Administered by:

BlueCross BlueShield of Texas









Your Dental Care Benefits Program

Dental Benefits

Current Dental Terminology© American Dental Association

Genesis Energy, LLC

Account #086304

Group # 327262

January 1, 2024

DENTAL BENEFIT BOOKLET

This Benefit Booklet contains a description of the group dental benefits available to you. The Claims Administrator for the Plan is Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

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.

TABLE OF CONTENTS

Dental Schedule of Coverage

BlueCross BlueShield of Texas

January 1, 2024

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

BlueCare Dental[SM]

Covered Services	*Contracting Dentist*	*Non-Contracting Dentist*
Diagnostic Evaluations *(Deductible waived)*	100%	100%
Preventive Services *(Deductible waived)*	100%	100%
Diagnostic Radiographs *(Deductible waived)*	100%	100%
Miscellaneous Preventive Services *(Deductible waived)*	80%	80%
Basic Restorative Services	80%	80%
Non-Surgical Extractions	80%	80%
Non-Surgical Periodontal Services	80%	80%
Adjunctive Services	80%	80%
Endodontic Services	80%	80%
Oral Surgery Services	80%	80%
Surgical Periodontal Services	80%	80%
Major Restorative Services	70%	70%
Prosthodontic Services	70%	70%
Miscellaneous Restorative and Prosthodontic Services	70%	70%
Implants	Not Covered	Not Covered
Orthodontia *(Deductible waived)*	100%	100%
Limiting Age: 19		
Maximum Lifetime Benefits per individual for Orthodontia	$2,500	$2,500
Deductible Three-Month Deductible Carryover applies	$50 individual / $100 family	$50 individual / $100 family
Annual Maximum	$2,000	$2,000

Dental Schedule of Coverage

Benefits for services received from a Contracting Dentist are based on the Allowable Amount, and such Dentist cannot balance bill for charges in excess of this Allowable Amount.

Benefits for services received from a Non-Contracting Dentist will be based upon an Allowable Amount determined by the Claim Administrator, where non-contracting Allowable Amount will be not less than the amount the Claim Administrator would have paid, for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist, and it is possible that such Dentist will balance bill for amounts above this.

INTRODUCTION

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

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

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

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

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

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

Important Contact Information

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

Dental Customer Service Helpline

Dental Customer Service Representatives can:

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

BCBSTX Website

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

WHO GETS BENEFITS

Eligibility

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when the person becomes an Employee or a Dependent under the Plan as determined by your Employer or the Plan Administrator. The Eligibility Date is:

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

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

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

Dependent Eligibility

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

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

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

Applying For Coverage

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

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

Effective Dates of Coverage

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

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

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

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

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

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

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

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

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

Enrollment Application/Change Form

Use this form to:

- Notify the Plan and Claim Administrator 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 the Claim Administrator 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 Claim Administrator, as appropriate, in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage or placement of a foster child, adoption, or a child being involved in a suit for which an adoption of a child is sought, or your Employer receives a Court Order to

provide health or dental coverage for a Participant's child or your spouse, you must submit an *Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in this **WHO GETS BENEFITS** section.

- When you divorce , your child reaches the Dependent child age limit or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions.

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

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

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claim Administrator will pay for Eligible Dental Expenses you incur under the Plan. The portion of the charges by your Dentist that exceeds the Allowable Amount of the Claim Administrator 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 covered procedure or Course of Treatment, benefits will be covered for the least costly covered procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the person is responsible for expenses that exceed the amount covered for the least costly service.

Current Dental Terminology (CDT)

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

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

Freedom of Choice

Each time you need dental care, you can choose to:	
See a Contracting Dentist	***See a Non-Contracting Dentist***
• Your out-of-pocket maximum will generally be the least amount because Contracting Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses;	• Your out-of-pocket maximum may be greater because Non-Contracting Dentists have not entered into a contract with the Claim Administrator to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses;
• You are not required to file claim forms;	• You are required to file claim forms;
• You are not balance billed for costs exceeding the Claim Administrator's Allowable Amount for Contracting Dentists.	• You may be balanced billed by Non-Contracting Dentists for costs exceeding the Claim Administrator's Allowable Amount.

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

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

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

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

How Benefits are Calculated

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

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

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

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's dental care Plan with the Claim Administrator. 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 Claim Administrator.
- ***Your group number***. This is the number assigned to identify your Employer's dental care Plan with the Claim Administrator.
- ***Important telephone numbers***.

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

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

Predetermination of Benefits

If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of $300, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with and predetermined by the Claim Administrator prior to the commencement of treatment. The Claim Administrator may request copies of existing radiographic images, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. The Claim Administrator will review the reports and materials, taking into consideration alternative Courses of Treatment. The Claim Administrator 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.

