AcademicBlue℠

University of New Mexico Student Dental Insurance Plan 2025-2026

Underwritten by: Blue Cross and Blue Shield of New Mexico

Please review to understand your coverage.

Account Number: 190482

9202234.0225

AcademicBlue℠

Notice: This Policy is subject to: (1) Annual Maximums, for other than Pediatric Services; (2) the right to adjust the Premium upon 60 days' notice to You. Such adjustments in rates shall become effective on the date specified in said notice; (3) termination of coverage in accordance with the *Termination of Coverage* section as specified in this Policy.

THE COVERED PERSON SHALL HAVE THE RIGHT TO RETURN THIS POLICY WITHIN 30 DAYS OF ITS DELIVERY, AND TO HAVE ANY REQUIRED PREMIUMS REFUNDED, IF AFTER EXAMINATION OF THIS POLICY THE COVERED PERSON IS NOT SATISFIED FOR ANY REASON, PROVIDED NO CLAIM HAS BEEN PAID.

Blue Cross and Blue Shield of New Mexico

Herein called (BCBSNM, We, Us, Our)

Has issued this

Student Dental Insurance

Policy to

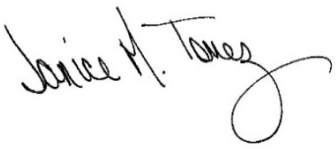
University of New Mexico

This Policy is effective from 12:01 a.m. on the Effective Date shown on the Identification Card and will be continued in effect by the payment of premiums at the rates determined by Us in accordance with the provisions in the Premiums section until terminated as provided in the Termination of Coverage provision.

Policyholder has confirmed to Us that it is an institution of higher education as defined in the Higher Education Act of 1965. This Policy does not make health insurance available other than in connection with enrollment as a Student (or a Dependent of a Student) in the Policyholder's Institution.

This Policy is issued in the State of New Mexico and is governed in accordance with the laws of this State.

Changes in state or federal law or regulations, or interpretation thereof, may change the terms and conditions of coverage.



Janice Torrez
President, Blue Cross and Blue Shield of New Mexico

THE DENTAL SCHEDULE OF BENEFITS ENCLOSED WITH THIS POLICY INDICATES BENEFIT PERCENTAGES, DEDUCTIBLES, MAXIMUMS, AND OTHER BENEFIT AND PAYMENT INFORMATION THAT APPLIES TO THIS POLICY.

NOTICE TO CONSUMER: THIS IS A LIMITED BENEFITS HEALTH POLICY. THE BENEFITS PROVIDED ARE SUPPLEMENTAL TO, AND NOT A SUBSTITUTE FOR, MAJOR MEDICAL COVERAGE, EVEN IN CONJUNCTION WITH OTHER LIMITED HEALTH POLICIES. TO APPLY FOR AN INDIVIDUAL OR SMALL- GROUP MAJOR MEDICAL POLICY, PLEASE VISIT THE WEBSITE OF THE NEW MEXICO HEALTH INSURANCE EXCHANGE AT WWW.BEWELLNM.COM OR CALL 1-833-862-3935 (TTY: 711).

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT NOTICE

1. Cost-sharing and Benefits limitations for an emergency Dental Service rendered by a Non-Contracting Dentist shall be the same as if rendered by a Contracting Dentist. Neither Predetermination of Benefits nor Prior Authorization is required for either emergency Clinical oral examinations or palliative treatment (emergency) of dental pain.

2. Cost-sharing and Benefits limitations for a Medically Necessary, non-emergent Dental Service rendered by a Non-Contracting Dentist at a participating Facility where the covered person has no ability or opportunity to choose to receive the service from a Contracting Dentist shall be the same as if the service was rendered by a Contracting Dentist.

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SCHEDULE OF BENEFITS – ADULT SERVICES

This Dental Schedule of Benefits is for Covered Persons age 19 and over.

Your dental care Benefits are highlighted below. To fully understand all of the terms, conditions, limitations, and exclusions which apply to your Benefits, please read the entire Policy.

The Deductibles, Coinsurance, Benefit Period maximum and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

BlueCare Dental 1B

Covered Services	Benefit Payable In Network	Benefit Payable Out of Network
Diagnostic Evaluations (Deductible waived)	90%	70%
Preventive Services (Deductible waived)	90%	70%
Diagnostic Radiographs (Deductible waived)	90%	70%
Miscellaneous Preventive Services	90%	70%
Basic Restorative Services	70%	50%
Non-Surgical Extractions	70%	50%
Non-Surgical Periodontal Services	70%	50%
Adjunctive Services	70%	50%
Endodontic Services	50%	30%
Oral Surgery Services	50%	30%
Surgical Periodontal Services*	50%	30%
Major Restorative Services*	50%	30%
Prosthodontic Services*	50%	30%
Miscellaneous Restorative and Prosthodontic Services*	50%	30%
Implants	Not Covered	
Orthodontia	Not Covered	
Deductible	$75 Individual/$225 Family	
Annual Maximum	$1,000	
Out-of-Pocket Maximum	None	

* 12 month Benefit waiting period applies.

All Benefits are based upon the Allowable Amount, which is the amount determined by BCBSNM as the maximum amount eligible for payment of Benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

SCHEDULE OF BENEFITS – PEDIATRIC SERVICES

This Dental Schedule of Benefits is for Covered Persons under the age of 19.

Your dental care Benefits are highlighted below. To fully understand all of the terms, conditions, limitations, and exclusions which apply to your Benefits, please read the entire Policy.

The Deductibles, Coinsurance, Benefit Period maximum and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

BlueCare Dental 1B

Covered Services	Benefit Payable In Network	Benefit Payable Out of Network
Diagnostic Evaluations (Deductible waived)	80%	60%
Preventive Services (Deductible waived)	80%	60%
Diagnostic Radiographs (Deductible waived)	80%	60%
Miscellaneous Preventive Services	80%	60%
Basic Restorative Services	50%	30%
Non-Surgical Extractions	50%	30%
Non-Surgical Periodontal Services	50%	30%
Adjunctive Services	50%	30%
Endodontic Services	50%	30%
Oral Surgery Services	50%	30%
Surgical Periodontal Services	50%	30%
Major Restorative Services	50%	30%
Prosthodontic Services	50%	30%
Miscellaneous Restorative and Prosthodontic Services	50%	30%
Implants	Not Covered	
Pediatric Orthodontia (Deductible waived)	50%	30%
Deductible	$75 Individual / $225 Family	
Out-of-Pocket Maximum		
1 Child	$425	
2+ Children	$850	
All Benefits are based upon the Allowable Amount, which is the amount determined by BCBSNM as the maximum amount eligible for payment of Benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.		

DEFINITIONS

Whenever used in this Policy and unless otherwise expressly stated in writing:

ACCIDENTAL INJURY means accidental bodily injury resulting, directly and independently of all other causes.

