

EMPLOYEE BENEFIT PLAN
(herein referred to as the “Dental Choice Plan”)

MASTER BENEFIT PLAN DOCUMENT
Describing the
STATE OF TEXAS
DENTAL CHOICE PLANSM

Administered by HumanaDental

For the

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

Dental Choice Plan Effective Date: September 1, 2009

Group Number: 536957

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Article I General Information

A. Name of Dental Choice Plan

Name of the dental Preferred Provider Organization (PPO) plan under the Texas Employees Group Benefits Program shall be known as the State of Texas Dental Choice Plan for the Employees Retirement System of Texas (ERS).

B. Type of Plan

A voluntary, self-funded dental PPO plan with a national dental network of participating Dental Providers.

C. Type of Administrator

Benefits administered by HumanaDental.

D. Address for Dental Choice Plan Administration

HumanaDental - ERS
PO Box 14639
Lexington, KY 40512-4639
toll-free (877) 377-0987

E. Dental Choice Group Number 536957

F. Choice of Dental Provider

Each Covered Person has the right to choose any licensed Dental Provider. If a participating Dental Provider is used, a lower Coinsurance will be paid by the Participant rather than if a non-participating Dental Provider is used. The Dental Choice Plan does not guarantee that participating Dental Providers are available in all areas or specialties.

G. Entire Contract; Changes

This document is the entire contract of coverage. ERS has the right to change the terms and conditions of the Dental Choice Plan. Any change will be made in writing. Any such change will be binding on all Covered Persons without notice to or consent by them.

Article II Definitions

As Used Herein:

Abutment - A tooth, tooth root, or Implant fixture that supports a fixed or removable prosthesis.

Accidental injury – Is damage to the teeth, and supporting tissue, due directly to an accident and independent of all other causes. Accidental Injury does not include damage to the teeth, Appliances, or prosthetic devices which results from chewing or biting food or other substances.

Acid Etch - The etching of a tooth with a mild acid to help in the retention of Composite filling material.

Acrylic - Plastic materials used in the fabrication of Dentures and Crowns and as a component of filling material for Restorations.

Act - The Texas Employees Group Benefits Act (Chapter 1551 of the *Texas Insurance Code*).

Active Employee - An Employee as defined in the Act.

Adverse Decision - A determination by HumanaDental or ERS that the dental services proposed to be furnished to a Participant are not Dentally Necessary or otherwise denying benefits or coverage to a Participant.

Allowable Amount - The actual charge, or portion thereof, for a service or supply to the extent such service or supply is reasonably priced based on the diagnosis.

A Dental Providers' charge is an Allowable Amount if (based on the data base compiled by the Claims Administrator) it falls within the range of the charges for similar services or supplies customarily made by Dental Providers of dental services with similar training, experience, and facilities in the region as defined by the Claims Administrator. Regions, for this purpose, need not be composed of contiguous geographical areas and will be located only in the state of Texas.

- Contracting Provider:

Allowable Amount is based on the provisions of the Dental Provider contract and the payment methodology in effect on the date of service.

- Non-Contracting Provider:

Allowable Amount shall be determined by HumanaDental. HumanaDental determines the Allowable Amount, when possible, by using standard industry guides, such as national charge table of prevailing health care charges using the 80th percentile. This means that out of every 100 claims, 20 charged amounts may be more, but 80 charged amounts will be the allowed amount or less.

When HumanaDental has an insufficient data base for charges above a predetermined amount, HumanaDental shall determine an Allowable Amount by utilizing data from HumanaDental plans in other regions where such procedure is more common and a procedure code and sufficient charge table exists. In making a determination of the Dental Provider's Allowable Amount, the Claims Administrator shall consider unusual circumstances, or medical or dental complications requiring additional time, skill, experience, and facilities in connection with a particular service, which are specifically brought to the Claims Administrator's attention. The Claims Administrator will evaluate the charge table for the Allowable Amount determination on at least an annual basis to determine the need for adjustment.

Alternative Benefit Provision - There is often more than one service, supply or choice of treatment option that can be used to treat a dental problem or disease. In considering the benefits allowed on a claim or Predetermination of Benefits review, these different methods of treatment and materials will be considered. The Covered Dental Expense will be limited to the

- Contracted Fee amount for the most economical Covered Service or material which meets broadly accepted standards of dental care as determined by HumanaDental if a PPO/Traditional Preferred Network Dental Provider provides the service or supply, or
- The Usual and Customary Charge for the most economical service or material which meets broadly accepted standards of dental care as determined by HumanaDental if an Out-of-Network Dental Provider provides the service or supply.

The benefits payable are limited to the benefit that would have been payable if the least costly Covered Service had been provided. This is the Alternative Benefit. Any difference between the Alternative Benefit and the charge actually incurred is a Participant's responsibility, including any applicable Coinsurance.

HumanaDental determines Alternative Benefit for Covered Services when the claim is received. To avoid incurring expenses that are not covered by the Dental Choice Plan, a Participant should request a Predetermination of Benefits before treatment is started.

Amalgam - A metal alloy usually consisting of silver, tin, zinc, and copper combined with liquid pure mercury and used as restorative material in operative dentistry.

Anesthesia –

- **Local** - The condition produced by the administration of specific agents to achieve the loss of pain sensation in a specific location or area of the body.
- **General** - The condition produced by the administration of specific agents to render the patient completely unconscious and without pain sensation.

Anterior – The teeth or tissues located toward the front of the mouth; incisors and canines.

Annuitant – An individual eligible to participate in the GBP under Section 1551.102 of the Act.

Appliance - A device to splint teeth, move teeth, protect teeth, or replace missing teeth.

Benefits Coordinator - The person employed by the State Agency, college, or university who can provide assistance to Participants enrolling in various benefit plans and changing coverage. For Retirees, this assistance is provided by ERS.

Billed Charges – PPO/Traditional Preferred Network Dental Provider - Actual billed charges; except when the Dental Provider has contracted directly or indirectly with HumanaDental for a different amount. If the Dental Provider is contracted, then charges will be calculated based on a PPO/Traditional Preferred Network determined fee schedule or on a HumanaDental determined percentage of actual billed charges.

Bitewing - A type of dental X-ray film that has a tab or wing upon which the patient bites to hold the film in position.

Bridgework or Prosthetic Appliance –

- **Fixed** - Pontics (replacement teeth) retained with Crowns or Inlays cemented to the natural teeth, which are used as Abutments.
- **Fixed/Removable** – An Appliance that can be removed by the Dental Provider and not the patient.
- **Removable** - A Partial Denture held in place by attachments (normally clasps) that allow the Denture to be removed.

Calendar Year - The period of time, which starts January 1 and ends December 31 of each year. For any Covered Person who first becomes covered after January 1 of any year, a Calendar Year shall be deemed to be the continuous period of time between the date coverage became effective and December 31 of that year. Accumulation of Deductibles and annual maximums are based on Calendar Year.

Caries - A disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

Child - An unmarried child under 25 years of age, including:

- The natural Child of an Employee/Retiree;
- A legally adopted Child (including a Child living with the adopting parents during the period of probation);
- A stepchild whose primary place of residence is the household of the Employee/Retiree;
- A foster Child whose primary place of residence is the Employee/Retiree household and who is not covered by another governmental health program;
- A Child whose primary place of residence is the household of which the Employee/Retiree is head and to whom the Employee/Retiree is legal guardian of the person;
- A child who is in a parent-child relationship to the Employee/Retiree, provided the Child's primary place of residence is the household of the Employee/Retiree, the Employee/Retiree provides the necessary care and support for the Child, and if the natural parent of the Child is 21 years of age or older, the natural parent does not reside in the same household;
- A Child who is considered a Dependent of the Employee/Retiree for federal income tax purposes and who is a Child of the Employee/Retiree's Child;
- An eligible Child, as defined in this subsection, for whom the Employee/Retiree must provide medical support pursuant to a valid order from a court of competent jurisdiction; or
- A Child eligible under Section 1551.004 of the Act, provided that the Child's mental retardation or physical incapacity is a medically determinable condition which prevents the Child from engaging in self-sustaining employment, that the condition commences before the date of the Child's 25th birthday, and that satisfactory proof of such condition and dependency is submitted by the Employee/Retiree within 31 days following such Child's attainment of age 25 and at such intervals thereafter as may be required by the Employees Retirement System of Texas.

