AcademicBlue℠

Houston City College Student Health Dental Plan 2026-2027

Underwritten by: Blue Cross and Blue Shield of Texas

Please review to understand your coverage.

AcademicBlue is offered by 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

9204528.0226

AcademicBlue℠

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)

Has issued this

Student Dental Insurance

Policy to

Houston City College

This **policy** describes the terms and conditions of coverage as issued to the policyholder named above. This **policy** is issued in the state of Texas and is governed by its laws. This **policy** becomes effective at 12:01 A.M. on the **policy effective date** at the policyholder's address.

Blue Cross and Blue Shield of Texas ("the plan"), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (the "insurer") and the policyholder have agreed to all of the terms of this **policy** as stated herein.

Policyholder has confirmed to us that it is an **institution** of higher education as defined in the Higher Education Act of 1965. This **policy** does not make dental insurance available other than in connection with enrollment as a **student** (or a **dependent** of a **student**) in the policyholder's **institution**. If you have any questions once you have read this **policy**, you can call us at the toll-free telephone number on the back of your **identification card**. It is important to all of us that you understand the protection this coverage gives you.

James Springfield
President, 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.

Have a complaint or need help?

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

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

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation

To get information or file a complaint with your insurance company or HMO:
Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-888-697-0683
Email: BCBSTXComplaints@bcbstx.com
Mail: P. O. Box 660044, Dallas, TX 75266-0044

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation

Para obtener información o para presentar una queja ante su compañía de seguros or HMO:
Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-888-697-0683
Correo electrónico: BCBSTXComplaints@bcbstx.com
Dirección postal: P. O. Box 660044, Dallas, TX 75266-0044

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439 Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-OP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

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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 amounts**, annual maximums and/or out-of-pocket limits below are subject to change as permitted by applicable law.

BlueCare Dental 1B

Covered Services	Benefit Payable In Network	Benefit Payable Out of Network
Diagnostic Evaluations (Deductible waived)	90%	90%
Preventive Services (Deductible waived)	90%	90%
Diagnostic Radiographs (Deductible waived)	90%	90%
Miscellaneous Preventive Services	90%	90%
Basic Restorative Services	70%	70%
Non-Surgical Extractions	70%	70%
Non-Surgical Periodontal Services	70%	70%
Adjunctive Services	70%	70%
Endodontic Services	50%	50%
Oral Surgery Services	50%	50%
Surgical Periodontal Services*	50%	50%
Major Restorative Services*	50%	50%
Prosthodontic Services*	50%	50%
Miscellaneous Restorative and Prosthodontic Services*	50%	50%
Implants	Not Covered	
Orthodontia	Not Covered	
Deductible	$75 Individual / $225 Family	$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 Benefits is for Covered Persons 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 amounts**, 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 In Network	Benefit Payable Out of Network
Diagnostic Evaluations (Deductible waived)	80%	80%
Preventive Services (Deductible waived)	80%	80%
Diagnostic Radiographs (Deductible waived)	80%	80%
Miscellaneous Preventive Services	80%	80%
Basic Restorative Services	50%	50%
Non-Surgical Extractions	50%	50%
Non-Surgical Periodontal Services	50%	50%
Adjunctive Services	50%	50%
Endodontic Services	50%	50%
Oral Surgery Services	50%	50%
Surgical Periodontal Services	50%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Miscellaneous Restorative and Prosthodontic Services	50%	50%
Implants	50%	
Pediatric Orthodontia (Deductible waived)	50%	
Deductible	$75 Individual / $225 Family	$75 Individual / $225 Family
Annual Maximum	None	
Out-of-Pocket Maximum		
1 Child:	$450	
2+ Children:	$900	

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.

GLOSSARY

Throughout this policy, many words are used which have a specific meaning when applied to your health care coverage. These terms will always be bolded. When you come across these terms while reading this policy, you can refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition is bolded, it means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER. In this policy we refer to our company as "Blue Cross and Blue Shield of Texas" and we refer to the institution of higher education in which you are enrolled and active as the "institution."

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 us and the **dentist**:

- 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.

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.

Benefit Period means the period of time during which you receive the covered services for which we 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 this **policy**. The **benefit period** is as agreed to by the policyholder and BCBSTX.

Benefit Waiting Period means the amount of time you must be continuously covered under this **policy** before you are eligible for a certain class of benefits. The **benefit waiting period** for each class of benefits is shown in the SCHEDULE OF BENEFITS.

