



State of Texas
DENTAL CHOICE

PlanSM

Administered by HumanaDental

A Dental PPO Plan for State of Texas and Certain
Higher Education Employees, Retirees and Eligible
Dependents

BENEFITS BOOK

Effective September 1, 2009

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Section 1

Introduction to the Dental Choice Plan

This benefits book describes the State of Texas Dental Choice PlanSM provided to employees, retirees, and their eligible Dependents under the state of Texas Employees Group Benefits Program (GBP). Please refer to it when you need dental care or when you have a question about your Dental Choice Plan benefits.

This Dental Choice Plan is self-funded. This means that your premiums are not paid to an insurance company. Your payroll deduction goes into the GBP trust fund and is used to pay the costs of the plan. Self-funding gives you a stake in the plan's success.

HumanaDental has been approved by the Employees Retirement System of Texas (ERS) as the administrator of the Dental Choice Plan. In addition to processing your dental claims, HumanaDental also is responsible for answering any questions you may have about your dental benefits.

Contact Information:

Customer Service: (877) 377-0987

Website: Link to our website from the ERS website, www.ers.state.tx.us

File claims or predetermination of benefits to:

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

The PPO/Traditional Preferred Network of dentists will be available to employees, retirees and their eligible Dependents covered under the Dental Choice Plan. Providers of dental care and treatment who are members of the PPO/Traditional Preferred Network have entered into a contract with HumanaDental to provide services at predetermined fees. If you utilize a PPO/Traditional Preferred Network Dental Provider, your Coinsurance amount may be lower because it is based on this predetermined fee, not the dentist's billed charge. Sealants are a covered benefit only if you use a PPO/Traditional Preferred Network dentist.

However, you are not required to utilize a PPO/Traditional Preferred Network dentist to receive dental services. Each time you or a covered Dependent requires dental treatment, you have the option of choosing a Dental Provider who is not part of the PPO/Traditional Preferred Network. You may go to any dentist outside of the network to receive care, but your Coinsurance amount will be based on the dentist's actual billed charge. Additionally, you will be responsible for the difference between the billed charge and HumanaDental's determination of the Usual and Customary Charge.

Section 2

General Information About Benefits

Benefit Provision - After the Deductible has been satisfied, benefits will be paid for Covered Dental Expenses incurred by the Participant according to the Schedule of Benefits.

In no event will benefits paid for any covered person exceed the Maximum Benefit.

Deductible - The Deductible is shown in the Schedule of Benefits. The Deductible applies separately to each covered person once each Calendar Year, except as provided under "Deductible Family Limit" below.

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 the Participant will not have to satisfy a Deductible at the end of one year and at the start of another year.

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

Once these limits have been reached, the Deductible for your entire family will be satisfied for that calendar year.

Maximum Benefit - The Maximum Benefit is shown in the Schedule of Benefits. It applies separately to Covered Dental Expenses for each covered person. No further benefits are payable once the Maximum Benefit is reached.

Networks - The PPO/Traditional Preferred Network is subject to change. It is the Participants 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, in all areas, or that the HumanaDental maximum allowable charge is less than what can be obtained from Out-of-Network Dental Providers.

Information on PPO/Traditional Preferred Network Dental Providers can be obtained free of charge from HumanaDental's website which is linked through 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.

Section 3 Schedule of Benefits

Introduction

Covered Dental Expenses are classified as:

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

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

Refer to Section 4 for a detailed description of these covered dental services.

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.

Section 4

Covered Dental Expenses

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 (defined in the Definitions Section); and
- Do not exceed the Usual and Customary Charges (defined in the Definitions Section) 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.

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.

Section 4

Covered Dental Expenses

- 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 Rebased 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.

Section 4

Covered Dental Expenses

- 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.
- Removeable 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:
 - The replacement is needed to replace teeth that are extracted after the Participant's date of coverage with ERS; or
 - The existing Partial Denture, 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
 - 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:
 - The tooth is fractured or has major decay; and
 - 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 your 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:
 - 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
 - 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.

Section 4

Covered Dental Expenses

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; and
 - 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;
 - Impression was taken prior to the date coverage ends; and
 - 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.

Section 5

Limitations and Exclusions

The State of Texas Dental Choice Plan, like other dental plans, has certain limits on dental coverage in order to keep plan rates affordable for you. 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 the 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 Alternate 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 your Dependent utilizes a PPO/Traditional Preferred Dental Provider.

Section 5

Limitations and Exclusions (Continued)

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.