Claims Administrator - HumanaDental

Coinsurance - The stated percentage of Covered Expenses and supplies incurred by a Participant that must be paid by a Participant after any applicable Deductible has been met.

Composite - Tooth colored filling material primarily made up of resin and quartz particles.

Contracted Fee - PPO/Traditional Preferred Network Dental Provider – The total compensation that a Dental Provider who participates in the HumanaDental Network has agreed to accept as payment in full for dental procedures and services.

Cosmetic Procedure - Any procedure or portion of a procedure performed primarily to improve physical appearance or is performed for psychological purposes.

Course of Treatment - A planned program to correct a diagnosed dental problem or disease. A Course of Treatment starts when the Dental Provider first treats the dental problem.

Covered Oral Surgery - Oral and maxillofacial surgical procedures limited to those expenses listed and defined under Covered Service or Covered Dental Expenses.

Covered Person - A Participant or eligible Dependent who is covered under the Dental Choice Plan.

Covered Service or Covered Dental Expenses – A service or supply for which the Dental Choice Plan provides benefits. A full list of Covered Services is shown in Article V. To be a Covered Service, the service must be incurred while the person receiving the service is a Covered Person. Covered Services are subject to Dental Choice Plan provisions for exclusions and limitations and must meet acceptable standards of dental practice as determined by HumanaDental.

Crown - A natural Crown is a portion of a tooth covered by enamel. An artificial Crown (cap) restores the anatomy and function of the natural Crown.

Deductible - The initial dollar amount of services incurred in any Calendar Year for which no benefits are payable. Once this dollar amount has been met by the Participant, benefits under the Dental Choice Plan will be available at the applicable Coinsurance percentage.

Deductible Family Limit -

- **Diagnostic & Preventive Services:**
PPO/Traditional Preferred Network Dental Provider: \$0
Non-PPO/Traditional Preferred Network Dental Provider: \$150
- **Basic and Major Services:**
PPO/Traditional Preferred Network Dental Provider: \$150
Non-PPO/Traditional Preferred Network Dental Provider: \$300

When this happens, the Deductible for the entire family will be satisfied for that Calendar Year.

Dental Choice Plan – State of Texas Dental Choice PlanSM.

Dental Choice Plan Administrator - The Employees Retirement System of Texas (ERS).

Dental Provider - An individual who is duly licensed to practice dentistry or dental hygiene and is acting within the lawful scope of his or her license.

Dentally Necessary or Dental Necessity - Those services or supplies covered under the Dental Choice Plan, which, as determined by the Claims Administrator, are:

- Consistent with, appropriate to, and provided for the diagnosis or the direct care and treatment of the condition, illness, disease, or injury; and
- Not primarily for the convenience of the Participant or Dental Provider; and
- The most economical care or levels of service that are appropriate and available for the safe and effective treatment of the Participant, and
- Consistent with standards of good dental practice, and
- Not Experimental and Investigational in nature at the time services or supplies are provided.

In determining whether the use of any treatment, procedure, drug, device, or supply is Dentally Necessary, as that term is defined above, the Claims Administrator shall consider the views of the state and national dental associations, published articles and studies and other dental literature, and the views and practices of Medicare, Medicaid or other government-financed programs. The fact that a Dental Provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Dentally Necessary or make the charge a Covered Service or Supply even though it is not specifically listed as an exclusion.

The authority of the Claims Administrator to determine Dental Necessity is subject to the right of the ERS Executive Director, to order payment of a claim.

Denture - A device replacing missing teeth. The term usually refers to full or Partial Dentures, but it actually means any substitute for missing natural teeth.

Dependent – The spouse of an Employee or Retiree and eligible unmarried children under age 25, as further described in Section 1551.004 of the Act and Chapter 81.1(11) of the ERS Rules.

Disabled - The presence of any medically determinable physical or mental condition which prevents the Child from engaging in self-sustaining employment; provided that the disability commences and the Child was covered immediately prior to such Child's attainment of age 25 and that satisfactory proof of such disability and dependence is submitted by the Employee or Retiree within 31 days following such Child's attainment of age 25 and at such intervals thereafter as may be required by ERS.

Effective Date - The date the Participant's coverage begins under the Dental Choice Plan.

Eligible Person - Any Employee, Retiree, or their Dependent under the GBP as determined to be eligible by ERS.

Emergency - The sudden onset of a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of dental health, to believe that his condition, sickness or injury is of such a nature that failure to get immediate dental care could reasonably result in:

1. Placing the Participant's health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ; or
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee - An appointive or elective state officer or Employee in the service of the state of Texas, including an Employee of an institution of higher education, as defined in the Act, Chapter 1551, *Texas Insurance Code*.

Employer - The state of Texas and its state agencies, as State Agency is defined in the Act.

Endodontic Therapy - Treatment of diseases of the dental pulp.

Enrollment Period - The time period which begins with a Participant(s)' eligibility date and ends when the Participant is no longer an Eligible Person.

ERS - An acronym for Employees Retirement System of Texas.

Experimental and Investigational - A drug, device, equipment, facility, procedure, or treatment that is not generally accepted as standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval, if such approval has not been granted at the time services are provided.

Family Deductible - The total Deductible amount that a family must pay each Calendar Year. Once met, any remaining individual deductible amounts for that Calendar Year will be waived. See Deductible Family Limit definition for applicable family deductible amounts.

Fluoride - A solution of fluoride applied Topically to the teeth for the purpose of preventing dental decay.

Fund - The insurance trust fund created by the Act.

GBP - An acronym for the state of Texas Employees Group Benefits Program.

He/His - He or she and his or her unless the context clearly indicates otherwise.

Immediate Family Member - A person related by blood or marriage who is a spouse, parent, sister, brother, or child.

Implant - A device surgically inserted into or onto the jawbone. It may support a Crown or Crowns, Partial Denture, complete Denture or may be used as an Abutment for a Fixed Bridge.

Impression - A negative reproduction of a given area. It is made in order to produce a positive form or cast of the recorded teeth and/or soft tissues of the mouth.

Inlay - A Restoration made in a laboratory to fit a prepared tooth cavity and then cemented into place.

Malocclusion - An abnormal contact and/or position of the opposing teeth when brought together.

Maximum Allowable Charge - The maximum amount allowed by the Dental Choice Plan for Covered Services. HumanaDental's determination of what is allowable is final for the purpose of determining benefits payable under the Dental Choice Plan.

Maximum Benefit - The maximum amount that may be payable for each Covered Person, for services. The applicable Maximum Benefit is shown on the Schedule of Benefits. No further benefits are payable once the Maximum Benefit is reached.

Member - Any covered Eligible Person; a Participant.

Member Identification Number (Member ID) - The number shown on the HumanaDental Dental ID card which identifies the Member.

Network - The PPO/Traditional Preferred Network of Dental Providers that has been established by HumanaDental and approved to provide services for the Dental Choice Plan.

Network Benefits - The benefits available under the Dental Choice Plan for services and supplies provided by a PPO/Traditional Preferred Network Dental Provider.

Occlusion - How the upper and lower teeth make contact when brought together.

Office Visit - A visit performed by a Dental Provider for a Covered Service in which the reimbursement for the charge is not included in any other procedure already considered for benefits.

Onlay - A cast Restoration that completely covers one or more cusps on the chewing surface of a tooth.

Orthodontics – The branch of dentistry primarily concerned with the detection, prevention and correction of abnormalities in the positioning of teeth in their relationship to the jaws.

Out-of-Network – Services or supplies rendered by a provider outside the PPO/Traditional Preferred Network of Dental Providers that has been established by HumanaDental.

Out-of-Network Benefits - The benefits available, under the Dental Choice Plan, for services and supplies that are provided by an Out-of-Network Dental Provider and are specified in the Dental Choice Plan as Out-of-Network. Dental Provider benefits.

Out-of-Network Dental Provider - A Dental Provider who does not participate in the PPO/Traditional Preferred Network. Out-of-Network Dental Providers are not required to limit charges to the Maximum Allowable Charge and can balance bill the Participant for the difference between the Maximum Allowable Charge and their charges.

Palliative - To relieve, but not cure the source of pain.

Partial Denture - A prosthesis replacing one or more, but not all, of the natural teeth and associated structures.

