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
Student Dental Insurance
Policy to
University of Houston System

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

This Policy is effective from 12:00 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.

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

President of 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.

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: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

# ¿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 or HMO:
Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-800-697-0683
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: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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# 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.

BlueCare Dental 1B

| 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 | $75 individual / $225 family |
| Annual Maximum | $1,000 |
| Out-of-Pocket Maximum | None |

*12 Month Benefit Waiting Period applies.

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.

# Schedule of Benefits

## Pediatric Services

This Dental Schedule of Coverage 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.

BlueCare Dental 1B

| 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 | $75 individual / $225 family |
| Annual Maximum | Unlimited |
| Out-of-Pocket Maximum | |
| 1 Child: | $375 |
| 2+ Children: | $750 |

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.

# 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.

**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 PERIOD** means the period of time during which the Participant receives the Covered Services for which the Plan will provide benefits. The Benefit Period is the period of time beginning with the Effective Date of this Policy through the Termination Date as shown on the Face Page of the Policy. The Benefit Period is as agreed to by the Policyholder and the Insurer.

**BENEFIT WAITING PERIOD** means the amount of time a Participant must have been continuously covered under this Policy before he 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 Ours** 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.

**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 concurrently revealing the need for such procedures or treatments.

**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 the 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 Participant's spouse or Domestic Partner, or a Participant's Child under 26 years of age who has been determined to be eligible for coverage and who is covered under this Policy.

Child means:

a. The natural child of the Participant or his spouse or Domestic Partner; or
b. A legally adopted child of the Participant or his spouse or Domestic Partner (including a child for whom the Participant is a party in a suit in which the adoption of the child is being sought); or
c. A stepchild; or
d. An eligible foster child of the Participant or his spouse or Domestic Partner; or
e. A child for whom the Participant or his spouse or Domestic Partner must supply coverage because of a court order or administrative order pursuant to state law; or
f. Each grandchild of the Participant or his spouse or Domestic Partner, who is younger than 25 years of age, and a Dependent of the Participant or his spouse or Domestic Partner for federal income tax purposes at the time the application for coverage of the grandchild is made; or
g. Any other child the Participant or his spouse or Domestic Partner is the legal guardian of, so long as the Child is under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, employment status, marital status, eligibility for other coverage or any combination of those factors.

For the purposes of this plan, the term Dependent also includes a child who is over the age of 26, chiefly supported by the Participant and is incapable of self-sustaining employment due to mental or physical handicap. Proof of the Child's condition must be submitted to Us within 31 days after the date the Child ceases to qualify as a Child for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

**DOMESTIC PARTNER** means a person with whom the Participant has entered into a domestic partnership in accordance with the guidelines established by BCBSTX, as appropriate.

**EFFECTIVE DATE** means the date the Participant's coverage becomes effective under this Policy.

**ELIGIBLE EXPENSES** means covered dental services as described in this Policy.

**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 Participant indicating pertinent information applicable to his coverage under this Policy, including applicable Copayment Amounts.

**INSTITUTION** means an institution of higher education as defined in the Higher Education Act of 1965.

**INTERCOLLEGIATE SPORT** means a sport, which is not an Interscholastic Activity (as defined in this policy); and is administered by such Institution's department of intercollegiate athletics; and for which benefits for injuries are not provided for nor payable under this Policy while Insureds are playing, participating, and/or traveling to or from an intercollegiate sport, contest or competition, including practice or conditioning for such activity.

**INTERSCHOLASTIC ACTIVITY** means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

**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 Dental Necessity criteria.

**PARTICIPANT** means the Insured [or a Dependent], as defined herein.

**PEDIATRIC ORTHODONTIC SERVICES** means coverage limited to children under age 19 with an orthodontic condition meeting Dental Necessity criterion (e.g., severe, dysfunctional malocclusion).

**POLICY MONTH** means each succeeding monthly period beginning on the Effective Date.

**SCHEDULED BENEFIT** means the specific benefit amount for each particular dental procedure shown in the

attached Schedule of Benefits.

