

- **Orthodontic Treatment Plan and Records** - The preparation of orthodontic records and a treatment plan by the orthodontist (models, x-rays, etc.).
- **Interceptive/Transitional Orthodontic Treatment** - Treatment prior to full eruption of the permanent teeth, frequently a first phase prior to comprehensive therapy.
- **Comprehensive Orthodontic Treatment** - Treatment after eruption of most permanent teeth (i.e. braces).
- **Retention (Post Treatment Stabilization)** - The period following comprehensive treatment where you may wear an appliance to maintain and stabilize the new position of the teeth.

The Solstice orthodontic benefit allows for a total of 24 months of orthodontic treatment whether it be entirely “comprehensive” or 12 months of “Interceptive” and 12 months of Comprehensive, etc. The patient charge for your entire orthodontic case, including retention, will be based upon the appropriate Schedule of Benefits in effect on the date of your visit for treatment plan and records. Factors that could alter the total charge might be the type of brackets utilized (ceramic, clear, lingual vs. metal), required surgery, appliances to guide minor tooth movement, harmful habit appliances, as well as the evaluation of the difficulty or case type of the orthodontic treatment and/or the degree to which the treatment plan deviates from a “typical” or normal case difficulty as discerned entirely by the Orthodontist. Solstice bears no liability towards treatment unable to be completed due to a terminated status or a treatment planned case, originally thought to be completed within 24 months, at the end of which, more therapy is evident to achieve a satisfactory result as discerned by the Orthodontist.

If you/your Dependent is in the middle of orthodontia treatment of any type at the time of initial enrollment, you must contact Solstice to see if you are eligible for reimbursement under the orthodontia benefit.

Exclusions of Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility.

- Services not listed on the Schedule of Benefits are charged to you, the Member/Dependent, at a 25% discount of the provider’s usual and customary fee.
- Services provided by a non-Network General Dentist or Dental Specialist without Solstice Benefit's prior approval, except emergencies.
- Services related to an injury or illness paid under worker’s compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or public program, other than Medicaid.
- Services relating to injuries which are intentionally self-inflicted.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- General anesthesia or IV sedation is ONLY covered when medically necessary and prior approval is acquired from Solstice.
- Prescription drugs.

- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact) or (2) diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ") unless TMJ therapy is specifically listed on your Schedule of Benefits or specified as an orthodontic benefit.
- Dental procedures initiated prior to the Member's eligibility under this Dental Plan or initiated after the Member's termination from the Dental Plan.
- Replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Services associated with the placement or prosthodontic restoration of a dental implant.
- Services considered to be unnecessary or experimental in nature.
- Any inpatient or outpatient hospitalization, including any associated incremental charges for dental services or medical services performed in a Hospital.
- Treatment of malignancies, cysts or neoplasms.
- Services to the extent you or your enrolled Dependent is compensated under any group medical plan, no-fault auto insurance policy, or an insured motorist policy.
- Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the Member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local and or general anesthetics.
- Surgical removal of impacted tooth is ONLY covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
- Cosmetic Services. We do not Cover cosmetic services or surgery unless explicitly stated on the Schedule of Benefits.
- Coverage Outside of the United States, Canada or Mexico. We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico.
- Experimental or Investigational Treatment. We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an independent review organization certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.
- Medical Services. We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

- Medically Necessary. In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise Covered under the terms of this Certificate.

- Military Service. We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

- No-Fault Automobile Insurance**.** We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

- Services Not Listed. We do not Cover services that are not listed in this Certificate as being Covered.

- Services with No Charge. We do not Cover services for which no charge is normally made.

- War. We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

- Workers' Compensation. We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability.

SECTION X

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. Either You or the Provider must file a claim form with Us. If the Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at www.mymile365.com/stateofaz. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to Us electronically by sending it to the email address in the How Your Coverage Works section of this Certificate.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, You must submit it as soon as reasonably possible.

D. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

E. Preauthorization Claim Determinations.

1. A preauthorization claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a preauthorization claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Preauthorization Reviews. With respect to urgent preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

F. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

G. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XI

Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us by phone at the number on Your ID card or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 5 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, a description of Our grievance procedures and time frames, and indicate what additional information, if any, must be provided. We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	We will resolve a Grievance involving Emergency Dental Care services within the earlier 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 3 business days of receipt of Your Grievance.
Preauthorization Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an appeal. Please see the attached *Health Care Insurer Appeals Process Information Packet,* which describes the appeal process and includes an Appeal Request Form.

