



**BlueCross BlueShield
of Texas**



Your Health Care Benefits Program

Dental Benefits

Current Dental Terminology[®] American Dental
Association

Plan ID d601

CERTIFICATE OF COVERAGE

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

Hereby certifies that it has issued a Group **Comprehensive Dental Benefits** Contract (herein called the "Plan") for the Employees of the Employer named on this Benefit Booklet. Subject to the provisions of the Plan, each Employee (Subscriber) to whom a Blue Cross and Blue Shield Identification Card is issued, together with his 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.



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 Dental Schedule of Coverage specifies benefits for:

Comprehensive Dental Benefits

**THE INSURANCE CONTRACT UNDER WHICH THIS BENEFIT BOOKLET IS ISSUED IS
NOT A CONTRACT OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD
CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A
SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

IMPORTANT NOTICE

To obtain information or make a complaint:

- You may call Blue Cross and Blue Shield of Texas's toll-free telephone number for information or to make a complaint at:

1-800-521-2227

- You may also write to Blue Cross and Blue Shield of Texas at:

P. O. Box 660044
Dallas, Texas 75266-0044

- You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

- You may write the Texas Department of Insurance at:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 475-1771
Web: <http://www.tdi.texas.gov>
E-mail: ConsumerProtection@tdi.texas.gov

- **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.
- **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

- Usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas's para informacion o para someter una queja al:

1-800-521-2227

- Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al:

P. O. Box 660044
Dallas, Texas 75266-0044

- Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

- Puede escribir al Departamento de Seguros de Texas:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 475-1771
Web: <http://www.tdi.texas.gov>
E-mail: ConsumerProtection@tdi.texas.gov

- **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).
- **UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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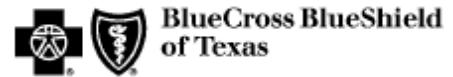
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Dental Schedule of Coverage



d601 Dental Plan

Plan Overall Payment Provisions	Dental Benefits
Dependent Child Age Limit	<i>Age 26</i>
Deductibles <ul style="list-style-type: none"> <i>Calendar Year Deductible</i> <i>Three month Deductible carryover applies</i> 	<i>\$50 – per individual</i> <i>\$150 – per family</i>
Predetermination Amount	\$300
Maximum Calendar Year Benefits per Participant for Categories I, II, III, IV, V, VI, VII, VIII, IX	\$1,000
I. Diagnostic & Preventive Care Services <i>Calendar Year Deductible does not apply</i>	<i>100% of Allowable Amount</i>
II. Miscellaneous Services	<i>80% of Allowable Amount after Calendar Year Deductible</i>
III. Restorative Services	<i>80% of Allowable Amount after Calendar Year Deductible</i>
IV. General Services	<i>50% of Allowable Amount after Calendar Year Deductible</i>
V. Endodontic Services	<i>50% of Allowable Amount after Calendar Year Deductible</i>
VI. Periodontal Services	<i>50% of Allowable Amount after Calendar Year Deductible</i>
VII. Oral Surgery Services	<i>50% of Allowable Amount after Calendar Year Deductible</i>
VIII. Crowns, Inlays/Onlays Services	<i>50% of Allowable Amount after Calendar Year Deductible</i>
IX. Prosthodontic Services	<i>50% of Allowable Amount after Calendar Year Deductible</i>

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. There are provisions throughout this Benefit Booklet that affect 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. In the event of any conflict between any components of this Plan, the Benefit Program Application provided to your Employer by BCBSTX prevails.

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. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

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.
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 Plans

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.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

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

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. 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, adoption, or suit for adoption).

Employee Eligibility

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 Employee.

Dependent Eligibility

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

1. Your spouse or your Domestic Partner (Note: Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available for your Group);
2. A child under the limiting age shown in the Dental Schedule of Coverage;
3. A child of any age who is medically certified as Disabled and dependent on the parent;
4. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child 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 his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment application for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Contract is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

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 or 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 for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Contract Anniversary; and

WHO GETS BENEFITS

3. Become eligible after the Contract Date and if the application is received by the Carrier within the first 31 days following your Eligibility Date, the coverage will become effective as provided in the Contract (see your Employer for this Effective Date information).