Coinsurance Amount means the dollar amount (expressed as a percentage) of **eligible expenses** incurred by you during a **benefit period** 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.

Covered Person means any eligible **student** or an eligible **dependent** (if applicable) who applies for coverage, and for whom the required premium is paid.

Deductible means the dollar amount of **eligible expenses** that you must incur before benefits under this **policy** will be available.

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

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

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

Dependent means your spouse, **domestic partner** (if applicable), or a 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 natural child of you or your **dependent**

- A legally adopted child of you, your spouse, or **domestic partner** (if applicable), including a child for whom you are a party in a suit in which the adoption of the child is being sought
- A stepchild
- An eligible foster child of you, your spouse, or **domestic partner** (if applicable)
- A child for whom you, your spouse, or **domestic partner** (if applicable) must provide coverage because of a court order or administrative order pursuant to state law
- Each grandchild of you, your spouse, or **domestic partner** (if applicable) who is younger than 26 years of age, and is a **dependent** of you, your spouse, or **domestic partner** (if applicable), for federal income tax purposes at the time the application for coverage of the grandchild is made
- Any other child you, your spouse, or **domestic partner** (if applicable) 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 **policy**, the term **dependent** also includes a child who is over the age of 26, chiefly supported by you 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 you have entered into a domestic partnership in accordance with the guidelines established by BCBSTX, as appropriate.

Effective Date means the date your coverage becomes effective under this **policy**.

Eligible Expense 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

- 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 you indicating pertinent information applicable to your coverage under this **policy**, including applicable copayment and **deductible** 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 you 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.

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 means this **policy** issued by Blue Cross and Blue Shield to the **institution**, any addenda, the **institution's** application for student dental insurance, the **covered person's** application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

Student means an individual **student** who meets the eligibility requirements for this dental coverage, as described in the eligibility requirements of this **policy**.

Teledentistry means services delivered by a **dentist** or other health professional acting under the delegation and supervision of a **dentist**, acting within the scope of the **dentist's** or other health professional's license or certification to a patient via telephone or similar technology.

You, Your, Yours means the **student** to whom this **policy** is issued.

ELIGIBILITY FOR INSURANCE

Each person in one of the classes 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 this **policy** is in force. You must meet the **institution's** requirements for maintaining your status as an eligible **student**. Please contact your **institution** for further information. We maintain the right to investigate **student** status and attendance records to verify that eligibility requirements have been met.

Classes of Eligible Persons

Only International Students are eligible for coverage under this policy.

NOTE: Multiple classes may be added depending on the **institution**.

A person may not be insured as a **dependent** and a **student** at the same time.

Individuals who are eligible to receive Medicare benefits are not eligible to enroll in this **policy** unless they fall within a federal exception.

No eligibility rules or variations in premium will be imposed based on a student's health status, medical condition, claims experience, receipt of health care, medical or dental history, genetic information, evidence of insurability, disability, or any other health status factor. A student will not be discriminated against for coverage under this policy on the basis of race, color, national origin, disability, age, life expectancy, quality of life, sex, gender identity, sexual orientation, religion, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits. Variations in the administration, processes, or benefits of this policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

EFFECTIVE DATE OF COVERAGE

This **policy** begins on the **policy effective date** at 12:01 AM, Standard Time, at the address of the policyholder.

Coverage when you enroll 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 receive the completed enrollment form
- The date after the required premium is paid
- The date you enter the eligible class

After the time periods described above, you and/or your **dependent** (if applicable) 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 your newborn child until that child is 31 days old.

Adopted children, as defined by this **policy**, will be covered on the same basis as a newborn child from the date the child is placed for adoption with you or the date you 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 your legal obligation terminates.

Qualifying Event

You and your eligible **dependents** (if applicable) who have a change in status and lose coverage under another health care plan are eligible to enroll for coverage under this **policy**. Within 31 days of the qualifying event, you or your **dependent** must complete supporting documentation. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, including **domestic partner** (if applicable), whether by death, divorce, or annulment, gain of a **dependent** whether by birth, adoption, suit for adoption, court-ordered **dependent** coverage, or loss of **dependent** status because of age. 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 you or your **dependent** enroll for coverage under this **policy** and pay the required premium, or the day after the prior coverage ends. Please contact your **institution** for further information.

