Dental Plan Benefit Booklet

Texas Association *of* Counties
Health and Employee Benefits Pool

This booklet does not contain certain details specific to the individual plan(s) offered by your employer such as Deductibles, Copays, Co-Insurance, and Out-of-Pocket amounts and limits.

These details can be found in **Benefit Highlights** documents located in the Resource Guide published by the Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) and provided to you by your employer's benefits administrator. The Benefit Highlights documents are also accessible through your TAC HEBP employee member portal at www.mybenefits.county.org.

TABLE OF CONTENTS

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your dental care expenses for Dentally Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your dental care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Service Agreement provided to the Group Health Plan (GHP) by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.
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 defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun "his," "he," or "him" will be considered to include the feminine unless the context clearly indicates otherwise.

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

You are covered only for those benefit categories 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	**1−855-357-5228**	**Monday – Friday 8:00 a.m. – 6:00 p.m.**
Blue Cross Blue Shield of Texas Website	**www.bcbstx.com**	**24 hours a day 7 days a week**
Texas Association of Counties Health and Employee Benefits Pool Website	**https://mybenefits.county.org**	**24 hours a day 7 days a week**

Dental Customer Service Helpline

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 Requirements for Coverage

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

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. For a new Dependent of an Employee already having coverage under the Plan, the date the Employee acquired the Dependent (date of marriage, birth, court order, adoption, or suit for adoption).

Employee Eligibility

Any person eligible under this 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.

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 Dental Schedule of Coverage;
3. 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 his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent and only one of you may cover any Dependent children.

All dependent spouses applying for coverage with the Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) January 1, 2007 or later, who are eligible for employer−sponsored group health coverage at their Employer, must first enroll in their employer−sponsored plan and provide proof of coverage, in order to be eligible to enroll in the TAC HEBP plan as a Dependent. Should the spouse's employer−sponsored group coverage situation be misrepresented, the Employee and their Dependents could lose eligibility for coverage with TAC HEBP.

Effective Dates of Coverage

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

Timely Applications

It is important that your application for coverage under the Plan is received timely by the Claims Administrator through the Plan Administrator.

If you apply for coverage and pay any required contribution for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claims Administrator through the Plan 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 for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; and
3. Become eligible after the Plan Effective Date and if the application is received by the Claims

Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Dependent Coverage

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

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

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

Other Dependents: Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

Late Applications

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

Dental Enrollment Opportunities

During your Employer's Open Enrollment Period, you may apply for coverage for yourself or for yourself and any eligible Dependents. Coverage will become effective on the Plan Anniversary Date, provided your application is received timely by the Claims Administrator through the Plan Administrator. *NOTE: Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) does not hold open enrollment for dental coverage each year.*

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

Refer to the **Group Enrollment Application/Change Form** subsection for additional information. In no event will your Dependent's coverage become effective prior to your Effective Date.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Plan and the Claims Administrator of a change to your name
- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify the Claims Administrator of all changes in address for yourself and your Dependents.

You may obtain this form from your Employer, by calling the Claims Administrator's 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

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, adoption, or a child being involved in a suit for which an adoption of a child is sought, or your Employer receives a court order to provide health coverage for a Participant's child, you must submit a *Group Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Coverage.***

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

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

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

HOW THE PLAN WORKS

Allowable Amount

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

Course of Treatment

Your Dentist may decide on a planned series of dental procedures which a dental exam shows you need. In cases where there is more than one professionally acceptable Course of Treatment, benefits will be covered for the most economical procedures.

Current Dental Terminology (CDT)

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

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

Freedom of Choice

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

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

- any applicable Deductibles;
- Co−Share Amounts;
- Services that are limited or not covered under the Plan.

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

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

How Benefits are Calculated

Your benefits are based on a percentage of the Dentist's Allowable Amount. To determine your benefits, subtract the Deductible (if not previously satisfied) from your Eligible Dental Expenses, then, multiply the difference by the Co−Share 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 Co−Share Amount will be your responsibility to pay to your Dentist.

Identification Card

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

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 Claims Administrator will provide a new Identification Card.

Predetermination of Benefits

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

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

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Claim Forms

When the Claims 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. Claim forms may also be obtained by accessing the BCBSTX website.

