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INTRODUCTION

EXPLANATION

This Plan has been designed and selected by your Employer as one of the benefits of your employment. Please read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. This Benefit Booklet summarizes Plan benefits and provisions for Dental Benefits. In the event of any conflict between any components of this Plan, the Schedule of Specifications provided to your Employer by BCBSTX prevails.

Benefits for the Covered Dental Expenses described in this Benefit Booklet are determined by the benefit categories listed below. The benefit percentage to be applied to each benefit category is shown on your Schedule of Coverage.

- Group I - Diagnostic and Preventive Care
- Group II - Basic Care
- Group III - Major Care
- Group IV - Orthodontic Care

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

The Claims Administrator has written contracts with Dentists (herein called DentaBlueSM Dentists) and you may limit your out-of-pocket expenses by choosing a Dentist from the DentaBlueSM Directory. You do, however, have the freedom to go to either a contracting or non-contracting Dentist.

IDENTIFICATION CARD

You will be issued an Identification Card indicating “Dental Benefits Only.” This card identifies you and any covered family members as Participants in your Employer’s dental benefits Plan. Your card contains important information about you, your Employer group, and the benefits to which you are entitled.

Always remember to carry your Identification Card with you and present it to your Dentist when receiving dental services or supplies. Dentists will use the information on your card to file claims for you and any covered family members. Any time a change in your family takes place, it may be necessary for a new Identification Card to be issued to you. Contact the Dental Customer Service Helpline for more information. Upon receipt of the change information, a new Identification Card will be issued and forwarded to your Employer for distribution to you.

DENTAL CUSTOMER SERVICE HELPLINE

If you have any questions regarding dental coverage, call the Dental Customer Service Helpline, Monday C Friday 8:00 a.m. - 4:30 p.m., Central Time.

**Toll free: 1-800-647-0620
or 1-800-521-2227**

WHO GETS BENEFITS

ELIGIBILITY REQUIREMENTS FOR COVERAGE

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

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

Employee Eligibility

You are eligible for coverage under the Plan if you are:

1. All City of Beaumont Fire and Civilian regular Employees(excluding sworn Police personnel) in Active Service who work a minimum of thirty (30) hours per week for the Employer; or
2. Retirees - Civilian Employees who are eligible for and retired under the Employer's Early Retirement Program and/or in accordance with other city policies;
3. All other Employees are excluded.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. However, if you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children. A Dependent is described in **DEFINITIONS** in this Benefit Booklet

EFFECTIVE DATES OF COVERAGE

The Effective Date is the date coverage for a Participant actually begins. It may be different from the Eligibility Date. Your Employer will advise you of your Effective Date.

Actively at Work/Non-Confinement Requirement

Coverage under the Plan will become effective as explained below, but only if you and any eligible Dependents to be covered have satisfied the Actively at

Work/Non-Confinement requirement on the date coverage is to become effective.

If you or a Dependent (other than a newborn child or a child added by court order) have not satisfied the Actively at Work/Non-Confinement requirements on the date coverage would otherwise become effective, the coverage will become effective on the date following the first day you or the Dependent satisfy the requirements.

However, your coverage must become effective before any Dependent coverage can be effective.

Timely Applications

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

If you apply for coverage for yourself or for yourself and your eligible Dependents, and if:

1. You are eligible on the Plan Effective Date (the date on which coverage under the Plan begins for the Employer) and the Claims Administrator receives the application prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date; or
2. You become eligible on or after the Plan Effective Date and the Claims Administrator receives the application through the Plan Administrator within the first 30 days following your Eligibility Date, the coverage will become effective as provided in the Plan (see your Employer for this Effective Date information).

Coverage of your natural child born after your Effective Date or a child of a Participant for whom the Employer has received a court order requiring health coverage be provided will automatically be in effect from the (1) date of birth for the newborn child or, (2) date the court order is received by the Employer, through the 31st day following such date. For coverage to continue for the newborn child or the child added by court order, the Plan Administrator **must** receive notification from you on an enrollment form for Dependent addition during the 31-day period to add the child as a Dependent.