PREMIUM AND REINSTATEMENT PROVISIONS

The premiums for this **policy** will be based on the rates currently in force, BCBSTX, and the 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 **benefit period**, BCBSTX reserves the right, at its option, to charge the policyholder for such amounts or adjust the premium rates to reflect such increase on the effective date of such increase. Upon request, the policyholder 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 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. This **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 this **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, you shall have the same rights under this **policy** as you had immediately before the due date of the defaulted premiums, including your right to apply the period of time this **policy** was in effect immediately before the due date of the defaulted premiums toward satisfaction of any **benefit waiting period** or benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Refund of Premium

A refund of premium will be made only in the event:

- Of your death
- You enter 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 you or the **dentist**. This payment constitutes our full responsibility to you under this **policy**.

Except as provided above, the rights and benefits of this **policy** shall not be assignable, either before or after services and supplies are provided. However, if a written assignment of benefits is made by you to a **dentist** and the written assignment is delivered to us with the claim for benefits, we will make any payment directly to the **dentist**.

Any benefits payable to you shall, if unpaid at your death, be paid to your surviving beneficiary. If there is no surviving beneficiary, then such benefits shall be paid to your estate.

Participant/Dentist Relationship

The choice of a **dentist** should be made solely by you. BCBSTX does not furnish services or supplies but only makes payment for **eligible expenses** incurred by you. BCBSTX is not liable for any act or omission by any **dentist**. BCBSTX does not have any responsibility for a **dentist's** failure or refusal to provide services or supplies to you. 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 you or on your behalf. Expenses must be incurred while this **policy** is in force and after the **benefit waiting period**, if applicable, and while the person is covered by this **policy**. Any **deductible**, **coinsurance amount** and annual and lifetime benefit maximums, if applicable, are shown in the SCHEDULE OF BENEFITS.

Allowable Amount

The **allowable amount** is the maximum amount of benefits BCBSTX will pay for **eligible expenses** you incur under this **policy**. In determining the **allowable amount**, BCBSTX will consider such factors as 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 your **dentist** that exceeds the **allowable amount** of BCBSTX will be your responsibility to pay to your **dentist**, except when you have used a **contracting dentist**. You will also be responsible for charges for services, supplies, and procedures limited or not covered under this **policy** and any applicable **deductibles**.

Review the definition of **allowable amount** in the GLOSSARY 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 you 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 **covered persons** will be deemed to have satisfied their **deductible** for the remainder of that calendar year. No **covered person** 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 you 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 you 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 6-month or 12-month **benefit waiting period** for certain classes of benefits as indicated in the SCHEDULE OF BENEFITS. The **benefit waiting period** applies to each **covered person** separately and begins for each **covered person** on their **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
- On the date the service is performed for all other services

Predetermination of Benefits

Predetermination is an estimate by BCBSTX of your eligibility under this **policy** 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 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 your **dentist** of:

- Your eligibility under this **policy**
- Your **deductible**, copayment and **coinsurance amount** related to dental benefits or covered dental services
- 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.

This **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.

It is important for you to refer to your SCHEDULE OF BENEFITS to find out what your **deductible**, **coinsurance amount** and annual maximum will be for a covered service. If you do not have a SCHEDULE OF BENEFITS, please call Customer Service at the toll-free telephone number on the back of your **identification card**.

Your dental benefits include coverage for the following covered services as long as these services are rendered to you 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 until the end of the month they turn 19
- 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 **covered persons** under age 19 and are limited to two applications every 12 months

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 **covered persons** up to age 19 and one set per calendar year for **covered persons** 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 **covered persons** under age 19
- Space Maintainers - benefits for space maintainers are limited to **covered persons** under age 19. Benefits are not available for nutritional, tobacco, or oral hygiene counseling

Basic Restorative Services

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

- Amalgam restorations - benefits are limited to one restoration per surface per tooth.
- Resin-based composite restorations - benefits are limited to one restoration per surface per tooth
- Non-surgical extractions

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

- Removal of retained coronal remnants - deciduous tooth
- Removal of erupted tooth

Non-Surgical Periodontal Services

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

- Periodontal scaling and root planing - benefits are limited to one per quadrant every 24 months
- 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 **covered persons** with a disability or for a justifiable medical, mental, or dental condition. A person's apprehension does not constitute **dental necessity**
- Therapeutic parenteral drugs - therapeutic parenteral drugs will be covered for **covered 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 - benefits are limited to once per lifetime
- 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 **covered persons** age 19 and over, benefits are limited to one per site every 24 months. This benefit limits do not apply to **covered persons** 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.

