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

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

Within ten days after its delivery to You, this Policy may be surrendered by delivering or mailing it to Us at Our Administrative Office, branch office, or agent through whom it was purchased. Upon such surrender, any premiums paid will be returned.

Blue Cross and Blue Shield of Texas

Herein called (BCBSTX, We, Us, Our)
Administrative Office: Richardson, Collin County, Texas

Has issued this
Dental Insurance Policy
To

The Subscriber named on the Identification Card issued for this Policy.

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

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

Purchasing This Policy

This Policy may be purchased through the Exchange (also known as the Health Insurance Marketplace) or outside of the Exchange. If this Policy is purchased outside of the Exchange, all references to the Exchange are not applicable.

For Policies purchased through the Exchange, this Policy is currently certified by the Exchange as an Exchange-Certified Dental Plan.

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

James Springfield
Blue Cross and Blue Shield of Texas

THIS IS NOT A CONTRACT OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS CONTRACT AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKER'S COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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

Have a complaint or need help?

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

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

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
To get information or file a complaint with your insurance company or HMO:

Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-888-697-0683
Email: BCBSTXComplaints@bcbstx.com
Mail: P. O. Box 660044, Dallas, TX 75266-0044

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

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

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance), por su nombre en inglés) pueda ayudar. Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-888-697-0683
Correo electrónico: BCBSTXComplaints@bcbstx.com
Dirección postal: P. O. Box 660044, Dallas, TX 75266-0044

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

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

Table of Contents

BlueCare Dental℠ 1B
Schedule of Benefits

Adult Services (Age 19 and Over)

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

The Deductibles, Coinsurance Amount, Annual Maximum and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

Covered Services	Benefit Payable
Diagnostic Evaluations (Deductible waived)	90%
Preventive Services (Deductible waived)	90%
Diagnostic Radiographs (Deductible waived)	90%
Miscellaneous Preventive Services	90%
Basic Restorative Services	70%
Non-Surgical Extractions	70%
Non-Surgical Periodontal Services	70%
Adjunctive Services	70%
Endodontic Services	50%
Oral Surgery Services	50%
Surgical Periodontal Services*	50%
Major Restorative Services*	50%
Prosthodontic Services*	50%
Miscellaneous Restorative and Prosthodontic Services*	50%
Orthodontia	
Optional Orthodontia	Not covered
Deductible	$50 individual / $150 family
Annual Maximum	$1,000

*12 Month Benefit Waiting Period may apply.

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

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

BlueCare Dental℠ 1B
Schedule of Benefits

Pediatric Services

This Dental Schedule of Benefits is for Dependent Children under the age of 19.

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

The Deductibles, Coinsurance Amount, Annual Maximum and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

Covered Services	Benefit Payable
Diagnostic Evaluations (Deductible waived)	80%
Preventive Services (Deductible waived)	80%
Diagnostic Radiographs (Deductible waived)	80%
Miscellaneous Preventive Services	80%
Basic Restorative Services	50%
Non-Surgical Extractions	50%
Non-Surgical Periodontal Services	50%
Adjunctive Services	50%
Endodontic Services	50%
Oral Surgery Services	50%
Surgical Periodontal Services	50%
Major Restorative Services	50%
Prosthodontic Services	50%
Miscellaneous Restorative and Prosthodontic Services	50%
Implants	50%
Orthodontia (Deductible waived)	
Pediatric Orthodontia	50%
Optional Orthodontia	Not Covered
Deductible	$50 individual / $150 family
Annual Maximum	Unlimited
Out-of-Pocket Maximum	
1 Child:	$400
2+ Children:	$800

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

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

Definitions

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

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

ADA Code means the American Dental Association Code assigned to a particular dental procedure.

Advance Premium Tax Credit means the advance payment to an eligible individual of the Premium Tax Credit (in lieu of the eligible individual applying the Credit at the end of the year).

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

- ***For certain Dentists contracting with BCBSTX*** – The Allowable Amount is based on the terms of the Dentist's contract and BCBSTX's methodology in effect on the date of service. The methodology used may include relative value, global pricing, or a combination of methodologies.
- ***For Dentists not contracting with BCBSTX*** **–** The Allowable Amount is based on the amount BCBSTX would have paid for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist.

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

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

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

Authorized Administrator means Dental Network of America.

Benefit Waiting Period means the amount of time a Participant must have been continuously covered under this Policy before the Participant is eligible for a certain class of benefits. The Benefit Waiting Period for each class of benefits is shown in the Schedule of Benefits.

BCBSTX, We, Us, or **Our** means Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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

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

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

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination. 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 economical procedure or Course of Treatment, as determined by BCBSTX. 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.

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

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

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

Dentist means a person, when acting within the scope of 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 a Subscriber's spouse or Domestic Partner or child under 26 years of age who has been determined to be eligible for coverage and who is covered under this Policy.

Child means:

- The natural child of the Subscriber or the Subscriber's spouse or Domestic Partner; or
- A legally adopted child of the Subscriber or the Subscriber's spouse or Domestic Partner (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought); or
- A stepchild; or
- An eligible foster child of the Subscriber or the Subscriber's spouse or Domestic Partner; or
- Child for whom the Subscriber or the Subscriber's spouse or Domestic Partner must provide coverage because of a court order or administrative order pursuant to state law regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, enrolled in or eligible for other coverage, or any combination of those factors.