The Claims 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

Dentists that contract with the Claims Administrator (such as BlueCare Dentists) will usually submit your claims directly to the Claims 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 Claims Administrator using a Subscriber−filed claim form provided by the Claims Administrator. Your Employer should have a supply of dental claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the Dentist printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

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

Where to Mail Completed Claim Forms

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

Who Receives Payment

Benefit payments will be made directly to the Dentists when they bill the Claims Administrator. Written agreements between the Claims 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 section **Assignment and Payment of Benefits,** rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

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

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claims 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 managing or possessory conservator must submit to the Claims 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 Claims 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 Claims Administrator from benefit payments of amounts owed to the Claims 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 to the Claims Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claims Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Administrative Office of the Claims Administrator 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 Claims Administrator may contact either you or the Dentist for the additional information.

Review of Claim Determinations

Claim Determinations

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

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

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

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

Right to Review Claim Determinations

If you believe the Claims Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, write to the Administrative Office of the Claims Administrator. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator will honor telephone requests for information, however, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical/dental information within 180 days after you receive notice of a denial or partial denial. The Claims Administrator will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims procedures or the review procedure, write to the Administrative Office of the Claims Administrator or call the toll−free Dental Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the dental care plan and the discretion to interpret and determine benefits in accordance with the dental care plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation of the dental care plan.

Any powers to be exercised by the Claims Administrator of 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.

Claims Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your dental care plan.

After exhaustion of all remedies offered by the Claims Administrator, you may exercise your right to appeal all adverse determinations with the Plan Administrator of your dental care plan. The Plan Administrator is the final interpreter of the dental care plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable. All final determinations and actions concerning the dental care plan administration and interpretation of benefits shall be made by the Plan Administrator. The Claims Administrator will cooperate in providing the Plan Administrator documents relevant to the claim or preauthorization decision but only upon receipt of a valid written authorization from you or your representative to release the relevant information.

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(s) in this Benefit Booklet. Your benefits are calculated on a Plan Year benefit period basis unless otherwise stated. At the end of a Plan Year, a new benefit period starts for each Participant.

Deductibles

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

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

The following is an exception to the Deductibles described above:

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

Maximum Dental Benefits

Maximum Plan Year Benefits

The total amount of benefits available to any one Participant for all combined categories of services for a Plan Year shall not exceed the "Maximum Plan Year Benefits" amount shown on your Dental Schedule of Coverage. Preventive & Diagnostic services benefits do not apply to annual maximum.

This Maximum Plan Year Benefits amount includes:

1. All payments made by the Claims Administrator under the benefit provisions of the Plan Services.
2. Any benefits provided to a Participant under a dental care plan held by the Employer with the Claims 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 shown on your Dental Schedule of Coverage.

Changes in Benefits

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

COVERED DENTAL SERVICES

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

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

I. Diagnostic and Preventive Care Services

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

a. Routine oral evaluations - **2 per Plan Year**.

   (1) Problem-Focused and non-routine exams - limited to **1 per Plan Year** not combined with Routine oral evaluations

   (2) Consultations – covered with no frequency limitation

b. X−Rays (dental radiographs):

   (1) Full mouth / Panoramic X−Rays – **1 every 60 months**;

   (2) Bitewing X-Rays - **1 per Plan Year**;

   (3) Periapical X-Rays – **4 per Plan Year**;

   (4) Intraoral Occlusal X-Rays – **2 per Plan Year**;

   (5) Cone Beam CT to be covered - **2 per Plan Year**;

c. Professional cleaning, scaling, and polishing teeth (prophylaxis) limited to **2 per plan year;**

d. Fluoride treatment (topical application), limited to **2 per Plan** Year for Participants up to age 19;

e. Sealants - **1 per tooth every 36 months** up to age 19; for permanent unrestored bicuspids and molars, excluding wisdom teeth;

f. Periodontal Maintenance - **2 per Plan Year**; not combined with Preventive Prophylaxis;

g. Full Mouth Debridement - **1 per lifetime**

h. Interim Caries Arresting Medicament Application - Covered up to age 19; **1 per Plan Year per tooth**; and

i. Space Maintainers – up to age 19; **1 per arch per lifetime.**

II. Miscellaneous Services

Benefits are available for Eligible Dental Expenses incurred for:

a. Pulp vitality test;

b. Palliative (emergency) treatment to relieve dental pain except when performed in conjunction with definitive dental treatment; and

   (1) Lab and tests.