**SUBSCRIBER** means the Insured or a Dependent, as defined herein.

**STUDENT** means an individual student or continued person who meets the eligibility requirements for this dental coverage, as described in the eligibility requirements of this Policy.

**YOU, YOUR, YOURS** means the Participant to whom this Policy is issued.

# Enrollment and Effective Date of Coverage

**Each person in one of the Class(es) of Eligible Persons shown below is eligible to be insured under this Policy. This includes anyone who is eligible on the Policy Effective Date and may become eligible after the Policy Effective Date while the Policy is in force. Students must meet the Institution's requirements for maintaining their status as an eligible Student. Home study, correspondence, and television (TV) courses do not fulfill the eligibility requirements. Students must maintain their eligibility in order to maintain or continue coverage under this policy. Covered Students who lose eligibility status prior to the end of their enrolled coverage period will no longer be covered as of the first month following the loss of eligibility. Students enrolled for the Summer sessions will not experience a loss in coverage as long as they were covered immediately preceding Summer sessions. (These Students may be eligible for continuation coverage as provided for in the policy for 3 months.) We maintain the right to investigate student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any unearned premium paid for that person.**

**Classes of Eligible Persons**

**Class I: Student Eligibility requirement for the following campuses:**

- ***University of Houston – Main Campus***
- ***University of Houston – Clear Lake***
- ***University of Houston – Victoria***
- ***University of Houston – Downtown***

***Domestic Students:***

***Undergraduate*** students enrolled in six (6) or more credit hours (three (3) for summer session) are eligible to enroll for coverage within the posted open enrollment period.

***Graduate*** students who are enrolled in three (3) or more credit hours are eligible to enroll for coverage within the posted open enrollment period.

***International Students:***

***International*** students with "F" or "J" visa status are required to be covered under the UH System (UHS) Student Health Insurance Plan or have equivalent health insurance coverage, regardless of the number of credit hours taken. At the time of registration, the student will automatically be enrolled in the mandatory UHS-endorsed Student Health Insurance Plan (SHIP) and will be charged for the coverage period on their student financial account. UH Main International students with "F" or "J" visa status may request a waiver of coverage based on the UH System's waiver criteria. For more information regarding the waiver, please go to uhsystem.myahpcare.com.

**Class II: Student Eligibility requirements for the following campuses:**

- ***University of Houston - College of Medicine***

All ***University of Houston College of Medicine*** students are required to have the Student Health Insurance Plan unless comparable coverage is provided.

- ***University of Houston – Visiting Scholars/Students***

***International*** students with "F" or "J" visa status are required to be covered under the UH System (UHS) Student Health Insurance Plan or have equivalent health insurance coverage, regardless of the number of credit hours taken. At the time of registration, the student will automatically be enrolled in the mandatory UHS-endorsed Student Health Insurance Plan (SHIP) and will be charged for the coverage period on their student financial account.

***Visiting Scholars*** with "F" or "J" visa status may request a waiver of coverage based on the UH System's waiver criteria. For more information regarding the waiver, please go to uhscholars.myahpcare.com and click on the "Opt-Out" tab.

- ***University of Houston-Language and Culture Center (LCC)***

***Domestic Students:***

***Domestic students***, including U.S. citizens and Permanent Residents, will not be enrolled in the Plan. Domestic Students may seek coverage by enrolling in the Plan during the open enrollment period and paying the required premium.

***International Students:***

Each term, all international students with "F" or "J" visa status in the Language and Culture Center (LCC) will be automatically enrolled in and charged for the UHS Student Health Insurance Plan. International students in non-F and non-J statuses will not be enrolled in the Plan.

**Class III: Dependent Eligibility and Enrollment are offered for the following schools:**

- ***UH-Language and Culture Center***
- ***UH-Visiting Scholars/Students***

A student must actively attend classes for at least the first 31 days after the date for which coverage is purchased, unless he or she withdraws from classes due to an Injury or Sickness and the absence is an approved medical leave. We maintain the right to investigate student status and attendance records to verify that the eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any unearned premium paid for that person.

A person may be insured only under one class of eligible persons even though he or she may be eligible under more than one class.