Participant - An Employee, Retiree, or a Dependent, as defined in the Act, and surviving Dependents of deceased Employees and Retirees who are eligible for coverage under the Dental Choice Plan in accordance with ERS Rules, which are incorporated herein by reference, and whose coverage under the Dental Choice Plan has become effective in accordance with ERS Rules.

Part-Time Employee – A Part-Time Employee as defined in the Act.

Periodontics - The science of examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth.

Plan Year - Begins each September 1st and ends each August 31st.

Pontic - The part of a Fixed Bridge that replaces a missing tooth or teeth.

PPO/Traditional Preferred Network Dental Provider - A Dental Provider who participates in the HumanaDental Network and agrees to limit charges to a maximum charge as determined by the HumanaDental Network.

Posterior - Teeth or tissue toward the back of the mouth; distal to the canines includes premolars and molars.

Predetermination of Benefits - A process by which the Claims Administrator will review a proposed dental procedure to determine if benefits may be available under the Dental Choice Plan. A request for Predetermination of Benefits must be submitted in writing to the Claims Administrator. This request should provide enough dental information from the Participant's Dental Provider to determine the availability of benefits.

The Claims Administrator may request such information as:

1. Procedure code of the service to be rendered, and
2. Documentation with supporting records such as X-rays or study models.

A Predetermination of Benefits confirms the Dental Necessity of the care the Participant may receive. It does not guarantee payment. Payment will be determined after the claim is filed and is subject to eligibility, Allowable Amount, and other Dental Choice Plan provisions, limitations and exclusions in effect at the time services are rendered.

Premium - Contributions that are required to be paid to maintain coverage under the Dental Choice Plan.

Program - The Texas Employees Group Benefits Program as established by the ERS Board of Trustees.

Proof of Loss - Written Proof of Loss must be furnished to the Claims Administrator at its designated office, or to its duly authorized agent, no later than 18 months from the date that the services or supplies are provided to the Participant.

Prophylaxis - The removal of tartar and stains from the teeth; the cleaning of the teeth by a Dental Provider.

Rebase - A process of refitting a Denture by the replacement of the entire Denture-base material without changing the occlusal relations of the teeth.

Reline - To resurface the tissue-borne areas of a Denture with new material.

Restoration - A broad term applied to any Inlay, Onlay, Crown, Bridge, Partial Dentures, or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form or function of part or all of a tooth or teeth.

Retiree - An Employee who has retired as defined in the Act.

Root Canal Therapy – The complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals, and filling these spaces with a sealing material.

Rule or Rules - Those rules adopted by the Board of Trustees of ERS pursuant to the Act.

Scaling - The removal of calculus (tartar) and stains from teeth with special instruments.

Sealant - A resinous agent applied to the grooves and pits of teeth to prevent decay.

Splinting - Stabilizing or immobilizing teeth to gain strength.

State Agency – A commission, board, department, division, certain institutions of higher education or other agency of the state of Texas created by the constitution or statutes of this State. This term also includes the Texas Municipal Retirement System and the Texas County and District Retirement System.

Succeeding Plan - A Dental Plan that replaces the coverage of the Dental Choice Plan with its coverage.

Topical or topically - Painting the surface of teeth, as in Fluoride treatment, or applying an anesthetic formula to the surface of the gum.

Trustee - The Employees Retirement System of Texas, or its Board of Trustees.

Vertical Dimension - The degree of jaw separation when the teeth are in contact.

Usual and Customary Charge - For any service or supply, the Usual and Customary Charge will not exceed:

- The amount customarily charged by the Dental Provider for it; or
- The charge for the service or supply made by Dental Providers for comparable services or supplies in the same locality.

Usual and Customary Charge Special Provision - A special provision will apply when there is an insufficient charge table for comparable services or supplies in the same locality, or in the event of an unusual type of service or supply. When this happens, HumanaDental will determine the Allowable Amount, based on:

- The complexity involved;
- The degree of professional skill required;
- The cost of supplies; and
- Other pertinent factors.

HumanaDental may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized.

**Article III Eligibility for Coverage;
Effective Dates**

A. Authority

Any Employee or Retiree and/or his eligible Dependents who is an appointive or elective State officer or Employee in the service of the State of Texas, including an Employee of an institution of higher education, as defined in the Act, Chapter 1551, *Texas Insurance Code*, shall be eligible to apply for coverage under this Dental Choice Plan. The following eligibility and Effective Date provisions shall apply. Wherever the term “Retiree” is used, it shall mean the definition described in Article II.

B. Eligibility for Coverage

1. Any Employee or Retiree may, upon the date he becomes eligible, apply for coverage under the Dental Choice Plan for himself or for himself and his family members as Dependents in accordance with the Rules established by ERS, incorporated herein by reference. A Dependent, who is covered as an Employee or Retiree in the GBP, is not eligible for coverage as a Dependent in the GBP. A Dependent may not be covered by more than one Employee or Retiree in the GBP.
2. Eligible Dependents acquired after the Effective Date of the Employee’s or Retiree’s coverage shall become eligible in accordance with the Rules.
3. Coverage of the Employee or Retiree shall be a condition precedent to coverage of his eligible Dependents and no Dependent shall be covered under the Dental Choice Plan prior to the Employee’s or Retiree’s Effective Date.
4. A Participant should contact his Benefits Coordinator if an Employee, or ERS if a Retiree, for information regarding how and when a Participant may:
 - Add Dependents to coverage;
 - Drop Dependents from coverage; or
 - Obtain more information on when Dependents are no longer eligible for coverage.

C. Application for Coverage

Coverage of each eligible Employee or Retiree and his eligible Dependents shall be contingent upon the Employee or Retiree making application in accordance with the Rules.

D. Effective Dates – Timely Applications

If the application is for the initial coverage of an Employee or Retiree and his eligible Dependents and if the application is received by the Employing Office Benefits Coordinator or ERS within the first thirty-one (31) days following the Employee’s or Retiree’s date of eligibility, the coverage will become effective in accordance with the Rules. If the application is received on or before the first day of eligibility, coverage will become effective on the first day of eligibility.

E. Effective Dates – Late Applications

If an application for coverage for those eligible in accordance with Article III, is received by the Employing Office Benefits Coordinator or ERS more than thirty-one (31) days after the date such Employee or Retiree or Dependent becomes eligible, no coverage shall become effective unless a qualifying event occurs or until the next summer enrollment.

Article IV Payment of Benefits; Participant/Dental Provider Relationship; Coordination of Benefits

A. Payment of Benefits

1. Payment of benefits to the Dental Provider furnishing the service or to the Employee or Retiree, as the Claims Administrator may elect, shall constitute full discharge of all responsibility to the Employee or Retiree on account of benefits available to any Participant under the Dental Choice Plan, subject to Dental Choice Plan provisions.
2. Notwithstanding Subsection 1, above, of this Section A:
 - a. If payment in full or part has not been made to either the Dental Provider furnishing the service or to the Employee or Retiree for services or supplies provided to a minor Child who is a Dependent of the Employee or Retiree, benefits may be paid on behalf of such Child to a person other than the Dental Provider, Employee, or Retiree if an order by a court of competent jurisdiction names such person the managing conservator of such Child and such person has paid for the services or supplies provided to the Child; and
 - b. To be eligible to receive benefits, a managing conservator of a Child must submit to the Claims Administrator, with the claim form, proof of payment of charges for such services or supplies, written notice that such person is the managing conservator of the Child on whose behalf the claim is made, and a certified copy of a court order establishing the person as managing conservator.
3. The rights and benefits of the Dental Choice Plan shall not be assignable, either before or after services and supplies are provided, except for direct payment that the Participant may assign to Dental Providers.
4. It is understood and agreed that the allowances set out in Article IV for services and supplies furnished by a Dental Provider are not intended to and do not fix the value of the services of the Dental Provider nor in any way relate to or regulate such value; that such Dental Provider is privileged to make its regular charges and that the stipulated amounts are merely to apply credits thereon.
5. Any benefits payable to the Employee or Retiree shall, if unpaid at his death, be paid on the establishment of a valid claim to the person or persons surviving at the date of his death, in the following order of precedence:

First, to the beneficiary or beneficiaries designated by the Employee or Retiree in a signed and witnessed writing received before death by the Employing Office Benefits Coordinator. For this purpose, a designation, change, or cancellation of beneficiary in a will or other document not so executed and filed has no force or effect.

