BlueCross BlueShield of Texas

Your Health Care Benefits Program

Dental Benefits

Current Dental Terminology© American Dental Association

City of New Braunfels

Account #369628

Group #369630 – Low Plan

3696300004.1023

CERTIFICATE OF COVERAGE

Blue Cross and Blue Shield of Texas
(herein called "BCBSTX" or "Carrier")

Hereby certifies that it has issued a **Group Dental Benefits** Contract (herein called the "Plan"). Subject to the provisions of the Plan, each Employee (Subscriber) to whom a Blue Cross and Blue Shield of Texas Identification Card is issued, together with their eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if the Employer makes timely payment of total premium due to the Carrier. Issuance of this Benefit Booklet by BCBSTX does not waive the eligibility and Effective Date provisions stated in the Plan.

James Springfield
President of Blue Cross and Blue Shield of Texas

The Dental Schedule of Coverage enclosed with this Benefit Booklet indicates benefit percentages, Deductibles, maximums, and other benefit and payment issues that apply to the Plan.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OFWORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation

To get information or file a complaint with your insurance company or HMO:

Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-800-521-2227
Email: BCBSTXComplaints@bcbstx.com
Mail: P. O. Box 660044, Dallas, TX 75266-0044

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-800-521-2227
Correo electrónico: BCBSTXComplaints@bcbstx.com
Dirección postal: P. O. Box 660044, Dallas, TX 75266-0044

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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Dental Schedule of Coverage

BlueCross BlueShield of Texas

The Deductibles, and Coinsurance Amount, and Annual Maximum below are subject to change as permitted by applicable law.

BlueCare Dental℠

Covered Services	*Contracting Dentist*	*Non-Contracting Dentist*
Diagnostic Evaluations *(Deductible waived)*	100%	100%
Preventive Services *(Deductible waived)*	100%	100%
Diagnostic Radiographs *(Deductible waived)*	100%	100%
Miscellaneous Preventive Services *(Deductible waived)*	100%	100%
Basic Restorative Services	80%	80%
Non-Surgical Extractions	80%	80%
Non-Surgical Periodontal Services	Not Covered	Not Covered
Adjunctive Services	Not Covered	Not Covered
Endodontic Services	Not Covered	Not Covered
Oral Surgery Services	Not Covered	Not Covered
Surgical Periodontal Services	Not Covered	Not Covered
Major Restorative Services	Not Covered	Not Covered
Prosthodontic Services	Not Covered	Not Covered
Miscellaneous Restorative and Prosthodontic Services	Not Covered	Not Covered
Implants	Not Covered	Not Covered
Orthodontia	Not Covered	Not Covered

Deductible	$50 individual / $150 family	$50 individual / $150 family
Annual Maximum	$1,000	$1,000

All benefits are based upon the Allowable Amount, which is the amount determined by BCBSTX 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 covered services provided by a Non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely thatthe Non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your dental care expenses for Dentally Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affects your dental care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee.

Benefits available under the Plan are explained in the **COVERED DENTAL SERVICES** section. The benefits available to you are indicated on the Dental Schedule of Coverage in this Benefit Booklet.

You are covered only for those benefit categories of services selected by your Employer and shown on your Dental Schedule of Coverage.

The benefit percentage to be applied to each category of service is shown on your Dental Schedule of Coverage.

Important Contact Information

Resource	Contact Information	Accessible Hours
Dental Customer Service Helpline	**1-800-521-2227**	**Monday – Friday 8:00 a.m. – 6:00 p.m. (hours are subject to change)**
Website	**www.bcbstx.com**	**24 hours a day 7 days a week**

Dental Customer Service Helpline

Dental Customer Service Representatives can:

- Give you information about Contracting Dentists;
- Distribute claim forms;
- Answer your questions on claims;
- Assist you in identifying a Contracting Dentist (but will not recommend specific Dentists);
- Provide information on the features of the Plan.

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Eligibility

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when the person becomes an Eligible Employee or a Dependent under the Plan. The Eligibility Date is:

- The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
- For a new Dependent of an Employee already having coverage under the Plan, the date the Employee acquired the Dependent (date of marriage, birth, Court Order, placement of a foster child, adoption, or suit for adoption).

Any person eligible under this Contract and covered by the Employer's previous dental care Plan on the date prior to the Contract Date, including any person who has continued group coverage under applicable federal or state law is eligible on the Contract Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Eligible Employee.

If you are a retired Employee and your Employer provides coverage for retired Employees, you may continueyour coverage under the Plan, but only if you were covered under the Employer's dental care plan as an Employee on the date of retirement.

Dependent Eligibility
If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse;
2. A child under the limiting age shown in the definition of Dependent;
3. A child of any age who is medically certified as Disabled and dependent on you;
4. A grandchild who is your Dependent for federal income tax purposes at the time application for coverage of the grandchild is made;
5. Any other child included as an eligible Dependent under the Contract. A detailed description of Dependent is in the DEFINITIONS section of this Benefit Booklet.

An Employee must be covered first in order to cover their eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date.

Applying For Coverage

You may apply for coverage for yourself and your eligible Dependents by submitting an *Enrollment Application/Change form* to your Employer or BCBSTX.

No eligibility rules or variations in premium will be imposed based on your health status, dental condition, claims experience, receipt of health care, dental history, genetic information, evidence of insurability,disability, or any other health status related factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated, reasonable dental management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Effective Dates of Coverage

The Effective Date is the date the coverage for a Participant actually begins. The Effective Date is shown on your Identification Card.

It is important that your application for coverage under the Plan is received timely by the Carrier. If you apply for coverage and pay any required premium for yourself and your eligible Dependents and if you:

1. Are eligible on the Contract Date and the application is received by the Carrier prior to or within 31 days following such date, your coverage will become effective on the Contract Date;

2. Enroll for coverage for yourself or your Dependents during an Open Enrollment Period, coverage shall become effective on the Contract Anniversary Date, provided your application is received timely by the Carrier.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Late Applications
If you apply for coverage for yourself or for yourself and any Dependents and your application is not received within 31 days from your Eligibility Date, you will not be eligible to apply for coverage until the next Open Enrollment Period unless qualified for a Special Enrollment Period.