If you wait until after this 31-day period to add the child, coverage will become effective as described under *Late Applications*.

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

WHO GETS BENEFITS

3. Date of the adoption or suit for adoption,

through the 31st day following such date. For coverage to continue, the Plan Administrator **must** receive notification from you on an enrollment form for Dependent addition during the 31-day period to add the child as a Dependent. If you wait until after this 31-day period to add the child, coverage will become effective as described under the **Late Applications** paragraph below, and the Actively at Work/Non-Confinement requirement will apply to the Dependent.

Late Applications

If you apply for coverage for yourself, a Dependent, or for yourself and your eligible Dependents (see *Adding New Dependents* below), and the Claims Administrator receives the application through the Plan Administrator more than 30 days following your Eligibility Date, see your Employer for this Effective Date information. Several Effective Date options are available to your Employer under this Plan for late applications.

Adding New Dependents

You may add your newly acquired Dependents to your coverage. If the Claims Administrator receives the application through the Plan Administrator within 30 days of the Dependent's Eligibility Date, the coverage will become effective on the Dependent's Eligibility Date, but only if the Actively at Work/Non-Confinement requirement is met as described above. If the Claims Administrator receives the application through the Plan Administrator more than 30 days after the Dependent's Eligibility Date, see your Employer for this Effective Date information. Several Effective Date options are available to your Employer under this Plan for late applications.

CHANGES IN YOUR FAMILY

When the following events take place:

- You marry or divorce,
- A child is born, adopted, or involved in a suit for which the adoption of a child is sought,
- A child marries or reaches the age limit described below,
- A Participant in your family dies, or
- Your Employer receives a court order to provide health coverage for a Participant's child,

you should promptly notify the Plan Administrator by filling out a form which has been furnished to your Employer. If you are adding a Dependent, you must submit an application and the coverage will become

effective when the Claims Administrator receives the form from the Plan Administrator as described in **Adding New Dependents**.

The Dental Benefits Schedule of Coverage indicates a "Dependent child age limit" selected by your Employer after which coverage under the plan *automatically* terminates.

When a child marries or reaches the "Dependent child age limit", coverage under the Plan *automatically* terminates. For additional information, see the **CONTINUATION OF GROUP COVERAGE – FEDERAL** section of this Benefit Booklet.

Notify your Employer promptly if any of these events occur. Once we are notified, the coverage terminates *automatically* and benefits for expenses incurred after termination are not available. If claims are paid prior to notification, refunds will be requested.

Coverage for your Dependent spouse *automatically* terminates upon divorce. In that event, please refer to **CONTINUATION OF GROUP COVERAGE - FEDERAL** in this Benefit Booklet.

PARTICIPANT CHANGE FORM

Use this form to...

- Change your name,
- Add Dependents,
- Drop Dependents, or
- Cancel all or a portion of your coverages

You may obtain this form from your Employer or by calling the Claims Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form (see **Address Changes**, below).

After you have completed the Participant Change Form, return it to your Employer.

ADDRESS CHANGES

Notify the Claims Administrator through the Plan Administrator of all changes in address for yourself and your Dependents.

DENTAL BENEFITS PROVIDED

Benefits for the Covered Dental Expenses described in this Benefit Booklet are determined by the benefit categories listed below. The benefit percentage to be applied to each benefit category is shown on your Schedule of Coverage.

- Group I - Diagnostic and Preventive Care
- Group II - Basic Care
- Group III - Major Care
- Group IV - Orthodontic Care

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

DENTABLUESM DENTISTS

You have the freedom to go to a Dentist who either contracts or does not contract with the Claims Administrator. You may limit your out-of-pocket expenses, however, by choosing a contracting Dentist (referred to as a DentaBlueSM Dentist) from the DentaBlueSM Directory.

When you receive care from a DentaBlueSM Dentist:

- Confirm the Dentist's continued DentaBlueSM participation at each visit.
- Ask about procedures for claim filing/payment policy.
- You are not responsible for charges that exceed the Allowable Amount.

