Policyholder: BEXAR APPRAISAL DISTRICT
Group Number: 790650
Coverage Effective Date: 01/01/2018

Summary of Your Benefits

This summary provides an overview of plan *benefits*. Refer to the **Your plan benefits** and **Waiting periods** provisions for detailed descriptions, including additional limitations or exclusions. Paid *benefits* are based on the *reimbursement limit.*

This plan provides benefits for services at the coinsurance percentages noted below regardless of the provider seen. Services obtained from contracted and non-contracted providers will be paid at these same coinsurance percentages

Dental benefits

Individual maximum benefit:
$2,000 per *year* per *covered person* for Preventive, Basic, and Major Services.

Individual extended maximum benefit: When a *covered person* has reached his or her Individual Maximum Benefit *covered expenses* for Preventive, Basic and Major *services* will be paid at 30% for the remainder of that *year*. Coverage of these *services* will be subject to all provisions of this Certificate, including but not limited to, the eligibility of the *covered person,* the *reimbursement limit*, and all limitations and exclusions. The Individual Extended Maximum Benefit does not apply to, and no additional benefits are available for Orthodontic services.

Individual deductible:
$50 per *year* per *covered person* for Basic and Major Services.

Maximum family deductible:
Covered expenses applied to the plan *deductible* of each *covered person* are combined to a *year* maximum of $150.

Orthodontic lifetime maximum benefit:
$1,500 per each covered *dependent* child age 18 and under.

Preventive Services:
Benefits are paid at 100%.

- Routine teeth cleaning (prophylaxis)
- Topical fluoride treatment
- Sealants
- X-rays
- Oral examinations
- Space maintainers

Basic Services:
Benefits are paid at 80% after the *deductible*.

- Fillings (amalgam and composite restorations)
- Non-surgical extractions
- Non-surgical residual root removal
- Oral Surgery
- Non-cast prefabricated crowns
- Emergency exam and palliative care for pain relief
- Harmful habits and thumb-sucking appliances
- Periodontics (gum disease)
- Endodontics (root canals)

Major Services:
Benefits are paid at 50% after the *deductible*.

- Crowns
- Inlays and onlays
- Removable or fixed bridgework
- Partial or complete dentures
- Denture relines or rebases
- Partial and denture repairs and adjustments

Orthodontic Services:
Benefits are paid at 50%.

Please refer to the Orthodontic Services Rider of *your* certificate to determine who is eligible for coverage under this *benefit*.

Waiting periods:

This provision describes to the *employer* the waiting period criteria that will apply to *members* before *benefits* are available for *covered services*. *Dependents* added after the effective date of the *employee* may be subject to a separate waiting period. Please call *us* for the waiting period that applies to those *dependents*.

Any *member* who is a *late applicant*, is subject to a 12-month waiting period before he or she is eligible for coverage for any *service* except Preventive *services*.

If a *member* enrolls timely, Major and Orthodontic *services* MAY be subject to a 12-month waiting period before they are eligible for coverage. This 12-month waiting period can be decreased by the amount of time the *member* had prior dental coverage immediately before his or her coverage with *us*.

If a member has continuous dental coverage without a break of more than 63 days between the termination of creditable coverage and his or her enrollment date under the policy, any period of time that was satisfied under the prior plan will be applied to the appropriate waiting periods under the policy, if any. The *employee* will then be eligible for benefits under the policy when the balance of the waiting period has been satisfied, whether the *member* is timely or a *late applicant*.

Please see *your* Summary of Benefits for waiting period provisions that are specific to *you*.

Preventive Services:
No waiting periods apply to Preventive *services*.

Basic Services:
No waiting periods apply to Basic *services*, unless the *member* is a *late applicant*.
If a *member* is a *late applicant*, he or she must be insured under this policy for a period of 12 continuous months before Basic *services* will be covered.

Major Services:
For Major Services, coverage is effective as follows:

Groups with fewer than 10 dental lives with no prior dental coverage, coverage is effective 12 months after the effective date of coverage.

Groups with fewer than 10 dental lives with prior dental coverage, coverage is effective on the effective date of coverage.

Groups with more than 10 dental lives with or without prior dental coverage, coverage is effective on the effective date of coverage.