Special Enrollment Periods
Special enrollment periods have been designated during which you may apply for or request a change in coverage for yourself and/or your eligible Dependents. You must apply for coverage within 31 days from the date of a triggering event in order to qualify for the changes described in this ***Special Enrollment Period*** subsection, including the following:

1. **Birth, Adoption, or Party to a Suit for Adoption, Placement of a Foster Child or Court-Ordered Dependent Coverage**
   The Effective Date of coverage will be the date of birth, adoption, or party to a suit for adoption or date of placement of a foster child. The Effective Date of coverage for Court-Ordered Dependent coverage will be determined by BCBSTX in accordance with the provisions of the Court Order.
2. **Marriage**
   The Effective Date of coverage will be no later than the first day of the month following your marriage date.

BCBSTX **must** receive notification from you on an Enrollment Application/Change Form during the 31-day period after the event. If you wait until after this 31-day period, the coverage will become effective on the Contract Anniversary Date following your Employer's next Open Enrollment Period.

Enrollment Application/Change Form

Use this form to...

- Notify the Plan and BCBSTX of a change to your name;
- Add Dependents (other than a newborn child where notification only is required);
- Drop Dependents;
- Cancel all or a portion of your coverage;
- Notify BCBSTX of all changes in address for yourself and your Dependents.

You may obtain this form from your Employer, by calling the BCBSTX Dental Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSTX website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

Changes in Your Family

You should promptly notify the Carrier, as appropriate, in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage or placement of a foster child, adoption, or a child being involved in a suit for which an adoption of a child is sought, or your Employer receives a Court Order to provide health or dental coverage for a Participant's child or your spouse, you must submit an Enrollment Application/Change Form and the coverage of the Dependent will become effective as described in this **WHO GETS BENEFITS** section.
- When you divorce , your child reaches the Dependent child age limit or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions.

Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, premium refunds will not be made for any period before the date of notification. If benefits are paid prior to notification to BCBSTX, refunds will be requested.

Please refer to the **Continuation of Group Coverage - Federal** subsection in this Benefit Booklet for additional information.

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Dental Expenses you incur under the Plan. The portion of the charges by your Dentist that exceeds the Allowable Amount of BCBSTX will be your responsibility to pay to your Dentist, except when you have used a Contracting Dentist.You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan and any applicable Deductibles and Coinsurance Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by BCBSTX.

Course of Treatment

Your Dentist may decide on a planned series of dental procedures which a dental exam shows you need. In cases where there is more than one professionally acceptable covered procedure or Course of Treatment, benefits will be covered for the least costly covered procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the person is responsible for expenses thatexceed the amount covered for the least costly service.

Current Dental Terminology (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled"Current Dental Terminology and Procedure Codes (CDT)" is used when classifying dental services.

The Allowable Amount for an Eligible Dental Expense will be based on the most inclusive procedure codes.

Freedom of Choice

Each time you need dental care, you can choose to:

See a Contracting Dentist	***See a Non-Contracting Dentist***
• Your out-of-pocket cost will generally be the least amount because Contracting Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses; • You are not required to file claim forms; • You are not balance billed for costs exceeding the BCBSTX Allowable Amount for Contracting Dentists.	• Your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept the maximum Allowable Amount as payment in full for Eligible Dental Expenses; • You are required to file claim forms; • You may be balanced billed by Non-Contracting Dentists for costs exceeding the BCBSTX Allowable Amount.

In each event as described above, you will be responsible for the following:

- Any applicable Deductibles;
- Coinsurance Amounts;
- Services that are limited or not covered under the Plan.

If your Dentist is not a Contracting Dentist, you may be responsible for filing your claim, as described in the **CLAIM FILING AND APPEALS PROCEDURES** portion of this Benefit Booklet. You may also be responsible for payment in full at the time services are rendered.

To find a Contracting Dentist, you may look up a dental Provider in the Dental Directory, log on to the Blue Cross and Blue Shield of Texas website at www.bcbstx.com and search for a Dentist using Provider Finder, or call the Dental Customer Service Helpline number located in this Benefit Booklet or on your Identification Card.

How Benefits are Calculated

Your benefits are based on a percentage of the Dentist's Allowable Amount. To determine your benefits, subtract the Deductible (if applicable and not previously satisfied) from your Eligible Dental Expenses, then, multiply the difference by the Coinsurance Amount percentage applicable to the benefit category of services shown on your Dental Schedule of Coverage. The resulting total is the amount of benefits available.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, except when you have used a Contracting Dentist, any Deductible, and your Coinsurance Amount will be your responsibility to pay to your Dentist.

When using a Non-Contracting Dentist, your out–of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept the maximum Allowable Amount as payment in full for Eligible Dental Expenses. You may be balanced billed by Non-Contracting Dentists for costs exceeding the BCBSTX Allowable Amount.

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's dental care plan with BCBSTX. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number***. This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Carrier.
- ***Your group number***. This is the number assigned to identify your Employer's dental care Plan with BCBSTX.
- ***Important telephone numbers***.

Always remember to carry your Identification Card with you and present it to your Dentist when receiving dental care services or supplies. Do not let anyone who is not named in your coverage use your Identification Card to receive benefits.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Carrier will provide a new Identification Card.

Predetermination of Benefits

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'scharge should be filed with and predetermined by BCBSTX prior to the commencement of treatment.

BCBSTX may request copies of existing radiographic images, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. BCBSTX will review the reports and materials, taking into consideration alternative Courses of Treatment. BCBSTX will notify you and the Dentist of the benefits to be provided under the Plan. Predetermination gives you and your Dentist the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

CLAIM FILING AND APPEALS PROCEDURES

Filing of Claims Required

Notice of Claim
You must give written notice to BCBSTX within 20 days, or as soon as reasonably possible, after any Participant receives services for which benefits are provided under the Plan. Failure to give notice within this time will not invalidate or reduce any claim if you show that it was not reasonably possible to give notice and that notice was given as soon as it was reasonably possible.

Claim Forms
When BCBSTX receives notice of claim, it will furnish to you, or to your Employer for delivery to you, or to the Dentist, the dental claim forms that are usually furnished by it for filing Proof of Loss. If the forms are not furnished within 15 days after receipt of notice by BCBSTX, you have complied with the requirements of the Plan for Proof of Loss by submitting, within the time fixed under the Plan for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

BCBSTX must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Provider-filed claims
Contracting Dentists will usually submit your claims directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Dentists in filing your claims, you should carry your Identification Card with you.