ALLOWABLE AMOUNT means the maximum amount determined by BCBSNM to be eligible for consideration of payment for a particular service, supply, or procedure.

For certain Dentists Contracting with BCBSNM - The Allowable Amount is based on the terms of the Dentist's contract and BCBSNM's methodology in effect on the date of service. The methodology used may include relative value, global pricing, or a combination of methodologies.

For Dentists not contracting with BCBSNM - The Allowable Amount is based on the amount BCBSNM would have paid for the same covered service, supply, or procedure if performed or provided by a contracting Dentist.

Unless otherwise stipulated by a Policy between the Dentist and BCBSNM:

1. For services performed in New Mexico - The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills;
2. For services performed outside of New Mexico - The Allowable Amount will be established by identifying Dentists with similar experience or skills in order to establish the applicable amount for the procedure, services, or supplies;
3. For multiple surgical procedures performed in the same operative area - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services; and
4. When a less expensive professionally acceptable service, supply, or procedure is available - The Allowable Amount will be based upon the least expensive services. This is not a determination of Dental Necessity, but merely a contractual Benefit allowance.

The Allowable Amount for all Eligible Expenses also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

AUTHORIZED ADMINISTRATOR means Dental Network of America.

BCBSNM, We, Us, or Ours means Blue Cross and Blue Shield of New Mexico, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

BENEFIT mean any payment, reimbursement, or indemnification of any kind which Covered Persons will receive under this Policy.

BENEFIT PERIOD means the period of time during which the Covered Person receives the covered services for which this Policy will provide Benefits. The Benefit Period is the period of time beginning with the Effective Date of this Policy through the Termination Date as shown on the face page of this Policy. The Benefit Period is as agreed to by the Policyholder and Us.

CLAIM means notification in a form acceptable to Us that a service has been rendered or furnished to the Covered Person. This notification must include full details of the services received, including the identifying information of the Covered Person, the name and address of the dental provider, an itemized statement of the service rendered or furnished to the Covered Person, the diagnosis, the Claim charge, and any other information We may request in connection with the services rendered.

COINSURANCE AMOUNT means the dollar amount (expressed as a percentage) of Eligible Expenses incurred by a Covered Person during a Benefit Period that exceeds Benefits provided under this Policy.

CONTRACTING DENTIST means a Dentist who has entered into a written agreement with BCBSNM, who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC) and/or who has entered into an agreement with another entity with which HCSC or any of its subsidiaries has contracted.

COURSE OF TREATMENT means any number of dental procedures or treatments performed by a Dentist in a contracted series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

COVERED PERSON means any eligible Student who applies for coverage, and for whom the required premium is paid.

DEDUCTIBLE means the dollar amount of Eligible Expenses that must be incurred by a Covered Person before Benefits under this Policy will be available.

DENTALLY NECESSARY or DENTAL NECESSITY means those services, supplies, or appliances covered under this Policy which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury;
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States;
3. Not primarily for the convenience of the Covered Person or his Dentist; and
4. The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Covered Person.

DENTIST means a person, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

DOMESTIC PARTNER means a companion of the same or opposite sex with whom the Covered Person has entered into a Domestic Partnership in accordance with the guidelines established by BCBSNM, as appropriate.

DOMESTIC PARTNERSHIP means a same or opposite sex couple in a committed relationship, similar to marriage, but without an official marriage license.

EFFECTIVE DATE means the date the Covered Person's coverage becomes effective under this Policy.

ELIGIBLE EXPENSES means covered dental services as described in this Policy.

EXPERIMENTAL/INVESTIGATIONAL means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

1. Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
2. Are appropriate for the hospital or provider in which they were performed; and
3. The Dentist has had the appropriate training and experience to provide the treatment or procedure.

The medical/dental staff of BCBSNM shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination. If a decision is based on Dental Necessity, We will follow the process outlined in the Review of Claim Determination section.

Although a Dentist may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSNM still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial, or a research study is Experimental/ Investigational.

IDENTIFICATION CARD means the card issued to the Covered Person indicating pertinent information applicable to his coverage under this Policy, including applicable Copayment Amounts.

INSTITUTION means an institution of higher education as defined in the Higher Education Act of 1965.

INTERCOLLEGIATE SPORT means a sport, which is not an Interscholastic Activity (as defined in this Policy); and is administered by such Institution's department of intercollegiate athletics; and for which Benefits for injuries are not provided for nor payable under this Policy while Covered Persons are playing, participating, and/or traveling to or from an intercollegiate sport, contest, or competition, including practice or conditioning for such activity.

INTERSCHOLASTIC ACTIVITY means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

MEDICALLY NECESSARY or MEDICAL NECESSITY means health care or dental services determined by a Provider, in consultation with BCBSNM, to be appropriate or necessary, according to:

1. Any applicable generally accepted principles and practices of good medical/dental care;
2. Practice guidelines developed by the federal government, national or professional medical societies, boards, and associations; and
3. Any applicable clinical protocols or practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury, or disease.

MINIMUM ESSENTIAL COVERAGE means health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group, or government health insurance coverage. For additional information on whether particular coverage is recognized as *Minimum Essential Coverage*, please call the Customer Service telephone number shown on the back of your Identification Card or visit www.cms.gov.

OPTIONAL ORTHODONTIC SERVICES means coverage for orthodontic conditions not meeting Dental Necessity criteria.

OUT-OF-POCKET MAXIMUM means the maximum amount of Coinsurance and Deductible that a Covered Person must pay before this Policy begins to pay 100% of Eligible Expenses.

PEDIATRIC ORTHODONTIC SERVICES means coverage limited to children under the age of 19 with an orthodontic condition meeting Dental Necessity criterion (e.g., severe, dysfunctional malocclusion).

POLICY means this Policy issued by Blue Cross and Blue Shield of New Mexico to the Institution, any addenda, the Institution's Application for Student Dental Insurance, the Covered Person's application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

STUDENT means an individual Student or continued person who meets the eligibility requirements for this dental coverage, as described in the eligibility requirements of this Policy.

WE, OUR, US means Blue Cross and Blue Shield of New Mexico or its authorized agent.

YOU, YOUR, YOURS means the Student to whom this Policy is issued.

ELIGIBILITY FOR INSURANCE

Each person in the *Classes of Eligible Persons* shown below is eligible to be insured as a Student under this Policy. This includes anyone who is eligible on the Policy Effective Date and may become eligible after the Policy Effective Date while this Policy is in force. Please contact your Institution for more information. We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met.

Classes of Eligible Persons:

Students and their spouse (including Domestic Partner) are eligible for coverage under this policy. Dependent children are not eligible for coverage.

NOTE: Multiple classes may be added depending on the Institution.

A person may not be insured as a Dependent and a Student at the same time.