You are responsible for:

- Any Deductibles,
- Co-Share Amounts, and
- Services that are limited or not covered by the Plan.

HOW BENEFITS ARE CALCULATED

Your benefits are based on a percentage of the Claims Administrator's Allowable Amount. To determine your benefits, subtract the Deductible (if not previously satisfied) from your Covered Dental Expenses, then, multiply the difference by the benefit percentage applicable to the benefit category. The resulting total is the amount of benefits available. The remaining unpaid expenses, including any excess portion above the

Allowable Amount, will be your responsibility to pay to your Dentist.

DEDUCTIBLE

The Deductible shown on your Dental Benefits Schedule of Coverage will be subtracted once during each Calendar Year from the total eligible Covered Dental Expenses incurred for that Calendar Year. It will apply to each benefit category, unless your Dental Benefits Schedule of Coverage indicates it is waived for a particular benefit category. It will apply to each Participant. The following exceptions will apply:

1. If "Three-Month Deductible Carryover" is shown on your Dental Benefits Schedule of Coverage, any Covered Dental Expenses incurred during the last three months of a Calendar Year and applied toward satisfaction of the Deductible for that Calendar Year, may be applied toward satisfaction of that Deductible for the following Calendar Year.
2. When the total number of family Participants shown under "Family Deductible" on your Dental Benefits Schedule of Coverage have each, individually, satisfied the Deductible for a Calendar Year, any other Participants under your coverage will not have to satisfy a Deductible for that Calendar Year.

ALLOWABLE AMOUNT DETERMINATION

In determining the Allowable Amount, the Claims Administrator will consider such factors as your Dentist's usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances. The portion of the charges by your Dentist that exceeds the Allowable Amount of your Claims Administrator will be your responsibility to pay to your Dentist. In other words, a certain amount of the Dentist's charge may not be considered for benefits.

For purposes of this portion of the Plan, **Allowable Amount** means the maximum amount determined by the Claims Administrator to be eligible for consideration of payment for a particular service, supply, or procedure. To calculate the Allowable Amount, the Claims Administrator uses the most appropriate method in consideration of the Dentist and/or type of service.

In the instance or absence of an agreement between the Dentist and the Claims Administrator:

DENTAL BENEFITS PROVIDED

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

Unless otherwise stipulated by a contract between the Dentist and Claims Administrator:

- a. For services performed in Texas, Allowable Amount is based upon the applicable methodology for Dentists in the same locale as described by the Claims Administrator.
- b. For services performed outside of Texas, Allowable Amount is based upon the applicable methodology for Dentists in the Dallas locale, or higher, if deemed appropriate by the Claims Administrator.
- c. For multiple surgical procedures performed in the same operative area, the Allowable Amount for all procedures combined will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
- d. When a less expensive professionally acceptable service, supply or procedure is available, the Allowable Amount will be based upon the least expensive service. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

PREDETERMINATION OF BENEFITS

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

The Claims Administrator may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. The Claims Administrator for the Plan will review the reports and materials, taking into consideration alternative Courses of Treatment. The Claims Administrator will notify you or the Dentist of the benefits to be provided under the Plan. Predetermination gives you and your Dentist the opportunity to know the extent of the benefits available and any cutbacks made in his charges before any dental procedures are done.

MAXIMUM DENTAL BENEFITS

Maximum Calendar Year Benefits

The maximum amount of benefits available for all combined Groups I, II, and III Covered Dental Expenses for a Calendar Year for any one Participant is the amount shown in your Dental Benefits Schedule of Coverage. This Calendar Year maximum benefit does not include Group IV Covered Dental Expenses

Maximum Lifetime Benefits

The maximum lifetime benefits available for any one Participant for Group IV Covered Dental Expenses is the amount shown on your Dental Benefits Schedule of Coverage. This maximum lifetime benefit amount does not apply to Groups I, II, and III Covered Dental Expenses.