Filing of Claims Required

Claim Forms
When the Claim Administrator 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.

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

Who Files Claims

Provider-filed claims
Contracting Dentists will usually submit your claims directly to the Claim Administrator 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 the Claim Administrator using a Participant-filed claim form provided by the Claim Administrator. You can obtain a Dental Claim Form from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the Dentist printed on their letterhead and show the:

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

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

Where to Mail Completed Claim Forms

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

Who Receives Payment

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

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

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

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

In order for benefits to be payable to a managing or possessory conservator of a child, the conservator must submit to the Claim Administrator, 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.

The Claim Administrator 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 the Claim Administrator from benefit payments of amounts owed to the Claim Administrator, will be considered in satisfaction of its obligations to you under the Plan.

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

When to Submit Claims

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

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

Receipt of Claims by the Claim Administrator

A claim will be considered received by the Claim Administrator for processing upon actual delivery to the Claim Administrator's 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 the Claim Administrator may contact either you or the Dentist for the additional information.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When the Claim Administrator receives a properly submitted claim, it has authority under the Plan to interpret and determine benefits in accordance with the Plan provisions. The Claim Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claim Administrator and the Plan Administrator.

After processing the claim, the Claim Administrator will notify the Participant by way of an EOB for Dental Care.

If a Claim Is Denied or Not Paid in Full

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

- The reasons for the determination;
- A reference to the benefit Plan provisions on which the determination is based;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available;
- An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's dental circumstances, if the denial was based on Dental Necessity, Experimental/Investigational treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

- **Pre-Service Claim** is any request for benefits or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining dental care.
- **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Pre-Service Claims

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

Post-Service Claims

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

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both: (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30−day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Claim Appeal Procedures

Claim Appeal Procedures - Definitions
An "**Adverse Benefit Determination**" means a denial, reduction, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, or failure to provide in response to a claim, or Pre-Service Claim, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Dentally Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces such treatment (other than by amendment or termination of the Employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

- The reasons for the determination;
- A reference to the benefit Plan provisions on which the determination is based;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available;
- An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator denies your appeal, in whole or in part, or you do not receive a timely decision, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the ***How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)*** section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)
An "**Adverse Determination**" means a determination by the Claim Administrator or its designated utilization review organization that a dental care service that is a covered service has been reviewed and, based upon the information provided, is determined to be Experimental/Investigational, or does not meet the Claim Administrator's

requirements for Dental Necessity, or appropriateness and the requested service or payment for the service is therefore denied or reduced.

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

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

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

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

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

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

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

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

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the limited authority to process claims per the terms and conditions of the Plan and to determine benefits in accordance with the Plan's provisions.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Actions Against BCBSTX

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

ELIGIBLE DENTAL EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Dental Expenses

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

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

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

This Annual Maximum Benefit amount includes:

1. All payments made by the Claim Administrator under the benefit provisions of the Plan except for Orthodontic Services, when indicated on your Dental Schedule of Coverage; and

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

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

This Maximum Lifetime Benefits amount includes all payments made by the Claim Administrator under the Orthodontic Services provision of the Plan as indicated on your Dental Schedule of Coverage.

Changes in Benefits

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

COVERED DENTAL SERVICES

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

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

Diagnostic Evaluations

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

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

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

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

Preventive Services

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

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

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

Diagnostic Radiographs

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

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 60 months.
- Bitewing films – Benefits are limited to four horizontal images or eight vertical radiographic images once every Calendar Year.
- Bitewing films are not separately eligible when taken on the same date as full-mouth films.
- Periapical films, as necessary for diagnosis – Benefits are limited to six every Calendar Year.

Miscellaneous Preventive Services

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

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

Basic Restorative Services

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

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

Non-Surgical Extractions

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

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

Non-Surgical Periodontal Services

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

- Periodontal scaling and root planing – Benefits are limited to once per quadrant every 36 months.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
- Periodontal maintenance procedures – Benefits are limited to two every Calendar Year following active periodontal treatment.

Enhanced Benefits

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

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

Enhanced benefits apply to the annual benefit maximum.

Adjunctive Services

Adjunctive general services include:

- Palliative treatment (emergency) of dental pain, when treatment is not performed in conjunction with a definitive treatment or service.
- Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Medically Necessary by the Plan for Participants with documented medical or dental conditions. A person's apprehension does not constitute a Medical Necessity.

Endodontic Services

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

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.
- Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Pulpal debridement is considered part of endodontic therapy when performed by the same Dentist and not associated with a definitive emergency visit.