Dependent Coverage

Coverage of your natural child born after your Effective Date, a child of a Participant for whom the Employer has received a court order requiring health coverage be provided, your adopted child, or a child involved in a suit for adoption will automatically be in effect from the:

1. Date of birth for the newborn child,
2. Date the court order is received by the Employer, or
3. Date of the adoption or suit for adoption,

through the 31st day following such date. For coverage to continue, BCBSTX **must** receive notification from you on an enrollment form for Dependent addition during the 31-day period to add the child as a Dependent. If you wait until after this 31-day period to add the child, the Dependent child's coverage will become effective on the Contract Anniversary following your Employer's next Open Enrollment Period.

Court Ordered Coverage for a Spouse: If a court has ordered you, the Employee, to provide coverage for a spouse, written enrollment must be received within 31 days after issuance of the court order. Coverage will become effective on the first day of the month following the date the application for coverage is received and the required premium is paid within the 31-day period. If application is not made within the initial 31 days, your spouse's coverage will become effective on the Contract Anniversary following your Employer's next Open Enrollment Period.

Other Dependents: Written application must be received within 31 days of the date that a spouse or your Domestic Partner or child first qualifies as a Dependent. (Note: Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available for your Group.) If the written application is received within 31 days, coverage will become effective on the date the spouse or child first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Contract Anniversary following your Employer's next Open Enrollment Period.

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.

Dental Enrollment Opportunities

During your Employer's Open Enrollment Period, you may apply for coverage for yourself or for yourself and any eligible Dependents. Coverage will become effective on the Contract Anniversary date, provided your application is received timely by the Carrier.

If you are a Participant under the Plan, you may enroll your Dependent children who are less than 5 years of age at any time. In this event, coverage will become effective on the first day of the Contract Month following receipt of the application by the Carrier.

Refer to the **Enrollment Application/Change Form** subsection for additional information.

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

WHO GETS BENEFITS

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 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 establishment of a domestic partnership, 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 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 ***Dependent Coverage***.
- When you divorce or terminate a domestic partnership, your child marries or reaches the age indicated on the Dental Schedule of Coverage as "Dependent child age limit" or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

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.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Dental Expenses you incur under the Plan. In determining the Allowable Amount, BCBSTX will consider such factors as your Dentist's usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances, and whether your Dentist is a Contracting Dentist. 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.

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 Course of Treatment, benefits will be covered for the most economical procedures.

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

<i>Each time you need dental care, you can choose to:</i>		
<i>See a Contracting Dentist</i>		<i>See a Non-Contracting Dentist</i>
BlueCare Dentist	DentaBlue Dentist	
<ul style="list-style-type: none">Your out-of-pocket maximum will generally be the least amount because BlueCare Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental ExpensesYou are not required to file claim formsYou are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists	<ul style="list-style-type: none">Your out-of-pocket maximum may be greater because DentaBlueSM Dentists have contracted to accept a higher Allowable Amount as payment in full for Eligible Dental ExpensesYou are not required to file claim formsYou are not balance billed for costs exceeding the BCBSTX Allowable Amount for DentaBlue Dentists	<ul style="list-style-type: none">Your out-of-pocket maximum may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses.You are required to file claim formsYou are balance billed for costs exceeding the BCBSTX Allowable Amount

HOW THE PLAN WORKS

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 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 DentaBlue or BlueCare 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 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 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.

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 Health Benefit 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.

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

Your Dental Schedule of Coverage indicates a "Predetermination Amount." If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of this predetermined amount, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with and predetermined by BCBSTX prior to the commencement of treatment.