Dependents, as defined by this Policy, of ***Class III*** persons are eligible for coverage under this Policy.

A person may not be insured as a Dependent and an Insured at the same time.

An Insured's Dependent is eligible on the date:

- the Insured is eligible, if the Insured has Dependents on that date; or
- the date the person becomes a Dependent of the Insured, if later.

In no event will a Dependent be eligible if the Insured is not enrolled for coverage under this Policy. Individuals who are eligible to receive Medicare benefits are not eligible to enroll in this Plan, unless they fall within a Federal exception.

The Plan Administrator along with the Institution will designate annual open enrollment periods during which Students may apply for or change coverage for themselves and/or their eligible spouse and/or Dependents.

This section "Annual Open Enrollment Periods" is subject to change by Blue Cross and Blue Shield, and/or applicable law, as appropriate.

**Qualifying Event**

Eligible Students and eligible Dependents who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Policy provided, within 31 days of the qualifying event, such Students must complete and forward a qualifying events form and the letter of ineligibility. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, including Domestic Partner, whether by death, divorce or annulment, gain of a Dependent whether by birth, adoption, or suit for adoption or court-ordered Dependent coverage, or loss of dependent status because of age. The premium will be the same as The premium will be prorated based on what] it would have been at the beginning of the semester or quarter, whichever applies. However, the Effective Date will be the later of the date the Student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends.

# Enrollment and Effective Date of Coverage

**Effective Date of Insurance**

The Policy begins on the Policy Effective Date at 12:00 AM, Standard Time at the address of the Policyholder.

Insurance for an Eligible Person who enrolls during the program's enrollment period, as established by the Institution, is effective on the latest of the following dates:

- the Policy Effective Date;
- the date We received the completed enrollment form;
- the date after the required premium is paid; and
- the date the Student enters the Eligible Class

Coverage for a Student's eligible Dependent who enrolls:

- during the enrollment period established by the Policyholder; or
- within 31 days after the Student acquires a new Dependent; or
- within 31 days after a Dependent terminates coverage under another Dental Care Plan,

is effective on the latest of the following dates:

- the first day of the Coverage Period;
- the date the Student enters the Eligible Class; and
- the date after the required premium is paid.

After the time periods described above, the Student and/or Dependent must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another Dental Care Plan.

We will pay benefits for a newborn child of the Participant until that child is 31 days old. Coverage may be continued beyond the 31 days if the Covered Person notifies Us of the child's birth and pays the required premium, if any.

Adopted children, as defined by the Policy, will be covered on the same basis as a newborn child from the date the child is placed for adoption with the Participant or the date the Participant becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the Participant's legal obligation terminates.

**Continuation of Coverage**

A Participant who has been insured under this Policy may continue to be insured under this Policy when coverage terminates subject to the following:

- Continuation of Coverage is available to Participants and his covered Dependents, when the Participant leaves the Institution, dies, or when the covered Dependent no longer qualifies as an eligible Dependent.
- The Participant requesting coverage must have been insured under this Policy for at least 3 consecutive months.
- Requests for Continuation of Coverage, with the applicable premium, must be mailed to the Administrator, within 30 days of:
  - the date the existing coverage would otherwise terminate; or
  - the date the Participant is notified by the Plan Administrator or the Institution of the right to continue the coverage.

- Coverage and benefits will be the same as those, which are applicable prior to continuation.
- Premium rates for Continuation of Coverage are higher than student rates. Rates, and forms to request Continuation of Coverage, are available in the Student Insurance Office.
- The maximum period for which coverage may be continued is 3 months.
- Continuation of Coverage is not available to persons who are eligible for coverage under another Dental Care Plan, including Medicare.

# Premium and Reinstatement Provisions

The premiums for this Policy will be based on the rates currently in force, the plan, and amount of insurance in effect.

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 the Participant for such amounts, or adjust the Premium rates to reflect such increase, on the effective date of such increase. Upon request, the Participant 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. The Participant's premium payments should be submitted to BCBSTX at the address shown on the billing statement.