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim

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

Claim Forms

When the Claims Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, or the Dentist, the claim forms that are usually furnished by it for filing your claim.

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

DENTAL BENEFITS PROVIDED

Who Files Claims

Provider-filed claims

Dentists that contract with the Claims Administrator (such as DentaBlueSM Dentists) will submit your claims directly to the Claims Administrator for services provided to you or any of your covered Dependents.

At the time services are provided, inquire if they will file claim forms for you. To assist Dentists in filing your claims, you should carry your Identification Card with you.

Participant-filed claims

If your Dentist does not submit your claims, you will need to submit them to the Claims Administrator using a form provided by the Claims Administrator. Your Employer should have a supply of claim forms. Remember to file each Participant's expenses separately because Deductibles, maximum benefits, and other provisions are applied to each Participant separately.

Include itemized bills from the Dentist printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

Where to Mail Completed Dental Claim Forms

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

Who Receives Payment

Benefit payments will be made directly to the Dentists when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Dentists may require payment directly to them. Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **ASSIGNMENT AND PAYMENT OF BENEFITS**, rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

Benefits Paid to a Managing or Possessory Conservator

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

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

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

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

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted within 90 days of the date you receive the services or supplies. Claims not submitted and received by the Claims Administrator within 12 months after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claims Administrator

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

Review of Claim Determinations

Claim Determinations

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

DENTAL BENEFITS PROVIDED

administrative practices and procedures established in writing between the Claims Administrator and the Plan Administrator. The Claims Administrator will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If the Claims Administrator requires further information in order to process the claim, the Claims Administrator will request it within that 30-day period.

After processing the claim, the Claims Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

Right to Review Claim Determinations

You have the right to seek and obtain a full and fair review of any determination of a claim or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If you believe all or part of your benefits were incorrectly denied, you may have your claim determination reviewed.

The Claims Administrator will review its decision in accordance with the following procedure:

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

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

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator will honor telephone requests for information, however, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see documents relevant to the denial or partial denial and may submit written issues, comments and additional medical or dental information within 180 days after you receive notice of a denial or partial denial. The Claims Administrator will give you a written decision within 60 days after it receives your request for review.

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

Interpretation of Plan Provisions

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

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

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

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section, prior to taking further action under your Health Benefit Plan.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

COVERED DENTAL EXPENSES

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

Group I - Diagnostic and Preventive Care

- Routine oral examinations (limited to two in any 12-month period)
- X-rays - full mouth (limited to one in any 36-month period); bitewing (limited to four in any six-month period); other x-rays as necessary for diagnosis (except in connection with a program of orthodontics)
- Professional cleaning (limited to two in any 12-month period)
- Space maintainers for Participants under 19 years of age
- Topical application of fluoride/sealants C fluoride application limited to two in any 12-month period and to Participants under 19 years of age; sealants limited to one lifetime sealant per tooth, permanent molars only, for Participants under 16 years of age.

Group II - Basic Care

- Emergency pain relief (limited to emergency treatment of an abscess or infection of the tooth or supporting structures)
- Extractions
- Oral surgery, including biopsies of oral tissues
- Fillings - amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations. Gold and baked porcelain fillings are not covered
- General anesthesia, including I.V. sedation, when administered in connection with oral or maxillofacial surgery (excluding analgesia gases)
- Treatment of disease of the gums and related tissue
- Treatment of the tooth pulp, including root canal therapy and pulp vitality tests
- Injection of antibiotic drugs
- Repair or recementation of crowns, inlays, onlays, bridgework, or dentures. Relining or rebasing of dentures more than six months after the denture was installed (limited to one service within any 36-month period).

Group III - Major Care

- Inlays, onlays, crowns and other Gold and baked porcelain restorations (but only when the tooth is damaged beyond restoration by a routine filling)
- Initial installation of bridgework (including inlays and crowns as abutments)
- Initial installation of partial or full removable dentures (including any adjustments during the six-month period following installation)
- Replacement of:
 - a. An existing partial; or

- b. A full removable denture; or
- c. A fixed bridgework by a new denture or new bridgework; or
- d. The addition of teeth to an existing partial removable denture or bridgework.