HOW THE PLAN WORKS

BCBSTX may request copies of existing x-rays, 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

CLAIM FILING 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

Dentists that contract with BCBSTX (such as DentaBlueSM and BlueCare 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 Subscriber-filed claim form provided by BCBSTX. Your Employer should have a supply of dental claim forms or you can obtain copies 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 showing the services performed, dates of service, charges, and name of the Participant involved.

**VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER 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 bill 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.

CLAIM FILING AND APPEALS PROCEDURES

Except as provided in the section **Assignment and Payment of Benefits**, 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 managing or possessory 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 of the date you receive the services or supplies. Claims not submitted and received by BCBSTX within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

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 and discretion 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 any other determination made by BCBSTX of your benefits under the Plan.

If a Claim Is Denied or Not Paid in Full

On occasion, BCBSTX may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *EOB for Dental Care* summary prepared by BCBSTX; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to BCBSTX and request a review of the decision. Include your full name, group and subscriber numbers with the request.

CLAIM FILING AND APPEALS PROCEDURES

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 denial;
- A reference to the health care plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by BCBSTX if you do not agree with the denial.

Right to Review Claim Determinations

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 a denial or partial denial, write to BCBSTX's Administrative Office. BCBSTX will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

- You may also designate a representative to act for you in the review procedure. 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.
- BCBSTX will honor telephone requests for information, however, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical/dental information within 180 days after you receive notice of a denial or partial denial. BCBSTX will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims procedures or the review procedure, write to BCBSTX's Administrative Office or call the toll-free Dental Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.
- If you have a claim for benefits which is denied or ignored, in whole or in part, and your Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

Interpretation of Employer's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. Your Employer has given BCBSTX full and complete authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits.

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 Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar 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:

Calendar 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 Calendar 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:

Your Schedule of Coverage indicates “Three-Month Deductible Carryover applies.” This means that any Eligible Dental Expenses incurred during the last three months of a Calendar Year and applied toward satisfaction of the “Deductible” for that Calendar Year may be applied toward satisfaction of that Deductible for the following Calendar Year.

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 Calendar Year. No Participant will contribute more than the individual Deductible amount to the family Deductible amount.

Maximum Dental Benefits

Maximum Calendar Year Benefits

The total amount of benefits available to any one Participant for all combined categories of service for a Calendar Year shall not exceed the “Maximum Calendar Year Benefits” amount shown on your Dental Schedule of Coverage.

This Maximum Calendar Year Benefits 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.

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 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 booklet.

I. Diagnostic and Preventive Care Services

Benefits are available for Eligible Dental Expenses incurred for services that are used to prevent dental disease or to determine the nature or cause of a dental disease.

- a. Routine oral evaluations (limited to two per Calendar Year)
- b. X-rays (dental radiographs):
 - 1. full mouth or panorex x-ray limited to once every 36 months
 - 2. bitewing limited to 4 horizontal films or 8 vertical films twice per Calendar Year
 - 3. other x-rays as necessary for diagnosis (except in connection with a program of orthodontics).
- c. Professional cleaning, scaling, and polishing teeth (prophylaxis) limited to two per Calendar Year
- d. Fluoride treatment (topical application), limited to two per Calendar Year for Participants up to age 19

II. Miscellaneous Services

Benefits are available for Eligible Dental Expenses incurred for:

- a. Sealants, limited to one per unrestored permanent molar for Participants up to age 17
- b. Space maintainers for Participants up to age 19
- c. Pulp vitality test
- d. Palliative (emergency) treatment to relieve dental pain except when performed in conjunction with definitive dental treatment
- e. Lab and tests

III. Restorative Services

Benefits are available for Eligible Dental Expenses incurred for the process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g. cavities). Tooth preparation, all adhesive (including amalgam bonding agents), liners and bases are included as part of the restoration. Eligible Dental Expenses include:

- a. Amalgam restorations limited to once per surface per tooth in any Calendar Year
- b. Pin retention, per tooth, in conjunction with the restoration
- c. Composite restorations limited to once per surface per tooth per Calendar Year
- d. Simple tooth extractions

