Termination of Coverage

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

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

Termination in a Dental Plan purchased through the Exchange

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

a. When the Participant terminates his coverage in this Dental Policy including as a result of his obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to BCBSTX. For the purposes of this section, reasonable notice is defined as 14 days from the requested effective date of termination; or

   The last day of coverage will be:

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

b. This Dental Plan terminates or is decertified; or

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

Termination by Blue Cross and Blue Shield of Texas

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

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

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

   c. On the date the Participant's coverage for dental insurance cancels or terminates; or

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

   e. On the Participant's date of death; or

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

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

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

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

      (2) Coverage for any unmarried child who is medically certified as Disabled and dependent upon the Participant shall not terminate upon reaching age 26 if the child continues to be both: (a) Disabled, and (b) dependent upon the Participant for more than one-half of his support as defined by the Internal Revenue Code of the United States.

      Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under this Policy and before the child attains 26. The Participant must submit satisfactory proof of the disability and dependency to Us within 31 days following the child's attainment of age 26. As a condition to the continued coverage of a child as a disabled Dependent beyond age 26.We may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of age 26.

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

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

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

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

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

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

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

General Provisions

Claim Forms

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

Disclosure Authorization

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

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

Gender

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

Legal Actions

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

Member Data Sharing

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

Non-Agency

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

other than those obligations created under other provision of this Policy.

Notice of Claim

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

Physical Examinations and Autopsy

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

Policy; Amendments

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

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

Proof of Loss

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

Refund of Benefit Payments

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

Reimbursement

a. If We pay or provide benefits for the Participant under this Policy, We are subrogated to all rights of recovery which he has in contract, tort or otherwise against any person, organization or insurer for the amount of benefits We have paid or provided. That means We may use the Participant's rights to recover money through judgment, settlement or otherwise from any person, organization or insurer.

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

c. Right of Reimbursement: In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, We will have a right of reimbursement. If any Participant covered under this Policy recovers money from any person, organization or insurer for an injury or condition for which We paid benefits under this Policy, all Participants covered under this Policy agrees to reimburse Us from the recovered money for the amount of benefits paid or provided by Us. That means any Participant covered under this Policy will pay Us the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits We paid or provided.

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

e. Our process to recover by subrogation or reimbursement will be conducted in accordance with Texas Civil Practice and Remedies Code Title 6, Chapter 140.

Rescission of Coverage

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

Review of Claim Determinations

a. Claim Determinations

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

If a Claim Is Denied or Not Paid in Full

On occasion, We may deny all or part of the Participant's claim. There are a number of reasons why this may happen. We suggest that the Participant first read the *Explanation of Benefits* summary prepared by Us; then review this Policy to see whether the Participant understands the reason for the determination. If the Participant has additional information that he believes could change the decision, send it to Us and request a review of the decision as described in Claim Appeal Procedures below.

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

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

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's dental circumstances, if the denial was based on dental necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are two types of claims, as defined below.

1. Pre-Service Claim is any request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining dental care.

2. Post-Service Claim is notification in a form acceptable to Us that a service has been rendered or furnished to the Participant. This notification must include full details of the service received, including the Participant's name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the claim charge, and any other information which We may request in connection with services rendered to the Participant.

Pre-Service Claims

Type of Notice	Timing
BCBSTX must notify the Participant of the claim determination (whether adverse or not):	
if We have received all information necessary to complete the review, within:	2 working days of or our receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar days of the request, if the claim is denied.

Post-Service Claims

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

* This period may be extended one time by Us for up to 15 days, provided that We both (1) determine that such an extension is necessary due to matters beyond the control of the Plan and (2) notify the Participant in writing, prior to the expiration of the initial 30−day period, of the circumstances requiring the extension of time and the date by which We expect to render a decision. If the period is extended because We require additional information from the Participant or his Provider, the period for Our making the determination is tolled from the date We send notice of extension to the Participant until the earlier of: i) the date on which we receive the information; or ii) the date by which the information was to be submitted.

b. Claim Appeal Procedures

Claim Appeal Procedures - Definitions

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

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

How to Appeal an Adverse Benefit Determination

The Participant has the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, 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 in writing, by the Participant or a person authorized to act on his behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about the Participant except to his authorized representative. To obtain an Authorized Representative Form, the Participant or his representative may call Us at the number on the back of his ID card. The Participant may orally request an appeal if the requested dental service has been denied on the basis that it is not dentally necessary or it is experimental or investigational.

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

- Within 180 days after the Participant receives notice of a denial or partial denial, he may write to BCBSTX. We will need to know the reasons why the Participant does not agree with the denial or partial denial. Send the request to:

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

- We will honor telephone requests for information. However, such inquiries will not constitute a request for review.

- In support of the Participant's claim review, the Participant has the option of presenting evidence and testimony to Us. The Participant and his authorized representative may ask to review his file and any relevant documents and may submit written issues, comments and additional dental information within 180 days after he receives notice of an Adverse Benefit Determination or at any time during the claim review process.

We will provide the Participant or his authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of his claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to the Participant or his authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give the Participant a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a dental judgment, the appeal determination will be made by a Dentist associated or contracted with Us and/or by external advisors, but who were not involved in making the initial denial of the Participant's claim.

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

Timing of Appeal Determinations

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

Notice of Appeal Determination

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

The written notice to the Participant and his authorized representative will include:

- A reason for the determination;

- A reference to the benefit plan provisions on which the determination is based

- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available;

- An explanation of Our external review processes (and how to initiate an external review);

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

- The Participant's right, if applicable, to request external review by and Independent Review Organization; and

- Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

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

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

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

Any party whose appeal of an Adverse Determination is denied by Us may seek review of the decision by an IRO. At the time the appeal is denied, We will provide the Participant, his designated representative or Provider of record, information on how to appeal the denial, including the approved form, which the Participant, his designated representative, or his Provider of record must complete.

- We will submit dental records, names of Providers and any documentation pertinent to the decision of the IRO.

- We will comply with the decision by the IRO.

- We will pay for the independent review.

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

- information relied upon to make the decision;

- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;

- descriptions of the administrative process and safeguards used to make the decision;

- records of any independent reviews conducted by Us;

- dental judgments, including whether a particular service is Experimental/Investigational or not dentally necessary or appropriate; and

- expert advice and consultation obtained by Us in connection with the denied claim, whether or not the advice was relied upon to make the decision.

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

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

State Government Programs

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

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

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

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

(3) We receive written notice at Our Administrative Office, affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

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.