Satisfactory evidence must be presented that:

- a. Added teeth are required by the extraction of teeth after the denture or bridgework was installed; or
- b. The existing denture or bridgework cannot be made serviceable and if it was installed under this Plan, at least five years have elapsed after its installation, or
- c. The immediate existing temporary denture cannot be made permanent and its replacement occurs within 12 months of its installation.

Normally, dentures will be replaced by dentures, but if achieving a professionally acceptable Course of Treatment requires bridgework, such bridgework may be covered.

- Implants are covered under this Plan.

Group IV - Orthodontic Care

- Orthodontic diagnostic procedures and treatment including oral examinations, surgery, and extractions for Participants covered under this Plan.

LIMITATIONS AND EXCLUSIONS

*In addition to those benefit maximums and limitations described in the **Covered Dental Expenses** section, the benefits of the Plan are not available for any Covered Dental Expenses incurred:*

1. In connection with an occupational illness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
2. For which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality; provided, however, 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.
3. As a result of disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
4. Primarily for cosmetic purposes, except for:
 - Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan; or
 - Covered orthodontic diagnostic procedures and treatment; or
 - Services provided to a newborn child which are necessary for treatment or correction of congenital defects.
5. For which a benefit is not specifically listed on the Schedule of Coverage, or for procedures which the American Dental Association has not approved a specific procedure code.
6. For services provided or received for consultation purposes.
7. For replacement of dentures, removable or fixed prostheses, and dental restorations due to theft, misplacement or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within five years after receiving such dentures, prostheses or restorations.
8. For any full-mouth x-ray provided within three years from the date of the Participant's last full-mouth x-ray. Any bitewing x-ray or prophylaxis provided within six months of the previous bitewing x-ray or prophylaxis.
9. For which a professionally acceptable alternative Course of Treatment is more economical.
10. For personalized complete or partial dentures, overdentures and their related procedures, or other specialized techniques not normally taught in regular dental school classes.
11. For treatment provided before the Effective Date of a Participant's coverage or after termination of coverage under the Plan.
12. For appliances, restorations, or special equipment used to increase vertical dimension, correct or determine proper occlusion except as provided for under Comprehensive Dental Benefits; or to correct temporomandibular joint (TMJ) dysfunction or pain syndromes.
13. For the administration or cost of drugs and/or gases used for sedation or as an analgesia.
14. For which benefits are otherwise provided under *Inpatient Hospital Expense* or *Medical-Surgical Expense* coverages.
15. For treatment by other than a Dentist, except that x-rays, scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is provided under the supervision and guidance of the Dentist.
16. For prosthetic devices (including bridges), crowns, inlays, onlays, and the fitting thereof, or duplication of such devices, which began before the Effective Date of the Participant's coverage under the Plan.
17. For replacement or repair of an orthodontic appliance.
18. For treatment provided through a medical department, clinic, or similar facility furnished or maintained by the Participant's Employer.

LIMITATIONS AND EXCLUSIONS

19. For which no charge is made; for which the Participant is not legally obligated to pay; for which no charge would be made in the absence of this or similar dental coverage; “discounts” or waiver of a Deductible or Copayment; or treatment by a Dentist who is related to the Participant by blood or marriage.
20. For services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/Investigational in nature or not fully approved by the Council of the American Dental Association.
21. For a duplicate prosthetic device, other duplicate appliances or duplicate dental restoration.
22. For dietary instructions or a plaque control program.
23. For services or supplies not Dentally Necessary.
24. For any charge:
 - Resulting from the failure of a Participant to keep a scheduled visit with a Dentist;
 - For completion of any insurance or claim forms;
 - For telephone consultations; or
 - For records or x-rays necessary for the Claims Administrator for the Plan to make a benefit determination.
 - If the Participant has been continuously covered under a group dental care contract, which includes prosthetic benefits, held by the Employer with this Claims Administrator for a period of 24 consecutive months following the Participant’s Effective Date; or
 - To Participants effective on the Effective Date of this Plan who were covered under a previous group dental care contract held by the Employer with another carrier immediately prior to the Effective Date of the Plan.
25. For splinting of teeth, including double abutments for prosthetic abutments.
26. For prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
27. For any services or supplies not specifically listed as Covered Dental Expenses under this Plan.