COVERED DENTAL SERVICES

IV. General Services

Benefits are available for Eligible Dental Expenses incurred for:

- a. Intravenous sedation
- b. General anesthesia
- c. House/extended care facility call
- d. Injection of antibiotic drugs
- e. Stainless steel crowns limited to one per tooth in a 60-month period and not to be used as a temporary crown

V. Endodontic Services

Benefits are available for Eligible Dental Expenses incurred for services for prevention, diagnosis, and treatment of diseases and injuries affecting tooth and dental pulp. Eligible Dental Expenses include the following:

- a. Root canal therapy including treatment plan, clinical procedures, pre- and post-operative radiographs, and follow-up care
- b. Direct pulp cap
- c. Apicoectomy/periradicular services
- d. Apexification/recalcification
- e. Retrograde filling
- f. Root amputation/hemisection
- g. Therapeutic pulpotomy
- h. Gross pupal debridement

VI. Periodontal Services

Benefits are available for Eligible Dental Expenses incurred for services that treat diseases of the tissues that surround and support the teeth (e.g. gums and supporting bone); limited to two exams per Calendar Year. Periodontal maintenance includes the following:

- a. Periodontal scaling and root planing, limited to one time per quadrant per Calendar Year
- b. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, limited to one time per Calendar Year
- c. Gingivectomy or gingivoplasty, limited to one time per quadrant per Calendar Year
- d. Gingival flap procedure (includes root planning), limited to one time per quadrant per Calendar Year
- e. Osseous surgery, including flap entry with closure, limited to one time per quadrant per Calendar Year
- f. Osseous grafts, limited to one time per site per Calendar Year
- g. Soft tissue grafts (includes donor site)

VII. Oral Surgery Services

Benefits are available for Eligible Dental Expenses incurred for services for the treatment of certain dental conditions by operative or cutting procedures, such as:

COVERED DENTAL SERVICES

- a. Alveoloplasty
- b. Surgical tooth extractions
- c. Vestibuloplasty
- d. Other Dentally Necessary surgical procedures

VIII. *Crowns, Inlays/Onlays Services*

Benefits are available for Eligible Dental Expenses incurred for services resulting from extensive disease or fracture, limited to one per tooth in a 60-month period, such as:

- a. Prefabricated post and cores
- b. Cast post and cores
- c. Repair of crowns, inlays/onlays
- d. Recementation of crowns, inlays/onlays

Services include the replacement of a lost or defective crown, whether placement was under this Plan or under any prior dental coverage, even if the original crown was stainless steel.

IX. *Prosthodontic Services*

Benefits are available for Eligible Dental Expenses incurred for services that restore and maintain the oral function, comfort and health of a patient by replacing missing teeth and surrounding tissue with artificial substitutes including bridges, partial dentures and complete dentures.

- a. Initial installation of bridgework (including inlays and crowns as abutments) limited to once per tooth in any 60-month period, whether placement was under this Plan or under any prior dental coverage;
 - 1. Bridge repair
 - 2. Recementing a bridge
 - 3. Post and core buildup
- b. Initial installation of removable complete, immediate or partial dentures (including any adjustments, relines or rebases during the 6-month period following installation), limited to once in any 60-month period, whether placement was under this Plan or under any prior dental coverage.

Eligible Expenses are available for the replacement of complete or partial dentures, but only if the appliance is 60-months old or older and cannot be made serviceable.

- c. Adjustments limited to 3 times per appliance in any Calendar Year.
- d. Repairs
- e. Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures), limited to a lifetime maximum of once per tooth.
- f. Denture rebase and reline procedures, limited to one in any 36-month period.

DENTAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Dentally Necessary.
2. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.
3. 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.
4. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future 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.
5. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage.
6. Any services or supplies provided for injuries sustained:
 - a. As a result of war, declared or undeclared, or any act of war; or
 - b. While on active or reserve duty in the armed forces of any country or international authority.
7. Any charges:
 - a. Resulting from the failure to keep a scheduled visit with a Dentist; or
 - b. Completion of any insurance forms; or
 - c. Telephone consultations; or
 - d. Records or x-rays necessary for BCBSTX to make a benefit determination.
8. Any benefits in excess of any specified dollar, Calendar Year, or lifetime maximums.
9. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving dental services, supplies, or drugs.
10. Any services primarily for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve esthetics, except for:
 - a. Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan
11. Any services or supplies for which the American Dental Association has not approved a specific procedure code.
12. Any services provided or received for:
 - a. Behavior management or
 - b. Consultation purposes.
13. Any replacement of dentures, crowns, inlays/onlays, removable for fixed prostheses, and dental restorations due to theft, misplacement, or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within 60 months after receiving such dentures, prostheses, or restorations.
14. Any full-mouth x-ray provided within 36 months from the date of the Participant's last full-mouth x-ray.

DENTAL LIMITATIONS AND EXCLUSIONS

15. Any benefits for an alternate Course of Treatment which exceeds the most economical procedures.
16. Any personalized complete or partial dentures, overdentures, and their related procedures, or other specialized techniques not normally taught in regular dental school classes.
17. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
18. Any administration or cost of drugs and/or gases used for sedation or as an analgesia including nitrous oxide. Any administration of any local anesthesia and necessary infection control as required by OSHA or state and federal mandates when billed separately.
19. Any services or supplies which are otherwise provided under inpatient hospital expense or medical-surgical expense coverage under the medical benefits of the Health Benefit Plan.
20. Any treatment by other than a Dentist, except that x-rays, scaling, cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the Dentist.
21. Any prosthetic devices (including bridges), crowns, inlays, onlays, and the fitting thereof, or duplication of such devices, which began before the Effective Date of the Participant's coverage under this Plan with BCBSTX.
22. Any replacement or repair of an orthodontic appliance.
23. Any treatment provided through a medical department, clinic, or similar facility furnished or maintained by the Participant's Employer.
24. Any services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the American Dental Association.
25. Any duplicate prosthetic device, other duplicate appliances or duplicate dental restoration.
26. Any dietary instructions or plaque control programs.
27. Splinting of teeth, including double abutments for prosthetic abutments.
28. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
29. Any Accidental Injuries including tooth transplantation or tooth reimplantation.
30. Any pin retention **not** performed on the same date of service and in conjunction with a covered amalgam or composite restoration.
31. Any palliative (emergency) treatment performed in conjunction with definitive dental treatment.
32. Any indirect pulp capping.
33. Any 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.
34. Any bacteriological studies for determination of pathologic agents and soft tissue allograft.
35. Any biological materials, cytology sample collection, and histopathological examinations.
36. Any canal preparation and fitting of prefabricated dowel and post if billed separately.
37. Any caries susceptibility tests.
38. Any chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy.
39. Any crowns to restore occlusion or incisal edges due to bruxism or harmful habits.