Participant-filed claims
If your Dentist does not submit your claims, you will need to submit them to BCBSTX using a Participant- filed claim form provided by BCBSTX. You can obtain a Dental Claim Form from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the Dentist printed on their letterhead and show the:

- services performed;
- dates of service;
- charges; and
- name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR DENTAL CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Blue Cross and Blue Shield of Texas
Dental Claims Division
P. O. Box 660247
Dallas, Texas 75266-0247

Who Receives Payment

Benefit payments will be made directly to the Dentists when they submit your claim to BCBSTX. Written agreements between BCBSTX and some Dentists may require payment directly to them. Any benefits payable to you, if unpaid at your death, will be paid to your beneficiary or to your estate, if no beneficiary is named.

Except as provided in the **Assignment and Payment of Benefits** section**,** rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator
Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a Court Order as managing or possessory conservator of the child; and
- BCBSTX has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the conservator must submit to BCBSTX, with the claim form, proof of payment of the expenses and a certified copy of the Court Order naming that person the managing or possessory conservator.

BCBSTX may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Dentist, or deduction by BCBSTX from benefit payments of amounts owed to BCBSTX, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits (EOB) for Dental Care* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted within 90 days after the date you receive the services or supplies. Claims not submitted and received by BCBSTX within 90 days do not invalidate or reduce a claim if:

- it was not reasonably possible to provide the claim within that time;
- the written claim is provided as soon as reasonably possible; and
- unless the claimant does not have the legal capacity to provide it, the claim is provided not later than twelve (12) months after that date the claim is otherwise required.

Receipt of Claims by BCBSTX

A claim will be considered received by BCBSTX for processing upon actual delivery to the BCBSTX Administrative Office in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or BCBSTX may contact either you or the Dentist for the additional information.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority under the Plan to interpret and determine benefits in accordance with the Plan provisions. BCBSTX will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If BCBSTX requires further information in order to process the claim, we will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim or anyother determination made by BCBSTX of your benefits under the Plan.

If a Claim Is Denied or Not Paid in Full

If the claim is denied in whole or in part, you will receive a written notice from BCBSTX with the following information, if applicable:

- The reasons for the determination;
- A reference to the benefit Plan 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;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental 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;
- An explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- 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;
- 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;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's dental circumstances, if the denial was based on Dental Necessity, Experimental/Investigational treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim.There are two types of claims as defined below.

- **Pre-Service Claim** is any request for benefits or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining dental care.
- **Post-Service Claim** is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your 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 BCBSTX may request in connection with services rendered to you.

Pre-Service Claims

Type of Notice	Timing
BCBSTX must notify you of the claim determination (whether adverse or not):	
if We have received all information necessary to complete thereview, within:	**2 working days of or our receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar daysof the request, if the claim is denied.**

Post-Service Claims

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	**45 days** after receiving notice
BCBSTX must notify you of any adverse claim determination:	
if the initial claim is complete, within:	**30 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

*This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you 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 BCBSTX expects to render a decision.

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, including any such denial, reduction, or failure to provide in response to a claim, or Pre-Service Claim, 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/Investigational or not Dentally Necessary or appropriate. If an ongoing courseof treatment had been approved by BCBSTX and BCBSTX reduces such treatment (other than by amendment or termination of the Employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your Plan. An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a dental care Provider may appeal on their own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your Identification Card. If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to BCBSTX to request a claim review. If the appeal is made orally, BCBSTX will acknowledge the request in writing and include a one-page appeal form sent to the appealing party. BCBSTX will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:

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

- BCBSTX will honor telephone requests for information; however, such inquiries will not constitute a request for review. Any complaint concerning dissatisfaction or disagreement with an Adverse Benefit Determination constitutes an appeal.

- In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional dental information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

BCBSTX will provide you or your authorized representative with any new or additional evidence or rationaleand any other information and documents used in the review of your 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 you or your authorizedrepresentative sufficiently in advance of the date a final decision on appeal is made in order to give you 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 BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim.

If you have any questions about the claims procedures or the review procedure, write to BCBSTX's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Timing of Appeal Determinations
BCBSTX will render a determination on an appeal of an Adverse Benefit Determination as soon as possible but not later than 30 days after the appeal has been received by BCBSTX.

If You Need Assistance
If you have any questions about the claims procedures or the review procedure, write or call BCBSTX Headquarters at 1-800-521-2227. The BCBSTX Customer Service Helpline is accessible from 8:00 A.M. to 8:00 P.M., Monday through Friday.

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

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your Identification Card. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272).

Notice of Appeal Determination
BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any dental care Provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you or your authorized representative will include:

- The reasons for the determination;
- A reference to the benefit Plan provisions on which the determination is based;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental 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;
- An explanation of BCBSTX's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
- 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;

- 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;
- 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; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

If BCBSTX denies your appeal, in whole or in part, or you do not receive a timely decision, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your 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 BCBSTX or its 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/Investigational, or does not meet BCBSTX's requirements for Dental Necessity, or appropriateness and the requested service or payment for the service is therefore denied or reduced.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by BCBSTX at the completion of BCBSTX's internal review/appeal process.

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 BCBSTX may seek review of the decisionby an IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative or Provider of record, information on how to appeal the denial, including the approved form, which you, your designated representative, or your Provider of record must complete.

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

Upon request and free of charge, you or your designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by BCBSTX;
- dental judgments, including whether a particular service is Experimental/Investigational or not Dentally Necessary or appropriate; and
- expert advice and consultation obtained by BCBSTX in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief; a declaratory judgment or other relief available under law. If your Plan is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring civil action under 502(a) of ERISA.

For more information about the IRO process, call Texas Department of Insurance (TDI) on the IROinformation line at (866) 554-4926, or in Austin call (512) 676-6000.

Actions Against BCBSTX

No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of 60 days after Proof of Loss has been filed in accordance with the requirement of the Plan and no such action will be brought at all unless brought within three years from the expiration of the time within which Proof of Loss is required by the Plan.

ELIGIBLE DENTAL EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Dental Expenses

The Plan provides coverage for services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each category of service is shown on the Dental Schedule of Coverage.