DEFINITIONS

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

Actively at Work/Non-Confinement, Active Work, or Active Service means:

1. As applied to an Employee (other than a retired Employee), the active expenditure of time and energy in the services of the Employer at the Employee's usual and customary place of employment by an Employee who is physically and mentally capable of performing on a regular basis all of the usual and customary duties required for his position; provided, however, that an Employee shall be deemed to be so actively expending time and energy on each day of a regular paid vacation, or on a regular nonworking day, on which he is not Totally Disabled, provided he was so actively expending time and energy on the last scheduled working day preceding such vacation or nonworking day; and
2. As applied to a retired Employee or a Dependent (other than a newborn child or a child added by court order), the person will not be considered to have satisfied the Actively at Work/Non-Confinement requirements if Totally Disabled or confined in any institution, or at home under medical care, to the point of not being able to carry on any of the normal duties or activities of a person in good health who is the same sex and approximate age.

Allowable Amount means the maximum amount determined by the Claims Administrator to be payable for a particular service, supply, or procedure. To calculate the Allowable Amount, the Claims Administrator uses the most appropriate method in consideration of the Dentist and/or type of service.

In the instance or absence of a contract between the Dentist and the Claims Administrator:

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

Unless otherwise stipulated by a contract between the Dentist and the Claims Administrator:

- a. For services performed in Texas, Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.
- b. For services performed outside of Texas, Allowable Amount is based upon the applicable methodology using Texas regional or state allowable amounts applicable to procedures, services, or supplies of Dentists with similar skills and experience.
- c. 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.
- d. When a less expensive professionally acceptable service, supply, or procedure is available, the Allowable Amount will be based upon the least expensive service. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

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

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

Claims Administrator may also mean any successor named by the Plan Administrator.

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

Covered Dental Expenses means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant under the Comprehensive Dental Benefits portion of the Plan which are provided to a Participant by a Dentist on or after the Effective Date of coverage and for which the Participant acquires an obligation for payment.

DEFINITIONS

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

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

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

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

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

Dependent means:

- Your spouse; or
- Any unmarried *child* who is:
 - Under the limiting age selected by your Employer as shown on the Dental Benefits Schedule of Coverage; or
 - A child of any age who is medically certified as disabled and dependent on the parent for support.

Child means:

- Your natural child; or

- Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or
- Your stepchild whose primary residence is your household; or
- A child for whom a Participant has received a court order requiring that Participant to have financial responsibility for providing health coverage; or
- A child:
 - whose primary residence is your household; and
 - to whom you are legal guardian; and

who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

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

Eligibility Date means the date the Participant satisfies the definition of either Employee or Dependent and is in a class eligible for coverage under the Plan as described in the **Who Gets Benefits** section of this Benefit Booklet.

Employee means a person who:

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

If the Employer has elected to cover retired Employees, the term *Employee* shall also include those persons, who are considered retired Employees under the Employer's established procedures whereby individual selection by the Employer or the Employee to be included in the retired Employee classification is precluded.

DEFINITIONS

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

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

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, 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: (1) have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated; (2) are appropriate for the hospital or facility in which they were performed; and (3) the Dentist has had the appropriate training and experience to provide the treatment or procedure.

The Claims Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Gold means alloys containing at least 70% gold metal by weight.

Nonprecious Metals means alloys of base metals of no special intrinsic value containing no Gold or platinum, such as stainless steel, chrome, copper, cobalt, or nickel.

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

Plan Administrator means the named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

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

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

Proof of Loss means written evidence of a claim including:

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

Semiprecious Metals means alloys of noble metals or those metals of special intrinsic value, such as platinum.