No eligibility rules or variations in premium will be imposed based on a Student's health status, medical condition, Claims experience, receipt of health care, medical or dental history, genetic information, evidence of insurability, disability, or any other health status factor. A Student will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, life expectancy, quality of life, sex, gender identity, sexual orientation, religion, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving Benefits. Variations in the administration, processes or Benefits of this Policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

EFFECTIVE DATE OF COVERAGE

This Policy begins on the Policy Effective Date at 12:01 AM, Standard Time, at the address of the Policyholder.

Coverage for an eligible person who enrolls during the program's enrollment period, as established by the Institution, is effective on the latest of the following dates:

1. This Policy Effective Date;
2. The date We received the completed enrollment form;
3. The date after the required premium is paid; or
4. The date the Student enters the Eligible Class.

After the time periods described above, the Student must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another dental care Policy.

We will pay Benefits for a newborn child of the Covered Person until that child is 31 days old.

Adopted children, as defined by this Policy, will be covered on the same basis as a newborn child from the date the child is placed for adoption with the Covered Person or the date the Covered Person becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the Covered Person's legal obligation terminates.

PREMIUM AND REINSTATEMENT PROVISIONS

The premiums for this Policy will be based on the rates currently in force, this Policy, and amount of insurance in effect.

Payment of Premium

Coverage does not become effective until payment of the first month's premium.

Policy Grace Period

A Policy Grace Period of 31 days will be granted for the payment of the required premiums. This Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end upon the expiration of the Grace Period. The Policyholder will be liable for any unpaid premium for the time this Policy was in force.

Reinstatement

If default is made in the stipulated premium payments for this Policy, the subsequent acceptance of such premium payments by BCBSNM shall reinstate this Policy. For purposes of reinstatement, mere receipt and/or negotiation of a late premium shall not constitute acceptance. The reinstated Policy shall not cover loss due to covered dental expenses incurred after the date of termination. In all other respects, the Covered Person shall have the same rights under this Policy as he had immediately before the due date of the defaulted premiums, including his right to apply the period of time this Policy was in effect immediately before the due date of the defaulted premiums toward satisfaction of any Benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Refund of Premium

A refund of Premium to the Covered Person will only be made in the event of:

1. A Covered Person's death; or
2. The Covered Person enters full-time active duty in any Armed Forces, and We receive proof of such active-duty service.

PAYMENT OF BENEFITS; COVERED PERSON/DENTIST RELATIONSHIP

Payment of Benefits

When Benefits are payable, We will pay either the Covered Person or the Dentist. This payment constitutes Our full responsibility to the Covered Person under this Policy.

Except as provided above, the rights and Benefits of this Policy shall not be assignable, either before or after services and supplies are provided. However, if a written assignment of Benefits is made by the Covered Person to a Dentist and the written assignment is delivered to Us with the Claim for Benefits, We will make any payment directly to the Dentist.

Any Benefits payable to the Covered Person shall, if unpaid at his death, be paid to his surviving beneficiary; if there is no surviving beneficiary, then such Benefits shall be paid to his estate.

Covered Person/Dentist Relationship

The choice of a Dentist should be made solely by the Covered Person. BCBSNM does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Covered Persons. BCBSNM is not liable for any act or omission by any Dentist. BCBSNM does not have any responsibility for a Dentist's failure or refusal to provide services or supplies to the Covered Person. Care and treatment received are subject to the rules and regulations of the Dentist selected and are available only for treatment acceptable to the Dentist.

We will pay Eligible Expenses incurred by the Covered Person or on behalf of him. Expenses must be incurred while this Policy is in force and while the Covered Person is covered by this Policy. Any Deductible, Coinsurance Amount, and annual Benefit maximums, if applicable are shown in the Schedule of Benefits.

BCBSNM shall accept, investigate and address Provider grievances about plan operations.

Allowable Amount

The Allowable Amount is the maximum amount of Benefits BCBSNM will pay for Eligible Expenses the Covered Person incurs under this Policy. In determining the Allowable Amount, BCBSNM will consider such factors as the Dentist's usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances, and whether the Dentist is a Contracting Dentist. The portion of the charges by the Covered Person's Dentist that exceeds the Allowable Amount of BCBSNM will be the Covered Person's responsibility to pay to his Dentist, except when he has used a Contracting Dentist. The Covered Person will also be responsible for charges for services, supplies, and procedures limited or not covered under this Policy and any applicable Deductibles.

Review the definition of Allowable Amount in the DEFINITIONS section of this Policy to understand the guidelines used by BCBSNM.

Deductibles

The Deductible is the dollar amount of Eligible Expenses that must be incurred by the Covered Person during a Benefit Period for which no Benefits will be paid. The amounts applied to the Deductible are based on the Benefit allowance in the Schedule of Benefits. The following Deductibles will apply:

1. An individual Deductible as indicated in the Schedule of Benefits; and
2. A family Deductible as shown in the Schedule of Benefits. When the family Deductible equals the amount indicated in the Schedule of Benefits, all Covered Persons will be deemed to have satisfied their Deductible for the remainder of that Calendar Year. No one Covered Person is allowed to satisfy more than the individual Deductible amount.

The Deductible may not apply to some Benefits as shown in the Schedule of Benefits.

DENTAL BENEFIT INFORMATION

Annual Maximum Benefit

The Annual Maximum Benefit is the maximum dollar amount We will pay for all covered services for each Covered Person during a Benefit Period, according to the terms of this Policy and the coverage outlined in the Schedule of Benefits.

The maximum Benefits payable during a Benefit Period for any one Covered Person under this Policy for all Eligible Expenses is shown in the Schedule of Benefits. Benefits paid for Orthodontic Services, if covered under this Policy, do not apply to the Annual Maximum Benefit.

Eligible Expenses

To be an Eligible Expense, the dental service must be performed by a Dentist, or licensed dental hygienist acting under the supervision and direction of a Dentist.

Eligible Expenses are deemed incurred on the earlier of:

1. The date the final impression is taken for full and partial dentures;
2. The date the teeth are first prepared for fixed bridges, crowns, inlays and onlays;
3. The date the pulp chamber is opened for root canal therapy;
4. The date surgery is performed for periodontal surgery;
5. The date the appliance or bands are inserted; or
6. On the date the service is performed for all other services.

Predetermination of Benefits

Predetermination is an estimate by BCBSNM of your eligibility under this Policy for dental Benefits or covered dental services, the amount of your Deductible, Copayment or Coinsurance Amount related to Dental Benefits or covered Dental services and the maximum Benefit limits for Dental Benefits or covered Dental services.

If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of $300, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with BCBSNM prior to the commencement of treatment.

BCBSNM may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. BCBSNM will review the reports and materials, taking into consideration alternative Courses of Treatment.