For benefits available for Eligible Dental Expenses, please refer to the Dental Schedule of Coverage in this Benefit Booklet. Your benefits are calculated on a Plan Year basis unless otherwise stated. At the end of a Plan Year, a new benefit period starts for each Participant.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Dental Schedule of Coverage. The Deductibles are explained as follows:

Plan Year Deductible: The individual Deductible amount shown under "Deductible" on your Dental Schedule of Coverage must be satisfied by each Participant under your coverage each Plan Year. This Deductible, unless otherwise indicated, will be applied to all categories of services, before benefits are available under the Plan.

The following are exceptions to the Deductibles described above.

If you have several covered Dependents, all charges used to apply toward a "per individual" amount will be applied toward the "per family" amount shown on your Dental Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Plan Year. No Participant will contribute more than the individual Deductible amount to the family Deductible amount.

Maximum Dental Benefits

Annual Maximum Benefit
The total amount of benefits available to any one Participant for all combined categories of services for a Plan Year shall not exceed the "Annual Maximum Benefit" amount shown on your Dental Schedule of Coverage.

This Annual Maximum Benefit amount includes:

1. All payments made by BCBSTX under the benefit provisions of the Plan; and

2. Any benefits provided to a Participant under a dental care plan held by the Employer with BCBSTX immediately prior to the Participant's Effective Date of coverage under this Plan.

Maximum Lifetime Benefits
The total amount of benefits available to any one Participant under the Plan shall not exceed the "Maximum Lifetime Benefits"amount as shown on your Dental Schedule of Coverage.

Changes in Benefits

Benefits for Eligible Dental Expenses incurred during a Course of Treatment that begins before the change will be those benefits in effect on the day the Course of Treatment was started.

COVERED DENTAL SERVICES

The Plan will provide benefits for the following Eligible Dental Expenses, subject to the limitations and exclusions described in this Benefit Booklet, only if the category of service is shown on your Dental Schedule of Coverage. The benefit percentage applicable to each category of service is also shown on your Dental Schedule of Coverage.

You are covered only for those categories of services shown on the Dental Schedule of Coverage issued with this Benefit Booklet.

Diagnostic Evaluations

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

- Periodic oral evaluations for established patients.
- Problem focused exam, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children under three years of age, including counseling with primary caregiver.

Benefits for periodic, extensive, and detailed oral evaluations are limited to a combined maximum of two exam(s) every Plan Year. Comprehensive oral evaluations are limited to one every 36 months when performed by the same Dentist.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations when Eligible Dental Expenses are rendered on the same date as any other oral evaluation by the same Dentist.

Preventive Services

Preventive services are performed to prevent dental disease. Eligible Dental Expenses include:

- Prophylaxis – Professional cleaning and polishing of the teeth. Benefits are limited to two cleaning(s) every Plan Year.
- Scaling in presence of generalized moderate or severe gingival inflammation. Benefits are limited to one per Plan Year.
- Topical application of fluoride – Benefits for topical application of fluoride are available for Participants under age 16 and are limited to two applications every Plan Year.

Combination of prophylaxes, scaling in presence of generalized moderate or severe gingival inflammation, and periodontal maintenance treatments are limited to a combination of two every Plan Year.

Diagnostic Radiographs

Diagnostic radiographic images are taken to diagnose a dental disease and include their interpretations. Eligible Dental Expenses include:

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 60 months.
- Bitewing films – Benefits are limited to four horizontal images or eight vertical radiographic images once every Plan Year.

- Bitewing films are not separately eligible when taken on the same date as full-mouth films.
- Periapical films, as necessary for diagnosis – Benefits are limited to six every Plan Year.

Miscellaneous Preventive Services

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

- Sealants – Benefits for sealants are limited to one per permanent (first and second) molar per lifetime and are available for Participants under age 14.
- Space Maintainers – Benefits for space maintainers are limited to a lifetime maximum of one appliance per arch for Participants up to age 14.

Basic Restorative Services

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

- Amalgam restorations – Benefits are limited to one restorative service per tooth every 12 months.
- Resin-based composite restorations – Benefits are limited to one restorative service per tooth every 12 months.

Non-Surgical Extractions

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

- Removal of retained coronal remnants – deciduous tooth.
- Removal of erupted tooth or exposed root.

Enhanced Benefits

Participants diagnosed and receiving active medical care for the following medical conditions as determined by the Plan such as – pregnancy, diabetes, cardiovascular disease and prediabetics – may receive one of the following enhanced dental benefits after standard benefits are completed:

- One additional cleaning; or
- Periodontal scaling and root planing (up to 2 quadrants); or
- Periodontal maintenance.

Enhanced benefits apply to the annual benefit maximum.

Teledentistry Dental Service

Your Dentist may provide Teledentistry Dental Services, which may also include Teledentistry Dental Services which are delegated and supervised by your Dentist, on the same basis and to the same extent that this Rider provides coverage for the service or procedure in an in-person setting. Deductibles, Coinsurance Amounts or Annual Maximum benefits for Eligible Dental Expenses will be the same as required for an in-person consultation. Predetermination of Benefits requirements will apply.

DENTAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to all services described in this dental Contract. Dental coverageis limited to services provided by a Dentist, a dental auxiliary, (as defined in the **DEFINITIONS** section) licensed to perform services covered under this dental Contract.

Important Information About Your Dental Benefits

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

  Please note that in order to provide you with dental care benefits at a reasonable cost, this Contract provides benefits only for those Eligible Dental Expenses that are determined by the Plan to be Medically Necessary.

  No benefits will be provided for procedures which are not Medically Necessary.

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

- ***Care By More Than One Dentist***

  If you change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

- ***Alternate Benefits***

  In all cases in which there is more than one covered procedure or Course of Treatment possible to treat a covered dental condition, the benefit will be based upon the least costly covered procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the Participant is responsible for expenses that exceed the amount covered for the least costly service.

  If you and your Dentist decide on:

  - personalized restorations; or
  - personalized complete or partial dentures and overdentures; or
  - to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, asdetermined by the Plan.

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

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

Exclusions and Limitations

No benefits will be provided under this Contract for:

1. Services or supplies not specifically listed as an Eligible Dental Expense, or when they are related to anon-covered service.
2. Amounts which are in excess of the Allowable Amount, as determined by the Plan.
3. Dental services for treatment of congenital or developmental malformation, or services performed forcosmetic purposes, including but not limited to:
   - bleaching teeth; and
   - grafts to improve aesthetics.
4. Dental services, radiographic images, or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this BenefitBooklet or if resulting from an Accidental Injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Benefit Booklet.