Second, if there is no designated beneficiary, to the widow or widower of the Employee or Retiree.

Third, if none of the above, to the child or children of the Employee or Retiree and descendants of deceased children by representation.

Fourth, if none of the above, to the parents of the Employee or Retiree or the survivor of them.

Fifth, if none of the above, to the duly appointed executor or administrator of the estate of the Employee or Retiree.

Sixth, if none of the above, to other kin of the Employee or Retiree entitled under the laws of the domicile of the Employee or Retiree at the date of his death.

If, within one year after the death of the Employee or Retiree, no claim for payment has been filed by a person entitled under the order of precedence named above, or if payment to the person within that period is prohibited by any statute or regulation, payment may be made in the order of precedence as if the person had predeceased the Employee or Retiree; and the payment bars recovery by any other person.

If, within two years after the death of the Employee or Retiree, no claim for payment has been filed by a person entitled under the order of precedence named above and neither the Trustee nor the Claims Administrator has received notice that such a claim will be made, payment may be made to the claimant who, in the judgment of the Trustee, if equitably entitled thereto, and the payment bars recovery by any other person.

If, within four years after the death of the Employee or Retiree, payment has not been made under this Section A and no claim for payment by a person entitled under this Section A is pending, the amount payable escheats to the credit of the Fund as defined in the Act.

B. Participant/Dental Provider Relationship

The choice of a Dental Provider is made solely by a Participant. The Dental Choice Plan does not furnish services or supplies but only makes payment for Covered Services and supplies incurred by Participants. Neither the Dental Choice Plan nor the Claims Administrator is liable for any act or omission by any Dental Provider, and they do not have any responsibility for a Dental Provider's failure or refusal to provide services or supplies to a Participant.

C. Coordination of Benefits

It is the intent of the Dental Choice Plan that the availability of benefits specified shall be subject to coordination of benefits as described below. A Participant must tell HumanaDental if he or a covered Dependent has other dental coverage. This is called "double coverage."

When a Participant has other dental coverage, one dental plan normally pays its benefits in full as the primary payer and the other dental plan pays a reduced benefit as the secondary payer. HumanaDental, like most Claims Administrators, determines the order of benefit payment according to the National Association of Insurance Commissioner's (NAIC) guidelines. The exception is Medicare. If a Participant has Medicare coverage, HumanaDental will follow Medicare's rules for which coverage is primary.

When the Dental Choice Plan is primary, regular benefits will be paid.

When the Dental Choice Plan is secondary, HumanaDental will determine the Allowable Amount. After the primary plan pays, HumanaDental will pay what is left of the Allowable Amount up to the regular benefit. There is no change in benefit limits or maximums when HumanaDental is the secondary payer.

Other Dental Coverage means any dental plan, contract or other means of paying the cost of dental care, including but not limited to:

- Group or blanket coverage;
- Any dental service plan for prepaid group coverage or direct reimbursement plan;
- Any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended;
- Government programs, including compulsory no-fault automobile coverage, and Medicare, unless applicable law prohibits coordinating benefits with these types of programs.

When a plan provides services directly, the reasonable cash value of each service is deemed to be both an allowable expense and a benefit paid.

Other Dental Coverage does not include:

- An accidental injury policy provided through a school either on a 24-hour basis or while traveling to and from school;
- A hospital indemnity plan, except as allowed by law;
- The Department of Defense health care program for Active Duty personnel and their families, military Retirees and their families (TRICARE);
- An individual policy, unless the policy is issued on a blanket or franchise basis;
- Medicaid; or,
- Any plan when by law its benefits are in excess of those of any private insurance program or other non-governmental program.

If Other Dental Coverage covers a person, the order of benefit payment will be made according to the following NAIC guidelines, unless the other coverage is Medicare:

- If the other plan does not provide for Coordination of Benefits, it will pay its benefits first.
- If the other plan covers an individual as the Member, it will pay before the plan that covers the individual as a Dependent.
- If both parents cover a Child, and the parents are still married, the plan of the parent whose birthday occurs first in the Calendar Year, excluding year of birth, will pay first.
- If a Child is covered by both parents, and the parents are divorced or legally separated, the plan of the parent with managerial custody will pay first before the plan of the stepparent or non-custodial parent unless, by court decree, one parent is held responsible for the health care expenses of the Child.

If a Covered Person is also eligible for Medicare, the order of benefit payment will be made according to Medicare law. This Dental Choice Plan will pay first if the Covered Person is:

- An active Employee age 65 or older;
- The Dependent spouse of an Active Employee who is age 65 or older;
- An active Employee's Disabled Dependent under age 65; or,
- A Covered Person eligible for Medicare due to end-stage renal disease and in the first 30 consecutive months of dialysis treatment.

Article V Benefits Provided

Covered Dental Expenses are charges for the services and supplies shown below. The services or supplies must be both:

- Dentally Necessary, and
- Ordered or prescribed by a Dental Provider

Charges will be covered only to the extent that they:

- Do not exceed the amount allowed under the Alternative Benefit Provision; and
- Do not exceed the Usual and Customary Charges generally made in the same area under similar conditions.

An expense is considered incurred on the date in which:

1. The teeth are prepared for Fixed Bridgework, Crowns, Inlays, or Onlays;
2. The final impression is made for Partial or complete Dentures;
3. The pulp chamber of a tooth is opened for Root Canal Therapy;
4. Periodontal surgery is performed; or
5. The service is performed for Covered Services not listed under 1, 2, 3, or 4 above.

The service must be completed in order to be considered a Covered Dental Expense. Special conditions apply to Orthodontic Treatment.

For all Covered Dental Expenses, the following services will be considered an integral part of the entire dental service. A separate fee for these services is not considered a Covered Service:

- Local Anesthesia;
- Pulp caps;
- Study models/diagnostic casts; and
- Temporary dental services, including but not limited to stainless steel Crowns on permanent teeth.

The Covered Dental Expenses are:

DIAGNOSTIC AND PREVENTIVE SERVICES

- Routine oral examinations, 2 times per Calendar Year.
- Emergency (problem focused) examinations.
- Office Visits, 2 times per Calendar Year.
- Consultations.
- Routine cleaning of teeth, but not more than 2 times per Calendar Year.
- Fluoride applied on teeth of your Dependent children under age 19, but not more than 2 times per Calendar Year.
- Space maintainers for your Dependent children under age 19, to replace teeth prematurely removed or missing.

- Dental X-rays:
 - Full mouth or panoramic (single or multiple films), but not more than once every 36 months, unless due to an Accidental Injury;
 - Bitewings, 2 times per Calendar Year; or
 - Other X-rays when needed to diagnose and treat a specific covered condition.
- Palliative (Emergency) treatment to relieve pain, but not on the same day as any other service except X-rays.

For persons who elect to utilize a PPO/Traditional Preferred Dental Provider, Diagnostic and Preventive Services will include.

- Topical application of Sealant for Dependent children under age 14 on the occlusal surface of permanent bicuspid and molars which are free of decay and restoration. Only one treatment per tooth in any 3 Calendar Years.

BASIC SERVICES

- Amalgam and Composite fillings for decayed or fractured teeth, except as listed under Major Services. Composite fillings on molar teeth are not a Covered Service when rendered by a Non-PPO/Traditional Preferred Network Dental Provider. However, an Alternative Benefit Provision will be applied allowing benefits for an Amalgam restoration.