A *child* also includes an unmarried grandchild of the Subscriber who is dependent upon the Subscriber for Federal income tax purposes at the time application for coverage is made.

Domestic Partner means a person with whom you have entered into a domestic partnership in accordance with the guidelines established by the Exchange or BCBSTX, as appropriate.

Effective Date means the date Your coverage becomes effective under this Policy.

Eligible Expenses means covered dental services as described in this Policy.

Exchange (also known as health insurance marketplace) means a governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under applicable law, and makes Exchange-Certified Dental Plans available to Qualified Individuals and qualified employers (as these terms are defined by the Exchange). Unless otherwise identified, the term Exchange refers to the State Exchanges, regional Exchanges, subsidiary Exchanges and/or a Federally facilitated Exchange on which Blue Cross and Blue Shield of Texas offers Exchange-Certified Dental Plans. For additional information about the roles and responsibilities of the Exchange, please refer to the Policy, Amendments provision in General Provisions.

Exchange-Certified Dental Plan means a dental care benefit program that has in effect a certification that it meets the applicable standards issued or recognized by the Exchange through which such program is offered.

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

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

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

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

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

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

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

Identification Card means the card issued to the Subscriber indicating pertinent information applicable to his coverage under this Policy, including applicable Copayment Amounts.

Medically Necessary means a specific procedure or supply provided to you that is reasonably required, in the judgment of BCBSTX, 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 Dentist 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 BCBSTX. 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.

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

Optional Orthodontic Services means coverage for orthodontic conditions not meeting Medically Necessary criteria.

Participant means You or a Dependent, as defined herein, or a Qualified Individual for whom application has been made by the Subscriber and accepted by Us.

Pediatric Orthodontic Services means coverage limited to children under age 19 with an orthodontic condition meeting Medically Necessary criteria (e.g., severe, dysfunctional malocclusion).

Policy Month means each succeeding monthly period beginning on the Effective Date.

Policy Renewal Date means the date when the Subscriber’s dental coverage under this Policy renews for another Calendar Year is January 1 of each year.

Policy Year means the 12-month period beginning on January 1 of each year.

Premium Tax Credit means a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, 2013, to the extent provided under applicable law, where the credit is meant to offset all, or a portion of the premium paid by the individual for coverage obtained through the Exchange during the preceding Calendar Year.

Qualified Individual means an individual who has been determined eligible to enroll through the Exchange in an Exchange-Certified Dental Plan in the individual market.

Scheduled Benefit means the specific benefit amount for each particular dental procedure shown in the attached Schedule of Benefits.

Definitions

Subscriber means the person who has been determined eligible to enroll through the Exchange and who is named on the Identification Card provided for with this Policy.

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

You, Your, Yours means the Subscriber to whom this Policy is issued.

Enrollment and Effective Date of Coverage

Applying for Coverage

You may apply for dental coverage for Yourself and/or Your Dependents by submitting the application(s) for individual dental insurance form, along with any exhibits, appendices, addenda and/or other required information ("Application(s)") to the Exchange, if applicable, and BCBSTX. The Application(s) for coverage may or may not be accepted. No eligibility rules or variations in premium will be imposed based on your health status, dental condition, claims experience, receipt of healthcare, dental history, genetic information, evidence of insurability, disability, or any other health status related factor. You will not be discriminated against for coverage under this Policy based of Your race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Policy 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.

Child-Only Coverage

Eligible children that have not attained age 19 may enroll as the sole Subscriber under this Policy. In such event, this Policy is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole Subscriber; the parent or legal guardian is not covered and is not eligible for benefits under this Policy.
- Dependents who have not attained the age of 19 may be added to the enrolled Child's coverage.
- If a child is under the age of 18, his parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Exchange, if applicable, and BCBSTX. For any Child under 18 covered under this Policy, any obligations set forth in this Policy, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for a child-only coverage will not be accepted for an adult Child that has attained age 19 as of the beginning of the Policy Year. Adult children (at least 18 years of age but has not attained the age of 19 years of age) who are applying as the sole Subscriber under this Policy must apply for their own individual Policy and must sign or authorize the applications(s).

Enrollment

You may enroll in or change dental coverage for Yourself and Your Dependents during one of the following enrollment periods. Your and/or your Dependents' Effective Date will be determined by the Exchange, if applicable, and BCBSTX, depending upon the date your application is received, payment of the initial premiums no later than the day before the Effective Date of coverage (unless any Advance Premium Tax Credit, if applicable, is greater than the initial premium), and other determining factors. The Exchange, if applicable, and BCBSTX may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a Dependent under this Policy.

Annual Open Enrollment Period / Effective Date of Coverage

You may apply for or change coverage in dental coverage for Yourself and/or Your Dependents during the annual open enrollment period designated by the Exchange.

When You enroll during the annual open enrollment period Your and/or Your Dependents' Effective Date will be the following January 1, unless otherwise designated by the Exchange, if applicable, and BCBSTX.

Coverage under this Policy is contingent upon timely receipt by BCBSTX of necessary information and initial premium.

This section "Annual Open Enrollment Period/Effective Date of Coverage" is subject to change by the Exchange, if applicable, BCBSTX, and/or applicable law.