BCBSNM will notify you and the Dentist of:

1. Your eligibility under this Policy;
2. Your Deductible, Copayment and Coinsurance Amount related to dental Benefits or covered dental services; and
3. The maximum Benefit limits for Dental Benefits or covered Dental services.

Benefit payments may be reduced based on any Claims paid after a predetermination estimate is provided.

This Policy will provide Benefits for the following Eligible Expenses, subject to the limitations and exclusions described in this Policy. The Benefit amount applicable to each Coverage Level and covered service is also shown on Your Schedule of Benefits.

It is important for You to refer to Your Schedule of Benefits to find out what a Covered Person's Deductible, Coinsurance and annual maximum will be for a covered service. If You do not have a Schedule of Benefits, please call Customer Service at the number on the back of your Identification Card.

Covered Person's dental Benefits include coverage for the following covered services as long as these services are rendered to Covered Persons by a Dentist.

COVERED DENTAL SERVICES

Diagnostic Evaluations

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

1. Periodic oral evaluations for established patients;
2. Problem focused oral evaluations, whether limited, detailed, or extensive;
3. Comprehensive oral evaluations for new or established patients;
4. Comprehensive periodontal evaluations for new or established patients;
5. Oral evaluations of children, including counseling with primary caregiver is covered for a child under the age of three; and
6. Oral Examinations - Oral exams are limited to one every 6 months.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations if covered services are rendered on the same date as any other oral evaluation and by the same Dentist.

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

Preventive Services

Preventive services are performed to prevent dental disease. Covered services include:

1. Prophylaxis - Professional cleaning, scaling, and polishing of the teeth. Benefits are limited to two cleanings every 12 months; and
2. Topical fluoride application - Benefits for fluoride application are only available to Covered Persons under the age of 16 (or older if Medically Necessary) and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services:

1. Cleanings include associated scaling and polishing procedures.
2. Periodontal maintenance combined with prophylaxes treatments (see *Non-Surgical Periodontic Services*) are limited to four in a 12-month period following completion of active periodontal therapy.

Diagnostic Radiographs

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

1. Full-mouth (intraoral complete series) and panoramic films - Benefits are limited to a combined maximum of one every 36 months for Covered Persons over the age of 19;
2. Bitewing films - Benefits are limited to four horizontal or eight vertical images per Calendar Year unless greater frequency is deemed Medically Necessary; and
3. Periapical films – As Medically Necessary for diagnosis for Covered Persons over the age of 19.

Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

1. Sealants - Benefits for sealants are limited to one per tooth every 36 months and are available to Covered Persons up to age 19; and
2. Space Maintainers - Benefits for space maintainers are limited to children under the age of 19.

Benefits are not available for nutritional, tobacco, or oral hygiene counseling.

Basic Restorative Services

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners, and polishing. Covered services include:

1. Amalgam restorations;
2. Resin-based composite restorations; and
3. Non-Surgical Extractions.

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

1. Removal of retained coronal remnants - deciduous tooth; and
2. Removal of erupted tooth.

Non-Surgical Periodontal Services

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

1. Periodontal scaling and root planing - Benefits are limited to one per quadrant every 24 months;
2. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to one every 12 months;
3. Scaling in the presence of generalized moderate to severe gingival inflammation is limited to twice every 12 months combined with prophylaxes and periodontal maintenance; and
4. Periodontal maintenance procedures - limited to two every 12 months combined with prophylaxes after completion of active periodontal therapy. Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

Adjunctive Services

Adjunctive general services include:

1. Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment;
2. Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation - By report only and when determined to be Dentally Necessary for documented Covered Persons with a disability or for a justifiable medical or dental condition. A person’s apprehension does not constitute Dental Necessity; and
3. Therapeutic parenteral drugs - Therapeutic parenteral drugs will be covered for Eligible Persons under the age of 19.

Benefits will not be provided for local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application.

Endodontic Services

Endodontics is the treatment of dental disease of the tooth pulp and includes:

1. Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure. These services are considered part of the root canal procedure if root canal therapy is performed within 45 days of services;
2. Root canal therapy, including treatment Policy, clinical procedures, working and post-operative radiographs and follow-up care; and
3. Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Benefits will not be provided for the following *Endodontic Services*:

1. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist;
2. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal; and
3. Endodontic therapy if you discontinue endodontic treatment.

Oral Surgery Services

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

1. Surgical tooth extractions;
2. Alveoloplasty and vestibuloplasty;
3. Excision of benign odontogenic tumor/cysts;
4. Excision of bone tissue;
5. Incision and drainage of an intraoral abscess; and
6. Other Dentally Necessary surgical and repair procedures not specifically excluded in this Policy.

Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

Benefits will not be provided for the following Oral Surgery procedures:

1. Surgical services related to a congenital malformation;
2. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another Benefit Policy;
3. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
5. Treatment of fractures of facial bones;
6. External incision and drainage of cellulitis;
7. Incision of accessory sinuses, salivary glands, or ducts;
8. Reduction of dislocation; or
9. Excision of the temporomandibular joints.

Surgical Periodontal Services

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

1. Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) - Benefits are limited to one quadrant every 24 months;
2. Clinical crown lengthening;
3. Osseous surgery, including flap entry and closure - Benefits are limited to one per quadrant every 36 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease;
4. Osseous grafts - Benefits are limited to one per site every 24 months. Bone grafts are excluded in conjunction with extractions, apicoectomy or any non-covered service or non-eligible implants;
5. Soft tissue grafts/allografts (including donor site) - For Covered Persons age 19 and over Benefits are limited to one per site every 24 months. These Benefit limits do not apply to Covered Persons up to age 19;
6. Distal or proximal wedge procedure; and

7. Anatomical crown exposures - are not covered.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

Major Restorative Services

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

1. Single crown restorations;
2. Inlay/onlay restorations; and
3. Labial veneer restorations.

Benefits will not be provided for the replacement of a lost, missing, or stolen appliances and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

Benefits will not be provided for services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Policy or under any prior dental coverage, even if the original crown was stainless steel.

Benefits will not be provided for services to restore occlusion on incisal edges due to bruxism or harmful habits.

Prosthodontic Services

Prosthodontics involves procedures necessary for providing artificial replacements for missing natural teeth and includes:

1. Complete and removable partial dentures - Benefits will be provided for the initial installation of removable complete, immediate, or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month period, whether placement was provided under this Policy or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement, or loss;
2. Denture reline/rebase procedures - Benefits will be limited to one procedure every 36 months after the initial 6-month period following initial placement; and
3. Fixed bridgework - Benefits will be provided for the initial installation of a bridgework, including inlays/onlays, and crowns. Benefits will be limited to once every 60 months whether placement was under this Policy or under any prior dental coverage.

Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

NOTE:

An implant is a covered procedure of the Policy only if determined to be a dental necessity. Claim review for implant services are conducted by licensed Dentists who review the clinical documentation submitted by your treating Dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no Benefit will be allowed for the individual implant or implant procedure. Only the second phase of treatment (the prosthodontic phase-placement of the implant crown, bridge, or partial denture) may be subject to the alternate Benefit provision of this Policy.

Implant retained crowns, bridges, and dentures are subject to the alternate Benefit provision of the Policy.

Endosteal, eposteal, and transosteal implants - one every 60 months, only if determined to be a dental necessity.

Benefits will not be provided for the following Prosthodontic Services:

1. Treatment to replace teeth which were missing prior to the Effective Date;

2. Congenitally missing teeth;
3. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework; and
4. Miscellaneous Restorative and Prosthodontic Services. Other restorative and prosthodontics services include:

1. Prefabricated crowns - Benefits for stainless steel and resin-based crowns are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns;
2. Recementation of inlays/onlays, crowns, bridges, and post and core;
3. Core build up, post and core, and prefabricated post and core are limited to 1 per tooth every 60 months;
4. Crown and bridge repair services;
5. Denture Adjustments; and
6. Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp.

Medically Necessary Orthodontic Services

Medically Necessary orthodontic services are limited to members who meet the Policy's criteria related to a medical condition such as:

1. Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
2. Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services; and
3. Skeletal anomaly involving maxillary and/or mandibular structures.

Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment does not meet the definition of Medical Necessity.

Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Covered Persons covered for orthodontics as shown on the Schedule of Benefits. Covered services include:

1. Limited, interceptive, and comprehensive orthodontic treatment.

Special Provisions Regarding Orthodontic Services

1. Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic Benefit, if applicable. Benefits cease when the Covered Person is no longer covered, whether or not the entire Benefit has been paid out.
2. Orthodontic treatment is started on the date the bands or appliances are inserted.
3. Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the maximum Benefit for orthodontic services.
4. If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
5. If the Covered Person's coverage is terminated prior to the completion of the orthodontic treatment Policy, the Covered Person is responsible for the remaining balance of treatment costs.
6. Recementation of an orthodontic appliance by the same Dentist who placed the appliance and/or who is responsible for the ongoing care of the Covered Person is not covered.
7. Benefits are not available for replacement or repair of an orthodontic appliance.

For services in progress on the Effective Date, Benefits will be reduced based on the Benefits paid prior to this coverage beginning.

Benefits are available for Dentally Necessary covered services incurred for an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth.

TMJ/CMJ Services

This Policy covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders. Related orthodontic appliances and treatment, crowns, bridges and dentures are covered only if the disorder is the result of trauma.

LIMITATIONS AND EXCLUSIONS

These general Limitations and Exclusions apply to all services described in this dental Policy. Dental coverage is limited to services provided by a Dentist or a dental auxiliary, (as defined in the Definitions section) licensed to perform services covered under this dental Policy.

Important Information About the Covered Person's Dental Benefits

- ***Dental Procedures Which Are Not Dentally Necessary***

Please note that in order to provide the Covered Person with dental care Benefits at a reasonable cost, this Policy provides Benefits only for those covered services for eligible dental treatment that are determined by BCBSNM to be Dentally Necessary. No Benefits will be provided for procedures which are not Dentally Necessary.

The fact that a Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Dentally Necessary.

- ***Care by More Than One Dentist***

If the Covered Person changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if he had stayed with the same Dentist until his treatment was completed. There will be no duplication of Benefits.

- ***Alternate Benefits***

In all cases in which there is more than one service or Course of Treatment to treat a Covered Person's dental condition, the Benefit will be based on the less costly covered services or Course of Treatment, as determined by BCBSNM.

When two or more services are submitted, and the services are considered part of the same service, the Policy will pay the most comprehensive service as determined by the Policy.

When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), the Policy will pay for the service that represents the final treatment as determined by the Policy.

If the Covered Person and his Dentist decide on personalized restorations, or personalized complete or partial dentures and over dentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the least costly Course of Treatment or procedures for dental services, as determined by Us.

- ***Non-Compliance with Prescribed Care***

Any additional treatment and resulting liability which is caused by the lack of a Covered Person's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Covered Person.

Exclusions — What Is Not Covered

No Benefits will be provided under this Policy for:

- Services or supplies not specifically listed as a covered service, or when they are related to a non-covered service;
- Amounts which are in excess of the Allowable Amount, as determined by BCBSNM;
- Dental services treatment of congenital or developmental malformation or services performed for cosmetic purposes including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as included in the pediatric orthodontic Benefit;
- Dental services which are performed due to an Accidental Injury for Covered Persons age 19 and over. Any Injury caused by chewing or biting an object or substance placed in the Covered Person's mouth is not considered an accidental injury;
- Dental services which are performed due to injuries arising from Interscholastic Activities and Intercollegiate Sports;

- Services and supplies for any illness or injury suffered after the Covered Person's Effective Date as a result of war or any act of war, declared or undeclared, or while on active or reserve duty in the armed forces of any country or international authority;
- Services or supplies that do not meet accepted standards of dental practice;
- Experimental/Investigational services and supplies and all related services and supplies;
- Hospital and ancillary charges;
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants for Covered Person's age 19 and over;
- Services or supplies for which the Covered Person is not required to make payment or would have no legal obligation to pay if he did not have this or similar coverage;
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered;
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable;
- Services or supplies received for behavior management or consultation purposes;
- Any services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether or not Benefits are, or could upon proper Claim be, provided under the Workers' Compensation law;
- Any services or supplies for which Benefits are, or could upon proper Claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state Policy for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Covered Person for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- Charges for nutritional, tobacco or oral hygiene counseling;
- Charges for local, state, or territorial taxes on dental services or procedures;
- Charges for the administration of infection control procedures as required by local, state, or federal mandates;
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional appliances;
- Charges for telephone consultations, email, or other electronic consultations, missed appointments, completion of a Claim form or forwarding requested records or x-rays;
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers;
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques;
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers;
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to the Covered Person's Effective Date under this Policy; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after Your Effective Date;
- Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage;
- Case presentations or detailed and extensive treatment planning when billed for separately; or
- Charges for occlusion analysis or occlusal adjustments.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to this Benefit Program when a Student or a Student's covered Dependent has health care coverage under more than one Benefit Program.

The order of Benefit determination rules should be looked at first. Those rules determine whether the Benefits of this Benefit Program are determined before or after those of another Benefit Program. The Benefits of this Benefit Program:

1. Shall not be reduced when, under the order of Benefit determination rules, this Benefit Program determines its Benefits before another Benefit Program; but
2. May be reduced when, under the order of Benefits determination rules, another Benefit Program determines its Benefits first. This reduction is described below in *When this Benefit Program is a Secondary Program*.

In addition to the Definitions Section of this Policy, the following definitions apply to this section.

ALLOWABLE EXPENSE means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the Claim is made.

When a Benefit Program provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a Benefit paid.