5. Dental services which are performed due to an Accidental Injury. Injury caused by chewing or bitingan object or substance placed in your mouth is not considered an Accidental Injury.
6. Services and supplies for any illness or injury suffered after the Participant'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.
7. Services or supplies that are not Dentally Necessary or do not meet accepted standards of dental practice.
8. Services or supplies which are Experimental/Investigational in nature or not fully approved by a Councilof the American Dental Association.
9. Hospital and ancillary charges.
10. Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants, unless your Dental Schedule of Coverage shows that the dental Plan chosen provides coverage for implant services.
11. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
12. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance Amounts are offered.
13. 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.
14. Services or supplies received for behavior management or consultation purposes.
15. 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.
16. 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 plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
17. Charges for nutritional, tobacco or oral hygiene counseling.
18. Charges for local, state or territorial taxes on dental services or procedures.
19. Charges for the administration of infection control procedures as required by OSHA, local, state or federal mandates.
20. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
21. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or radiographic images.
22. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
23. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
24. 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.
25. Chemical treatments or localized delivery of chemotherapeutic agents.
26. Charges for local anesthesia, nitrous oxide analgesia, therapeutic, parenteral drugs, or other drugs or medicaments and/or their application.
27. Replacement of an extracted or missing third molar and/or congenitally missing teeth.

28. Any services, treatments or supplies included as Eligible Dental Expenses under other hospital, medical and/or surgical coverage.
29. Case presentations or detailed and extensive treatment planning when billed for separately.
30. Charges for occlusion analysis or occlusal adjustments.
31. Endodontic retreatment provided within 12 months of the initial endodontic therapy by the same Dentist.
32. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparations, fitting of preformed dowel and post, or post removal.
33. Endodontic therapy if you discontinue endodontic treatment.
34. Surgical services related to congenital or developmental malformation.
35. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological) or for bony impactions covered by another benefit plan.
36. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
37. Anatomical crown exposure.
38. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prosthesis); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
39. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
40. Charges for replacement of stolen, lost, or defective dentures, crowns or other appliances.
41. Splinting of teeth including double retainers for removable partial dentures and fixed bridgework.
42. Any procedure, service, or appliance for the purpose of altering or maintenance of vertical dimension of occlusion.
43. Appliances or restoration of teeth due to lost vertical dimension of occlusion, erosion, attrition, abrasion, or abfraction. Benefits are not provided for the appliances or restorations to restore occlusion or incisal edges due to bruxism or harmful habits.
44. Any procedure, service, or appliance provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall be considered cosmetic.
45. Precision or semiprecision attachments.
46. Gold foil restorations.
47. Tests and oral pathology procedures, or for re-evaluations.
48. The replacement of a lost or defective crown.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes.

Allowable Amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Dentists contracting with BCBSTX*** – The Allowable Amount is based on the terms of the Dentist's contract and BCBSTX's methodology in effect on the date of service.

- ***For Dentists not contracting with BCBSTX –*** The Allowable Amount is based on the amount BCBSTX would have paid for the same covered service, supply, or procedure if performed or providedby a Contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and BCBSTX:

- ***For services performed in Texas –*** The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.

- ***For services performed outside of Texas –*** 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.

- ***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.

- ***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 Dental Expenses also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

Coinsurance Amount means the dollar amount (expressed as a percentage) of Eligible Dental Expensesincurred by a Participant during a Plan Year that exceeds benefits provided under the Plan.

Contract Anniversary Date means the corresponding date in each year after the Contract Date for as longas the Contract is in force.

Contract Date means the date on which coverage for the Employer's Contract with BCBSTX commences.

Contracting Dentist means a Dentist who has entered into a written agreement with BCBSTX, who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC) and/or who hasentered 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 planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

Court Order means a direction issued by a court or a judge requiring a Participant to do or not do something.A Court Order may also include an administrative order.

Deductible means the dollar amount of Eligible Dental Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dentally Necessary or Dental Necessity means those services, supplies, or appliances covered under the Plan which are:

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

Dentist means a person, when acting within the scope of their 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.

Dependent means your spouse or any child who has been determined to be eligible for coverage, if applicable, and who is covered under the Plan.

Child means a natural child, a stepchild, an eligible foster child, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status or any combination of those factors. A grandchild must be dependent on you for federal income tax purposes at the time of application of coverage for the grandchild to be covered under the Plan. Coverage for the grandchild may not be terminated solely because the grandchild is no longer a Dependent for federal income tax purposes. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one- half of their support as defined by the Internal Revenue Code of the United States, is also considered a Dependent *child* under the Plan.

For purposes of this Plan, the term *Dependent will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA)* or continued under the appropriate provisions of the applicableTexas law, if any.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligible Dental Expenses means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant has an obligation to pay.

Eligible Employee means an Employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a Large Employer.

The term does not include an Employee who:

1. Works on a part-time, temporary, seasonal, or substitute basis, or
2. Is covered under (a) another Health Benefit Plan, or (b) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974, or
3. Elects not to be covered under the Small Employer's Health Benefit Plan and is covered under (a) theMedicaid program; (b) another federal program, including the TRICARE program or Medicare program; or (c) a benefit plan established in another country.

Employee means an individual employed by a Large Employer.

For purposes of this Plan, the term *Employee* may also include those individuals who are no longer an Employee of the Large Employer, but who are Participants covered under the Consolidated Omnibus BudgetReconciliation Act (COBRA) or continued under the appropriate provisions of the applicable Texas law, if any.

In addition, the term Employee will include a retired Employee who meets all the criteria established by theEmployer in order to be eligible for continued coverage under this Plan after retirement. Such criteria has been established by the Employer on a basis that precludes individual selection.

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 supplyhas 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 communityin the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or Provider in which they were performed; and
- the Dentist has had the appropriate training and experience to provide the treatment or procedure.

The medical/dental staff of BCBSTX 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.

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

Identification Card means the card issued to the Employee by the Carrier indicating pertinent information applicable to the Participant's dental coverage.

Large Employer (Employer) means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least 51 Employees on business days during the preceding Plan Year and who employs at least two Employees on the first day of the Plan Year.

Medically Necessary or Medical Necessity means a specific procedure or supply provided to you that is reasonably required, in the judgment of the Plan, for the treatment or management of your specific dental symptom, injury, or condition and is the most efficient and economical procedure that can safely be providedto you. The fact that a Provider may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and wherethe procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by the Plan. These consultants review the claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

Non-Contracting Dentist means a Dentist who is not a Contracting Dentist as defined herein.