Special Enrollment Periods / Effective Dates of Coverage

Special enrollment periods have been designated during which You may apply for or change dental coverage for Yourself and/or Your Dependents. You must apply for or request a change in dental coverage within 60 days from the date of a special enrollment event in order to qualify for the changes described in this Special Enrollment Periods / Effective Dates of Coverage section.

Except as otherwise provided below, if You apply between the first day and 15th day of the month, Your effective date will be no later than the first day of the following month, or if You apply between the 16th day and the end of the month, Your and Your Dependents' effective date will be no later than the first day of the second following month.

Special Enrollment Events:

- If You purchased this Policy through the Exchange and You experience a loss of Minimum Essential Coverage. New coverage for You and/or Your Dependents will be effective no later than the first day of the month following the loss.

  A loss of Minimum Essential Coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage, or situations allowing for a Rescission, as determined by the Exchange and BCBSTX, as appropriate.
- You gain a Dependent or become a Dependent through marriage. New coverage for You and/or Your Dependents will be effective no later than the first day of the following month.
- You gain a Dependent through birth, adoption (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought), placement for foster care or court-ordered Dependent Coverage. New coverage for You and/or Your Dependents will be effective on the date of the birth, adoption (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought), or placement for foster care. However, payments of any Advance Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. The Effective Date for court-ordered eligible Child coverage will be determined by BCBSTX in accordance with the provisions of the court order.
- You purchased this coverage through the Exchange and were not previously a U.S. citizen(s), national(s), or lawfully present in the U.S. and gain such status.
- Your enrollment or non-enrollment in an Exchange-Certified Dental Plan is unintentional, inadvertent, or erroneous as evaluated and determined by the Exchange and/or BCBSTX, as appropriate.
- You adequately demonstrate to the Exchange that the Exchange-Certified Dental Plan in which You are enrolled substantially violated a material provision of its contract in relation to You.
- You are determined newly eligible or newly ineligible for payments of the Advanced Premium Tax Credit or have a change in eligibility for cost-sharing reductions, regardless of whether You are already enrolled in an Exchange-Certified Dental Plan.
- You gain access to new Exchange-Certified Dental Plans or other Individual coverage as a result of a permanent move.
- You purchased this coverage through the Exchange, and You are an Indian, as defined by section 4 of the Indian health Care Improvement Act. You may enroll Yourself and/or Your Dependents in an Exchange-Certified Dental Plan or change from one Exchange-Certified Dental Plan to another one time per month.
- You purchased this coverage through the Exchange, and You demonstrate to the Exchange, in accordance with the guidelines issued by HHS, that You meet other exceptional circumstances as the Exchange may provide.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the established guidelines as established by the Exchange, if applicable, and BCBSTX.

This section "Special Enrollment / Effective Date of Coverage" is subject to change by the Exchange, if applicable, BCBSTX, and/or applicable law.

Who Is Not Eligible

The following individuals are not eligible for this coverage:

- Anyone who is not a citizen or is not a national of the United States;
- Any non-citizen who is not lawfully present in the United States, and is not reasonably expected to be a citizen or a national;
- Any non-citizen who is not lawfully present for the entire period for which enrollment is sought;
- Incarcerated individuals, other than incarcerated individuals pending disposition of charges;
- Individuals that do not meet any other Exchange, if applicable, and BCBSTX eligibility requirements or residency standards, as appropriate.

This section "Who is Not Eligible" is subject to change by the Exchange, if applicable, BCBSTX, and/or applicable law, as appropriate.

Premium and Reinstatement Provisions

Premiums

The premium applicable to this Policy is determined by Your place of residence on each premium due date, and the number and classification of the family members covered. You must notify BCBSTX and the Exchange, as appropriate, of any change in Your place of residence within 30 days of the date of change.

Your place of residence means the address where You principally reside and regularly maintain physical presence.

- **Change in Premium Upon Notice**

  We reserve the right to adjust the premium upon 60 days written notice to You. Such adjustments in rates shall become effective on the date specified in said notice. Except for a change in the number and classification of a family member, or changes in premium resulting from a change in residence under paragraph (b), below, no adjustment in premium rate shall be made within 12 months of the initial premium rate.

- **Change of Residence**

  If You change Your place of residence and such change results in a change in premium, the premium applicable to this Policy shall automatically change to the rate applicable to the new place of residence effective on the first day of the Policy Month following the date of change in residence; provided that if such change is to a lower premium rate and You fail to notify Us in writing of such change prior to the date of change, Your right to refund of overpayment shall be limited to the overpayment for the six months immediately preceding the date of notification to Us.

Premium rates are based upon the amount of taxes, fees, surcharges or other amounts currently in effect by various governmental agencies. If the amount of taxes, fees, surcharges or other amounts which BCBSTX is required to pay or remit are increased during the Policy Year, BCBSTX reserves the right, at its option, to charge You for such amounts or adjust the premium rates to reflect such increase, on the effective date of such increase. Upon request, You shall furnish to Us in a timely manner all information necessary for the calculation or administration of any such taxes, fees, surcharges or amounts.

Payment of Premium

Coverage does not become effective until payment of the first month's premium. Premiums are due on the first day of the month and may be paid to on a monthly or quarterly basis. Your premium payments should be submitted to BCBSTX at the address shown on the billing statement.

When You renew BCBSTX coverage or reenroll by selecting a new product, You will need to be current on Your premium payments. Any past due premium payments for coverage We provided will be due at the beginning of the new plan year in addition to current premium charges. New coverage will not be effective until all such payments are made.