For a *late applicant* added after the group's effective date under this policy, he or she MUST be insured under this policy for a period of 12 consecutive months before Major *services* will be covered.

Orthodontic Services:

Groups with fewer than 10 dental lives with no prior orthodontia coverage--orthodontia coverage is effective 24 months after the effective date of coverage.

Groups with fewer than 10 dental lives with prior dental and orthodontia coverage--orthodontia coverage is effective on the effective date of coverage.

Groups with fewer than 10 dental lives-orthodontic coverage is effective 24 months after the effective date of the covered *dependent* added after the effective date of the group's Policy.

Groups with more than 10 dental lives--orthodontia coverage is effective on the effective date of coverage.

Your plan benefits

We pay *benefits* on *covered expenses* as explained in the **How your plan works** section. *Benefits* for *covered services* explained below are limited to the *maximum benefit* shown in the **Summary of your benefits**.

Preventive services

1. Oral evaluations

    - Periodic exam – two per *year;*
    - Limited or problem focused exam– one per *year;*
    - Comprehensive exam – one every three years. Periodontal and comprehensive exams not in conjunction with each other.

2. Periodontal evaluations – one every three *years*.

3. Cleaning (prophylaxis), including all scaling and polishing procedures – two per *year*.

4. Adjunctive test to aid in oral cancer screening for *covered persons* age 40 and older– one per *year*.

5. Intra-oral complete series X-rays, or panoramic X-ray - once every five *years* for *covered persons* 12 years of age or older. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, the plan will consider these as a complete series.

6. Bitewing X-rays – one set of films per *year* for *covered persons* under age 10 and four films per *year* for *covered persons* age 10 and older.

7. Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.

8. Topical application of fluoride or fluoride varnish – provided to *covered persons* age 14 and younger. *Service* is payable once per *year.*

9. Sealants – application provided to *covered persons* age 14 *years* and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime.

10. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *covered persons* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

11. Finger stick test for diabetes screening for *covered persons* age 18 and older when performed by a licensed *dentist* and limited to one per year.

Basic services

1. Amalgam restorations (fillings) – limited to one per tooth per surface in a two *year* period. Multiple restorations on one surface are considered one restoration.

2. Composite restorations (fillings) on anterior teeth - limited to one per tooth per surface in a two *year* period. Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.

3. Gold foil restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Limited to a maximum of one per tooth every two years.

4. Recementing of inlays, onlays, crowns and bridges;

5. Non-cast pre-fabricated crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations.

6. Treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. *We* will consider the *service* as a separate *benefit* only if no other *service* is provided during the same visit.

7. Fixed and removable appliances to inhibit thumb sucking and other harmful habits. *Services* are payable only for *covered persons* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

Simple Oral surgery services

1. Extractions - coronal remnants of a primary tooth.
2. Extraction - erupted tooth or exposed root.

Complex Oral surgery services

1. Surgical extractions.

2. Bone Smoothing.

3. Trim or Remove over growth or non vital tissue or bone.

4. Removal of tooth or root from sinus and closing opening between mouth and sinus.

5. Surgical access of an unerupted tooth.

6. Mobilization of erupted or malpositioned tooth to aid eruption; or, surgical reposition of teeth.

7. Excision or removal of benign oral cysts or tumors.

8. Bone, cartilage, or synthetic grafts.

9. General anesthesia when based on review of clinical documentation provided and administered by a *dentist* in conjunction with a covered oral surgical procedure.

Periodontic services

1. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three year period. *Benefits* payable for a maximum of two quadrants on the same date of service. Additional quadrants are allowed after seven days or as allowed based on *clinical review*.

2. Scaling in presence of generalized moderate or severe gingival inflammation available based on *clinical review* a maximum of once a year. This service will reduce the number of routine cleanings available (under #3 in Preventive Services) so the total number of cleanings does not exceed two in a year per person.

3. Periodontal maintenance (following periodontal therapy) – procedure available four times per *year* for *covered persons* with periodontal history.

4. Periodontal surgery, available at a maximum of once per quadrant in a three-year period.

5. Occlusal adjustments when performed in conjunction with periodontal surgery – available at a maximum of once per quadrant in a three year period.