MAJOR SERVICES

- Extraction (removal) of teeth.
- Oral surgery (cutting procedures in the mouth).
- General anesthesia, when Dentally Necessary and when administered by a dentist in connection with a Covered Oral Surgery procedure. Local or regional Anesthesia is excluded if billed separately.
- Periodontal examinations, cleanings, Scaling and root planing, or surgery (including 3 months post surgical care) to remove diseased gum tissue or bone.
- Full mouth debridement, once per lifetime.
- Site therapy (localized delivery of antimicrobial agents) When the Covered Person has had prior periodontal therapy performed and pocket depths are 5mm or greater. Site therapy must be performed a minimum of 4 weeks following active periodontal therapy. Site therapy is limited to once per tooth per 12 months to a maximum of 3 tooth sites per quadrant.
- Endodontic treatment, including pulpotomies and Root Canal Therapy.
- Antibiotic injections when given by the Dental Provider in conjunction with Covered Oral Surgery.
- Repairs/maintenance and recementing of Crowns, Inlays, Onlays, Bridgework, Partial Denture or full Denture.
- Post/core build-ups for Crowns and Bridgework.
- Relining or Rebasing of Partial Dentures and full Dentures, but not within 6 months of initial placement and not more than one of either in a 36-month period.
- Stainless steel Crowns on primary (baby) teeth.
- Porcelain on the upper or lower Anterior and bicuspid teeth.
- Tissue conditioning, but not within 6 months of the initial placement.
- Implants, including the prosthesis placed over the Implant and adjustments of the prosthesis but only to replace teeth that are congenitally missing or extracted after the Participant's date of coverage with ERS. No Alternative Benefit Provision will apply. Includes 6 months post-installation care. Benefits are only available under the dental plan. Replacement of an Implant or prosthesis over the Implant will be a Covered Service if installed at least 5 years prior to its replacement and cannot be made serviceable, or if replaced as the result of an Accidental Injury.

- Removable or Fixed Bridgework and Partial or full Dentures, but only to replace teeth (excluding third molars) that are congenitally missing or extracted after the Participant's date of coverage with ERS. No benefits will be allowed for adjustments during the first 6 months after placement.
- Add teeth to an existing Partial or full Denture, but only to replace teeth that are extracted after a Participant's date of coverage with ERS.
- Replacement of an existing fixed bridge with a new bridge, replacement of an existing removable Partial Denture with a new Partial Denture, or replacement of an existing full Denture with a new Denture, are all subject to the following conditions:
 - a) The replacement is needed to replace teeth that are extracted after the Participant's date of coverage with ERS;
 - b) The existing Partial Denture or full Denture or Bridgework is certified by the Dental Provider to be at least 5 years old at the time of replacement and cannot be made serviceable, or if replaced as the result of an Accidental Injury; or
 - c) The existing Partial Denture or full Denture is certified by the Dental Provider to be an immediate temporary full Denture that cannot be made permanent and is replaced with a permanent Denture within 12 months of the date it was installed.
- Crowns, Inlays or Onlays to restore teeth, but only when: a) The tooth is fractured or has major decay; and b) The tooth cannot be restored with fillings such as Amalgam, plastic or Composite resin. Replacement of a Crown, Inlay or Onlay will be a Covered Service if installed at least 5 years prior to its replacement and cannot be made serviceable, or if replaced as the result of an Accidental Injury.

ORTHODONTIC SERVICES

- Orthodontic treatment for Dependent children through age 19, if the initial active Appliance is placed after coverage is in effect for the Dependent Child.
- Covered expenses will include examinations, X-rays, extractions, surgical exposure of erupted teeth, placement of a device to facilitate eruption of impacted teeth, active Appliances and adjustments of the Appliances. The Dentist must submit to HumanaDental a complete outline of the orthodontic problem, the proposed treatment, the charges for the treatment and the length of time for completion of the treatment.
- Charges will be considered, subject to other Dental Choice Plan conditions, as follows:
 - a) The lesser of 25% of the total case fee or the dentist's fee will be allowed and considered as being incurred on the date the initial active Appliance is placed; and
 - b) The remainder of the total case fee will be divided by the number of months for the total treatment plan and the resulting portion will be considered to be incurred on a monthly basis until the Dental Choice Plan maximum is paid, treatment is completed, or eligibility ends.

If you had no dental coverage prior to coming onto this plan, orthodontic services started prior to the Effective Date of coverage under this plan are not a Covered Service.

Orthodontic services are payable only for Dependent children through age 19 at the time treatment commences. If the Dependent Child has not completed his current treatment plan through age 19, benefits will continue for the Dependent Child to age 25 as long as such Dependent Child remains eligible for coverage under the Dental Choice Plan.

Subject to the conditions expressed herein and to the Limitations and Exclusions in Article VII, when any Participant, while covered under the Dental Choice Plan, shall incur Covered Services and supplies during a Calendar Year, benefits shall be determined as follows:

A. Dental Necessity

All services and supplies for which benefits are available under the Dental Choice Plan must be Dentally Necessary as determined by the Claims Administrator. Charges for services and supplies, which the Claims Administrator determines are not Dentally Necessary, will not be eligible for benefit consideration and may not be used to satisfy Deductibles.

B. Deductibles

The benefits of the Dental Choice Plan will be available after satisfaction of the applicable Deductibles specified for Covered Dental Expenses. The Deductibles are specified in Article VI.

Any Covered Dental Expense incurred during the last 3 months of the Calendar Year, which apply to the Deductible, may also apply to the Deductible for the next Calendar Year. This is so you will not have to satisfy a Deductible at the end of one year and at the start of another year.

C. Coinsurance

Benefits are payable at the applicable percentage rate shown on the Schedule of Benefits after the Deductible is satisfied each Calendar Year. The Coinsurance percentages are specified in Article VI.

D. Alternative Benefits

The Claims Administrator, with ERS' consent, may elect to provide Alternative Benefits which are not otherwise Covered Services and supplies under the Dental Choice Plan. Such election shall be made strictly on the initiative of ERS or the Claims Administrator. The Claims Administrator's determination to provide benefits in one instance shall neither commit the Claims Administrator to provide the same or similar Alternative Benefits for the same Participant or any other Participant, nor cause the Claims Administrator to waive its right to strictly apply the express provisions of the Dental Choice Plan in the future.

Any Alternative Benefits provided or considered or denied in accordance with this Master Benefit Plan Document shall not be subject to review as a contested case under the provisions of Texas Government Code Ann. Ch. 2001, or pursuant to the Act and the Rules.

E. Assignment of Benefits

Benefits may not be assigned to a third party except for direct payments, which the Participant may assign to a Dental Care Provider or a provider of health care services. Any assignment will be effective on the date it is assigned, subject to any actions HumanaDental may take prior to receipt of the assignment. HumanaDental assumes no responsibility for the validity of an assignment. HumanaDental has the right to pay the Participant or the Dental Provider at its option, whether or not HumanaDental received an assignment of benefits.

Article VI Schedule of Dental Benefits

The Schedule of Dental Benefits set out herein shall apply to the Master Benefit Plan Document for the State of Texas Dental Choice Plan. The group number shall be 536957.

Covered Dental Expenses are classified as:

- Diagnostic and Preventive Services;
- Basic Services;
- Major Services; and
- Orthodontic Services.

NOTE: Dental Deductible and maximums are calculated from January 1 through December 31 of each year.

SCHEDULE OF DENTAL BENEFITS		
	In-Network Dental Provider	Out-of-Network Dental Provider
Individual Maximum Benefit	Diagnostic and Preventive, Basic and Major Services: \$1,500 per Calendar Year	
Diagnostic and Preventive Calendar Year Deductible	Individual: \$0 Family: \$0	Individual: \$50 Family: \$150 aggregate
Diagnostic and Preventive Services	Covered Service is payable at 100%, not subject to a Deductible.	After Diagnostic and Preventive Deductible, Covered Service is payable at 90% Coinsurance.
Basic and Major Services Calendar Year Deductible	Individual: \$50 Family: \$150 aggregate	Individual: \$100 Family: \$300 aggregate
Basic Services	After Basic Services Deductible, Covered Service is payable at 90% Coinsurance.	After Basic Services Deductible, Covered Service is payable at 70% Coinsurance.
Major Services	After Major Services Deductible, Covered Service is payable at 50% Coinsurance.	After Major Services Deductible, Covered Service is payable at 40% Coinsurance.
Individual Lifetime Maximum Benefit for Orthodontic Services	\$1,500 Only for Dependent children through age 19.	
Orthodontic Services	Covered Service is payable at 50%, not subject to a Deductible.	Covered Service is payable at 50%, not subject to a Deductible.

NOTE: If services are covered under ERS's medical carrier (HealthSelect), then no coverage is available under this dental plan. However, if your medical carrier is someone other than HealthSelect, then your medical plan may pay as primary and this dental plan would pay as secondary.

Cross Accumulation of Deductibles and Maximums – Covered Dental Expenses from both In-Network and Out-of-Network Dental Providers are used to satisfy the Deductible. The Maximum Benefit shown will apply to the total of all benefits paid for both In-Network and Out-of-Network Dental Providers.

Article VII Limitations and Exclusions

Benefits will not be paid for the following Limitations and Exclusions.