Third Party Payments

Blue Cross and Blue Shield of Texas follows the premium payment process established by the Affordable Care Act in accordance with all Federal requirements. Blue Cross and Blue Shield of Texas only accepts premium and cost-sharing payments from:

A. The Member.

B. The Member's family.

C. Blue Cross and Blue Shield of Texas accepts premium payments from the following third-party entities on behalf of enrollees:

i. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

ii. An Indian tribe, tribal organization, or urban Indian organization; and

iii. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

D. Blue Cross and Blue Shield of Texas may accept premium payments on behalf of enrollees from private, not-for-profit foundations, if the payments are:

i. For the entire coverage period of the enrollee's policy;

ii. Based solely on the financial status of the enrollees;

iii. Regardless of the coverage the enrollee chooses; and

iv. Regardless of the enrollee's health status.

E. Blue Cross and Blue Shield of Texas may accept premium payments on behalf of enrollees from a Trust, Power of Attorney, or Legal Guardian.

F. Blue Cross and Blue Shield of Texas will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (ERISA) group health plan and either:

i. The employer facilitates premium payment collection through payroll deductions or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or

ii. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA), or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.

G. Blue Cross and Blue Shield of Texas will accept payments on behalf of an enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

Blue Cross and Blue Shield of Texas does not accept premium or cost-sharing payments from any other third party. Unauthorized premium and cost-sharing payments paid by a third party will not be credited to the Member's account and will be refunded to the unauthorized payer. If Blue Cross and Blue Shield of Texas fails to receive payment in full from an authorized source by the end of any premium grace period, Blue Cross and Blue Shield of Texas will retroactively terminate or cancel this coverage.

Unpaid Premium

At the time of payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted from the payment.

Grace Period

Except as provided below, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force, subject to its termination in accordance with the provisions hereof.

In the event you are receiving an Advance Premium Tax Credit under the Affordable Care Act, You have a three-month grace period for paying premiums. If full premium is not paid within one month of the premium due date, claim payments for Eligible Expenses received during the second and third months of the grace period under this Policy will be pended until full premium payment is made. If full payment of the premium is not made within the three months grace period, then coverage under this Policy will automatically terminate on the last day of the first month of the three-month grace period. BCBSTX will not process any claims for services after the date of termination, except as otherwise required by applicable state or federal law.

Reinstatement

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

Payment of Benefits; Participant/Dentist Relationship; Participant/Dentist Benefit Website

Payment of Benefits

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

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

Any benefits payable to You shall, if unpaid at Your death, be paid to Your surviving beneficiary; if there is no surviving beneficiary, then such benefits shall be paid to Your estate.

Participant/Dentist Relationship

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

Participant/Dentist Benefit Website

Information concerning Dental Services is available to You and Your Dentist on our website www.bcbstx.com.

Dental Benefit Information

We will pay Eligible Expenses incurred by You or on behalf of You or any insured Dependent. Expenses must be incurred while this Policy is in force and after the Benefit Waiting Period, if applicable, and while the person is covered by this Policy. Any Deductible, Coinsurance Amount, and annual and lifetime benefit maximums, if applicable are shown in the **Schedule of Benefits**.

Allowable Amount

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

Review the definition of Allowable Amount in the **Definitions** section of this Policy to understand the guidelines used by BCBSTX.

Deductibles

The Deductible is the dollar amount of Eligible Expenses that must be incurred by a Participant during a Calendar Year for which no benefits will be paid. The amounts applied to the Deductible are based on the benefit allowance in the **Schedule of Benefits**. The following Deductibles will apply:

- An individual Deductible as indicated in the **Schedule of Benefits**;
- A family Deductible as shown in the **Schedule of Benefits**. When the family Deductible equals the amount indicated in the **Schedule of Benefits**, all Participants will be deemed to have satisfied their Deductible for the remainder of that Calendar Year. No one Participant is allowed to satisfy more than the individual Deductible amount.

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

Annual Maximum Benefit

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

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

Benefit Waiting Period

There may be a 12-month or 24-month Benefit Waiting Period for certain classes of benefits as indicated in the **Schedule of Benefits**. The Benefit Waiting Period, if applicable, applies to each Participant separately and begins for each Participant on his Effective Date of coverage under this Policy. If this Policy is terminated for any reason, refer to the Reinstatement provision Provisions.

Eligible Expenses

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

Eligible Expenses are deemed incurred on the earlier of:

- The date the final impression is taken for full and partial dentures;
- The date the teeth are first prepared for fixed bridges, crowns, inlays and onlays;
- The date the pulp chamber is opened for root canal therapy;
- The date surgery is performed for periodontal surgery;

- The date the appliance or bands are inserted; and
- On the date the service is performed for all other services.

Pretreatment Estimate of Benefits and Treatment Plan

If Your Dentist recommends a Course of Treatment that will cost more than $300, Your Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to Your beginning the Course of Treatment. BCBSTX will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify You and Your Dentist of the estimated benefits which will be provided under this Policy. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered. BCBSTX's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Policy requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, You are responsible for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by Us.

Covered Dental Services

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

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

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

Your dental benefits include coverage for the following covered services as long as these services are rendered to You by a Dentist.

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 oral evaluations, 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 the age of three including counseling with primary caregiver.
- Oral Examinations – Oral exams are limited to one every 6 months. Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months.