Endodontic services

1. Root canal therapy, including root canal treatments and root canal fillings for permanent teeth - limited to one per tooth per lifetime.

2. Root canal retreatment, including root canal treatments and root canal fillings - limited to one per tooth per lifetime.

3. Apicoectomy - procedure available for permanent teeth only.

4. Partial pulpotomy for apexogenesis – procedure available for permanent teeth only.

5. Vital pulpotomy – procedure available for primary teeth,

6. Apexification/recalcification.

Major/Prosthodontic services

1. Repairs of bridges; full or partial dentures, and crowns.

2. Denture adjustments when done by a *dentist* other than the one providing the denture, or adjustments performed by the dentist providing the denture after initial installation - only after 6 months after initial installation.

3. Initial placement of laboratory-fabricated restorations for a permanent tooth when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. *Covered services* include inlays, onlays, crowns, veneers, core build-ups and posts. Inlays are considered an alternate *service* and will be payable as a comparable amalgam filling. *We* will not cover the *expense incurred* for pin retention when done in conjunction with core build-up.

4. Initial placement of bridges, complete dentures, immediate dentures only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while *you* are covered under this plan. *We* will not cover replacement of congenitally missing teeth.

5. Replacement of bridges, partial dentures, complete dentures, inlays, onlays, crowns, veneers, core build ups and posts or other laboratory-fabricated restorations. *Covered services* include the replacement of the existing prosthesis if:

- It has been at least five years since the prior insertion and is not, and cannot be made, serviceable;
- It is damaged beyond repair as a result of an *accidental injury* (non-chewing injury) while in the oral cavity; or
- Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis, necessitates the replacement of the prosthesis.

These *services* are covered only on permanent teeth.

6. Denture relines or rebases – once in a three year period after 6 months from installation.

7. Post and core build-up in addition to partial denture retainers with or without core build up.

8. Implant related services, subject to *clinical review.* Dental implant prosthetics including implant supported crowns, bridges, complete dentures or partial dentures. Implant supported complete or partial dentures are limited to a maximum of one every five years. All other services limited to a maximum of one every five years. Implant prosthetics noted above will be payable at the same level of benefits as the corresponding non-implant prosthetic. *You* will be responsible for the remaining *expense incurred*.

Integral service

The following *services* are considered integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense.*

1. Local anesthetics;

2. Bases;

3. Pulp caps;

4. Additional charges related to materials or equipment used in the delivery of dental care;

5. Study models/diagnostic casts;

6. Treatment plans;

7. Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;

8. Nitrous oxide;

9. Irrigation;

10. Tissue preparation associated with impression or placement of a restoration.

11. Any test, intraoperative, x-rays, laboratory, removal of existing posts, filling material, Thermafill carriers, and any other follow-up care is considered integral to root canal therapy.

Limitations & exclusions (all services)

In addition to the limitations and exclusions listed in **Your plan benefits** section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.

2. *Services*:

   - That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury.*

3. Any loss caused or contributed by:

   - War or any act of war, whether declared or not;

   - Any act of international armed conflict; or

   - Any conflict involving armed forces of any international authority.

4. Any expense arising from the completion of forms.

5. *Your* failure to keep an appointment with the *dentist*.

6. Any *service we* consider *cosmetic* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. *We* consider the following *cosmetic* procedures to include, but are not limited to:

   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.

   - Any *service* to correct congenital malformation;

   - Any *service* performed primarily to improve appearance;

   - Characterizations and personalization of prosthetic devices; or

   - Any procedure to change the spacing and/or shape of the teeth.

7. Charges for:

   - Any type of implant and all related services;
   - Precision or semi-precision attachments;
   - Overdentures and any endodontic treatment associated with overdentures;
   - Other customized attachments;
   - Any service for 3D imaging (cone beam images);
   - Temporary and interim dental services;
   - Additional charges related to material or equipment used in the delivery of dental care.
   - Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the *employer*;
   - The removal of any implants unless specified in the Summary of Your Benefits section of this *certificate*.

8. Any *service* related to:

   - Altering vertical dimension of teeth;
   - Restoration or maintenance of occlusion;
   - Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
   - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   - Bite registration or bite analysis.