BENEFIT PROGRAM means any of the following which provides Benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage; or
2. Coverage under a governmental Policy, or coverage required or provided by law. This does not include a state Policy under Medicaid (Title XIX of the Social Security Act).

Each Policy or other arrangement under (i) or (ii) above is a separate Benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate program.

CLAIM DETERMINATION PERIOD means the Benefit Period. However, it does not include any part of the Benefit Period during which a person has no coverage under this Benefit Program, or any part of the Benefit Period before the date this COB provision or a similar provision takes effect.

PRIMARY PROGRAM or SECONDARY PROGRAM means the order of payment responsibility as determined by the order of Benefit determination rules.

When this Benefit Program is the Primary Program, its Benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its Benefits are determined after those of the other Benefit Program and may be reduced because of the other program's Benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs and may be a Secondary Program as to a different program or programs.

ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program which has its Benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its Benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's Benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of Benefit payments using the first of the following rules which applies.

1. Child

If the Covered Person who receives care is a child, the longest covered parent's coverage pays first. The Benefits of the Benefit Program which covers the person as a Student (that is, other than a Dependent) are determined before those of the Benefit Program which covers the person as a Dependent, except that, if the person is also a Medicare beneficiary, Medicare is:

a. Secondary to the Benefit Program covering the person as a Dependent; and
b. Primary to the Benefit Program covering the person as other than a Dependent, for example a retired employee.

2. Dependent Child if Parents not Separated or Divorced

Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a Dependent of different persons, called "parents:"

a. The Benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but
b. If both parents have the same birthday, the Benefits of the program which covered the parents longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of Benefits, the rule in the other Benefit Program will determine the order of Benefits.

3. Dependent Child if Parents Separated or Divorced

If two or more Benefit Programs cover a person as a Dependent Child of divorced or separate parents, Benefits for the child are determined in this order:

a. First, the program of the parent with custody of the child;
b. Then, the program of the spouse of the parent with the custody of the child; and
c. Finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the program of that parent has actual knowledge of those terms, the Benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This paragraph does not apply with respect to any Claim Determination Period or Benefit Program year during which any Benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming Benefits to notify Blue Cross and Blue Shield and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Programs covering the child shall follow the order of Benefit determination rules outlined in 2 above.

5. Active or Inactive Employee

The Benefits of a Benefit Program which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Benefit Program which covered that person as a laid off or retired employee (or as that employee's Dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of Benefits, this rule is ignored.

6. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of Benefit determination:

a. First, the Benefits of a Benefit Program covering the person as an employee, member, or subscriber (or as that person's Dependent); and

b. Second, the Benefits under the continuation coverage.

7. Length of Coverage

If none of the above rules determines the order of Benefits, the Benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which covered that person for the shorter term.

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the Benefits of this Benefit Program may be reduced.

The Benefits of this Benefit Program will be reduced when the sum of:

1. The Benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The Benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a Claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of this Benefit Program will be reduced so that they and the Benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

When the Benefits of this Benefit Program are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of this Benefit Program.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or obtain the consent of, any person to do this. Each person claiming Benefits under this Benefit Program must give Blue Cross and Blue Shield any facts necessary to pay the Claim.

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, Blue Cross and Blue Shield may pay that amount to the organization which made that payment. That amount will then be treated as though it were a Benefit paid under this Benefit Program. Blue Cross and Blue Shield will not have to pay that amount again. The term *payment made* includes providing Benefits in the form of services, in which case *payment made* means reasonable cash value of the Benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by Blue Cross and Blue Shield is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The *amount of payments made* includes the reasonable cash value of any Benefits provided in the form of services.

TERMINATION OF INSURANCE

TERMINATION DATE OF INSURANCE

A Student's coverage will end on the earliest of the date:

1. This Policy terminates;
2. The Student is no longer eligible; or
3. The period ends for which premium is paid.

We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either We or the Policyholder may terminate this Policy on any Premium due date by giving 31day advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:

1. The Policy Termination Date shown in this Policy;
2. The Premium due date if Premiums are not paid when due; or
3. The Policy Effective Date of the renewal of this Policy if a Student decides to renew coverage under this Policy, and the Policy Effective Date of the renewal of this Policy becomes effective before this Policy terminates.

Termination takes effect at 12:00 AM, Standard Time at the address of the Policyholder on the date of termination.

REFUND OF PREMIUM

A refund of premium will be made only in the event:

1. Of a Covered Person's death; or
2. The Covered Person enters full-time active duty in any Armed Forces, and We receive proof of such active-duty service.

EXTENSION OF BENEFITS

If a Covered Person's coverage under this Policy terminates, Benefits will continue for any Covered Dental Services described in this Policy, as long as the Covered Service began prior to the date the coverage terminated and is completed within 30 days of a Covered Person's termination date. NOTE: If a Covered Person terminates coverage under this Policy, they will not be eligible to re-enroll for dental coverage until the next annual open enrollment period if applicable.

GENERAL PROVISIONS

Claim Forms

We will furnish to the Covered Person, his Physician or Dentist, upon receipt of a notice of Claim or prior thereto, such forms as We usually furnish for filing Proof of Loss. If such forms are not furnished within 15 days after receipt of such notice by Us, the Covered Person shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing such Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

Disclosure Authorization

The Covered Person shall be deemed to have authorized any attending Physician or Dentist to furnish Us all information and records or copies of records relating to the diagnosis, treatment, or care of any Covered Person included under this Policy; and such Covered Persons shall, by asserting Claim for Benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

Gender

Use herein of a personal pronoun in the masculine gender shall be deemed to include the feminine unless the context clearly indicates the contrary.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with the requirements herein and no such action shall be brought at all unless brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished by this Policy.

Member Data Sharing

The Covered Person may, under certain circumstances, as specified below, apply for, and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of New Mexico, a division of Health Care Service Corporation, or, if the Covered Person does not reside in the Blue Cross and Blue Shield of New Mexico service area, by the Host Blues whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of the Covered Person's health coverage sponsored by the Policyholder. As part of the overall Policy that Blue Cross and Blue Shield of New Mexico offers to, the Covered Person, if he does not reside in the Blue Cross and Blue Shield of New Mexico service area, Blue Cross and Blue Shield of New Mexico may facilitate his right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this We may (1) communicate directly with the Covered Person and/or (2) provide the Host Blues whose service area covers the geographic area in which the Covered Person resides, with his personal information and may also provide other general information relating to his coverage under the Policy the Policy holder has with Blue Cross and Blue Shield of New Mexico to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

Non-Agency

The Covered Person understands that this Policy constitutes a Policy solely between the Covered Person and BCBSNM. BCBSNM is a Division of Health Care Service Corporation (HCSC). HCSC is an Independent Licensee of the Blue Cross and Blue Shield Association (the Association). The license from the Association permits HCSC to use the Blue Cross and Blue Shield Service Marks in the State of New Mexico. BCBSNM is not contracting as the agent of the Association. The Covered Person also understands that he has not entered into this Policy based upon representations by a person other than BCBSNM. No person, entity, or organization other than BCBSNM shall be held accountable or liable to the Covered Person for any of its obligations whatsoever on the on the part of BCBSNM other than those obligations created under other provision of this Policy.