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

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

Preventive Services

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

- Prophylaxis – Professional cleaning, scaling, and polishing of the teeth. Benefits are limited to two cleanings every 12 months.
- Scaling in the presence of generalized moderate or severe gingival inflammation. Benefits are limited to one every 12 months.
- Topical fluoride application – Benefits for fluoride application are only available for Participants under age 19 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

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

Diagnostic Radiographs

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

- 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 two sets per Calendar Year for Participants up to age 19 and one set per Calendar Year for Participants age 19 and over.
- Intraoral Periapical films.

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

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 tooth every 36 months and are available for Participants up to age 19.
- Space Maintainers – Benefits for space maintainers are limited to children under age 19.

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

Basic Restorative Services

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

- Amalgam restorations – are limited to one restoration per tooth surface per tooth.
- Resin-based composite restorations – Benefits are limited to one restoration per surface per tooth.

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.

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 one per quadrant every 24 months. Scaling in the presence of generalized moderate to severe gingival inflammation is limited to once per quadrant every 6 months combined with prophylaxes and periodontal maintenance.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
- Periodontal maintenance procedures – 4 in 12 months combined with prophylaxis after completion of active periodontal therapy.

Adjunctive Services

Adjunctive general services include:

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

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

Endodontic Services

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

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure. These services are considered part of the root canal procedure if root canal therapy is performed within 45 days of services.
- 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.

Benefits will not be provided for the following “Endodontic Services”:

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

Oral Surgery Services

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

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

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

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

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); 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.

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 one quadrant every 24 months.
- Clinical crown lengthening.
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 36 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening

on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.

- Osseous grafts – Benefits are limited to one per site every 24 months. Benefits for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- Soft tissue grafts/allografts (including donor site) – For Participants age 19 and over benefits are limited to one per site every 24 months. This benefit limit does not apply to Participants up to age 19.
- Distal or proximal wedge procedure.
- Anatomical crown exposures – is not covered.

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

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

Major Restorative Services

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

- Single crown restorations.
- Inlay and onlay restorations.
- Labial veneer restorations.

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

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

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

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Policy or under any prior dental coverage, even if the original crown was stainless steel. 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 60-month period, whether placement was provided under this Contract or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement, or loss.
- Denture reline/rebase procedures are limited to one in a 36 month period after the initial 6 month period following initial placement.
- Fixed bridgework – Benefits will be provided for the initial installation of bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months whether placement was under this Policy or under any prior dental coverage.

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

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

Implant retained crowns, bridges, and dentures are subject to the Alternate Benefit Provision of this Policy.

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

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Effective Date.
- Congenitally missing teeth.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

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 60 months. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core.
- Core build up, post and core, and prefabricated post and core are limited to 1 per tooth every 60 months.
- Crown and bridge repair services.
- Denture Adjustments.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp.

Medically Necessary Orthodontic Services

Medically necessary orthodontic services are limited to members who meet the plans criteria related to a medical condition such as:

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

Benefits for Medically Necessary orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment does not meet the definition of medical necessity.

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

- Diagnostic orthodontic records and radiographs limited to a lifetime maximum of once per Participant.
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention limited to a lifetime maximum of one appliance per Participant.

Special Provisions Regarding Orthodontic Services:

- Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic benefit, if applicable. Benefits cease when the Participant is no longer covered, whether or not the entire benefit has been paid out.
- 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 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.

Limitations and Exclusions

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

Important Information About Your Dental Benefits

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

  Please note that in order to provide You with dental care benefits at a reasonable cost, this Policy provides benefits only for those covered services for eligible dental treatment that are determined by BCBSTX to be Dentally Necessary.

  No Benefits will be provided for procedures which are not Dentally Necessary.

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

- **Care By More Than One Dentist**

  If 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 BCBSTX. 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.

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

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

  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 least cost, as determined by Us.

- **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 — What Is Not Covered

No benefits will be provided under this Policy for:

- Services or supplies not specifically listed as a covered service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Amount, as determined by BCBSTX.
- Dental services treatment of congenital or developmental malformation or services performed for cosmetic purposes including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as included in the Medically Necessary Orthodontic Benefit subsection of the Covered Dental Services section.
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Policy or if resulting from Accidental Injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Policy.

- Dental services which are performed due to an Accidental Injury. For Participants age 19 and over any injury caused by chewing or biting an object or substance placed in your mouth is not considered an Accidental Injury.
- 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.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental/Investigational services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants for Participants age 19 and over.
- 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.
- Services or supplies for which "discounts" or waiver of Deductible or coinsurance amounts are offered.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Claims for a service which is for the same service performed on the same date for the same member.
- Services or supplies received for behavior management or consultation purposes.
- Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state 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.
- Charges for nutritional, tobacco or oral hygiene counseling.
- Charges for local, state, or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state, or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional appliances.
- Charges for audio-only telephone consultations, text-only email messages, facsimile transmissions, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to Your Effective Date under this Policy; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after Your Effective Date.