Open Enrollment Period means the 31-day period, selected by the Employer, preceding the next Contract Anniversary Date during which Employees and Dependents may enroll for coverage.

Participant means an Employee, a retired Employee, or Dependent whose coverage has become effective under this Contract.

Plan Year means the period commencing on the Contract Date/Contract Anniversary and ending on the daybefore the next Contract Anniversary Date. Please contact your Employer for Plan Year information.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Provider means a physician, Dentist or any other person, company, or institution furnishing to a Participant, when acting within their scope of their license, an item of service or supply listed as an Eligible Dental Expenses.

Teledentistry Dental Service means a health care service delivered by a Dentist, or a health professional acting under the delegation and supervision of a Dentist, acting within the scope of the Dentist's or health professional's license or certification to a patient at a different physical location than the Dentist or health professional using telecommunications or information technology.

Waiting Period means the number of days of continuous employment required by the Employer that mustpass before an individual, who is a potential enrollee under the Plan, is eligible to be covered for benefits.

Agent

The Employer is not the agent of the Carrier.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and BCBSTX.

Assignment and Payment of Benefits

If a written assignment of benefits is made by a Participant to a Dentist and the written assignment is delivered to the BCBSTX with the claim for benefits, the BCBSTX will make any payment directly to the Dentist. Payment to the Dentist discharges BCBSTX's responsibility to Participant for any benefits available under the Plan.

Blue Cross and Blue Shield of Texas as an Independent Plan

The Employer, on behalf of itself and its Employees, hereby expresses acknowledges its understanding that the Plan constitutes a contract solely between the Employer and BCBSTX, that BCBSTX is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting BCBSTX to use the Blue Cross and Blue Shield ServiceMark in the state of Texas, and that BCBSTX is not contracting as the agent of the Association. The Employer further acknowledges and agrees that it has not entered into the Plan based upon representations by any person other than BCBSTX and that no person, entity, or organization other than BCBSTX shall be held accountable or liable tothe Employer for any of BCBSTX's obligations to the Employer created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of BCBSTX other than those obligations created under other provisions of the Plan.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any Dentist, insurance carrier, or other entityto furnish BCBSTX all information and records or copies of records relating to the diagnosis, treatment, or care ofany individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Participant/Dentist Relationship

The choice of a Dentist should be made solely by you or your Dependents. BCBSTX does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. BCBSTX is not liable forany act or omission by any Dentist. BCBSTX does not have any responsibility for a Dentist's failure or refusal to provide services or supplies to you or your Dependents. 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.

Participant/Dentist Benefit Website

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

Refund Of Benefit Payments

If BCBSTX pays benefits for Eligible Dental Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSTX has the right to a refund from the Participant 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, BCBSTX may deduct any refund due from any future benefit payment.

State Government Programs

1. If a Participant under the Plan is also a Medicaid recipient, any benefits for services, supplies, or appliances under the Plan will not be excluded solely because benefits are paid or payable for such services, supplies, or appliances under Medicaid. Any benefits available under the Plan will be payableto the Texas Health and Human Services Commission to the extent required by the *Texas Insurance Code*; and
2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Health and Human Services Commission where:

    a. The Texas Health and Human Services Commission is paying benefits pursuant to provisions in the *Human Resources Code*; and
    b. The parent who is covered under the Plan has possession or access to the child pursuant to a CourtOrder, or is not entitled to access or possession of the child and is required by the court to pay child support; and
    c. The Carrier receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Health and Human Services Commission.

Reimbursement

When BCBSTX pays benefits under the Contract and it is determined that a negligent third party is liable for the same expenses, BCBSTX has the right to receive reimbursement from the monies payable from the negligent third party equal to the amount BCBSTX has paid for such expenses. The Participant hereby agrees to reimburse BCBSTX from any monies recovered from a negligent third party as a result of a judgment against, settlement with,or otherwise paid by the third party. The Participant agrees to take action against the third party, furnish all information, and provide assistance to BCBSTX regarding the action taken, and execute and deliver all documentsand information necessary for BCBSTX to enforce our rights of reimbursement.

BCBSTX's process to recover by subrogation or reimbursement will be conducted in accordance with Texas Civil Practice and Remedies Code Title 6, Chapter 140.

Coordination of Benefits

Coordination of Benefits ("COB") applies when you have health/dental care coverage through more than one Health Care Plan. The order of benefit determination rules govern the order in which each Health Care Plan will pay a claim for benefits. The Health Care Plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses.The Health Care Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total Allowable Expense.

For purposes of this section only, the following words and phrases have the following meanings:

Allowable Expense means a health/dental care expense, including Deductibles, Coinsurance Amount, and copayments, that is covered at least in part by any Health Care Plan covering the person for whom claim is made. When a Health Care Plan (including this Health Care Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. In addition, any expense that a health/dental care Provider or physician by law or in accord with a contractual agreement is prohibited from charging a Participant is not an Allowable Expense.

Health Care Plan means any of the following (including this Plan) that provide benefits or services for, or by reason of, medical/dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

Group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred Provider benefit plans and exclusive Provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in force policies; uninsured arrangements of group orgroup-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

Health Care Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non- medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental planthat, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable Deductible.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

BCBSTX has the right to coordinate benefits between this Health Care Plan and any other Health Care Plancovering you.

The rules establishing the order of benefit determination between this Plan and any other Health Care Plancovering you on whose behalf a claim is made are as follows:

1. The benefits of a Health Care Plan that does not have a coordination of benefits provision shall in all casesbe determined before the benefits of this Plan.

2. If according to the rules set forth below in this section the benefits of another Health Care Plan that containsa provision coordinating its benefits with this Health Care Plan would be determined before the benefits ofthis Health Care Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Health Care Plan.

The order of benefits for your claim relating to **paragraphs 1 and 2** above, is determined using the first of the following rules that applies:

1. Nondependent or Dependent. The Health Care Plan that covers the person other than as a Dependent, for example as an Employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Health Care Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicarebeneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the personas a dependent and primary to the Health Care Plan covering the person as other than a dependent, then theorder of benefits between the two plans is reversed so that the Health Care Plan covering the person as an Employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Health Care Planis the primary plan. An example includes a retired Employee.