1. Expenses incurred prior to your Effective Date under the Dental Choice Plan or after the date coverage under the Dental Choice Plan ceases for a Participant for any reason.
2. Fixed Bridgework, Partial or complete Dentures to replace teeth that were extracted prior to the date a Participant became covered under this Dental Choice Plan.
3. Services or supplies from anyone other than a Dental Provider. Routine cleaning of teeth and Fluoride application when performed by a licensed dental hygienist under the direct supervision of, and billed by the Dental Provider will be covered.
4. Porcelain or similar material placed on molar Crowns or Pontics (teeth or spaces to the rear of the second bicuspid). An Alternative Benefit Provision will be applied allowing benefits for a full cast Crown.
5. Services or supplies that are partially or wholly cosmetic in nature, or directed toward a cosmetic end. This exclusion shall not apply to: (a) operations necessary to repair disfigurement due to an accident occurring while covered for dental expense benefits under the Dental Choice Plan, and (b) treatment of a congenital anomaly in a Child born while a parent is covered for dental expense benefits under the Dental Choice Plan.
6. Replacing a lost, broken, missing or stolen prosthetic Appliance.
7. Charges billed to a Participant for missing a scheduled appointment.
8. Any services received from a medical department, clinic or any facility provided or furnished by a Participant's Employer.
9. Any service that is not necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending Dental Provider.
10. Services or supplies that do not meet accepted standards of dental practice including Experimental and Investigational services or supplies.
11. Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
12. Any duplicate prosthetic Appliance except as specifically provided under the Dental Choice Plan.
13. Claim form completion.
14. Sealants, unless a PPO/Traditional Preferred Dental Provider is utilized.
15. Preventive control programs, including but not limited to, oral hygiene or dietary instruction, take home items or plaque control programs.
16. Any Splinting procedure, including but not limited to, multiple Abutments or any service to stabilize periodontally weakened teeth.

17. An injury or illness arising from any employment or occupation.
18. An injury or illness covered by Workers' Compensation.
19. Services or supplies for which a Participant is not required to pay.
20. Expenses incurred outside the United States or Canada are not covered except as follows:
 - You live in the United States or Canada, are traveling for business or pleasure and require dental treatment from a provider outside of the United States or Canada; or,
 - You live in the United States and use a provider in Mexico.
21. Appliances, Restorations, or any procedures to alter Vertical Dimension, restore Occlusion, or replace tooth structure lost by attrition, abrasion or erosion.
22. Any service or supply that is covered in whole, or in part, by a plan provided, or sponsored by the GBP.
23. Nitrous oxide and intravenous sedation.
24. Speech or myofunctional therapy.
25. Occlusal guards, including their Reline/repair, or athletic mouth guards.
26. Veneers and their maintenance/repairs.
27. Caries susceptibility testing, lab tests, anaerobic cultures and sensitivity testing.
28. Sterilization/infection control fees.
29. Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), including but not limited to charges for: TMJ exams, X-rays and consultations; TMJ surgery, kinesiographic analysis and muscle testing; TMJ splints and Appliances; splint equilibration and adjustments or physical therapy for symptoms including but not limited to, headaches.
30. Osteotomies.
31. Harmful habit Appliance.
32. Stressbreakers.
33. Pulp vitality tests.
34. Occlusal adjustments.
35. Gold foil fillings and their maintenance/repairs. An Alternative Benefit Provision will be applied allowing benefits for an Amalgam restoration.
36. Precious (gold) Crowns and their maintenance/repairs. An Alternative Benefit Provision will be applied allowing benefits for a semi-precious Crown.
37. Overdentures and their maintenance/repairs.
38. Precision or semi-precision attachments.

39. Major Services performed on other than permanent teeth.
40. Prescription drugs or pre-medications.
41. Any hospital charges or for services of any anesthesiologist.
42. The extent the expense exceeds the Usual and Customary Charge for the service, treatment or supply in the locality where furnished.
43. Services or supplies not specifically listed under Covered Dental Expenses.
44. Any Covered Expenses to the extent of any amount received from others for the Accidental Injuries or losses which necessitate such benefits.

Article VIII Termination of Coverage

- A. The coverage of all Participants under the Dental Choice Plan shall automatically terminate when the Dental Choice Plan is terminated in writing by the Trustee, such termination to be effective on the first day of the month immediately following notification of cancellation.
- B. The coverage of any Employee or Retiree and his Dependents included under the Dental Choice Plan shall automatically terminate:
 - 1. On the date an Employee's employment terminates;
 - 2. The day following the last day of the last period for which his portion of the group contribution is paid to the Plan Administrator;
 - 3. The effective date of an amendment to the Plan which terminates the coverage of any class of Employees or Retirees to which he belongs;
 - 4. The last day of the month in which the Employee's or Retiree's death occurs;
 - 5. The date the Employee or Retiree is expelled from the GBP for misrepresentation, fraud or attempted fraud;
 - 6. The end of the month in which a Participant ceases to be a Participant as defined in Article I, except:
 - a. An eligible member of the Texas Legislature
 - 1) Who held office on or after May 17, 1979, and
 - 2) Who, on ending service as a member of the Legislature, has established the minimum amount of creditable service required of an elective official for eligibility for service requirement benefits at 60 years of age, and
 - 3) Who notified the Plan Administrator within 30 days of leaving office of his intent to continue coverage and remit the necessary Premiums therefore, or
 - b. Persons who have at least ten years of creditable service in ERS as an Employee of the Texas Legislature as defined in Texas state statutes and the Rules of the Board of Trustees of ERS may continue coverage under the Dental Choice Plan for himself or for himself and his family members as Dependents.
 - 7. The last day of the month during which an Employee is on an approved leave of absence without pay status; or,
 - 8. When this Master Benefit Plan Document is terminated.
- C. The coverage of any Dependent of an Employee or Retiree included under the Dental Choice Plan shall automatically terminate at the end of the month in which such Dependent ceases to be a Dependent as defined in Article I.
- D. In the event coverage for a Retiree or an Active Employee, who meets the age and service credit requirements to qualify for a retirement benefit or a survivor's annuity, ends by reason of death, a surviving Dependent of the deceased shall have the right to continue coverage under the Dental Choice Plan provided: (1) each Dependent continues to be an eligible Dependent as defined herein; and (2) payment of contributions is made to ERS according to its administrative Rules and practices.
- E. Under no circumstances shall the Claims Administrator be obligated to notify any Participant of the termination of the Dental Choice Plan or of his coverage under the Dental Choice Plan.

Article IX Extension of Benefits

Extended Dental Benefits

If a Covered Person is incurring Covered Dental Expenses and this coverage ends, benefits will be considered as follows:

Charges for Dentures will be considered Covered Dental Expenses if:

- the Impression was made prior to the date coverage ends;
- the Denture was ordered prior to the date coverage ends.

Charges for Fixed Bridgework, Crowns and Inlays will be considered Covered Dental Expenses if:

- the tooth or teeth were prepared prior to the date coverage ends;
- the impression was taken prior to the date coverage ends;
- the Fixed Bridgework, Crown or Inlay was ordered prior to the date coverage ends.

Charges for endodontic treatment, to include Root Canal Therapy will be considered Covered Dental Expenses if the tooth was opened prior to the date coverage ends.

Article X Option to Continue Group Coverage and Conversion Privilege

A. Continuation of Group Coverage

1. If under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, any Participant is granted the right to continuation of coverage beyond the date his coverage would otherwise terminate, the Dental Choice Plan shall be deemed to allow continuation of coverage to the extent necessary to comply with the provisions of the statute, subject to the following special provisions.
2. Timely payment of the contribution for all contribution payment periods is required to continue the coverage. The Plan Administrator shall collect the proper contributions from all continued Participants for each contribution payment period.
3. As long as the Dental Choice Plan is not terminated, if continued coverage is elected, such coverage shall automatically terminate after the expiration of the maximum period allowed by statute; provided, however, should any event(s) occur which is specified in the statute as shortening the maximum period required for continued coverage, the continued coverage automatically shall terminate upon the occurrence of such event(s).
4. The Claims Administrator shall not be considered the agent of the Employer or plan administrator and shall not be responsible for the performance of any Duty imposed on them by any applicable statute.
5. If the Dental Choice Plan replaces a group dental PPO plan of the Employer and any person acquired rights to continuation of coverage under the statute prior to the plan effective date for a period of time that has not expired on the plan effective date, such person shall be entitled to the rights of a continued Participant under the Dental Choice Plan for the remainder of such period, provided he complies with all requirements of this Article X during the period of continued coverage under the Dental Choice Plan.