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 6 - month period following installation. Benefits for replacements are limited to once in any 60 - month period, whether placement was provided under this **policy** or under

any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss
- Dentures 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 only if determined to be a **dental necessity**. Claim reviews 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 this **policy**.

Endosteal, eposteal, and transosteal implants - one every 60 months, only if determined to be a **dental necessity**.

Benefits will not be provided for the following prosthodontic services:
- Treatment to replace teeth which were missing prior to the **effective date**
- Congenitally missing teeth
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework

Miscellaneous Restorative and Prosthodontic Services

Other restorative and other prosthodontic restorative services include:
- Prefabricated crown - 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 **covered persons** who meet the 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 **covered persons** covered for orthodontics as shown on the SCHEDULE OF BENEFITS. Covered services include:

- Limited, interceptive, and comprehensive orthodontic treatment

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 you are 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
- If orthodontic treatment is terminated for any reason before completion, benefits will cease on the date of termination
- If your coverage is terminated prior to the completion of the orthodontic treatment plan, you are 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 your ongoing care 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.

Teledentistry

Benefits for teledentistry are provided on the same basis, and to the same extent, as benefits that are provided for services that are received in an in-person setting.

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 GLOSSARY section) licensed to perform services covered under this dental **policy**.

Important Information About Your Dental Benefits

Dental Procedures Which Are Not Dentally Necessary

Please note that in order to provide you with dental care benefits at a reasonable cost, this **policy** provides benefits only for those covered services for eligible dental treatment that are determined by BCBSTX to be **dentally necessary**. No benefits will be provided for procedures which are not **dentally necessary**.

The fact that 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 you change **dentists** in the middle of a particular **course of treatment**, benefits will be provided as if you had stayed with the same **dentist** until 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 your 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, we will pay the most comprehensive service as determined by us.

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

If you and your **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 your cooperation with the **dentist** or from non-compliance with prescribed dental care will be your responsibility.

Exclusions - What Is Not Covered

No benefits will be provided under this **policy** for:

- Services or supplies not specifically listed as a covered service, or when they are related to a non-covered service
- Amounts which are in excess of the **allowable amount**, as determined by BCBSTX

- Dental services treatment of congenital or developmental malformation or services performed for cosmetic purposes, including but not limited to, bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as included in the pediatric orthodontic benefit
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this **policy** or if resulting from **accidental injury**. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this **policy**
- Dental services which are performed due to an **accidental injury** for **covered persons** age 19 and over. Any injury caused by chewing or biting an object or substance placed in your mouth is not considered an **accidental injury**
- Dental services which are performed due to injuries arising from **interscholastic activities** and **intercollegiate sports**
- Services and supplies for any illness or injury suffered after your **effective date** as a result of war or any act of war, declared or undeclared, or while on active or reserve duty in the armed forces of any country or international authority
- Services or supplies that do not meet accepted standards of dental practice
- Experimental/Investigational services and supplies and all related services and supplies
- Hospital and ancillary charges
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants for covered persons age 19 and over
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage
- Services or supplies for which "discounts" or waiver of **deductible** or **coinsurance amounts** are offered
- Services or supplies received from someone other than a **dentist**, except for those services received from a licensed dental hygienist under the supervision and guidance of a **dentist**, where applicable
- Services or supplies received for behavior management or consultation purposes
- Any services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by you for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy
- Charges for nutritional, tobacco or oral hygiene counseling
- Charges for local, state, or territorial taxes on dental services or procedures
- Charges for the administration of infection control procedures as required by local, state, or federal mandates
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional appliances

- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers
- Charges for personalized complete or partial dentures and over dentures, related services and supplies, or other specialized techniques
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your **effective date** under this **policy**; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your **effective date**
- Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage
- Case presentations or detailed and extensive treatment planning when billed for separately
- Charges for occlusion analysis or occlusal adjustments

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to this benefit program when you or your covered dependent (if applicable) 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:

- Shall not be reduced when, under the order of benefit determination rules, this benefit program determines its benefits before another benefit program
- Benefits 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 GLOSSARY 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 your 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:

- The other benefit program has rules coordinating its benefits with those of this benefit program
- 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.