Limitations and Exclusions

- Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis, diagnostic casts, or occlusal adjustments.
- Gold foil restorations.
- Cone beam imaging and cone beam MRI procedures.
- Sealants for teeth other than permanent molars.
- Orthodontic care for dependent children age 19 and over.
- Localized delivery of antimicrobial agents or chemotherapeutic agents.
- Bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- Anatomical crown exposures.
- The replacement of lost, missing or stolen appliances and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
- Restoration occlusion on incisal edges due to bruxism or harmful habits.
- Treatment to replace teeth which were missing prior to the Effective Date.
- Congenitally missing teeth.
- Replacement or repair of an orthodontic appliance.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
- Comprehensive periodontal evaluations or problem-focused evaluations if covered services are rendered on the same date as any other oral evaluation and by the same Dentist.
- Tests and oral pathology procedures, or for re-evaluations.
- Any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
- Local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
- Endodontic therapy if you discontinue endodontic treatment.
- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); 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.
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

Termination of Coverage

This Policy is renewable at the option of the Subscriber unless terminated as discussed below.

If Your coverage this Dental Policy is terminated for any reason BCBSTX will provide You with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage.

If You purchased this Policy through the Exchange, BCBSTX will also notify the Exchange, of the termination effective date and the reason for termination.

Termination in a Dental Plan purchased through the Exchange

For Plans purchased through the Exchange, Your and Your Dependents' coverage will be terminated due to the following events and will end on the dates specified below:

a. When You terminate Your coverage in this Dental Policy including as a result of Your obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to the Exchange, if applicable, and BCBSTX. For the purposes of this section, reasonable notice is defined as 14 days from the requested effective date of termination; or

   The last day of coverage will be:

   - The termination date specified by You if You provide reasonable written notice; or
   - 14 days after the termination is requested by You, if You do not provide reasonable notice; or
   - On a date determined by BCBSTX, if BCBSTX is able to effectuate termination in fewer than 14 days and You request an earlier termination effective date; or

b. You are no longer eligible for Exchange-Certified Dental Plan coverage through the Exchange. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange unless You request and earlier termination effective date; or

c. This Dental Plan terminates or is decertified; or

d. You change from one Dental Plan to another during an annual open enrollment period or special enrollment period. The last day of coverage in Your prior Dental Plan is the day before the effective date of coverage in Your Dental Plan.

Termination by Blue Cross and Blue Shield of Texas

1. The coverage of the Subscriber and all covered Dependents under this Policy will terminate on the earliest of the following dates:

   a. On the last day of the last period for which the premium for this Policy has been paid, subject to the grace period provided in the section entitled **Premiums** of this Policy; or

   b. On the last day of any Policy Month upon written request for termination of this Policy made by You and received prior thereto; or

   c. On the date Your coverage for dental insurance cancels or terminates; or

   d. On the Policy Effective Date for fraudulent or intentional misrepresentation of a material fact; or

   e. On Your date of death; or

   f. On the date following 90 days advance notice by Us to the Subscriber, but only if We are terminating all other this particular type of individual coverage for all Subscribers provided that We act uniformly without regard to any Health-Status Related Factor of covered individuals.

2. In addition to the provisions of Section 1, above, the coverage of any Dependent under this Policy shall terminate on the earliest of the following dates:

   a. At the end of the Policy Month in which the Dependent ceases to be a Dependent as defined in the Definitions section of this Policy, provided that:

      (1) If such date falls within a period for which We have accepted premium, coverage shall not terminate until the last day of such period;

(2) Coverage for any unmarried child who is medically certified as Disabled and dependent upon You shall not terminate upon reaching age 26 if the child continues to be both: (a) Disabled, and (b) chiefly dependent upon You for support and maintenance.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. You must submit satisfactory proof of the disability and dependency to Us within 31 days following the child's attainment of age 26. As a condition to the continued coverage of a child as a disabled Dependent beyond age 26 We 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 age 26.

b. On the date of death of the Dependent; or

c. On the last day of any Policy Month on written request for termination of the Dependent's coverage made by You and received by Us prior thereto.

3. Notwithstanding the provisions of Section 1, above, within 30 days of the death of the Subscriber:

   a. If there is a surviving spouse, all remaining eligible Dependents may jointly elect in written notice to Us to continue this Policy with the surviving spouse as Subscriber.

   b. If there is no surviving spouse, each Dependent may elect in written notice to Us to continue this Policy in his own name.

4. Notwithstanding the provisions of Section 2, above, within 30 days of a divorce, marriage of a child, or a child attaining age 26, the former Dependent losing coverage may elect to apply for coverage in his own name.

   Upon timely application, We will allow coverage under the name of the applicant at the then prevailing premium rate for persons of the same geographical location.

If You purchased coverage through the Exchange and there is a conflict between **Termination in a Dental Plan purchased through the Exchange** and **Termination by BCBSTX**, the provision that is most favorable to the Subscriber will apply.

Coordination of Benefits

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

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

Allowable Expense means a dental care expense, including deductibles, coinsurance, and copayments, which is covered at least in part by any Plan covering the person for whom claim is made. When a Plan (including this Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. In addition, any expense that a dental care provider or Physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

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

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

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

BCBSTX has the right to coordinate benefits between this Plan and any other Plan that provides for dental coverage covering you.

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

1. The benefits of a Plan that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Plan.
2. If according to the rules set forth below in this section the benefits of another Plan that contains a provision coordinating its benefits with this Plan would be determined before the benefits of this Plan have been determined, the benefits of the other Plan will be considered before the determination of benefits under this Plan.

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

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

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

   a. For a Dependent child, whose parents are married or are living together, whether or not they have ever been married:

      (i) The Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or

      (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

   b. For a Dependent child, whose parents are divorced, separated, or not living together, whether or not they have ever been married:

      (i) if a court order states that one of the parents is responsible for the Dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree.