B. Conversion Privilege

1. When coverage for any Participant is terminated under Article VIII or Section A of this Article X, the Participant shall have the right of conversion to new individual coverage as provided in Subsection 2, below.
2. Any Participant becoming eligible for conversion as provided for in the preceding Subsection 1 may, within 31 days after termination of his coverage under the Dental Choice Plan, submit application for a HumanaOne individual dental plan.

If the Participant is no longer eligible to continue coverage with the Dental Choice Plan because the Participant's COBRA continuation of coverage ends, the Participant is eligible to apply for the HumanaOne individual dental plan.

The Participant may apply for the conversion policy prior to the end of this coverage under the Dental Choice Plan. If issued, the HumanaOne individual dental plan will go into effect the first of the month following approval.

If you have any questions about your conversion privilege or need an application, please call (877) 377-0987.

Article XI Claim Provisions

A. Examination

HumanaDental has the right, at its expense, to have anyone on whom a claim is based examined by a Dental Provider of its choice during the pendency of the claim.

B. Payment of Benefits

Unless another order of payment is specified herein, all Dental Choice Plan benefits are payable in the following order promptly after receipt of the claim.

- To any assignee of record; otherwise
- To the Member, if living; otherwise
- According to the order of precedence in Tex. Ins. Code 1551.259.

HumanaDental reserves the right to request any information required to determine benefits or process a claim. You or the Dental Provider will be contacted if additional information is needed to process your claim.

C. Predetermination of Benefits

If the Course of Treatment will exceed \$200, a Predetermination of Benefits may be requested. HumanaDental will respond to a Predetermination of Benefits with an estimate of Covered Services. The estimate is not a guarantee of payment since future changes such as changes in a Participant's enrollment or eligibility under the Dental Choice Plan may affect benefits. A Dental Provider may request a predetermination of any extensive treatment. Predetermination of treatment provides an estimation of coverage and treatment. A Predetermination of Benefits is not a guarantee of benefits. Services will be subject to all terms and provisions of the plan at the time treatment is rendered.

If treatment is to commence more than 90 days after the issuance of a Predetermination of Benefits, HumanaDental will require the Participant to submit another treatment plan.

D. Facility of Payment

If any benefits become payable to anyone who, in the opinion of the Claims Administrator, is legally incapable of providing HumanaDental a valid receipt or release, HumanaDental may pay a portion of such benefits to any individual or institution HumanaDental reasonably believes has assumed custody or principle support for such person, provided a request for payment from the person's legal guardian or other legally appointed representative has not been received by HumanaDental. Any payment made by HumanaDental in good faith will fully discharge it to the extent of such payment.

E. Proof of Loss

Written proof must be given to HumanaDental within 18 months after the date of service. Claims should be filed within 90 days from the date the expense for which claim is being made was incurred, unless timely filing was prevented by legal incapacity, provided the claim was submitted as soon as reasonably possible. HumanaDental will not accept a claim submitted later than 18 months past the date of the expense for which the claim is being made was incurred, except where the Participant was legally incapacitated. HumanaDental may, at its option, require supporting documentation with respect to such legal incapacity.

F. Notification of Claim Decision

A Participant will be notified of HumanaDental's decision on his claim within 30 days of receipt of the claim. If an extension of time is necessary due to matters beyond the Dental Choice Plan's control, HumanaDental may extend this 30-day period by up to 15 days. The Participant will be notified in writing of the extension before the end of the initial 30-day period. The notice will explain the need for an extension and the date a decision on a Participant's claim will be made.

If an extension is due to a Participant's failure to submit the information needed for a decision, the notice of extension will specifically describe the required information and provide at least 45 days from the Participant's receipt of the notice to provide that information. HumanaDental's deadline for deciding a claim is calculated from the date a claim is filed, without regard to whether the initial filing included all of the information necessary to decide the claim. Within 15 days of receipt of the required information, HumanaDental will complete the processing of the claim. If the required information is not received in 45 days, HumanaDental will make a determination based on the information submitted.

G. Claim Denial and Appeal

If claimed benefits are reduced or denied, the Participant may ask HumanaDental to reconsider the claim by submitting a request in writing along with additional information about the claim to:

HumanaDental - ERS
PO Box 14639
Lexington, KY 40512-4639

If the claim is again denied after reconsideration, HumanaDental will send the Participant a letter with instructions on how to file an appeal with ERS. The Participant should then send a written request, along with copies of all correspondence from HumanaDental and any other related information to:

Grievance Administrator
Employees Retirement System of Texas
P.O. Box 13207
Austin, Texas 78711-3207

A request must be made within 90 days of the date of the notice of the Participant's right to appeal. The Participant will receive a decision in writing from ERS.

The Customer Benefits Division of ERS will provide information and assistance to the Participant. The Participant may contact the Customer Benefits Division by calling (512) 867-7711 or (877) 275-4377, or by writing to:

Customer Benefits Division
Employees Retirement System of Texas
P.O. Box 13207
Austin, Texas 78711-3207

H. Loss of Benefits Due to Fraud

ERS has established sanctions for fraudulent behavior, including but not limited to, improper use of a Dental Choice Plan ID card or filing a fraudulent claim.

A Participant could be sanctioned, which may include being expelled from the GBP for fraudulent use of the Dental Choice Plan.

I. **Legal Actions**

No action may be brought to recover under the Dental Choice Plan until 60 days after Proof of Loss has been given. No action can be brought after 3 years from the date written Proof of Loss was required to be furnished. The administrative appeal process provided for herein and in the ERS Rules is the exclusive remedy available to Participants for a denial of benefits under the Dental Choice Plan.

J. **Dental Provider Change**

If a Participant changes from one Dental Provider to another during the Course of Treatment, or if more than one Dental Provider performs the same Covered Service, HumanaDental will provide the same amount of benefits as if there had been only one Dental Provider involved in the Participant's treatment.

K. **Provisions Applicable to All Coverage**

Although the ERS executive director has the exclusive authority to determine eligibility for coverage, any representations or statements made to the Employee by any State Agency or higher education institution employee or Benefits Coordinator, ERS, its representative or agent, about the availability of benefits for any specific treatment under this Dental Choice Plan, which disagree with the provisions of the Dental Choice Plan shall not:

- be considered as representations or statements made by, or on behalf of ERS or HumanaDental; and
- bind ERS or HumanaDental for benefits under the Dental Choice Plan; or,
- otherwise bind the Dental Choice Plan, HumanaDental or ERS.

ERS reserves the right to terminate, suspend, withdraw, amend or modify the Dental Choice Plan at any time. Any such change or termination in benefits will be based solely on the decision of ERS and may apply to Active Employees, future Retirees and current Retirees as either separate groups or as one group.

L. **Timely Payment of Claims**

All benefits provided by the Dental Choice Plan will be paid upon receipt of adequate Proof of Loss.

Article XII General Provisions

A. Applicable Law and Remedies

The Dental Choice Plan is issued in Texas and is subject to Texas law. All disputes arising under this Master Benefit Plan Document shall be resolved in accordance with the Act and in accordance with the Rules adopted by the ERS Board of Trustees. Following completion of the administrative appeal process, a petition for judicial review, if any, of ERS' final determination shall, pursuant to Tex. Ins. Code § 1551.359, be filed only with the District Court in Travis County, Texas, and the standard of review is by substantial evidence. Pursuant to Tex. Ins. Code § 1551.014, the remedies provided under the Act are the exclusive remedies available to an Employee, Participant, Annuitant or Dependent.

B. Copies; Dental Choice Plan Information

Any Participant may obtain copies of this Master Benefit Plan Document and other Dental Choice Plan information related to the Participant's coverage upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies. Such copies will be supplied within 30 days. Any Participant may also inspect copies of all Dental Choice Plan documents at any time during normal working hours. A Participant may not be permitted to inspect or obtain copies of information considered to be protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations adopted under HIPAA without proper written authorization from the subject of PHI.

C. Networks

The PPO/Traditional Preferred Network is subject to change. It is the Participant's responsibility to verify that the Dental Provider currently participates in the HumanaDental Network before care is received.