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
   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
   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
   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:

- The benefits that would be payable for the allowable expenses under this benefit program in the absence of this COB provision
- 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:

- The persons it has paid or for whom it has paid
- Insurance companies
- Other organizations

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

TERMINATION OF COVERAGE

Termination Date of Insurance

Your coverage will end on the earliest of the date:

- This **policy** terminates
- You are no longer eligible
- The period ends for which the premium is paid

We may terminate this **policy** by giving 31 days written (authorized electronic or telephonic) notice to the policyholder. Either we or the policyholder may terminate this **policy** on any premium due date by giving 31 day advance written (authorized electronic or telephonic) notice to the other. This **policy** may be terminated at any time by mutual written or authorized electronic/telephonic consent of us and the policyholder.

This **policy** terminates automatically on the earlier of:

- The termination date shown in this **policy**
- The premium due date if premiums are not paid when due
- The **policy effective date** of the renewal of this **policy** if you decide to renew coverage under this **policy**, and the **policy effective date** of the renewal of this **policy** becomes effective before this policy terminates

Termination takes effect at 12:00 AM, Standard Time at the address of the policyholder on the date of termination.

Refund of Premium

A refund of premium will be made only in the event:

- Of your death
- You enter full-time active duty in any Armed Forces, and we receive proof of such active-duty service

Extension of Benefits

If your coverage under this **policy** terminates, benefits will continue for any covered dental services described in this **policy**, as long as the covered service began prior to the date the coverage terminated and is completed within 30 days of your termination date. NOTE: If you terminate coverage under this **policy**, you will not be eligible to re-enroll for dental coverage until the next annual open enrollment period if applicable.

Continuation of Coverage

A **covered person** 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 insureds and their covered **dependents** (when applicable) when the **student** leaves school, dies, or when the covered **dependent** no longer qualifies as an eligible dependent.
- The **covered person** requesting coverage must have been insured under this **policy** for at least 4 months.

- Requests for continuation of coverage, with the applicable premium, must be submitted within 30 days of:
    - The date the existing coverage would otherwise terminate
    - The date the **covered person** is notified of the right to continue the coverage
- Coverage and benefits will be the same as those which were applicable prior to continuation.
- Premium rates for continuation of coverage may be higher than **student** rates.
- 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.

GENERAL PROVISIONS

Claim Forms

We will furnish to you, your physician, or **dentist**, upon receipt of a notice of claim or prior thereto, such forms as we usually furnish for filing proof of loss. If such forms are not furnished within 15 days after receipt of such notice by us, you shall be deemed to have complied with the requirements of this **policy** as to proof of loss upon submitting, within the time fixed in this **policy** for filing such proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Disclosure Authorization

You shall be deemed to have authorized any attending physician or **dentist** to furnish us all information and records or copies of records relating to your diagnosis, treatment, or care included under this **policy**; and you shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

Gender

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

Legal Actions

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

Member Data Sharing

You may, under certain circumstances as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, or if you do not reside in the Blue Cross and Blue Shield of Texas service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your coverage sponsored by the policyholder. As part of the overall **policy** that Blue Cross and Blue Shield of Texas offers to you, if you do not reside in the Blue Cross and Blue Shield of Texas service area, Blue Cross and Blue Shield of Texas may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue service area in which you reside. To do this we may communicate directly with you and/or provide the Host Blues whose service area covers the geographic area in which you reside with your personal information and may also provide other general information relating to your coverage under this **policy** the policyholder 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

You understand that this **policy** constitutes a contract solely between you 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. You also understand that you have 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 you for any of its obligations whatsoever on the on the part of BCBSTX other than those obligations created under other provisions of this **policy**.

Notice of Claim

You shall give written notice to BCBSTX within 30 days, or as soon as reasonably possible, after you receive 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 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 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 policyholder 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 you. 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, 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** (if applicable) 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 you for such benefits that 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**.

We provide 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

If we pay or provide benefits for you under this **policy**, we are subrogated to all rights of recovery which you have in contract, tort or otherwise against any person, organization, or insurer for the amount of benefits we have paid or provided. That means we may use your rights to recover money through judgment, settlement or otherwise from any person, organization or insurer.

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

Right of Reimbursement: In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, we will have a right of reimbursement. If you recover money from any person, organization or insurer for an injury or condition for which we paid benefits under this **policy**, you agree to reimburse us from the recovered money for the amount of benefits paid or provided by us. That means you will pay us the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits we paid or provided.