Notice of Claim

The Covered Person shall give or cause to be given written notice to BCBSNM within 30 days or as soon as reasonably possible after any Covered Person receives any of the services for which Benefits are provided herein.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the person of the Covered Person for whom Claim is made, when and so often as We may reasonably require during the pendency of a Claim hereunder and also in case of death, the right and opportunity to make an autopsy where it is not prohibited by law.

Entire Contract

This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. Any statements made shall be deemed representations and not warranties, and no statement made by the Covered Person in the application for this Policy shall be used in any contest or in defense of a Claim hereunder unless a copy of the application is attached to this Policy when issued.

Proof of Loss

Written Proof of Loss must be furnished to BCBSNM, no later than 90 days from the date that the services, supplies, or appliances are provided to the Covered Person. Failure to furnish such proof within the time required shall not invalidate or reduce any Claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Covered Person/Dentist Benefit Website

Information concerning covered Dental services is available to you and your Dentist on our website www.bcbsnm.com.

Refund of Benefit Payments

If BCBSNM pays Benefits for Eligible Dental Expenses incurred by you and it is found that the payment was more than it should have been, or was made in error, BCBSNM has the right to a refund from the Covered Person for whom such Benefits were paid, any other insurance company, any other organization, or from the Dentist who received the overpayment. If no refund is received, BCBSNM may deduct any refund due it from any future Benefit payment but, will not deduct the amount of an overpayment of a Claim from a payment or reimbursement for a dental care service provided by a Dentist who did not receive the overpayment.

Payment or Reimbursement of Dentist

The payment or reimbursement process for a non-Contracting Dentist will be the same as the payment or reimbursement for a Contracting Dentist.

The Policy provides one or more methods of payment or reimbursement that provide the Dentist the full contracted amount of the payment or reimbursement without the Dentist incurring a fee to access payment or reimbursement.

Reimbursement

1. If We pay or provide Benefits for the Covered Person under this Policy, We are subrogated to all rights of recovery which he has in Policy, tort or otherwise against any person, organization, or insurer for the amount of Benefits We have paid or provided. That means We may use the Covered Person's rights to recover money through judgment, settlement or otherwise from any person, organization, or insurer.
2. For the purposes of this provision, Subrogation means the substitution of one person or entity (BCBSNM) in the place of another (any Covered Person covered under this Policy) with reference to a lawful Claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or Claim, and its rights or remedies.
3. Right of Reimbursement: In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, We will have a right of reimbursement. If any Covered Person covered under this Policy recovers money from any person, organization or insurer for an injury or condition for which We paid Benefits under this Policy, all Covered Persons covered under this Policy agrees to reimburse Us from the recovered money for the amount of Benefits paid or provided by Us. That means any Covered Person covered under this Policy will pay Us the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization, or insurer, up to the amount of Benefits We paid or provided.
4. Right to Recovery by Subrogation or Reimbursement: Any Covered Person covered under this Policy agrees to promptly furnish to Us all information concerning any Covered Person's rights of recovery from any person, organization, or insurer and to fully assist and cooperate with Us in protecting and obtaining its reimbursement and subrogation rights. Any Covered Person covered under this Policy, or their attorney, will notify Us before settling any Claim or suit so as to enable Us to enforce Our rights by participating in the settlement of the Claim or suit. Any Covered Person covered under this Policy further agrees not to allow the reimbursement and subrogation rights BCBSNM to be limited or harmed by any acts or failure to act on the part of any Covered Person.

Rescission of Coverage

Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on the Covered Person's application may result in the cancellation of his coverage retroactive to the Effective Date, subject to 30 days' prior notification.

Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect;
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or
3. The cancellation or discontinuance of coverage is initiated by the covered person or the covered person's authorized representative and the employer or health care insurer did not, directly or indirectly, take action to influence the covered person's decision or otherwise retaliate against, interfere with, coerce, threaten or intimidate the covered person.

In the event of such cancellation, Blue Cross and Blue Shield of New Mexico (BCBSNM) may deduct from the premium refund any amounts made in Claim payments during this period and the Covered Person may be liable for any Claims payment amount greater than the total amount of premiums paid during the period for which cancellation is affected. At any time when Blue Cross and Blue Shield of New Mexico is entitled to rescind coverage

already in force or is otherwise permitted to make retroactive changes to this Policy, Blue Cross and Blue Shield of New Mexico may at its option make an offer to reform the Policy already in force or is otherwise permitted to make retroactive changes to this Policy and/or change the rating category/level.

In the event of reformation, this Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

Review of Claim Determinations

Claim Determinations

When We receive a properly submitted Claim, We have authority under this Policy to interpret and determine Benefits in accordance with the Policy provisions. We will receive and review Claims for Benefits and will accurately process Claims consistent with administrative practices and procedures established in writing.

The Covered Person has the right to seek and obtain a review by Us of any determination of a Claim, or any other determination made by Us of the Covered Person's Benefits under this Policy.

If a Claim Is Denied or Not Paid in Full

On occasion, We may deny all or part of the Covered Person's Claim. There are a number of reasons why this may happen. We suggest that the Covered Person first read the *Explanation of Benefits* summary prepared by Us; then review this Policy to see whether the Covered Person understands the reason for the determination. If the Covered Person has additional information that he believes could change the decision, send it to Us and request a review of the decision as described in Claim Appeal Procedures below.

If the Claim is denied in whole or in part, the Covered Person will receive a written notice from Us with the following information, if applicable:

1. The reasons for determination;
2. A reference to the Benefit provisions on which the determination is based, A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available;
4. An explanation of Our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
5. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claim for Benefits;
6. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
7. An explanation of the scientific or clinical judgment relied on in the determination as applied to the Covered Person's dental circumstances, if the denial was based on dental necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request; and
8. Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Post-Service Claim is notification in a form acceptable to Us that a service has been rendered or furnished to the Covered Person. This notification must include full details of the service received, including the Covered Person's name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the Claim Charge, and any other information which We may request in connection with services rendered to the Covered Person.