Section 5

Limitations and Exclusions (Continued)

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.

SECTION 6

Important Plan Provisions

Eligible Employees, Retirees, and Dependents

Employees Retirement System of Texas (ERS) determines eligibility for the Dental Choice Plan under the GBP. If you have a specific question about your eligibility or that of your Dependents, contact your benefits coordinator if you are an employee, or ERS if you are a retiree.

Adding and Dropping Dependents From Your Dental Choice Plan Coverage

Contact your benefits coordinator if you are an employee, or ERS if you are a retiree, for information regarding how and when you may:

- Add Dependents to your coverage;
- Drop Dependents from your coverage; or
- Obtain more information on when your Dependents are no longer eligible for coverage.

Termination of Your Dental Choice Plan Coverage

When Employee Coverage Ends

Your Dental Choice Plan coverage as an employee will end on the last day of the month:

- When your employment ends;
- When you stop making the required premium payments, unless your employment status allows for continuation of coverage; or
- When the Dental Choice Plan ends or stops covering you as an employee.
- When you are expelled from the GBP for misrepresentation, fraud or attempted fraud.

When Retiree Coverage Ends

Your Dental Choice Plan coverage as a retiree will end on the last day of the month:

- When the Dental Choice Plan ends or stops covering your retiree class;
- When you stop making the required premium payments; or
- When you die.
- When you are expelled from the GBP for misrepresentation, fraud or attempted fraud.

When Dependent Coverage Ends

A Dependent's Dental Choice Plan coverage ends the last day of the month:

- When your coverage ends;
- When he or she is no longer an eligible Dependent (for example, your spouse's coverage will end if you get divorced, and a child's coverage will end if he or she gets married or reaches age 25, unless eligible as a disabled Dependent); or
- When you stop making the required premium payments.

COBRA Continuation of Coverage Requirements

COBRA continuation of dental coverage will be determined by the ERS eligibility and enrollment rules. Any eligible individual electing to continue coverage must pay the full premium rates plus an additional 2% administrative fee.

SECTION 6

Important Plan Provisions (Continued)

Conversion Privilege

When a Participant is no longer eligible to continue coverage under the Dental Choice Plan because COBRA continuation of coverage ends, the participant is eligible to apply for a HumanaOne individual dental plan.

To be eligible, the Participant, or their qualified Dependents, must apply within 31 days after the last day of coverage. However, the Participant may apply for the conversion policy prior to the end of 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.

Coordination of Benefits

A Participant must tell HumanaDental if they, or a covered Dependent, have 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; or
- 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.

SECTION 6

Important Plan Provisions (Continued)

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.

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. This can be from or to any other insurance company, organization or person, without notice to or consent of the covered person.

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

Right of Recovery

HumanaDental has the right to retrieve any overpayments that may have been paid over that called for by these or any other provisions. This can be from the covered person for whom the payments were made. It can also be from any other insurance company or organization. Covered persons shall fully cooperate with HumanaDental in obtaining reimbursement of overpaid amounts.

When Others are Responsible for Injuries

If a covered person should suffer an accident or become ill because of another person's act or omission, and a Participant later receives compensation from that person and/or their own or other insurance, the Participant is required to refund the Dental Choice Plan.

SECTION 7

Claim Payment Provisions

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 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.

Claim Forms

Special claim forms are not required. Please ask the provider of service to give you or your Dependent a copy of their itemized bill. Bills and receipts should be itemized and show:

- Name of patient and relationship to you;
- Member identification number;
- Name, degree, address and signature of the provider;
- Dates that services or treatment were received;
- Description of each service or treatment in English;
- Tooth number(s) and tooth surface(s) when applicable;
- American Dental Association (ADA) procedure codes; and
- Charge for each service or treatment.

Canceled checks, cash register receipts or balance due statements are not acceptable.

If you or your Dependents have other dental coverage that pays first, you must first submit your dental claim to your other plan(s), then submit your dental claim to the State of Texas Dental Choice Plan, along with the other plan's Explanation of Benefits (EOB).

Submit claims to:

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

If you need help in filing your claim, call HumanaDental toll-free at (877) 377-0987.

Keep a separate record of the dental expenses of each covered person, as Deductibles and maximum benefit limits apply separately to each covered person. Save copies of all dental bills, including those you accumulate to satisfy a Deductible. In most instances they will serve as evidence of your claim. HumanaDental will not provide duplicate or year-end statements.