Oral Surgery Services

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

- Surgical tooth extractions.
- Alveoloplasty and vestibuloplasty.
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess. Intraoral soft tissue incision and drainage is covered only when provided as the definitive treatment for an abscess. Routine follow-up care is considered part of the procedure.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Plan.

Surgical Periodontal Services

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

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to no more than one surgical periodontal procedure (periodontal surgery, osseous surgery, gingivectomy or gingivoplasty) per quadrant every 36 months.
- Clinical crown lengthening once per lifetime per tooth.

- Osseous surgery, including flap entry and closure – Benefits are limited to per quadrant every 36 months. In addition, osseous surgery performed in conjunction with crown lengthening on the same date of service and in the same area of the mouth, will receive the benefit of crown lengthening in the absence of periodontal disease.
- Osseous grafts – Benefits are limited to one per quadrant every 36 months.
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per quadrant every 36 months.
- Distal or proximal wedge procedure limited to one per quadrant every 36 months, not in conjunction with osseous surgery.
- Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

Major Restorative Services

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

- Single crown restorations.
- Inlay/onlay restorations.
- Labial veneer restorations not performed for cosmetic reasons.
- Benefits for major restorations are limited to one per tooth every 8 years whether placement was provided under this Plan or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

Prosthodontic Services

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

- Complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 8 year period, whether placement was provided under this Plan or under any prior dental coverage.
- Denture reline/rebase procedures – Benefits will be limited to one procedure every 36 months.
- Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the prosthetic delivery.
- Fixed bridgework – Benefits will be provided for the initial installation of an eligible bridgework, including inlays/onlays and crowns. Benefits will be limited to one every 8 years whether placement was under this Plan or under any prior dental coverage.
- Prosthetics placed over implants will be covered.

Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

- Prefabricated crowns – Benefits for stainless steel and resin-based crowns are limited to one per tooth every 8 years. These crowns are not intended to be used as temporary crowns.

- Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to two recementations per Calendar Year. Recementation provided within months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect.
- Adjustments – Benefits will be limited to two time(s) per appliance per Calendar Year.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of a missing or broken tooth or clasp (unless additions are completed on the same date as replacement partials/dentures) - Benefits are limited to a lifetime maximum of once per tooth or clasp.

Orthodontic Services

Orthodontic procedures and treatment include examination records, tooth guidance repositioning (straightening) and retention of the teeth for Participants covered for orthodontics as shown on your Dental Schedule of Coverage. Covered services include:

- Limited**,** interceptive and comprehensive orthodontic treatment, which all accumulate to the Participant's lifetime maximum.

***Special Provisions Regarding Orthodontic Services*:**

- Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic benefit, as shown on your Dental Schedule of Coverage. Benefits cease when the Participant is no longer covered, whether or not the entire benefit has been paid.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic benefit and subject to the maximum benefit, as shown on your Dental Schedule of Coverage for orthodontic services.
- If orthodontic treatment is terminated for any reason before completion, benefits will cease on the date of termination.
- If the Participant's coverage is terminated prior to the completion of the orthodontic treatment plan, the Participant is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Dentist who placed the appliance and/or who is responsible for the ongoing care of the Participant is not covered.
- Benefits are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the Effective Date, benefits will be reduced based on the benefits paid prior to this coverage beginning.

DENTAL LIMITATIONS AND EXCLUSIONS

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

Important Information About Your Dental Benefits

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

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

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

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

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

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

- ***Alternate Benefits***

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

  If you and your Dentist decide on:
  - personalized restorations; or
  - personalized complete or partial dentures and overdentures; or
  - to employ specialized techniques for dental services rather than standard procedures,

  the benefits provided will be limited to the benefit for the standard procedures for dental services, as determined by the Plan.

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

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

Exclusions and Limitations

No benefits will be provided under this Plan for:

1. Services or supplies not specifically listed as an Eligible Dental Expense, or when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Amount, as determined by the Plan.
3. Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to:
   - bleaching teeth; and
   - grafts to improve aesthetics.

4. Dental services, radiographic images, or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Benefit Booklet or if resulting from an Accidental Injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Benefit Booklet.
5. Dental services which are performed due to an Accidental Injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an Accidental Injury.
6. Services and supplies for any illness or injury suffered after the Participant's Effective Date:
   - as a result of war or any act of war, declared or undeclared; or
   - while on active or reserve duty in the armed forces of any country or international authority.
7. Services or supplies that are not Dentally Necessary or do not meet accepted standards of dental practice.
8. Services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the American Dental Association.
9. Hospital and ancillary charges.
10. Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants, unless your Dental Schedule of Coverage shows that the dental Plan chosen provides coverage for implant services.
11. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
12. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance Amounts are offered.
13. Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
14. Services or supplies received for behavior management or consultation purposes.
15. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
16. Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
17. Charges for nutritional, tobacco or oral hygiene counseling.
18. Charges for local, state or territorial taxes on dental services or procedures.
19. Charges for the administration of infection control procedures as required by OSHA, local, state or federal mandates.
20. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
21. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or radiographic images.
22. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
23. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.