2. Dependent Child Covered Under More Than One Health Care Plan. Unless there is a court order stating otherwise, Health Care Plans covering a Dependent child must determine the order of benefits using the following rules that apply.

   a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
      (i) The Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primaryplan; or
      (ii) If both parents have the same birthday, the Health Care Plan that has covered the parent thelongest is the primary plan.

   b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
      (i) if a Court Order states that one of the parents is responsible for the Dependent child's health/dental care expenses or health/dental care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.
      (ii) if a Court Order states that both parents are responsible for the Dependent child's health/dental care expenses or health/dental care coverage, the provisions of 2.a. must determine the order of benefits.
      (iii) if a Court Order states that the parents have joint custody without specifying that one parent has responsibility for the health/dental care expenses or health/dental care coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.
      (iv) if there is no Court Order allocating responsibility for the Dependent child's health/dental care expenses or health/dental care coverage, the order of benefits for the child are as follows:
         (I) the Health Care Plan covering the custodial parent;
         (II) the Health Care Plan covering the spouse of the custodial parent;
         (III) the Health Care Plan covering the noncustodial parent; then
         (IV) the Health Care Plan covering the spouse of the noncustodial parent.

   c. For a Dependent child covered under more than one Health Care Plan of individuals who are not the parents of the child, the provisions of 2.a or 2.b. must determine the order of benefits as if those individuals were the parents of the child.

   d. For a Dependent child who has coverage under either or both parents' Health Care Plans and has their own coverage as a Dependent under a spouse's Health Care Plan, paragraph 5. below applies.

   e. In the event the Dependent child's coverage under the spouse's Health Care Plan began on the same date as the Dependent child's coverage under either or both parents' Health Care Plans, the order of benefits must be determined by applying the birthday rule in 2.a. to the Dependent child's parent(s) and the Dependent's spouse.

3. Active, Retired, or Laid-off Employee. The Health Care Plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary plan. The Health Care Plan that covers that same person as a retired or laid-off Employee is the secondary plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid- off Employee. If the Health Care Plan that covers the same person as a retired or laid-off Employee or as a Dependent of a retired or laid-off Employee does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Health Care Plan, the Health Care Plan covering the person as an Employee, member, subscriber, or retiree or covering the person as a Dependent of

an Employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Health Care Plan does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Health Care Plan that has covered the person as an Employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the Health Care Plan that has covered the person the shorter period is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Health Care Plans meeting the definition of Health Care Plan. In addition, this Health Care Plan will not pay more than it would have paid had it been the primary plan.

When this Health Care Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Health Care Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health/dental care coverage and apply that calculated amount to any Allowable Expense under its Health Care Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Health Care Plans for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary plan must credit to its plan Deductible (if applicable) any amounts it would have credited to its Deductible in the absence of other health/dentalcare coverage.

If a Participant is enrolled in two or more closed panel Health Care Plans and if, for any reason, including the provision of service by a nonpanel Provider, benefits are not payable by one closed panel Health Care Plan, COB must not apply between that Health Care Plan and other closed panel Health Care Plans.

When benefits are available to you as primary benefits under Medicare, those benefits will be determined first and benefits under this Plan may be reduced accordingly. You must complete and submit consents, releases, assignments and other documents requested by BCBSTX to obtain or assure reimbursement by Medicare. If you fail to cooperateor enroll in Part B, Part D and, if eligible, Part A of the Medicare program, you will be liable for the amount of money We would have received if you had cooperated or enrolled.

If inpatient care began when you were enrolled in a previous Health Care Plan, after you make your Coinsurance Amount under this Plan, BCBSTX will pay the difference between benefits under this Plan and benefits under the previous contract or insurance policy for services on or after the Effective Date of this Plan.

Benefits provided directly through a specified Provider of an Employer shall in all cases be provided before the benefits of this Plan.

For purposes of this provision, BCBSTX may, subject to applicable confidentiality requirements set forth in this Plan, release to or obtain from any insurance company or other organization necessary information under this provision. If you claim benefits under this Plan, you must furnish all information deemed necessary by Us to implement this provision.

None of the above rules as to coordination of benefits shall delay your health/dental services covered under this Plan.

Whenever payments have been made by BCBSTX with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Part, We shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as We shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

You must complete and submit consents, releases, assignments and other documents requested by Us to obtain or assure reimbursement under workers' compensation. If you fail to cooperate, you will be liable for the amount of money BCBSTX would have received if you had cooperated. Benefits under workers' compensation will be determined first and benefits under this Plan may be reduced accordingly.

Reimbursement – Acts of Third Parties

BCBSTX will provide services to you due to the act or omission of another person. However, if you are entitled to a recovery from any third party with respect to those services, you shall agree in writing:

1. To reimburse Us to the extent of the Allowable Amount that would have been charged to you for health/dental care services if you were not covered under this Plan. Such reimbursement must be made immediately upon collection of damages for hospital or medical expenses by you whether by action at law,settlement or otherwise.

2. To assign to BCBSTX a right of recovery from a third party for hospital and medical expenses paid by Us on your behalf and to provide Us with any reasonable help necessary for Us to pursue a recovery. In addition, BCBSTX will be entitled to recover attorneys' fees and court costs related to its subrogation efforts only if BCBSTX aids in the collection of damages from a third party.

Termination of Coverage

BCBSTX is not required to give you prior notice of termination of coverage. BCBSTX will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage
Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your portion of the group premium is not received timely by BCBSTX; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Carrier may refuse to renew the coverage of an Eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on you will not terminate upon reaching the limiting age shown in the definition of Dependent if the child continues to be both:

1. *Disabled*; and
2. Dependent upon you for support and maintenance as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Employer to the Carrier within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Carrier may require periodic certificationof the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group
The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Continuation of Group Coverage - Federal

The following "events" **may** provide you or your Dependents an option to continue group coverage:

1. Your death, divorce, retirement, or eligibility for Medicare;
2. The termination of your status as an Employee (except for reason of gross misconduct) or retirement;
3. If you are covered as a retired Employee, the filing of a Title XI bankruptcy proceeding by the group; or
4. Your child's marriage or reaching the "Dependent child age limit".

If such an event occurs, you or your Dependents should immediately contact your Employer to determine your rights.

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within a prescribed time period. You or your Dependents may be required to pay your own premium rates. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Dental Schedule of Coverage). Hence, changes in the group premium ratesor benefits will change the premium rates or benefits for any continued coverage.