III. Restorative Services

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

a. Amalgam Restorations - **once every 24 months** per tooth on the same surface;

b. Pin retention, per tooth, in conjunction with the restoration;

c. Resin-based Composite Restorations: – **once every 24 months per tooth** on the same surface

d. Simple tooth extractions.

IV. General Services

Benefits are available for Eligible Dental Expenses incurred for:

a. House/extended care facility call;

b. Injection of antibiotic drugs; and

c. Prefabricated Stainless Steel and Resin Crowns – **1 per tooth per 36 months;** No age limit; primary and permanent teeth.

V. Endodontic Services

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

a. Root canal therapy including treatment plan, clinical procedures, pre− and post−operative radiographs and follow−up care;

b. Direct pulp cap;

c. Apicoectomy/periradicular services;

d. Apexification/recalcification;

e. Retrograde filling;

f. Root amputation/hemisection;

g. Therapeutic pulpotomy; and

h. Gross pupal debridement

VI. Periodontal Services

Benefits are available for Eligible Dental Expenses incurred for services that treat diseases of the tissues that surround and support the teeth (e.g., gums and supporting bone).

a. Periodontal Scaling and Root Planing – **1 per 24 months per quadrant**

VII. Oral Surgery Services

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

a. Alveoloplasty;

b. Removal of completely/partial bony extractions covered under Dental plan only;

c. Surgical tooth extractions;

d. General Anesthesia

e. Intravenous Sedation

f. Vestibuloplasty; and

g. Other Dentally Necessary surgical procedures

h. Periodontal Surgery – **1 every 36 months per quadrant**

   (1) Gingivectomy or Gingivoplasty – **1 every 36 months per quadrant**

   (2) Gingival flap procedure – **1 every 36 months per quadrant**

   (3) Osseous surgery, including flap entry **– 1 every 36 months per quadrant**

   (4) Osseous grafts – **1 every 36 months per quadrant**

(5) Soft tissue grafts – **1 every 36 months per quadrant**

VIII. Crowns, Inlays/Onlays Services

Benefits are available for Eligible Dental Expenses incurred for services resulting from extensive disease or fracture, limited to **1 per tooth every 84 months**, such as:

a. Prefabricated post and cores;

b. Cast post and cores;

c. Labial Veneers;

d. Repair of crowns, inlays/onlays; and

e. Recementation of crowns, inlays/onlays.

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

IX. Prosthodontic Services

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

a. Initial installation of bridgework (including inlays and crowns as abutments), limited to **once per tooth every 84 months**, whether placement was under this Plan or under any prior dental coverage:

   (1) Bridge repair;
   (2) Recementing a bridge; and
   (3) Post and core buildup;

b. Initial installation of removable complete, immediate, or partial dentures (including any adjustments, relines, or rebases during the 6−month period following installation), **1 replacement every 84 months**, whether placement was under this Plan or under any prior dental coverage.

Eligible Dental Expenses are available for the replacement of complete or partial dentures, **1 replacement every 84 months**.

c. Denture Adjustments - **2 per Plan Year**;

d. Denture and Bridge Repairs – **1 per Plan Year**;

e. Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures), limited to a **lifetime maximum of 1 per tooth**;

f. Denture rebase and reline procedures, limited to **1 in any 36−month period**;

g. Occlusal Guard for Bruxism - **1 appliance every 36 months**; and

h. Implants – **1 per tooth every 84 months**.

X. Orthodontic Services

Benefits are available for Eligible Dental Expenses incurred for orthodontic procedures and treatment including examination records, tooth guidance and repositioning (straightening) of the teeth for covered Participants. Adult orthodontic services available for both Employee and Spouse (no age limitation).

Orthodontic services are paid over the Course of Treatment, up to the maximum lifetime orthodontic benefit amount shown on your Dental Schedule of Coverage. Benefits for Orthodontic Services ***are not*** subject to the “Maximum Plan Year Benefits” amount.