      (ii) if a court order states that both parents are responsible for the Dependent child's dental care expenses or dental care coverage, the provisions of 2.a. must determine the order of benefits.

      (iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.

      (iv) if there is no court order allocating responsibility for the Dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

         (I) the Plan covering the custodial parent;

         (II) the Plan covering the spouse of the custodial parent;

         (III) the Plan covering the noncustodial parent; then

         (IV) the Plan covering the spouse of the noncustodial parent.

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

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

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

3. **Active, Retired, or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the Plan that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off

employee does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.
5. **Longer or Shorter Length of Coverage**. The Plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the Plan that has covered the person the shorter period is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

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

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

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

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

Reimbursement – Acts of Third Parties

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

1. To reimburse Us to the extent of the Allowable Amount that would have been charged to you for dental care services if you were not covered under this Plan. Such reimbursement must be made immediately upon collection of damages for dental Hospital or medical expenses by you whether by action at law, settlement or otherwise.
2. To assign to BCBSTX a right of recovery from a third party for dental Hospital and medical expenses paid by Us on your behalf and to provide Us with any reasonable help necessary for Us to pursue a recovery. In addition, BCBSTX will be entitled to recover attorneys' fees and court costs related to its subrogation efforts only if BCBSTX aids in the collection of damages from a third party.

Review of Claim Determinations

a. **Claim Determinations**

When We receive a properly submitted claim, We have authority under this Policy to interpret and determine benefits in accordance with the Policy provisions. We will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing. You have the right to seek and obtain a review by Us of any determination of a claim, any determination of a request for preauthorization, or any other determination made by Us of Your benefits under this Policy.

If a Claim Is Denied or Not Paid in Full

On occasion, We may deny all or part of Your claim. There are a number of reasons why this may happen. We suggest that You first read the *Explanation of Benefits* summary prepared by Us; then review this Policy 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 Us and request a review of the decision as described in **Claim Appeal Procedures** below.

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

- The reasons for determination;
- A reference to the benefit provisions on which the determination is based, a description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available;
- An explanation of Our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- 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;
- The clinical basis for the determination including 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 treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- 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.

1. **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.
2. **Post-Service Claim** is notification in a form acceptable to Us 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 We may request in connection with services rendered to You.

Review of Claim Determinations

Pre-Service Claims

Type of Notice	Timing
BCBSTX must notify you of the claim determination (whether adverse or not):	
if We have received all information necessary to complete 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, We must notify You within:	**30 days**
If You are notified that Your claim is incomplete, You must then provide completed claim information to Us within:	**45 days** after receiving notice
BCBSTX must notify you of any adverse claim determination:	
if the initial claim is complete, within:	**30 days after receipt of the claim***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days, if we extended the period, less any days already utilized by Us during our review***

* This period may be extended one time by Us for up to 15 days, provided that We both (1) determine that such an extension is necessary due to matters beyond the control of the Plan and (2) notify 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 We expect to render a decision. If the period is extended because We require additional information from You or Your provider, the period for Our making the determination is tolled from the date We send notice of extension to You until the earlier of i) the date on which we receive the information; or ii) the date by which the information was to be submitted.

b. Claim Appeal Procedures

Claim Appeal Procedures - Definitions

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

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

Notice of Appeal Determination

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

The written notice to You and Your authorized representative will include:

- A reason 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, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available;
- An explanation of Our external review processes (and how to initiate an external review);
- 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, or 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;
- Your right, if applicable, to request external review by and Independent Review Organization; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

How to Appeal 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 Us in accordance with the benefits and procedures detailed in Your Policy.

An appeal of an Adverse Benefit Determination may be requested in writing, by You or a person authorized to act on Your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative. To obtain an Authorized Representative Form, You or Your representative may call Us at the number on the back of Your ID card. You may orally request an appeal if the requested dental service has been denied on the basis that it is not Dentally Necessary or it is experimental or investigational. A complaint filed with BCBSTX concerning Your dissatisfaction or disagreement with a denial of a dental service is an appeal. Upon receipt of your oral request for appeal, BCBSTX will provide You with a one-page appeal form.

If You believe We incorrectly denied all or part of Your benefits, You may have Your claim reviewed. We will review the decision in accordance with the following procedure:

- Within 180 days after You receive notice of a denial or partial denial, You may write to BCBSTX. We will need to know the reasons why You do not agree with the denial or partial denial. Send Your request to:

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

- We will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of Your claim review, You have the option of presenting evidence and testimony to Us. 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.
- We 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 change to respond. If the initial benefit determination regarding the claim is based in whole or in part on a dental judgment, the appeal determination will be made by a Dentist associated or contracted with Us and/or by external advisors, but who were not involved in making the initial denial of Your claim.

- If You have any questions about the claims procedures or the review procedure, write to Our Administrative Office or call the toll-free Customer Service Helpline number shown in this Policy or on Your Identification Card.

Timing of Appeal Determinations

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

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

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

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

Any party whose appeal of an Adverse Determination is denied by Us may seek review of the decision by an IRO. At the time the appeal is denied, We will provide 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.