DENTAL LIMITATIONS AND EXCLUSIONS

40. Any desensitizing medicaments and/or their application.
41. Any discing, enamel microabrasion, post removal, and provisional splinting.
42. Any excision/removal of non-odontogenic cysts/ tumors/lesions.
43. Any guided tissue regeneration.
44. Any occlusal adjustment if not performed with active periodontal therapy or following active periodontal therapy and occlusal analysis.
45. Any oral hygiene instruction and/or tobacco use counseling.
46. Any office visit charges for observation and/or second professional opinions.
47. Any periodontal maintenance procedures not following active periodontal therapy.
48. Any prescription drugs.
49. Any osseous grafts if the following procedures have been performed on the affected tooth or site on the same date of service:
 - a. apicoectomy;
 - b. extraction;
 - c. hemisection;
 - d. retrograde filling;
 - e. root amputation; or
 - f. root canal therapy.
50. Any polishing of restorations.
51. Any pulpotomy on permanent teeth.
52. Any recontouring and restoration overhang removal.
53. Any replacement of:
 - a. a prosthodontic appliance (fixed or removable) more often than once in any 60-month period (whether under this plan or under any prior dental coverage); or
 - b. restorations due to mercury or other possible allergies; or
 - c. serviceable prosthodontics and upgrading of serviceable dentistry.
54. Any surgical repositioning of teeth and surgical revision procedure.
55. Any services or supplies not specifically defined as Eligible Dental Expenses in this Plan or not shown as a covered category of service on your Dental Schedule of Coverage.
56. Any temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.).
57. Any appliances, materials, restorations, or special equipment used to increase vertical dimension, correct or restore the occlusion.
58. Any services to correct Temporomandibular Joint (TMJ) dysfunction or pain syndromes.
59. Any services or supplies, including splinting, grafting and preparation associated with implants.
60. Any diagnostic photographs.
61. Any services or supplies for removal of complete/partial bony extractions, unless "Oral Surgery Services" is shown on your Dental Schedule of Coverage.

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 certain 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. The methodology used may include relative value, global pricing, or a combination of methodologies.
- ***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 provided by a Contracting Dentist.

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

- ***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.

BlueCare Dentist means a Dentist who has entered into an agreement with BCBSTX to participate as a BlueCare Dental provider.

Calendar Year means the period commencing each January 1 and ending on the next succeeding December 31, inclusive.

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

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

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

Contract Month means each succeeding monthly period, beginning on the Contract Date.

DEFINITIONS

Contracting Dentist means a Dentist who has entered into a written agreement with BCBSTX to participate as a DentaBlue dental provider or a BlueCare dental provider.

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.

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

DentaBlue Dentist means a Dentist who has entered into a written agreement with BCBSTX to participate as a DentaBlue dental provider.

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 his Dentist; and
4. The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

Dependent means your spouse or any unmarried *child* covered under the Plan who is:

1. Under the limiting age shown on the Dental Schedule of Coverage; or
2. A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance.

Child means:

- a. Your natural child; or
- b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or
- c. Your stepchild; or
- d. A child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child of your child is made; or
- e. A child for whom a Participant has received a court order requiring that Participant to have financial responsibility for providing health insurance; or
- f. A child not listed above:
 - (1) whose primary residence is your household; and
 - (2) to whom you are legal guardian or related by blood or marriage; and
 - (3) who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

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).

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.

DEFINITIONS

Employee means a person who:

1. Regularly provides personal services at the Employee's usual and customary place of employment with the Employer; and
2. Works a specified number of hours per week or month as required by the Employer; and
3. Is recorded as an Employee on the payroll records of the Employer; and
4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means, in addition to the person, firm, or institution named in this Contract, one or more subsidiaries or affiliates, if any, listed in the **Special Provisions** section of the Schedule of Specifications attached to and made a part of the Contract.

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

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

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

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

- 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 research study is Experimental/Investigational.

Identification Card means the card issued to the Employee by the Carrier indicating pertinent information applicable to his coverage.

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 during which Employees and Dependents may enroll for coverage.

DEFINITIONS

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

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.

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

GENERAL PROVISIONS

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. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

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

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any Dentist, insurance carrier, or other entity to furnish BCBSTX all information and records or copies of records relating to the diagnosis, treatment, or care of any 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 for any 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.

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 person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, BCBSTX may deduct any refund due it 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 payable to the Texas Department of Human Services to the extent required by the *Texas Insurance Code*; and

GENERAL PROVISIONS

2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Department of Human Services where;
 - a. The Texas Department of Human Services 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 court order, 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 Department of Human Services.

GENERAL PROVISIONS

Subrogation

If the Carrier pays or provides benefits for you or your Dependents under this Plan, the Carrier is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Carrier has paid or provided. That means the Carrier may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Carrier) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Carrier will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Carrier paid benefits under this Plan, you or your Dependent agree to reimburse the Carrier from the recovered money for the amount of benefits paid or provided by the Carrier. That means you or your Dependent will pay to the Carrier the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Carrier.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Carrier all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Carrier in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Carrier before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Carrier to be limited or harmed by any acts or failure to act on your part.