The continued coverage automatically terminates after a period of time (never to exceed three years) but will be terminated earlier upon the occurrence of certain circumstances. These circumstances include, but are not limited to, nonpayment of premium, entitlement to or coverage under Medicare and coverage under any other group health coverage which does not contain a limitation with respect to a preexisting condition of the Participant (even if such coverage is less valuable than your current health plan). Your Employer will give you more detailed information upon your request.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

1. The Employer will furnish summary plan descriptions, annual reports, and summary annual reportsto you and other Plan Participants and to the government as required by ERISA and its regulations.
2. BCBSTX will furnish the Employer with this Benefit Booklet as a description of benefits available under this Plan.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Plan. Claim filing and claim review procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Plan.
5. This Benefit Booklet is a Certificate of Coverage and not a summary plan description.
6. The Employer has given BCBSTX the authority to interpret the Plan's provisions and to make eligibility and benefit determinations.

AMENDMENTS

AMENDMENT

This Amendment is to advise you of a change to your Policy with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

This Amendment is issued to and made a part of your Policy (the Plan) to which it is attached.

The section entitled **Have a complaint or need help?** Is hereby amended as follows:

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

El Departmento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

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

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Policy to which this amendment is attached will remain in full force and effect.

By: President, Blue Cross and Blue Shield of Texas

BlueCross BlueShield of Texas

1001 E Lookout Dr Richardson, TX, 75082-4144

LARGE GROUP NON-ACA DENTAL PLAN ENDORSEMENT FOR RESIDENTS OF THE STATE OF NEW MEXICO

If you are a resident of the state of New Mexico, this Endorsement is hereby issued and attached to your Large Group Non-ACA Dental Plan Benefit Booklet. The benefit changes indicated in this Endorsement apply to coverage provided under your Large Group Non-ACA Dental Plan Benefit Booklet. "Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Guide", or other evidence of coverage document issued to you under the Group Dental Policy or Contract.

EFFECTIVE DATE OF ENDORSEMENT: This Endorsement is effective on January 1, 2022, or upon your Group Dental Plan's renewal date, whichever is later.

CHANGES TO YOUR GROUP DENTAL PLAN: The following changes are hereby made to your Group Dental Plan Benefit Booklet.

1. **INTRODUCTION SECTION:** The Introduction section of the Benefit Booklet is hereby amended to include the following text:

   "For New Mexico Residents Only, this Plan is offered by the Group Policyholder or Group Contractholder as one of the benefits of your employment or membership, as applicable. The benefits provided are intended to assist you with many of your dental care expenses for Dentally Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity, sexual orientation or religion. There are provisions throughout your Benefit Booklet that affect your dental care coverage. It is important that you read your Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan."

2. **"Other Resources to Help You":** The following text is hereby added:

   For New Mexico Residents Only: Other Resources to Help You: For questions about your rights or for assistance, and filing a complaint, you can also contact the Consumer Assistance Bureau at the New Mexico 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
   Telephone: 1-855-4ASK-OSI (1-855-427-5674)

3. **CLAIM FILING AND APPEALS PROCEDURES:** The following text is hereby added to the Claim Filing and Appeals Procedures section or the Claim Appeals Procedure provision provided in the Benefit Booklet:

"For New Mexico Residents Only – Other Resources to Help You: For questions about your rights or for assistance; and filing a complaint, you can also contact the Consumer Assistance Bureau at the New Mexico Office of Superintendent of Insurance."

4. **COVERED DENTAL SERVICES:** The covered dental services section is hereby amended to add the following text:

"For New Mexico Residents Only, the following covered dental services are hereby included under the covered dental services section of your Benefit Booklet:

a. **DIAGNOSTIC RADIOGRAPHS (x-rays):** Bitewing films – Benefits are limited to four horizontal images or eight vertical radiographic images once every Calendar Year unless greater frequency is deemed Medical Necessary.

b. **MISCELLANEOUS PREVENTIVE SERVICES:** Sealants – Benefits for sealants are limited to one per permanent (first and second) molar every five years as Medically Necessary. Coverage may be excluded when an occlusal restoration has been completed on the tooth.

c. **BASIC RESTORATIVE SERVICES:** The following Basic Restorative Services will be provided as follows:

- Amalgam restorations – Benefits shall cover necessary fillings for cavities.
- Resin-based composite restorations – Benefits are limited to one restorative service per tooth every 12 months.

d. **PREVENTIVE SERVICES:** The following Preventive Services will be provided as follows:

- Preventive Services are performed to prevent dental disease. Eligible Dental Expenses include:
  - Prophylaxis – Professional cleaning and polishing of the teeth. Benefits are limited to two cleaning(s) every Calendar Year or Plan Year.
  - Scaling in presence of generalized moderate or severe gingival inflammation. Benefits are limited to one per Calendar Year or Plan Year. If this benefit is utilized, only one prophylaxis is allowed in a Calendar Year or Plan Year in combination.
  - Topical application of fluoride – Benefits for topical application of fluoride are available for Participants under age 16 or older if Medically Necessary and are limited to two applications every Calendar Year or Plan Year.

Combination of prophylaxes and periodontal maintenance treatments are limited to a combination of two every Calendar Year or Plan Year.

e. **TMJ/CMJ Services:** This Plan 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.

5. **DEFINITIONS:** The following text is hereby added to the Definitions section:

"**For New Mexico Residents Only,** the following definition is added to the Definitions section:

Dental Service includes a professional service rendered by a person duly licensed under the laws of the state of New Mexico to practice dentistry or dental therapy, or dental hygienists or dental hygienists certified in collaborative practice and any service constituting the practice of dentistry under New Mexico law."

6. **TERMINATION OF COVERAGE:** The following text is hereby added to the Termination of Coverage section:

"For New Mexico Residents only, Blue Cross Blue Shield of Texas (BCBSTX) will notify you of the discontinuance of the Group Policy or Group Contract within ten working days of notice to the Group Policy holder or Group Contract holder in whatever manner BCBSTX customarily uses to provide such notice."

Please Note: Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as amended by this Endorsement, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this Endorsement is issued and attached will remain in full force and effect.

Blue Cross and Blue Shield of Texas

James G. Springfield
President, Blue Cross Blue Shield of Texas

NOTICES

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits(under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A,
- Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or any one in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits(under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

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