Total Disability or **Totally Disabled** means:

1. As applied to an Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability; and
2. As applied to a Dependent, confinement as a bed patient in a hospital.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

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PARTICIPANT/DENTIST RELATIONSHIP

The choice of a Dentist is made solely by a Participant. The Claims Administrator does not furnish services but only makes payment for Covered Dental Expenses incurred by Participants. The Claims Administrator is not liable for any act or omission by any Dentist and does not have any responsibility for a Dentist's failure or refusal to provide services to a Participant.

ASSIGNMENT AND PAYMENT OF BENEFITS

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Dentist, the Claims Administrator reserves the right to make benefit payments to the Dentist or the Employee, as the Claims Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

SUBROGATION

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

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

Right of Reimbursement

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

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits under this Plan, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the

Plan the amount of money recovered by you through judgment, settlement, or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

Right to Recovery by Subrogation or Reimbursement

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

REFUND OF BENEFIT PAYMENTS

If the Plan pays benefits for Eligible Expenses incurred by you or your covered Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Plan may deduct any refund due it from any future benefit payment.

COORDINATION OF BENEFITS

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

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

Coordination of Benefits – Definitions

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

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- group or blanket insurance;
- franchise insurance that terminates upon cessation of employment;
- group hospital or medical service plans and other group prepayment coverage;
- any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
- governmental plans, or coverage required or provided by law.

Plan does not include:

- any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- a policy of health insurance that is individually underwritten and individually issued;
- school accident type coverage; or

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

2. **This Plan** means the part of this Contract that provides benefits for health care expenses.
3. **Primary Plan/Secondary Plan:** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.
4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.
5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan,

or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We or Us** means the Claims Administrator, (BCBSTX).

Order of Benefit Determination Rules

1. General Information

- a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.
- b. If We issue a separate dental and/or vision benefit contract to the Employer, the benefits provided by the health portion of this contract will be the Secondary Plan.

2. Rules

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

- a. **Non-Dependent/Dependent:** The benefits of the Plan which covers the Participant as an Employee, member, or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is
 - secondary to the Plan covering the Participant as a Dependent and
 - primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee),

then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

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

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

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

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

- First, the Plan of the parent with custody of the child;
- Then, the Plan of the spouse of the parent with custody, if applicable;
- Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan.

This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. ***Joint Custody:*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.
- e. ***Active/Inactive Employee:*** The benefits of a Plan which covers a Participant as an Employee who is

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

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

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

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

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

Effect on the Benefits of This Plan

1. When This Section Applies

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

2. Reduction in This Plan's Benefits

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

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made

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exceeds those Allowable Expenses in a Claim Determination Period.

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right to Recovery

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

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. Any other person or organization.

TERMINATION OF COVERAGE

The Claims Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claims Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

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

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. Your employment terminates; or
3. The Plan is amended to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

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

Coverage for a child of any age who is medically certified as disabled and Dependent on the parent will not terminate upon reaching the limiting age shown in the Dental Benefit Schedule of Coverage if the child continues to be both:

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

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

Termination of the Plan

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan. However, see **Continuation of Group Coverage**.

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CONTINUATION OF GROUP COVERAGE FEDERAL

The following events **may** provide an option to continue group coverage:

For your Dependents:

- Your death or divorce; or
- Your child's marriage or reaching the "Dependent child age limit."

For you and your Dependents:

- The termination of your status as an Employee (except for reason of gross misconduct) or retirement;
- If you are covered as a retired Employee, the filing of a Title XI bankruptcy proceeding by the group.

If such an event occurs, you or your Dependents should immediately contact your Employer to determine your rights. Also, refer to the *Important Notice to Employees and Dependents of Continuation Option (COBRA)* at the end of this Benefit Booklet.

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within 60 days. You or your Dependents may be required to pay your own contribution rates. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Dental Benefit Schedule of Coverage). Hence, changes in the group contribution rates or benefits will change the contribution rates or benefits for any continued coverage.