HumanaDental does not guarantee that HumanaDental Network Dental Providers are available for all specialties, are available in all areas or that the HumanaDental Maximum Allowable Charge is less than what can be obtained from non-Network Dental Providers.

Information on Network Dental Providers can be obtained free of charge from HumanaDental's website which is linked from the ERS website at www.humanadental.com/ers and click on "State of Texas Dental Choice Plan", then click on "Find a Dentist", or by phone at (877) 377-0987.

D. Coverage Data

The plan administrator shall furnish the Claims Administrator all information needed to effect coverage of Employees or Retirees and Dependents under the Dental Choice Plan and termination and changes in such coverage on a timely basis.

E. Disclaimer

Neither the Dental Choice Plan nor the Claims Administrator shall be liable for any act or omission by any Dental Provider or other, their agents or employees, in caring for a Participant receiving services covered under the Dental Choice Plan, and no responsibility attaches hereunder for inability of any Dental Provider or other to furnish accommodations or services.

F. Funding

The Dental Choice Plan is funded by participating Employees and Retirees in accordance with the Act.

G. 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.

H. Master Benefit Plan Document; Amendments

1. The Master Benefit Plan Document shall constitute the entire document governing the provision of benefits under the Dental Choice Plan. ERS and HumanaDental have also entered into a Contractual Agreement regarding the relationship and respective obligations between them, and have also entered into a Business Associates Agreement (BAA) with regard to each parties' respective obligations related to the requirements of HIPAA and the regulations adopted pursuant to HIPAA. The Contractual Agreement and BAA control with regard to matters not specifically addressed in the Master Benefit Plan Document.
2. This Master Benefit Plan Document may be amended or changed at any time by ERS upon 30 days prior written notice to the Claims Administrator, subject to Texas law, without the consent of the Employee, Retiree, or Dependents covered under the Dental Choice Plan or of their beneficiaries.

I. Medicare/Primary Carrier Determinations

Any exclusions of benefits in this Master Benefit Plan Document for services or supplies for which benefits are paid or payable under governmental programs and the definition of "Health Plan" in Article IV, Section C, or the Dental Choice Plan shall not be applicable to Medicare Part A and Part B benefits for those Employees or Retirees who the Employer determines are Employees or Retirees for whom the Employer's benefit plan is required to be primary to Medicare by the Age Discrimination in Employment Act (ADEA) for the period of time such primary coverage is so required. This provision shall also be applicable to Dependent spouses of Employees or Retirees so designated for the period of time, if any, that the spouse's coverage under the Employer's benefit plan is also required to be primary to Medicare. The same exclusions and definition of "Health Plan" described above are not applicable to Medicare Part A and Part B benefits for Participants who are in the first 12 months of Medicare entitlement for treatment of end-stage renal disease due to kidney transplant or self-dialysis training or who are in the first nine months of Medicare entitlement by reason of renal dialysis.

J. Not a Contract

The Dental Choice Plan shall not be deemed to constitute a contract between the Employer or ERS and any Employee, Retiree or Dependent, or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Dental Choice Plan shall be deemed to give any Employee the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge any Employee at any time.

K. Refund of Benefit Payments

If and when the Dental Choice Plan determines that benefit payments under the Dental Choice Plan have been made erroneously but in good faith, HumanaDental reserves the right to seek recovery of such benefit payments from the Participant, or Dental Provider to whom such payments were made. HumanaDental reserves the right to offset subsequent benefit payments otherwise available by the amount of any such overpayments.

L. State Government Programs

1. Benefits for services or supplies under the Dental Choice Plan will 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 State Department of Human Services to the extent required by Chapter 1204, Subchapter D or its successor statute of the *Texas Insurance Code*.

2. All benefits paid on behalf of a Child or children under the Dental Choice Plan must be paid to the Texas Department of Human Services where:
 - a. The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the Human Resources Code, and
 - b. The parent who is covered by the Dental Choice Plan has possession or access to the Child pursuant to a court order, or is not entitled to access or have possession of the Child and is required by the court to pay child support, and
 - c. The Claims Administrator receives written notice at its Home 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.

M. State or Federal Law

In all situations deemed applicable by ERS and where state or federal laws or regulations mandate specific terms or provisions which conflict with specific terms or provisions of the Master Benefit Plan Document or Rules, the Master Benefit Plan Document and appropriate Rules shall be interpreted and administered to comply with such laws or regulations.

N. Subrogation/Right of Recovery

This provision applies when another party (person or organization) is or may be considered responsible for payment because of a Participant's injury or sickness for which benefits under the Dental Choice Plan have been provided.

To the extent of such services provided, the Dental Choice Plan is subrogated to all rights of recovery the Participant has and the Dental Choice Plan may assert such rights independent of the Participant. Also, if the Participant has obtained or obtains a court judgment, settlement, arbitration, award, or other monetary recovery from another party, because of the injury or sickness, the Dental Choice Plan is entitled to reimbursement of the benefits the Dental Choice Plan has provided. This priority shall apply and reimbursement shall be required:

1. Even though the third-party payment does not compensate the Participant for his whole loss;
2. Whether or not liability for payment is admitted by the third-party;
3. Whether or not such recovery is itemized or called anything other than a recovery for medical expenses incurred;
4. From any recovery, including but not limited to, uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlements or awards, other group insurance including student plans and direct recoveries from liable parties.

The Participant is obligated to cooperate with the Dental Choice Plan to protect its subrogation rights and shall not prejudice the Dental Choice Plan's right of recovery and reimbursement. Failure to cooperate or prejudice the Dental Choice Plan's rights shall occur if the Participant fails to:

1. Complete a third-party information report, naming among other things:
 - a. The party who may be considered responsible for the injury or sickness;
 - b. Any current or anticipated third-party litigation, settlement negotiations, or other coverage;
 - c. The name, address, and telephone number of any attorney retained by the Participant to prosecute a third-party claim; and, the name, address, and telephone number, claim number, or policy number, as known to the Participant of any insurance companies insuring either the Participant, the third-party or others liable for payment to the Participant on account of his injuries;
2. Give statements and provide information about the other parties or the injury or sickness when requested by the Dental Choice Plan;

3. Execute and deliver any other documents or do whatever the Dental Choice Plan reasonably requires to secure its rights of subrogation;
4. Obtain the Dental Choice Plan's consent prior to releasing the third-party from any liability for payment of medical expenses; or
5. Reimburse the Dental Choice Plan when a recovery is made from any source as a consequence of third-party negligence or other actions.

In the event that the Participant fails to cooperate with the Dental Choice Plan or prejudices its subrogation rights, the Dental Choice Plan may deduct from any pending or subsequent claim made under the Dental Choice Plan any amounts the Participant owes the Dental Choice Plan until such time as cooperation is provided or the prejudice ceases.

No beneficiary hereunder shall incur any expenses on behalf of the Dental Choice Plan in pursuit of the Dental Choice Plan's rights hereunder, specifically, no court costs or attorney's fees may be deducted from the Dental Choice Plan's recovery without the prior express written consent of the Dental Choice Plan. This right shall not be defeated by any so-called "Fund Doctrine", or "Common Fund Doctrine", or "Attorney's Fund Doctrine".

The Dental Choice Plan shall recover the full amount of the benefits paid hereunder without regard to any claim of fault on the part of any beneficiary, whether under comparative negligence or otherwise.

O. Workers' Compensation Insurance

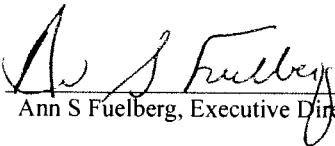
The Dental Choice Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by Workers' Compensation Insurance.

P. Right to Receive and Release Needed Information

HumanaDental has the right to obtain or give information needed to determine benefits available from other dental coverage to the extent permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations adopted pursuant thereto, and consistent with the Business Associate Agreement between HumanaDental and ERS. This information can be given from or to any other insurance company, organization or person authorized under HIPAA to retain or release such information, without notice to or consent of the Participant.

Any Participant claiming benefits must furnish HumanaDental with the necessary information needed to determine other dental coverage benefit payments.

For: Employees Retirement System of Texas

By: 
Ann S Fuelberg, Executive Director

For: HumanaDental

By: 
Mark M. Matzke, Vice President