**Policy Grace Period**

A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end upon the expiration of the Grace Period. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

**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 Participant shall have the same rights under the Policy as he had immediately before the due date of the defaulted premiums, including his 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.

**Refund of Premium**

A pro-rata refund of Premium by Us to the Participant will only be made in the event of:

- A Participant's death; or
- The Participant enters full-time active duty in any Armed Forces; and We receive proof of such active duty service.

# Payment of Benefits; Participant/Dentist Relationship

**Payment of Benefits**

When benefits are payable, We will pay either the Participant or the Dentist. This payment constitutes Our full responsibility to the Participant 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 the 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 the Participant shall, if unpaid at his death, be paid to his surviving beneficiary; if there is no surviving beneficiary, then such benefits shall be paid to his estate.

**Participant/Dentist Relationship**

The choice of a Dentist should be made solely by the Participant or his 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 the Participant or his 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.

We will pay Eligible Expenses incurred by the Participant or on behalf of him or any insured Dependent. Expenses must be incurred while the 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 the Participant incurs under the Policy. In determining the Allowable Amount, BCBSTX will consider such factors as the Dentist's usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances, and whether the Dentist is a Contracting Dentist. The portion of the charges by the Participant's Dentist that exceeds the Allowable Amount of BCBSTX will be the Participant's responsibility to pay to his Dentist, except when he has used a Contracting Dentist. The Participant 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 the Participant during a Benefit Period 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.

# Dental Benefit Information

**Annual Maximum Benefit**

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

The maximum benefits payable during a Benefit Period 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 is 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 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 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.

**Predetermination of Benefits**

Predetermination is an estimate by BCBSTX of your eligibility under the Plan for Dental benefits or covered Dental services, the amount of your Deductible, Copayment or Coinsurance Amount related to Dental benefits or covered Dental services and the maximum benefit limits for Dental benefits or covered Dental services.

If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of $300, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with BCBSTX prior to the commencement of treatment.

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

BCBSTX will notify you and the Dentist of:

- Your eligibility under the Plan;
- your Deductible, Copayment and Coinsurance Amount related to Dental benefits or covered Dental services; and
- the maximum benefit limits for Dental benefits or covered Dental services.

Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

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 a Participant's 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 1-855-267-0214.

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

# Covered Dental Services

**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, including counseling with primary caregiver is covered for a child under the age of three.
- 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.
- Topical fluoride application – Benefits for fluoride application are only available to 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 to 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, or oral hygiene counseling.

# Covered Dental Services

**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
- Resin-based composite restorations
- 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 planning – Benefits are limited to one per quadrant every 24 months
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
- Scaling in the presence of generalized moderate to severe gingival inflammation is limited to once every 6 months combined with prophylaxes and periodontal maintenance.
- Periodontal maintenance procedures – 4 in 12 months combined with prophylaxes after completion of active periodontal therapy. Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as 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. Bone grafts are excluded in conjunction with extractions, apicoectomy or any non- covered service or non-eligible 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 limits do not apply to Participants up to age 19.
- Distal or proximal wedge procedure.
- Anatomical crown exposures – are 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.

# Covered Dental Services

**Major Restorative Services**

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

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

Benefits will not be provided for the replacement of a 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 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.

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

**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 – Benefits will be limited to one procedure every 36 months after the initial 6-month period following initial placement.
- Fixed bridgework – Benefits will be provided for the initial installation of a 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.

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 the plan.

- Implant retained crowns, bridges, and dentures are subject to the alternate benefit provision of the plan.
- 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.

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 the 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.

Benefits are available for Dentally Necessary Covered Services incurred for an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth.

# 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 the Participant's Dental Benefits

- Dental Procedures Which Are Not Dentally Necessary

Please note that in order to provide the Participant 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 a 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 the Participant changes Dentists in the middle of a particular Course of Treatment, benefits will be provided as if he had stayed with the same Dentist until his treatment was completed. There will be no duplication of benefits.

- Alternate Benefits

In all cases in which there is more than one service or Course of Treatment to treat a covered person's dental condition, the benefit will be based on the less costly covered services or Course of Treatment, as determined by BCBSTX.