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

There is no conversion privilege available for dental coverage under the Plan.

INFORMATION CONCERNING EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information that the Claims Administrator has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions described in this Benefit Booklet. Claim filing and claim review procedures are found in the **DENTAL BENEFITS PROVIDED** section of this Benefit Booklet.
4. BCBSTX, as the Claims Administrator, is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet is not a Summary Plan Description.
6. The Plan Administrator has given the Claims Administrator the initial authority to make certain benefit determinations in accordance with the benefits and procedures detailed in the Health Benefit Plan. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan's provisions and determining questions of eligibility and benefits. Any decision made by the Plan Administrator shall be final and conclusive.

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AMENDMENTS

The Plan may be amended or changed at any time by the Plan Sponsor with prior written notice to the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

CLAIMS LIABILITY

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

NOTICES

Important Notice to Employees and Dependents of Continuation Option

(If you are married, both you and your spouse should take the time to read this notice carefully)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by the 99th Congress provides that when Participants (Employees and Dependents) lose their eligibility for group health coverage because of any of the events listed below, they may elect to continue group health coverage. The continued coverage can remain in effect for a maximum period of either 18, 29 or 36 months depending on the reason that eligibility terminated.

Events qualifying for 18-month continuation are loss of eligibility as a result of:

1. Reduction of Employee work hours; or
2. Employee retirement or termination (voluntary or involuntary), except for discharge for gross misconduct.
Note: The 18 months can be extended to up to 29 months when any Participant is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage and notice of such determination is provided both within 60 days of the determination and prior to termination of continuation coverage.

Events qualifying for 36-month continuation for Dependents are loss of eligibility as a result of:

1. Death of the Employee;
2. Divorce or legal separation of the Employee;
3. Medicare eligible Employee (Employee becomes eligible for Medicare, leaving Dependents without group health coverage); or
4. Children who lose coverage due to eligibility provisions (for example: limiting age, marriage).

Who is eligible for the continuation option?

Participants (Employees and Dependents) who are covered by the group health plan at the time of the qualifying event are qualified beneficiaries and are eligible to continue coverage. Each may make an independent election. A child born or adopted by the Employee during COBRA continuation is eligible to be a qualified beneficiary upon timely application.

How do the Participants apply?

1. If a qualifying event is either: (a) the divorce of an Employee; or (b) a child becoming ineligible for coverage, the eligible Participants must notify the Employer in writing. Then, the Employer will give written notice to the Participants of the continuation option. If the qualifying event is the Employee's death, Medicare eligibility, or termination of employment (or reduction of hours), the Employer will give written notice to the Participants of the continuation option.
2. The eligible Participants have 60 days to give written notice to the Employer of their desire to continue coverage. The election must specify names of covered individuals and the reason for and date of the qualifying event.
3. A Participants' coverage shall terminate upon the occurrence of any of the following:
 - a. The maximum time period expires;
 - b. A continued Participant obtains coverage after the date of election under any other group health plan (as an Employee or otherwise) which does not contain an applicable exclusion for any Preexisting Condition of the Participant;
 - c. A continued Participant becomes covered by any Medicare benefits after the date of election;
 - d. The Employer no longer provides group health coverage for Employees; or
 - e. The required payment to continue coverage is not made on a timely basis.

A continued Participant's coverage may also be terminated for fraud or intentional misrepresentation of material fact to the same extent the coverage for a similarly situated non-continued Participant could be terminated.

Benefits for a continued Participant will be the same as those for active Employees. Rates will be based upon the rates for active Employees. If the Employer changes benefits or rates, the continued Participants will receive the new benefits and a new rate.

A service fee of 2% of the premium paid by active Participants is added to the premium and is payable by the continued Participant. An extra premium of 50% may be added for Participants who extend coverage from 18 to 29 months. You are responsible for premium payment.

Contact your Employer if you have any questions about COBRA.

**If continuation coverage is not elected, your group coverage will end.
Note: COBRA is not applicable to certain small groups and to churches.**