- We will submit dental records, names of providers and any documentation pertinent to the decision of the IRO.
- We will comply with the decision by the IRO.
- We 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 Us;
- dental judgments, including whether a particular service is Experimental/Investigational or not Dentally Necessary or appropriate; and
- expert advice and consultation obtained by Us in connection with the denied claim, whether or not the advice was relied upon to make the decision.

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

Claim Forms

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

Disclosure Authorization

You, on behalf of Yourself and Your Dependents, shall be deemed to have authorized any attending Physician or Dentist to furnish Us all information and records or copies of records relating to the diagnosis, treatment, or care of any Participant included under this Policy; and such Participants shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 26, We shall have the right to require periodic certification of the child’s physical or mental condition and dependency, but not more frequently than annually after the two-year period following the child's attainment of age 26.

Gender

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

Legal Actions

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

Member Data Sharing

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

Non-Agency

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

General Provisions

Notice of Claim

You shall give or cause to be given written notice to BCBSTX within 30 days or as soon as reasonably possible after any Participant receives any of the services for which benefits are provided herein.

Physical Examinations and Autopsy

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

Policy; Amendments

This Policy and the application or applications for coverage by the Subscriber and any amendments, riders, or endorsements attached hereto, shall constitute the entire Policy. Any statements made shall be deemed representations and not warranties, and no statement made by the Subscriber in the application for this Policy shall be used in any contest or in defense of a claim hereunder unless a copy of the application is attached to this Policy when issued.

Only an authorized officer of BCBSTX has the power to change, modify, or waive the provisions of this Policy, and then only in writing prepared at the home office and attached or endorsed hereto. We shall not be bound by any promise or representation heretofore or hereafter made by or to any agent other than as specified above.

If this Policy is purchased through the Exchange, in no event shall Blue Cross and Blue Shield of Texas be considered the agent of the Exchange or be responsible for the Exchange. All information you provide to the Exchange and received by BCBSTX from the Exchange will be relied upon as accurate and complete. The Subscriber must promptly notify the Exchange and BCBSTX of any changes to such information.

Policy Renewal Date

The Policy renewal date when the Subscriber's dental coverage under this Policy renews for another Calendar Year is January 1 of each year.

Proof of Loss

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

Refund of Benefit Payments

If and when We determine that benefit payments hereunder have been made erroneously but in good faith, We reserve the right to seek recovery of such benefit payments from the Participant, any other insurance company to whom such payments were made or from the Dentist who received the overpayment. We reserve the right to offset subsequent benefit payments otherwise payable by the amount of any such overpayment.

Reimbursement

- If We pay or provide benefits for You under this Policy, We are subrogated to all rights of recovery which You have in contract, tort or otherwise against any person, organization, or insurer for the amount of benefits We have paid or provided. That means We may use the Subscriber's 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 (BCBSTX) in the place of another (any Participant covered under this Policy) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.
- **Right of Reimbursement:** In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, We will have a right of reimbursement. If any

Participant covered under this Policy recovers money from any person, organization, or insurer for an injury or condition for which We paid benefits under this Policy, all Participants covered under this Policy agrees to reimburse Us from the recovered money for the amount of benefits paid or provided by Us. That means any Participant covered under this Policy will pay Us the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits We paid or provided.

- **Right to Recovery by Subrogation or Reimbursement:** Any Participant covered under this Policy agrees to promptly furnish to Us all information concerning any Participant's rights of recovery from any person, organization, or insurer and to fully assist and cooperate with Us in protecting and obtaining its reimbursement and subrogation rights. Any Participant covered under this Policy, or their attorney will notify Us before settling any claim or suit so as to enable Us to enforce Our rights by participating in the settlement of the claim or suit. Any Participant covered under this Policy further agrees not to allow the reimbursement and subrogation rights BCBSTX to be limited or harmed by any acts or failure to act on the part of any Participant.
- Our process to recover by subrogation or reimbursement will be conducted in accordance with Texas Civil Practice and Remedies Code Title 6, Chapter 140.

Rescission of Coverage

Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on the Participant's application may result in the cancellation of Your coverage (and/or Your Dependent(s) coverage) retroactive to the Effective Date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield of Texas (BCBSTX) may deduct from the premium refund any amounts made in claim payments during this period and You may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is effected. At any time when Blue Cross and Blue Shield of Texas is entitled to rescind coverage already in force or is otherwise permitted to make retroactive changes to this Policy, Blue Cross and Blue Shield of Texas may at its option make an offer to reform the policy already in force or is otherwise permitted to make retroactive changes to this Policy **and/or** change the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

State Government Programs

Benefits for services or supplies under this Policy shall not be excluded solely because benefits are paid or payable for such services or supplies under a state plan for medical assistance (Medicaid) made pursuant to 42 U.S.C., Section 1346 et seq., as amended. Any benefits payable under such state plan for medical assistance shall be payable to the Texas Health and Human Services Commission to the extent required by Chapter 1504 the *Texas Insurance Code*.

All benefits paid on behalf of a child or children under this Contract must be paid to the Texas Health and Human Services Commission where:

- The Texas Health and Human Services Commission is paying benefits pursuant to provisions in the *Human Resources Code*; and
- The parent who is covered by this Contract has possession or access to the child pursuant to a court order or administrative order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
- We receive written notice at Our Administrative Office, affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Health and Human Services Commission.

Time of Payment of Claims

Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written Proof of Loss.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

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

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

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

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

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Texas

If you, or someone you are helping have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें । .
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.