9. Infection control, including but not limited to sterilization techniques.

10. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.

11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.

12. Prescription drugs or pre-medications, whether dispensed or prescribed.

13. Any *service* not specifically listed in **Your plan benefits**.

14. Any *service* that:

    - Is not eligible for benefits based upon *clinical review*;
    - Does not offer a favorable prognosis;
    - Does not have uniform professional acceptance; or
    - Is deemed to be experimental or investigational in nature.

15. Orthodontic *services* unless specified in *your* **Summary of your benefits**. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.

16. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under **Extension of benefits**).

17. Charges exceeding the *reimbursement limit* for the *service*.

18. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.

19. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service.*

20. Temporary dental *services.*

21. Repair and replacement of orthodontic appliances.

22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.

23. The oral surgery benefits under this plan does not include:

    a. Any *services* for orthognathic surgery;

    b. Any *services* for destruction of lesions by any method;

    c. Any *services* for tooth transplantation;

    d. Any *services* for removal of a foreign body from the oral tissue or bone;

    e. Any *services* for reconstruction of surgical, traumatic, or congenital defects of the facial bones;

    f. Any separate fees for pre and post-operative care.

24. General anesthesia or conscious sedation is not a *covered service* unless it is based on *clinical review* of documentation provided and administered by a *dentist* or *health care practitioner* in conjunction

with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for *covered services*.

General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:

1. Pain control unless a documented allergy to local anesthetic is provided.
2. Anxiety.
3. Fear of pain.
4. Pain management.
5. Emotional inability to undergo surgery.

25. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

26. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

27. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

28. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered *covered services* under the surgical periodontic services in this plan.

29. *We* do not cover *services* that generally are considered to be medical *services* except those specifically noted as covered in this certificate.

Supplemental Dental Expense Benefit

Orthodontic Services

This Supplemental Dental Expense Benefit is part of the certificate. The benefits outlined will be effective the latter of:

1. The effective date of *your* certificate; or
2. Completion of any applicable waiting period.

Please refer to the Waiting Periods provision to verify if an orthodontic waiting period applies to *you*.

Benefits are available only to covered *dependent* children age 18 and under at the time treatment begins.

We pay *benefits* based on *our reimbursement limits* and *your* orthodontic m*aximum benefit*. Except as modified below, all plan terms, conditions and limitations apply.

Covered services for orthodontia treatment

Covered services for orthodontic treatment include those that are:

1. For the treatment of--and appliances for--tooth guidance, interception and correction; and
2. Related to covered orthodontic treatment including:

   - X-rays;
   - Exams;
   - Space regainers; and/or
   - Study models.

How benefits will be paid if treatment begins <u>after</u> you are eligible for orthodontic benefits with us.

In order to have the full orthodontic treatment be considered for *benefits* under this plan, bands and appliances must be inserted after:

1. *Your* effective date under this plan; and
2. Exhaustion of any orthodontic waiting period.

If *services* are eligible under this plan at the time orthodontic appliances or bands are initially inserted, *we* will pay the lesser of:

1. 25 percent of the total *treatment plan* charge;
2. 25 percent of the total *maximum benefit* payable; or
3. The *dentist's* initial fee.

We will pay the remaining installments at the end of each quarter while *you* are covered for orthodontic benefits under this plan. If for any reason the *treatment plan* is terminated before treatment is completed, *we* will not pay further *benefits*.

Supplemental Dental Expense Benefit

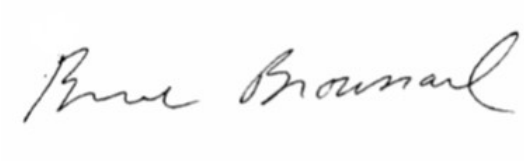
How benefits will be paid if treatment was started before you were eligible for orthodontic benefits with us.

Services for orthodontic treatment received prior to *your* effective date, or prior to exhaustion of the orthodontic waiting period, are not *covered services*.

Benefits are available only for the portion of the treatment after:

1. *Your* effective date under this plan; and
2. Exhaustion of any orthodontic waiting period.

Benefits will be prorated to account for the portion of treatment completed prior to orthodontic eligibility.



Bruce Broussard
President