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

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), the Plan will pay for the service that represents the final treatment as determined by the Plan.

If the Participant and his Dentist decide on personalized restorations, or personalized complete or partial dentures and over dentures, or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the least costly course of treatment or procedures for dental services, 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:

1. Services or supplies not specifically listed as a covered service, or when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Amount, as determined by BCBSTX.
3. 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 pediatric orthodontic Benefit.
4. 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.

5. 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 the Participant's mouth is not considered an accidental injury.
6. Dental services which are performed due to injuries arising from Interscholastic Activities and Intercollegiate Sports.
7. 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.
8. Services or supplies that do not meet accepted standards of dental practice.
9. Experimental/Investigational services and supplies and all related services and supplies.
10. Hospital and ancillary charges.
11. 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.
12. Services or supplies for which the Participant is not required to make payment or would have no legal obligation to pay if he did not have this or similar coverage.
13. Services or supplies for which "discounts" or waiver of Deductible or coinsurance amounts are offered.
14. 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.
15. Services or supplies received for behavior management or consultation purposes.
16. 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.
17. 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.
18. Charges for nutritional, tobacco or oral hygiene counseling.
19. Charges for local, state or territorial taxes on dental services or procedures.
20. Charges for the administration of infection control procedures as required by local, state or federal mandates.
21. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
22. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
23. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
24. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
25. 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.

26. Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to the Participant's 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.
27. Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage.
28. Case presentations or detailed and extensive treatment planning when billed for separately.
29. Charges for occlusion analysis or occlusal adjustments.

# Coordination of Benefits

Coordination of Benefits (COB) applies to this Benefit Program when a Student or a Student's covered Dependent has health care coverage under more than one Benefit Program.

The order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Benefit Program are determined before or after those of another Benefit Program. The benefits of this Benefit Program:

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

In addition to the Definitions Section of this Policy, the following definitions apply to this section:

**ALLOWABLE EXPENSE** means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless a Participant's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program.

When a Benefit Program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

**BENEFIT PROGRAM** means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

i. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

ii. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (i) or (ii) above is a separate benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate program.

**CLAIM DETERMINATION PERIOD** means the Benefit Period. However, it does not include any part of the Benefit Period during which a person has no coverage under this Benefit Program, or any part of the Benefit Period before the date this COB provision or a similar provision takes effect.

**PRIMARY PROGRAM or SECONDARY PROGRAM** means the order of payment responsibility as determined by the order of benefit determination rules.

When this Benefit Program is the Primary Program, its benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its benefits are determined after those of the other Benefit Program and may be reduced because of the other program's benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs and may be a Secondary Program as to a different program or programs.

**ORDER OF BENEFIT DETERMINATION**

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program which has its benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

# Coordination of Benefits

This Benefit Program determines its order of benefit payments using the first of the following rules which applies:

1. Non-Dependent or Dependent

   The benefits of the Benefit Program which covers the person as an employee, member or subscriber (that is, other than a Dependent) are determined before those of the Benefit Program which covers the person as a Dependent, except that, if the person is also a Medicare beneficiary, Medicare is:

   a. Secondary to the Benefit Program covering the person as a Dependent; and

   b. Primary to the Benefit Program covering the person as other than a Dependent, for example a retired employee.

2. Dependent Child if Parents not Separated or Divorced

   Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a Dependent of different persons, called "parents:"

   a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but

   b. If both parents have the same birthday, the benefits of the program which covered the parents longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

   If two or more Benefit Programs cover a person as a Dependent Child of divorced or separate parents, benefits for the child are determined in this order:

   a. First, the program of the parent with custody of the child;

   b. Then, the program of the spouse of the parent with the custody of the child; and

   c. Finally, the program 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 expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This paragraph does not apply with respect to any Claim Determination Period or Benefit Program year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify Blue Cross and Blue Shield and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share 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 Benefit Programs covering the child shall follow the order of benefit determination rules outlined in 2 above.

5. Active or Inactive Employee

   The benefits of a Benefit Program which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Benefit Program which covered that person as a laid off or retired employee (or as that employee's Dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of benefit determination:

a. First, the benefits of a Benefit Program covering the person as an employee, member or subscriber (or as that person's Dependent);
b. Second, the benefits under the continuation coverage.

7. Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which covered that person for the shorter term.

**WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM**

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the benefits of this Benefit Program may be reduced.

The benefits of this Benefit Program will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made;

Exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

When the benefits of this Benefit Program are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Program.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or obtain the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give Blue Cross and Blue Shield any facts necessary to pay the Claim.

**FACILITY OF PAYMENT**

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, Blue Cross and Blue Shield 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 Benefit Program. Blue Cross and Blue Shield will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**RIGHT OF RECOVERY**

If the amount of payments made by Blue Cross and Blue Shield is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

# Termination of Coverage

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

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

**Termination in a Dental Plan purchased through the Exchange**

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

a. When the Participant terminates his coverage in this Dental Policy including as a result of his obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to 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 the Participant, if he provides reasonable written notice; or
   - 14 days after the termination is requested by the Participant, if he does not provide reasonable notice; or
   - On a date determined by BCBSTX, if BCBSTX is able to effectuate termination in fewer than 14 days and the Participant requests an earlier termination effective date; or

b. This Dental Plan terminates or is decertified; or

c. The Participant changes from one Dental Plan to another during an annual open enrollment period or special enrollment period. The last day of coverage in the Participant's prior Dental Plan is the day before the effective date of coverage in his Dental Plan.

**Termination by Blue Cross and Blue Shield of Texas**

1. The coverage of the Participant 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 the Participant and received prior thereto; or
   c. On the date the Participant's 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 the Participant's date of death; or
   f. On the date following 90 days advance notice by Us to the Participant, but only if We are terminating all other of 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; or
      2. Coverage for any child who is medically certified as Disabled and Dependent upon the Participant shall not terminate upon reaching age 26 if the child continues to be both: (a)

Disabled, and (b) dependent upon the Participant 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 this Policy and before the child attains 26. The Participant 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 age26.

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 the Participant and received by Us prior thereto.

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

   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 Participant.

   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.

# General Provisions

**Claim Forms**

We will furnish to the Participant, his 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**

The Participant, on behalf of himself and his 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**

The Participant 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 the Participant does 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 the Participant resides. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of the Participant's health coverage sponsored by the Policyholder. As part of the overall Policy that Blue Cross and Blue Shield of Texas offers to, the Participant, if he does not reside in the Blue Cross and Blue Shield of Texas service area, Blue Cross and Blue Shield of Texas may facilitate his right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Participant resides. To do this We may (1) communicate directly with the Participant and/or (2) provide the Host Blues whose service area covers the geographic area in which the Participant resides, with his personal information and may also provide other general information relating to his coverage under the Policy the Policy holder 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 Participant understands that this Policy constitutes a contract solely between the Participant 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 Participant 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 Participant for any of its obligations whatsoever on the on the part of BCBSTX other than those obligations created under other provision of this Policy.

**Notice of Claim**

The Participant 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 Participant 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 Participant 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.

**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 Participant, later than one year from the time proof is otherwise required.

**Participant/Dentist Benefit Website**

Information concerning covered Dental services is available to you and your Dentist on our website www.bcbstx.com.

**Refund of Benefit Payments**

If BCBSTX pays benefits for Eligible Dental Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSTX has the right to a refund from the Participant for whom such benefits were paid, any other insurance company, any other organization, or from the Dentist who received the overpayment. If no refund is received, BCBSTX may deduct any refund due it from any future benefit payment but, will not deduct the amount of an overpayment of a claim from a payment or reimbursement for a dental care service provided by a Dentist who did not receive the overpayment.

**Payment or Reimbursement of Dentist**

The payment or reimbursement process for a Non-Contracting Dentist will be the same as the payment or reimbursement for a Contracting Dentist.

The Plan provides one or more methods of payment or reimbursement that provide the Dentist the full contracted amount of the payment or reimbursement without the Dentist incurring a fee to access payment or reimbursement.