Post Service Claims

Type of Notice or Extension	Timing
If the Covered Person's Claim is incomplete, We must notify the Covered Person within:	30 days
If the Covered Person is notified that his Claim is incomplete, he must then provide completed Claim information to Us within:	45 days after receiving notice
BCBSNM must notify the Covered Person of any adverse Claim determination:	
if the initial Claim is complete, within:	30 days after receipt of the Claim
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days, if we extended the period, less any days already utilized by Us during our review*

* This period may be extended one time by Us for up to 15 days, provided that We both (1) determine that such an extension is necessary due to matters beyond the control of the Policy and (2) notify the Covered Person in writing, prior to the expiration of the initial 30 - day period of the circumstances requiring the extension of time and the date by which We expect to render a decision. If the period is extended because We require additional information from the Covered Person or his Provider, the period for Our making the determination is tolled from the date We send notice of extension to the Covered Person until the earlier of i) the date on which we receive the information; or ii) the date by which the information was to be submitted.

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An *Adverse Benefit Determination* means a denial, reduction, or a failure to provide or make payment (in whole or in part) for, a Benefit in response to a Claim, including any such denial, reduction, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigational or not dentally necessary or appropriate. If an ongoing Course of Treatment had been approved by Us and We reduce such treatment (other than by amendment) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

A *Final Internal Adverse Benefit Determination* means an Adverse Benefit Determination that has been upheld by Us at completion of Our internal review/appeal process.

How to Appeal an Adverse Benefit Determination

The Covered Person has the right to seek and obtain a full and fair review of any determination of a Claim, or any other determination made by Us in accordance with the Benefits and procedures detailed in this Policy.

An appeal of an Adverse Benefit Determination may be requested orally or in writing, by the Covered Person or a person authorized to act on his behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about the Covered Person except to his authorized representative. To obtain an Authorized Representative Form, the Covered Person or his representative may call Us at the number on the back of his Identification Card.

If the Covered Person believes We incorrectly denied all or part of his Benefits, he may have his Claim reviewed. We will review the decision in accordance with the following procedure.

1. Within 180 days after the Covered Person receives notice of a denial or partial denial, he may write to BCBSNM. We will need to know the reasons why the Covered Person does not agree with the denial or partial denial. Send the request to:

   Dental Claim Review Section
   Blue Cross and Blue Shield of Texas
   P. O. Box 660247
   Dallas, Texas 75266-0247

2. We will honor telephone requests for information.
3. In support of the Covered Person's Claim review, the Covered Person has the option of presenting evidence and testimony to Us. The Covered Person and his authorized representative may ask to review his file and any relevant documents and may submit written issues, comments, and additional dental information within 180 days after he receives notice of an Adverse Benefit Determination or at any time during the Claim review process.

We will provide the Covered Person or his authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of his Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to the Covered Person or his authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give the Covered Person a chance to respond. If the initial Benefit determination regarding the Claim is based in whole or in part on a dental judgment, the appeal determination will be made by a Dentist associated or contracted with Us and/or by external advisors, but who were not involved in making the initial denial of the Covered Person's Claim.

If the Covered Person has any questions about the Claims procedures or the review procedure, they can write to Our Administrative Office or call the toll-free Customer Service Helpline number shown in this Policy or on the Covered Person's Identification Card.

Timing of Appeal Determinations

We will render a determination on post-service appeals as soon as practical, but in no event later than 30 days after the appeal has been received by Us.

Expedited Appeals

An expedited appeal is available for emergency care, life-threatening conditions and if you are hospitalized. If your situation meets the definition of an expedited appeal, you may be entitled to an appeal on an expedited basis. An *expedited clinical appeal* is an appeal of a clinically urgent nature related to dental care services, including but not limited to, procedures or treatments ordered by a health care provider or the denial of emergency care.

Before authorization of Benefits for an ongoing Course of Treatment is terminated or reduced (concurrent review), BCBSNM will provide you with notice and an opportunity to appeal. For the ongoing Course of Treatment, coverage will continue during the appeal process.

Upon receipt of an expedited or concurrent appeal of an adverse determination, BCBSNM will notify the party filing the appeal, as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. BCBSNM will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSNM.

Notice of Appeal Determination

We will notify the party filing the appeal, the Covered Person, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to the Covered Person and his authorized representative will include:

1. A reason for the determination;
2. A reference to the Benefit Policy provisions on which the determination is based;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available;
4. An explanation of Our external review processes (and how to initiate an external review);
5. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claim for Benefits;
6. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
7. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
8. The Covered Person's right, if applicable, to request external review by and Independent Review Organization; and
9. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If BCBSNM denies the Covered Person's appeal, in whole or in part, or he do not receive a timely decision, he has the right to request an external review of his Claim by an independent third party, who will review the denial and issue a final decision. The Covered Person's external review rights are described in the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO) section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)

An *Adverse Determination* means a determination by Us or Our designated utilization review organization that a dental care service that is a Covered Service has been reviewed and, based upon the information provided, is determined to be experimental or investigational, or does not meet Our requirement for dental necessity or appropriateness and the requested service or payment for the service is therefore denied, or reduced.

This procedure (not part of the Complaint process) pertains only to appeals of Adverse Determinations.

Any party whose appeal of an Adverse Determination is denied by Us may seek review of the decision by an IRO. At the time the appeal is denied, We will provide the Covered Person, his designated representative, or Provider of record, information on how to appeal the denial, including the approved form, which the Covered Person, his designated representative, or his Provider of record must complete.

We will submit dental records, names of Providers and any documentation pertinent to the decision of the IRO. We will comply with the decision by the IRO, and We will pay for the independent review.

Upon request and free of charge, the Covered Person or his designee may have reasonable access to, and copies of, all documents, records, and other information relevant to the Claim or appeal, including:

1. Information relied upon to make the decision;
2. Information submitted, considered, or generated in the course of making the decision, whether or not it was relied upon to make the decision;
3. Descriptions of the administrative process and safeguards used to make the decision;
4. Records of any independent reviews conducted by Us;
5. Dental judgments, including whether a particular service is Experimental/Investigational or not dentally necessary or appropriate; and
6. Expert advice and consultation obtained by Us in connection with the denied Claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit the Covered Person from pursuing other appropriate remedies, including civil action, injunctive relief; a declaratory judgment or other relief available under law.

For an appeal or filing a complaint to the Consumers Assistance Bureau of the Office of Superintendent of Insurance, send your request to:

Office of Superintendent of Insurance
Consumers Assistance Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689
Tel: 1-833-415-0566

Website: https://www.osi.state.nm.us/pages/bureaus/consumer/resources/consumer-assistance

NOTICES

Notice of Annual Meeting

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Health Care Service Corporation. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois at 12:30 p.m. on the last Tuesday in October.

BlueCross BlueShield of New Mexico

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, religion, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
ह िंदी	ननिःशुल्क भाषा या सिंचार स ायता प्राप्त करने के निए, कृपया में 855-710-6984 पर कॉि करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Nin1: Doo bilag1ana bizaad dinits'1'g00, sh1 ata' hodooni n7n7zingo, t'11j77k'eh bee n1haz'1. 1-866-560-4042 j8' hod7ilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.