Orthodontic lifetime benefits may be reduced by the amount paid by the previous dental carrier. Orthodontic services include:

a. Diagnostic orthodontic records limited to a lifetime maximum of once per Participant;

b. Limited, interceptive and comprehensive orthodontic treatment;

c. Minor treatments to control harmful habits; and

d. Orthodontic retention limited to a lifetime maximum of one appliance per Participant.

DENTAL LIMITATIONS AND EXCLUSIONS

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

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

15. Any benefits for an alternate Course of Treatment which exceeds the most economical procedures.

16. Any personalized complete or partial dentures, overdentures, and their related procedures, or other specialized techniques not normally taught in regular dental school classes.

17. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.

18. Any administration or cost of drugs and/or gases used for sedation or as an analgesia including nitrous oxide. Any administration of any local anesthesia and necessary infection control as required by OSHA or state and federal mandates when billed separately.

19. Any services or supplies which are otherwise provided under inpatient hospital expense or medical−surgical expense coverage under the medical benefits of the Health Benefit Plan.

20. Any treatment by other than a Dentist, except that x−rays, scaling, cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the Dentist.

21. Any prosthetic devices (including bridges), crowns, inlays, onlays, and the fitting thereof, or duplication of such devices, which began before the Effective Date of the Participant's coverage under this Plan with the Claims Administrator.

22. Any replacement or repair of an orthodontic appliance.

23. Any treatment provided through a medical department, clinic, or similar facility furnished or maintained by the Participant's Employer.

24. Any services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the American Dental Association.

25. Any duplicate prosthetic device, other duplicate appliances, or duplicate dental restoration.

26. Any dietary instructions or plaque control programs.

27. Splinting of teeth, including double abutments for prosthetic abutments.

28. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

29. Any Accidental Injuries including tooth transplantation or tooth re−implantation.

30. Any pin retention **not** performed on the same date of service and in conjunction with a covered amalgam or composite restoration.

31. Any palliative (emergency) treatment performed in conjunction with definitive dental treatment.

32. Any indirect pulp capping.

33. Any athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/ malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.

34. Any bacteriological studies for determination of pathologic agents and soft tissue allograft.

35. Any biological materials, cytology sample collection, and histopathological examinations.

36. Any canal preparation and fitting of prefabricated dowel and post if billed separately.

37. Any caries susceptibility tests.

38. Any chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy.
39. Any crowns to restore occlusion or incisal edges due to bruxism or harmful habits.
40. Any desensitizing medicaments and/or their application.
41. Any discing, enamel microabrasion, post removal, and provisional splinting.
42. Any excision/removal of non−odontogenic cysts/tumors/lesions.
43. Any guided tissue regeneration.
44. Any occlusal adjustment if not performed with active periodontal therapy or following active periodontal therapy and occlusal analysis.
45. Any oral hygiene instruction and/or tobacco use counseling.
46. Any office visit for observation and/or second professional opinions.
47. Any periodontal maintenance procedures not following active periodontal therapy.
48. Any prescription drugs.
49. Any osseous grafts if the following procedures have been performed on the affected tooth or site on the same date of service:
    a. apicoectomy;
    b. extraction;
    c. hemisection;
    d. retrograde filling;
    e. root amputation; or
    f. root canal therapy.
50. Any polishing of restorations.
51. Any pulpotomy on permanent teeth.
52. Any recontouring and restoration overhang removal.
53. Any replacement of:
    a. a prosthodontic appliance (fixed or removable) more often than once in any 60−month period (whether under this Plan or under any prior dental coverage); or
    b. restorations due to mercury or other possible allergies; or
    c. serviceable prosthodontics and upgrading of serviceable dentistry.
54. Any surgical repositioning of teeth and surgical revision procedure.
55. Any services or supplies not specifically defined as Eligible Dental Expenses in this Plan or not shown as a covered category of service on your Dental Schedule of Coverage.
56. Any temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.).
57. Any appliances, materials, restorations, or special equipment used to increase vertical dimension, correct, or restore the occlusion.
58. Any services to correct Temporomandibular Joint (TMJ) dysfunction or pain syndromes.
59. Any services or supplies, including splinting, grafting, and preparation, for or associated with implants.
60. Any diagnostic photographs.

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, in initial necessary care provided by a Dentist.