**Reimbursement**

a. If We pay or provide benefits for the Participant under this Policy, We are subrogated to all rights of recovery which he has 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 Participant's rights to recover money through judgment, settlement or otherwise from any person, organization or insurer.

b. 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.

c. 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.

d. 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.

e. 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 his coverage and/or his 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 the Participant may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is affected. 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.

**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.

The Participant has the right to seek and obtain a review by Us of any determination of a claim, or any other determination made by Us of the Participant's benefits under this Policy.

*If a Claim Is Denied or Not Paid in Full*

On occasion, We may deny all or part of the Participant's claim. There are a number of reasons why this may happen. We suggest that the Participant first read the *Explanation of Benefits* summary prepared by Us; then review this Policy to see whether the Participant understands the reason for the determination. If the Participant has additional information that he believes 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, the Participant 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;
- 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*

Post-Service Claim is notification in a form acceptable to Us that a service has been rendered or furnished to the Participant. This notification must include full details of the service received, including the Participant's 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 the Participant.

## Post-Service Claims

| Type of Notice or Extension | Timing |
|---|---|
| If the Participant's claim is incomplete, We must notify the Participant within: | 30 days |
| If the Participant is notified that his claim is incomplete, he must then provide completed claim information to Us within: | 45 days after receiving notice |
| *BCBSTX must notify the Participant 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 the Participant 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 the Participant or his Provider, the period for Our making the determination is tolled from the date We send notice of extension to the Participant 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, 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.

*How to Appeal an Adverse Benefit Determination*

The Participant has the right to seek and obtain a full and fair review of any determination of a claim, or any other determination made by Us in accordance with the benefits and procedures detailed in this Policy.

An appeal of an Adverse Benefit Determination may be requested orally or in writing, by the Participant or a person authorized to act on his 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 the Participant except to his authorized representative. To obtain an Authorized Representative Form, the Participant or his representative may call Us at the number on the back of his ID card.

If the Participant believes We incorrectly denied all or part of his benefits, he may have his claim reviewed. We will review the decision in accordance with the following procedure:

- Within 180 days after the Participant receives notice of a denial or partial denial, he may write to BCBSTX. We will need to know the reasons why the Participant does not agree with the denial or partial denial. Send the 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.
- In support of the Participant's claim review, the Participant has the option of presenting evidence and testimony to Us. The Participant and his authorized representative may ask to review his file and any relevant documents and may submit written issues, comments and additional dental information within 180 days after he receives notice of an Adverse Benefit Determination or at any time during the claim review process.

We will provide the Participant or his authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of his 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 the Participant or his authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give the Participant a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a dental judgment, the appeal determination will be made by a Dentist associated or contracted with Us and/or by external advisors, but who were not involved in making the initial denial of the Participant's claim.

- If the Participant has any questions about the claims procedures or the review procedure, they can write to Our Administrative Office or call the toll-free Customer Service Helpline number shown in this Policy or on the Participant's Identification Card.

*Timing of Appeal Determinations*

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

*Expedited Appeals*

An expedited appeal is available for emergency care, life-threatening conditions and if you are hospitalized. If your situation meets the definition of an expedited appeal, you may be entitled to an appeal on an expedited basis. An "expedited clinical appeal" is an appeal of a clinically urgent nature related to dental care services, including but not limited to, procedures or treatments ordered by a health care provider or the denial of emergency care.

Before authorization of benefits for an ongoing course of treatment is terminated or reduced (concurrent review), BCBSTX will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited or concurrent appeal of an adverse determination, BCBSTX will notify the party filing the appeal, as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. BCBSTX will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSTX.

*Notice of Appeal Determination*

We will notify the party filing the appeal, the Participant, 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 the Participant and his 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;
- The Participant's 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 the Participant's appeal, in whole or in part, or he do not receive a timely decision, he has the right to request an external review of his claim by an independent third party, who will review the denial and issue a final decision. The Participant's external review rights are described in the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO) section below.

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

An "Adverse Determination" means a determination by 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 the Participant, his designated representative or Provider of record, information on how to appeal the denial, including the approved form, which the Participant, his designated representative, or his 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, the Participant or his 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 the Participant from pursuing other appropriate remedies, including civil action, injunctive relief; a declaratory judgment or other relief available under law.