GENERAL PROVISIONS

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, 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 covered person 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 or group-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 plan that, 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 Plan covering you.

GENERAL PROVISIONS

The rules establishing the order of benefit determination between this Plan and any other Health Care Plan covering 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 cases be 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 contains a provision coordinating its benefits with this Health Care Plan would be determined before the benefits of this 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 Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the person as a dependent and primary to the Health Care Plan covering the person as other than a dependent, then the order 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 Plan is 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 primary plan; or
 - (ii) If both parents have the same birthday, the Health Care Plan that has covered the parent the longest 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;

GENERAL PROVISIONS

- (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 his or her 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/dental care coverage.

If a covered person 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.

GENERAL PROVISIONS

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 cooperate or 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 Copayment 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.

GENERAL PROVISIONS

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 the Plan is amended, at the direction of the Employer, to terminate the coverage of the class of Employees to which you belong; 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 the parent will not terminate upon reaching the limiting age shown in the Dental Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one-half of his support 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 certification of 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.

GENERAL PROVISIONS

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 rates or 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.

GENERAL PROVISIONS

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 reports to 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. Upon written request by the Employer, BCBSTX will send any information which BCBSTX has that will aid the Employer in making its annual reports.
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 and discretion to interpret the Plan provisions and to make eligibility and benefit determinations.

AMENDMENTS

**AMENDMENT TO THE BENEFIT BOOKLET
REGARDING CHANGES TO YOUR GROUP DENTAL COVERAGE**

Effective Date: December 1, 2015

The provisions in the Benefit Booklet are hereby changed as follows:

The Benefit Booklet is amended by deleting the IMPORTANT NOTICE and replacing it with TOLL FREE NOTICE 2015 AMND.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary Date or on the Plan Year of the Employer's Group Dental Plan.

Blue Cross and Blue Shield of Texas
(BCBSTX)

By: 

President, Blue Cross and Blue Shield of Texas

IMPORTANT NOTICE

To obtain information or make a complaint:

- You may call Blue Cross and Blue Shield of Texas's toll-free telephone number for information or to make a complaint at:

1-800-521-2227

- You may also write to Blue Cross and Blue Shield of Texas at:

P. O. Box 660044
Dallas, Texas 75266-0044

- You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

- You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

- **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.
- **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

- Usted puede llamar al número de teléfono gratuito de Blue Cross and Blue Shield of Texas's para obtener información o para presentar una queja al:

1-800-521-2227

- Usted también puede escribir a Blue Cross and Blue Shield of Texas:

P. O. Box 660044
Dallas, Texas 75266-0044

- Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al :

1-800-252-3439

- Usted puede escribir al Departamento de Seguros de Texas a:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

- **DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.
- **ADJUNTE ESTE AVISO A SU PÓLIZA:** Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

**AMENDMENT TO THE BENEFIT BOOKLET
REGARDING CHANGES TO YOUR GROUP DENTAL COVERAGE**

The provisions in the Benefit Booklet are hereby changed as follows:

The **DEFINITIONS** section of the Benefit Booklet is amended by replacing the **Dependent** definition and the **Domestic Partner** definition with the following:

Dependent means your spouse or Domestic Partner (provided your Employer covers Domestic Partners) or any *child* who has been determined to be 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 child of your child must be dependent on you for federal income tax purposes at the time of application of coverage for the child of your child is made under the Plan. 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 his 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 *Texas Insurance Code*.

Domestic Partner means a person with whom you have entered into a domestic partnership in accordance with the Employer's Plan guidelines. *Note:* Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available under your Plan.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary Date or on the Plan Year of the Employer's Group Dental Plan.

Blue Cross and Blue Shield of Texas

(BCBSTX)

By:



President, Blue Cross and 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 anyone 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.



**BlueCross BlueShield
of Texas**