Facility of Payment

If any benefits become payable to anyone who, in HumanaDental's opinion, is legally incapable of giving 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 HumanaDental has not received a request for payment from the person's legal guardian or other legally appointed representative.

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.

SECTION 7

Claim Payment Provisions (Continued)

Loss of Benefits Due to Fraud

Improper use of your Dental Choice Plan ID card, or filing a fraudulent claim is illegal and will result in higher costs for everyone. Therefore, ERS has established penalties for fraudulent behavior.

A Participant could lose their coverage in the GBP for fraudulent use of the Dental Choice Plan (for instance, using your ID card before the effective date or after your Dental Choice Plan coverage ends).

Notification of Claim Decision

A Participant will be notified of HumanaDental's decision on their claim within a reasonable period of time. Ordinarily, this notice will be provided within 30 days after 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 providing written notice. If this happens, HumanaDental will notify the Participant of the extension before the end of the initial 30-day period. The notice will explain why an extension of time is needed and specifically describe the required information. The Participant will be given at least 45 days from receipt of the notice to provide the required information. Within 15 days of receipt of the required information HumanaDental will complete the processing of the claim. If the required information is not received within 45 days, HumanaDental will make a decision on the claim based on the information submitted.

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 a Participant, if living; otherwise
- According to the order of precedence in Texas Insurance Code Chapter 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.

Predetermination of Benefits

If the Course of Treatment will exceed \$200, the Dental Choice Plan suggests you request a Predetermination of Benefits. 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 your enrollment or eligibility under the Dental Choice Plan may affect benefits. HumanaDental encourages you to ask your Dental Provider to submit a predetermination for any extensive treatment. By submitting the predetermination, you and your Dental Provider will have an estimate before treatment is started of what will be covered, and how it will be paid. This information can be valuable to you in making an informed decision on how to proceed with treatment and can help protect you from unexpected out-of-pocket costs should the treatment plan not be covered.

The Dental Provider should submit a completed dental predetermination claim form that itemizes the proposed procedure codes, charge for each procedure along with pretreatment plan, X-rays and any other diagnostic materials to:

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

SECTION 7

Claim Payment Provisions (Continued)

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 from the date of the expense for which the claim is being made was incurred, except where the Participant was legally incapable. HumanaDental reserves the right to request additional information and may require supporting documentation such as clinical reports, charts, X-rays and study models.

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 your treatment.

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; or
- 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.

Time of Payment of Claims

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

Appeal Procedure for a Denied Claim

If a Participant's claim for benefits is 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. Send the 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

SECTION 7

Claim Payment Provisions (Continued)

The Participant's 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

SECTION 8

Definitions

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.

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 called the Alternative Benefit. Any difference between the Alternative Benefit and the charge actually incurred is the 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 and tissues located towards the front of the mouth; incisors and canines.

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

Billed Charges – PPO/Traditional Preferred Network Dental Provider- The 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.

SECTION 8

Definitions (Continued)

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.

Coinsurance - The stated percentage of Covered Expenses and supplies incurred by a Participant that must be paid by the 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 HumanDental 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 Service or Covered Dental Expenses - Services or supplies for which the Dental Choice Plan provides benefits. A full list of Covered Services is shown in Section 4. 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 the 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.

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.

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.

SECTION 8

Definitions (Continued)

Dependent – The spouse of an employee or retiree and eligible unmarried children under age 25.

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.

Endodontic Therapy - Treatment of diseases of the dental pulp.

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

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.

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

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 the teeth in their relationship to the jaws.

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 Billed Charges.

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

SECTION 8

Definitions (Continued)

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 who is eligible for coverage under the Dental Choice Plan as determined by ERS.

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 which replaces a missing tooth or teeth.

Posterior – Teeth or tissues towards the back of the mouth; distal to the canines (includes premolars, bicuspid, and molars).

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.

Proof of Loss – Written Proof of Loss must be furnished to HumanaDental 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 Denture, 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.

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.

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 reduce decay.

Splinting - Stabilizing or immobilizing teeth to gain strength.

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

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

SECTION 8

Definitions (Continued)

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.

This benefits book is a summary of the Master Benefit Plan Document, statutes, and administrative rules governing the State of Texas Dental Choice Plan. In case of conflict between the provisions of this book and the plan document, statutes, or administrative rules, the appropriate plan document, statute, or rule will prevail. Although ERS intends to continue our dental PPO plan into the future, the agency reserves the right, at all times, to change, suspend, or end the plan.