SECTION XII

Utilization Review

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** If We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 3 business days of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need

additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

D. Retrospective Reviews.
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:
- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made

the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Appeals

You or Your designee may request an appeal of an adverse determination. Please see the attached *Health Care Insurer Appeals Process Information Packet,* which describes the appeal process and includes an Appeal Request Form.

SECTION XIII

Coordination of Benefits

If a person receiving dental care is an Enrollee of a prepaid dental plan and is an insured or certificate holder under an indemnity health insurance policy which provides benefits for the same treatment as the person's prepaid dental plan, the indemnity health insurance policy shall pay Benefits to its insured or certificate holder or the assignee thereof without regard to the existence of the prepaid dental plan.

The determination of which policy or program is primary shall be governed by the rules stated in the contract.

The indemnity plan insurer is not obligated to pay any amount for a procedure covered without charge to the Enrollee of the prepaid dental plan or to pay in excess of the amount of the Enrollee's obligation under the prepaid dental plan. In the event that the Enrollee's copayment obligation under the prepaid dental plan has been met, then the indemnity insurer shall remit any payments due to its insured or certificate holder.

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Solstice and Solstice may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Solstice shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under the Contract. Solstice shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Solstice chooses, the amount of any Benefits paid by Solstice which exceeds its obligations under these coordination of benefit provisions.

SECTION XIV

General Provisions

1. Agreements between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any dental benefits program.

2. Assignment.

You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits to any person, corporation or other organization. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this. However, You may request Us to make payment for services directly to Your Provider instead of You. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in This Certificate.

We may unilaterally change this Certificate upon renewal, if We give the Group 45 days' prior written notice.

4. Choice of Law.

This Certificate shall be governed by the laws of the State of Arizona.

5. Clerical Error.

Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.

Any term of this Certificate which is in conflict with Arizona State law or with any applicable federal law that imposes additional requirements from what is required under Arizona State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.

Some of the benefits in this Certificate may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Enrollment ERISA.

The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate; and

any other information required to confirm their eligibility for coverage. The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator. The Group will provide Us with the enrollment form including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Group's Contract with Us. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

9. Entire Agreement.

This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

10. Furnishing Information and Audit.

All persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider; or make decisions regarding the medical necessity of Your care.

11. Grace Period.

A grace period of thirty (30) days following the first unpaid month of benefits provided will be allowed for the payment of any Premium, except the first Premium. The Policy stays in force during a grace period. Full payment must be received by the thirtieth (30th) day of the grace period.

If the Group sends Solstice a notice of termination during the Grace Period, the Group must pay Premiums for any period that the Policy was in force. This includes the pro rata share of the Grace Period. If the Policy terminates for the Premium not being paid, all unpaid Premiums are due as well as the Premium due for the Grace Period.

12. Identification Cards.

Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

13. Incontestability.

No statement made by the Subscriber in an application for coverage under this Certificate shall void the Certificate or be used in any legal proceeding unless the application or an exact copy is attached to this Certificate. After two (2) years from the date of issue of this Certificate, no misstatements, except for fraudulent misstatements made by the Subscriber in the application for coverage, shall be used to void the Certificate or deny a claim.

14. Independent Contractors.

Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

15. Material Accessibility.

We will give You ID cards, Certificates, riders and other necessary materials.

16. More Information about Your Dental Plan.

You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

17. Notice.

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: P.O. Box 19199, Plantation, Florida 33318.

18. Premiums.

Your Group remits a monthly fee to Solstice for Members participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your benefits representative for information regarding any part of the fee to be withheld from your salary to be paid by you to the Group or the amount that the Group is paying on your behalf.

19. Premium Refund.

We will give any refund of Premiums, if due, to the Group to be distributed to the Subscriber.

20. Recovery of Overpayments.

On occasion a payment will be made to You when You are not covered, for a service that is not Covered, or

which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of health care professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

22. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

23. Severability.

The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

24. Significant Change in Circumstances.

If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

25. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Certificate and nothing in the Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate’s provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

26. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written

submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within three (3) years from the date the claim was required to be filed.

27. Translation Services.

Translation services are available under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

28. Venue for Legal Action.

If a dispute arises under this Certificate, it must be resolved in a court located in the State of Arizona. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to Arizona State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

29. Waiver.

The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

30. Who Receives Payment under this Certificate.

Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

31. Workers' Compensation Not Affected.

The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

32. Your Dental Records and Reports.

In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your dental records by Us.

We agree to maintain Your dental information in accordance with state and federal confidentiality

requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the Arizona Department of Insurance, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.