BlueCross BlueShield of Texas

BlueCare Dental[SM] 1D

Blue Cross and Blue Shield of Texas *(herein called "BCBSTX, We, Us, Our")*

REQUIRED OUTLINE OF COVERAGE

I. Read Your Policy Carefully. This Outline of Coverage provides a very brief description of some important features of Your Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of You, Your Physician or Professional Other Provider and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

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

II. The Policy is designed to provide You with coverage for diagnostic and preventive dental care, as well as almost every form of specialty dental treatment.

Coverage is provided for the Benefits outlined in Paragraph III. The Benefits described in Paragraph III may be limited by Paragraph IV.

III. Benefits. Your dental care Benefits are highlighted below.

A. **Benefit Period –** Your Benefit Period is a Calendar Year (begins January 1 and ends December 31).

B. **Deductible –** The Calendar Year Deductible will be subtracted once during each Calendar Year from each Participant's total Eligible Expenses.

Benefits	Deductible Amount
Calendar Year Deductibles • Individual • Maximum Annual Deductible per Family	 $50 $150

C. **Covered Services** – 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. A 6-month waiting period applies to some services.

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

Covered Services	Benefit Payable Adult Services (Age 19 and Over)	Benefit Payable Pediatric Services (Applies to Dependent Children under the age of 19.)
Diagnostic Evaluations (Deductible waived)	100%	80%
Preventive Services (Deductible waived)	100%	80%
Diagnostic Radiographs (Deductible waived)	100%	80%
Miscellaneous Preventive Services	100%	80%
Basic Restorative Services*	50%	50%
Non-Surgical Extractions*	50%	50%
Non-Surgical Periodontal Services*	50%	50%
Adjunctive Services*	50%	50%
Endodontic Services	Not Covered	50%
Oral Surgery Services		50%
Surgical Periodontal Services		50%
Major Restorative Services		50%
Prosthodontic Services		50%
Miscellaneous Restorative and Prosthodontic Services		50%
Implants		50%
Orthodontia (Deductible waived)		
Pediatric Orthodontia	Not Covered	50%
Optional Orthodontia	Not Covered	Not Covered
Annual Maximum	$1,000	Unlimited
Out-of-Pocket Maximum	None	
1 Child:		$425
2+ Children:		$850

*6 Month Benefit Waiting Period applies.

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

IV. Limitations and Exclusions

These general Limitations and Exclusions apply to all services described in the dental Policy. Dental coverage is limited to services provided by a Dentist or a dental auxiliary 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. Dentally Necessary generally means that a specific procedure provided to You is required for the treatment or management

of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to You, as determined by BCBSTX.

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

- **Care By More Than One Dentist**

  If You change Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if You had stayed with the same Dentist until Your treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

  In all cases in which there is more than one covered procedure or Course of Treatment possible to treat your dental condition, the Benefit will be based upon the least costly covered procedure or Course of Treatment, as determined by BCBSTX. If the Participant requests or accepts the more costly service, the Participant is responsible for expenses that exceed the amount covered for the least costly service.

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

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

  If You and Your Dentist decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the least costly Course of Treatment or procedures for dental services, as determined by Us.

- **Non-Compliance with Prescribed Care**

  Any additional treatment and resulting liability which is caused by the lack of a Participant's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Participant.

Exclusions — What Is Not Covered

No Benefits will be provided under this Policy for:

- Services or supplies not specifically listed as a covered service, or when they are related to a non-covered service;
- Amounts which are in excess of the Allowable Amount, as determined by BCBSTX;
- Dental services treatment of congenital or developmental malformation or services performed for cosmetic purposes including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as included in the Medically Necessary Orthodontic Benefit subsection of the Covered Dental Services section in the Policy;
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Policy or if resulting from Accidental Injury.
- Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Policy;
- Dental services which are performed due to an Accidental Injury. For Participants age 19 and over injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury;
- Services and supplies for any illness or injury suffered after the Participant's Effective Date as a result of war or any act of war, declared or undeclared, or while on active or reserve duty in the armed forces of any country or international authority;
- Services or supplies that do not meet accepted standards of dental practice;
- Experimental/Investigational and/or Unproven services and supplies and all related services and supplies;
- Hospital and ancillary charges;
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants for Participants age 19 and over;

- Services or supplies for which You are not required to make payment or would have no legal obligation to pay if You did not have this or similar coverage;
- Services or supplies for which "discounts" or waiver of Deductible or coinsurance amounts are offered;
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable;
- Claims for a service which is for the same service performed on the same date for the same member;
- Services or supplies received for behavior management or consultation purposes;
- Any services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether or not Benefits are, or could upon proper claim be, provided under the Workers' Compensation law;
- Any services or supplies for which Benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- Charges for nutritional, tobacco or oral hygiene counseling;
- Charges for local, state, or territorial taxes on dental services or procedures;
- Charges for the administration of infection control procedures as required by local, state, or federal mandates;
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional appliances;
- Charges for audio-only telephone consultations, text-only email messages, facsimile transmissions, 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, or preparations or medicament carriers;
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques;
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers;
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to Your Effective Date under this Policy; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after Your Effective Date;
- Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage;
- Case presentations or detailed and extensive treatment planning when billed for separately;
- Charges for occlusion analysis, diagnostic casts, or occlusal adjustments;
- Gold foil restorations;
- Cone beam imaging and cone beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Orthodontic care for dependent children age 19 and over;
- Localized delivery of antimicrobial agents or chemotherapeutic agents;
- Benefits for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants;
- Anatomical crown exposures;
- 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;
- Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions;
- Restoration occlusion on incisal edges due to bruxism or harmful habits;
- Treatment to replace teeth which were missing prior to the Effective Date;
- Congenitally missing teeth;
- Replacement or repair of an orthodontic appliance;
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework;

- Comprehensive periodontal evaluations or problem-focused evaluations if covered services are rendered on the same date as any other oral evaluation and by the same Dentist;
- Tests and oral pathology procedures, or for re-evaluations;
- Any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction;
- Local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application;
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal;
- Endodontic therapy if you discontinue endodontic treatment;
- Surgical services related to a congenital malformation;
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another Benefit plan;
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
- Treatment of fractures of facial bones;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints; or
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

BCBSTX may, without waiving these exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from the Participant's coverage, We will be entitled to recover the amount we have allowed for Benefits under this Policy. The Participant must provide BCBSTX with all documents We need to enforce its rights under this provision.

V. Renewability

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

If Your coverage this Dental Policy is terminated for any reason BCBSTX will provide You with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage. If You purchased this Policy through the Exchange, BCBSTX will also notify the Exchange, of the termination effective date and the reason for termination.

Termination in a Dental Plan purchased through the Exchange

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

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

   The last day of coverage will be:

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

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

c. This Dental Plan terminates or is decertified; or

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

Termination by Blue Cross and Blue Shield of Texas

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

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

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

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

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

e. On Your date of death; or

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

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

VI. Premiums

A. The initial premium rate for Your Plan selection under this Policy is $_____. Enclose the premium with your application.

Premiums are payable monthly or quarterly and are due on the first day of each Policy Month.

The initial premium is required to place the insurance in force. There is no insurance unless the first month's premium is paid.

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

B. **Grace Period**

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

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

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

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

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

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

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

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilnį.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.