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

- **For certain Dentists contracting with the Claims Administrator** – The Allowable Amount is based on the terms of the Dentist's contract and the Claims Administrator's methodology in effect on the date of service. The methodology used may include relative value, global pricing, or a combination of methodologies.
- **For Dentists not contracting with the Claims Administrator** – The Allowable Amount is based on the amount the Claims 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 Claims 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.

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

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

Contracting Dentist means a Dentist who has entered into a written agreement with the Claims Administrator to participate as a BlueCare dental provider.

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

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

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

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

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

The Claims 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 his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

Dependent means your spouse, domestic partner or any *child* covered under the Plan who is:

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

Child means:

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

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

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.

Eligibility Date means the date the Participant satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of the Benefit Booklet.

Employee means a person who:

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

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

Employer means the organization or entity that offers this health plan to its employees. An employer is an individual, organization, or entity that hires and employs one or more individuals, known as employees.

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 facility in which they were performed; and
- the Dentist has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claims 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 Claims 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.

Group Health Plan (GHP), as applied to this Benefit Booklet, means a self−funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

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

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

Open Enrollment Period means the 31−day period, selected by the Employer, preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.
Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Plan means a program of health and welfare benefits established for the benefit of its Participants 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 Group Health Plan (GHP) or the named administrator of the Plan having fiduciary responsibility for its operation. 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 Claims Administrator.

Plan Month means each succeeding 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.

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

Amendments

The Plan may be amended or changed at any time by agreement between TAC HEBP and the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided. In the absence of a written agreement with a Provider, the Claims Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claims Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claims Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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 Claims 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 Claims Administrator does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. The Claims Administrator is not liable for any act or omission by any Dentist. The Claims 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 Plan 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 Plan 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 Plan may deduct any refund due it from any future benefits payment.

Subrogation

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

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Claims Administrator) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so

that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

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

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

Right to Recovery by Subrogation or Reimbursement

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

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 Plan 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 Claims Administrator (Blue Cross and Blue Shield of Texas).

Order of Benefit Determination Rules

1. **General Information**

   a. 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 Plan 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 Claims Administrator is not required to give you prior notice of termination of coverage. The Claims 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 Plan 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 the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

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

The Claims 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 the parent will not terminate upon reaching the limiting age shown in the Dental Schedule of Coverage if the child continues to be both:

1. *Disabled,* and
2. Dependent upon you for more than one−half of his support as defined by the Internal Revenue Code of the United States.

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

Notice of Creditable Coverage

Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this 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 contributions. 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's contribution or benefits will change the contributions 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 contributions, 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.

NOTICES

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

HOW IS COBRA COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be

available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

Texas Association of Counties Health and Employee Benefits Pool Notice of Grievance Procedures

Information regarding claim reviews and preauthorization appeals is found in the ***Claim Filing and Appeals Procedures*** section of your dental benefit booklet. If you do not agree with the amount paid or determination made by the Claims Administrator, you may request a benefit exception.

STEP 1: You must first submit your appeal in writing and follow the process described in the Claim Filing Appeals Procedures section of your dental benefit booklet.

STEP 2: If you are not satisfied with the Claims Administrator's response in Step 1, you may submit a benefit exception request to a Grievance Committee of the Health and Employee Benefits Pool. This committee is comprised of three members of the Health and Employee Benefits Pool's Board of Directors and is independent of the Claims Administrator. Your request must be received at the following address within sixty (60) calendar days from time you were notified of the Claims Administrator's response to your appeal:

Texas Association of Counties Health and Employee Benefits Pool
Grievance Committee
P.O. Box 2131
Austin, TX 78768-2131
Fax: (512) 481-8481

Within forty-five (45) business days after your request is received, the Grievance Committee will meet to consider your request. Although you cannot attend, you will be provided with written notice of the date, time and location of their meeting. The decision of the Grievance Committee is final and you will be notified in writing of their decision within ten (10) days after their meeting.

If prompt action is required to address a serious dental need of a participant or to avoid undue expense to the Pool, and it is impractical for the Grievance Committee to meet promptly, the Chairman of the Board, or his designee, is authorized to make decisions on benefit exception requests.

P.O. Box 2131 • Austin, TX 78768-2131 • (512) 478-8753 • (800) 456-5974 • (512) 481-8481 FAX • www.county.org