For more information about the IRO process, call the Texas Department of Insurance (TDI) on the IRO information line at (866) 554-4926, or in Austin call (512) 322-4266.

**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:

(1) The Texas Health and Human Services Commission is paying benefits pursuant to provisions in the Human Resources Code; and

(2) The parent who is covered by this Contract has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and

(3) 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.

# Notice of Annual Meeting

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Health Care Service Corporation. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois at 12:30 p.m. on the last Tuesday in October.

**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
Email: CivilRightsCoordinator@hcsc.net

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<br>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<br>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<br>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<br>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<br>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<br>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<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।. |
| Italiano<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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. |

# NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

## Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

**Prohibitions:** We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

## Coverage and/or Benefits for Reconstructive Surgery After Mastectomy - Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including;

(a) all states of the reconstruction of the breast on which the mastectomy was performed;
(b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
(c) prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Deductibles, coinsurance and copayment amounts will be the same as those applied to other similarly covered medical services as shown on the Benefit Highlights.

**Prohibitions:** We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

# NOTICE OF CERTAIN MANDATORY BENEFITS

## Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and
(b) a prostate-specific antigen test for each covered male who is
  (1) at least 50 years of age; or
  (2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

## Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Since we provide in-home post-delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay.

**Prohibitions.** We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

## Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of: (a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or (b) a colonoscopy performed every 10 years.

# NOTICE OF CERTAIN MANDATORY BENEFITS

## Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

## Treatment of Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services:

(a) cognitive rehabilitation therapy;
(b) cognitive communication therapy;
(c) neurocognitive therapy and rehabilitation;
(d) neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
(e) neurofeedback therapy, remediation;
(f) post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
(g) reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the information above, please call Blue Cross and Blue Shield of Texas at 1-800-521-2227 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.

# NOTICE

## Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements

### Out-of-Area Services

Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, herein called BCBSTX has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you access healthcare services outside of BCBSTX service area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program, and may include Negotiated Arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

When you receive care outside our service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("non-participating healthcare Providers") don't contract with the Host Blue. We explain how we pay both types of Providers below.

### A. BlueCard® Program

Under the BlueCard Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you receive covered healthcare services outside BCBSTX's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

### B. Negotiated (non-BlueCard Program) Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a Negotiated Arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

## C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1) In General

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for Non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2) Exceptions

In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

A. the amount calculated using the methodology described in the Certificate for Non-Participating Providers located inside your service area (and described in Section C(a)(1) above); or

B. the following:

(i) for Professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

(ii) for Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Blue Cross and Blue Shield of Texas will make for the Covered Services as set forth in this paragraph.

## D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

## E. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSTX has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

## F. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered healthcare services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Emergency Care Services**

  This Contract covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Care and Urgent Care obtained outside of the United States. Follow-up care following an emergency is also available, provided the services are preauthorized by BCBSTX. Any other services will not be eligible for benefits unless authorized by BCBSTX.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**

  Outpatient Services are available for the treatment of Emergency Care and Urgent Care.

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSTX, the BlueCard Worldwide Service Center or online at www.bcbsglobalcore.com If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

## Texas Department of Insurance Notice

- You have the right to an adequate network of preferred providers (also known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
  - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

- You have the right, in most cases, to obtain estimates in advance:
  - from out-of-network providers of what they will charge for their services; and
  - from your insurer of what it will pay for the services.

- You may obtain a current directory of preferred providers at the following website: www.bcbstx.com or by calling the Customer Service number on the back of your ID card for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

- If the amount you owe to an out-of-network Facility-based Provider or emergency care provider is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) and the health benefit claim is for emergency care, health care services or supplies received in a network facility, you may be entitled to have the parties participate in a teleconference, and if the result is not to your satisfaction, in a mandatory mediation at no cost to you. For purposes of this mediation provision, a Facility-based Provider means a physician, Health Care Practitioner, or other health care provider who provides health care or medical services to patients of a facility; a Health Care Practitioner means an individual who is licensed to provide health care services; and an emergency care provider means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.