Right to Recovery by Subrogation or Reimbursement: You agree to promptly furnish to us all information concerning your rights of recovery from any person, organization or insurer and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights. You or your 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. You further agree not to allow the reimbursement and subrogation rights BCBSTX to be limited or harmed by any acts or failure to act on your part.

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 your application may result in the cancellation of your coverage and/or your dependent(s) coverage (if applicable) retroactive to the **effective date**, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield of Texas (BCBSTX) may deduct from

the premium refund any amounts made in claim payments during this period and you may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is 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

Claim Determinations

When we receive a properly submitted claim, we have authority under this **policy** to interpret and determine benefits in accordance with the **policy** provisions. We will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing.

You have the right to seek and obtain a review by us of any determination of a claim, or any other determination made by us of your benefits under this **policy**.

If a Claim Is Denied or Not Paid in Full

On occasion, we may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by us, then review this **policy** to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to us and request a review of the decision as described in the claim appeal procedures below.

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

- The reasons for determination
- A reference to the benefit provisions on which the determination is based, a description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available.
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review)
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request
- An explanation of the scientific or clinical judgment relied on in the determination as applied to your 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 you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the claim charge, and any other information which we may request in connection with services rendered to you.

Post-Service Claims

Type of Notice or Extension	Timing
If your claim is incomplete, we must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	45 days after receiving notice
BCBSTX must notify you of any adverse claim determination:	
If the initial claim is complete, within:	30 days after receipt of the claim
After receiving the completed claim (if the initial claim is incomplete), within:	45 days, if we extended the period, less any days already utilized by us during our review*

* This period may be extended one time by us for up to 15 days, provided that we both (1) determine that such an extension is necessary due to matters beyond our control and (2) notify you in writing, prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the period is extended because we require additional information from you or your provider, the period for our making the determination is tolled from the date we send notice of extension to you until the earlier of the date on which we receive the information or the date by which the information was to be submitted.

1. 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/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
You have the right to seek and obtain a full and fair review of any determination of a claim, or any other determination made by 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 you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on their own behalf.

Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

To obtain an authorized representative form, you or your representative may call us at the toll-free telephone number on the back of your **identification card**.

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

- Within 180 days after you receive notice of a denial or partial denial, you may write to BCBSTX. We will need to know the reasons why you do not agree with the denial or partial denial. Send 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 your claim review, you have the option of presenting evidence and testimony to us. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional dental information within 180 days after you receive notice of an adverse benefit determination or at any time during the claim review process.
- We will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse benefit determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a 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 your claim.
- If you have any questions about the claim procedures or the review procedure, you can write to our Administrative Office or call Customer Service at the toll-free telephone number on the back of your **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, you, and if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

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

- A reason for the determination
- A reference to the benefit plan provisions on which the determination is based
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available.
- An explanation of our external review processes (and how to initiate an external review)
- The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request
- Your right, if applicable, to request external review by an independent review organization
- Contact information for applicable office of health insurance consumer assistance or ombudsman

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

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

An "Adverse Determination" means a determination by us or our designated utilization review organization that a dental care service that is a covered service has been reviewed and based upon the

information provided is determined to be experimental or investigational or does not meet our requirement for **dental necessity** or appropriateness and the requested service or payment for the service is therefore denied or reduced.

This procedure (not part of the complaint process) pertains only to appeals of adverse determinations.

Any party whose appeal of an adverse determination is denied by us may seek review of the decision by an IRO. At the time the appeal is denied, we will provide you, your designated representative, or provider of record information on how to appeal the denial, including the approved form, which you, your designated representative, or your provider of record must complete.

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

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

- Information relied upon to make the decision
- Information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision
- Descriptions of the administrative process and safeguards used to make the decision
- Records of any independent reviews conducted by us
- Dental judgments, including whether a particular service is **experimental/investigational** or not **dentally necessary** or appropriate
- Expert advice and consultation obtained by us in connection with the denied claim, whether or not the advice was relied upon to make the decision

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

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 **policy** must be paid to the Texas Health and Human Services Commission where:

- The Texas Health and Human Services Commission is paying benefits pursuant to provisions in the Human Resources Code
- The parent who is covered by this **policy** 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
- 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.

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language 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, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

bcbstx.com TX1557_ENG_20250410

BlueCross BlueShield of Texas

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.