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

DEFINITIONS

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

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

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

- ***For Dentists contracting with the Claim Administrator*** – The Allowable Amount is based on the terms of the Dentist's contract and the Claim Administrator's methodology in effect on the date of service.
- ***For Dentists not contracting with the Claim Administrator*** **–** The Allowable Amount is based on the amount the Claim Administrator 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 the Claim Administrator:

- ***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.

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

Claim Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claim Administrator, may subcontract portions of its responsibilities.

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.

Contracting Dentist means a Dentist who has entered into a written agreement with the Claim Administrator 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.

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

DEFINITIONS

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

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

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

The Claim Administrator shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

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

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

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

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

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

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* may 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).

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

Employer means the person, firm, or institution named on this Benefit Booklet.

EOB means an Explanation of Benefits.

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 the Claim Administrator 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, the Claim Administrator 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 Claim Administrator indicating pertinent information applicable to the Participant's dental coverage.

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

consultants review the claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

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

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

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

Plan means a program of health benefits established by the Plan sponsor for the benefit of its Participants as part of the self-funded employee welfare benefit plan whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the named administrator of the Plan having fiduciary responsibility for its operation, in the alternative it means Employer. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as the Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claim Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Proof of Loss means written evidence of a claim including:

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

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

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 Claim Administrator.

Amendments

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

Assignment and Payment of Benefits

If a written assignment of benefits is made by a Participant to a Dentist and the written assignment is delivered to the Claim Administrator with the claim for benefits, the Claim Administrator will make any payment directly to the Dentist. Payment to the Dentist discharges the Claim Administrator's responsibility to 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 the Claim Administrator 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. The Claim Administrator does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any Dentist. The Claim Administrator 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 the Claim Administrator 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, the Claim Administrator 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, the Claim Administrator may deduct any refund due to them from any future benefit payment.

Reimbursement

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

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

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health/dental care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group- type coverage, whether insured or uninsured.

   This includes:
   a. group or blanket insurance;
   b. franchise insurance that terminates upon cessation of employment;
   c. group hospital or medical/dental service plans and other group prepayment coverage;
   d. any coverage under labor- management trustee arrangements, union welfare arrangements, or employer organization arrangements;
   e. governmental plans, or coverage required or provided by law.

   Plan does *not* include:
   a. any coverage held by the Participant for hospitalization, dental and/or medical- surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
   b. a policy of health insurance that is individually underwritten and individually issued;
   c. school accident type coverage; or
   d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

   Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Benefit Booklet that provides benefits for health/dental care expenses.

3. **Primary Plan/Secondary Plan**

   The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health/dental care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We** or **Us** means the Claim Administrator (Blue Cross and Blue Shield of Texas).

Order of Benefit Determination Rules

1. **General Information**

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

2. **Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(1) secondary to the Plan covering the Participant as a Dependent and
(2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than as a Dependent.

b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

(1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
(2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;
(2) Then, the Plan of the spouse of the parent with custody, if applicable;
(3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health/dental care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has

actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health/dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
(2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. **When This Section Applies**

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. **Reduction in this Plan's Benefits**

The benefits of This Plan will be reduced when the sum of:

a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information
We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery
If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, physicians, or other Providers; or
4. any other person or organization.

Termination of Coverage

The Claim Administrator is not required to give you prior notice of termination of coverage. The Claim Administrator 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 contribution for coverage under the Plan is not received timely by the Claim Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

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

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

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

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

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Employer to the Claim Administrator 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 Claim Administrator 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.

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.

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 Plan Administrator 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. The Claim Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Plan. Upon written request by the Plan Administrator, the Claim Administrator will send any information which the Claim Administrator has that will aid the Plan Administrator 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, as the Claim Administrator, is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Plan.

5. This Benefit Booklet is not a summary plan description.

6. The Plan Administrator has given the Claim Administrator the limited authority to process claims per the terms and conditions of the Plan and to determine benefits in accordance with the Plan's provisions. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Plan's provisions and determining questions of eligibility and benefit design. Any decisions regarding eligibility and benefit design made by the Plan Administrator shall be final and conclusive.

   Plan Administrator delegated to Claim Administrator limited authority to administer claims in accordance with the terms of the Plan's provisions and to make initial claim determinations and benefit determinations for appealed claims.

AMENDMENTS

NOTICES

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

HOW IS COBRA COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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









bcbstx.com