BlueCross BlueShield of New Mexico

Your Dental Care Benefit Booklet

A Guide to Your Group Dental Care Coverage

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

This dental care benefit program is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in dental care. Like most people, you probably have many questions about your coverage. This Benefit Book- let contains a great deal of information about the services and supplies for which benefits will be provided under your benefit program. Please read your entire Benefit Booklet very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Benefit Booklet we refer to our company as ''BCBSNM'' and we refer to the company or association that you work for as the ''Group.'' The *Definitions* section will explain the meaning of many of the terms used in this Benefit Booklet. All terms used in this Benefit Booklet, when defined in the *Definitions* section, begin with a capital letter. Whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under this benefit program.

BCBSNM and your Group may change the benefits described in this Benefit Booklet. If that happens, BCBSNM or your Group will notify you of those mutually agreed upon changes.

If you have any questions once you have read this Benefit Booklet, talk to your Group Administrator or call us at the number listed on the back of your Identification Card. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield of New Mexico! We are very happy to have you as a Member and pledge you our best service.

Sincerely,

Kurt Shipley
President
Blue Cross and Blue Shield of New Mexico

TABLE OF CONTENTS

DEFINITIONS

This section defines certain words used in this Dental Benefit Booklet.

Annual Maximum Benefit. - means the maximum dollar amount BCBSNM will pay for Covered Services for each Member during a Benefit Period, according to the terms of this Benefit Booklet and the coverage outlined on the Member's *Schedule of Benefits*. The amounts applied to the Annual Maximum Benefit are benefit payments made, which are based on the Maximum Allowance for all Covered Services for which benefits were received. The Annual Maximum Benefit does not include the Member's Deductible and/or Coinsurance amounts.

Appliance - means a device used to provide a function or a therapeutic effect (for example: a denture).

Benefit Booklet - means this document, which explains the benefits, limitations, exclusions, terms, and conditions of this Dental coverage and all endorsements, amendments, and riders attached hereto, now and in the future.

Benefit Period - means the period of time during which you receive Covered Service for which BCBSNM will provide Benefits. The Benefit Period is a period of one year which begins on your effective date of coverage.

Benefit Waiting Period. means the number of months that you must be continuously covered under this dental benefit program before you are eligible to receive benefits for certain Covered Services. (If you have a Benefit Waiting Period, it is listed in your *Schedule of Benefits.)*

Blue Cross and Blue Shield of New Mexico - means Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, also referred to as BCBSNM.

Coinsurance - means the specified percentage of the Maximum Allowance a Member pays for a Covered Service after the Deductible, if applicable, has been met.

Contract. -This agreement including, but not limited to, your Group's application with BCBSNM and any amendments between your Group and BCBSNM.

Course of Treatment. -means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

Covered Services -means services and supplies provided to a Member for which BCBSNM has an obligation to pay (under the terms of this Benefit Booklet) for treatment of conditions related to the teeth or structures supporting the teeth.

Dental Plan -This Benefit Booklet, Schedule of Benefits, and your application for coverage under the Blue Cross and Blue Shield Dental Plan described in this Benefit Booklet.

Deductible -means a specified amount of the Maximum Allowance for Covered Services that the Member must pay each Benefit Period. The Deductible amount is subtracted from the total Maximum Allowance for Covered Services that are subject to the Deductible.

Dentist -means a Dentist or Physician, legally licensed and entitled to practice dentistry in the state or jurisdiction where services are provided.

Dependent -An eligible spouse, eligible Domestic Partner or eligible child who has applied for and been granted coverage under the Subscriber's policy based on his/her family relationship to the Subscriber, limited to the following persons:

- the Subscriber's legal **spouse** or **Domestic Partner;**
- the Subscriber's spouse's or Domestic Partner's eligible child through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from

coverage unless the child is an Eligible Family Member under this Dental Plan due to a disability as described below.)

- the Subscriber's spouse's or Domestic Partner's **unmarried** Child age 26 or older who was enrolled as the Subscriber's covered child in this Dental Plan at the time of reaching the age limit, and who is medically certified as **disabled**, chiefly dependent upon the Subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his /her disability (Such condition must be certified by a Physician and BCBSNM. Also, a child may continue to be eligible for coverage beyond age 25 only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month during which the child's coverage would otherwise end.)

Domestic Partner - A companion of the same or opposite sex with whom the Subscriber has entered into a Domestic Partnership in accordance with the guidelines set forth in the *Enrollment and Termination Information* section of this Benefit Booklet. If your Group has elected to provide Domestic Partner coverage, all provisions of this Benefit Booklet (with the exception of COBRA Continuation Coverage), that pertain to a spouse, also pertain to a Domestic Partner once eligibility is determined. Check with your Group for information on whether Domestic Partner coverage is available under this Dental Plan. (NOTE: Federal law defines a spouse as a person of the opposite sex, who is a husband or wife. Therefore, a Domestic Partner is not recognized as a spouse for federally regulated programs, such as COBRA Continuation Coverage and Medicare.)

Domestic Partnership -A same-sex or opposite sex couple in a committed relationship, similar to a marriage, but without an official marriage license.

Effective Date of Coverage -means 12:01 a.m. of the date on which a Member's coverage under this dental benefit program begins.

Eligible Family Member -A Dependent of the Subscriber entitled to enroll for coverage under the Dental Plan. See "Eligible Family Members" in the *Enrollment and Termination Information* section of your Benefit Booklet for more information about Eligible Family Members.

Good Cause - means failure of the Subscriber to pay the premium or other applicable charges for coverage; a material failure to abide by the rules, policies or procedures of this benefit program; or fraud or material misrepresentation affecting coverage.

Group - A bonafide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and by-laws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

Identification Card - means the card BCBSNM gives to the Subscriber which is used to confirm a Member's coverage. It may show such information as the Subscriber's name, Subscriber number, group number, plan number or name, and date issued.

Maximum Allowance - means the amount determined by BCBSNM to be a reasonable and adequate allowance for a Covered Service. The Maximum Allowance is the maximum amount that is approved for any particular Covered Service. After the Member's share of BCBSNM's Maximum Allowance (Deductible and Coinsurance) for a Covered Service has been calculated, this benefit program pays any remaining amount up to the Maximum Allowance (not to exceed the Annual Maximum Benefit). These amounts may be amended from time to time by BCBSNM.

Medically Necessary -means that a specific procedure or supply provided to you is reasonably required in the judgment of BCBSNM, for the treatment or management of your specific dental symptom, injury, or condition and that the procedure performed is the most efficient and economical procedure that can safely be provided to you. The fact that a Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by BCBSNM. These consultants review the claim and

diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

Member - means the Subscriber and all dependents that are eligible for coverage under this Dental benefit program. When the term "you" and "your" is used, we also mean all eligible family Members.

Network Allowance - means the amount determined by BCBSNM that Network Dentists have agreed to accept as payment in full for a particular Covered Service.

Network Provider - means a dental care Provider, such as a Dentist or a Physician, who has entered into a Provider agreement with BCBSNM for direct billing of Covered Services, and who agrees to accept the benefit program's benefit payment plus the Member's share of BCBSNM's Maximum Allowance (Deductible and Coinsurance) as payment in full for such Covered Services. BCBSNM will pay the Network Provider directly.

Non-Network Allowance - The Allowable Charge for services from an Out-of-Network Dentist is the Provider's usual charge, as long as it does not exceed the amount the Plan allows for the same services rendered by a Participating Dentist. The Member is responsible for all charges that exceed the Allowable Charge from an Out-of-Network Provider.

Non−Network Provider - means an appropriately licensed health care Provider that has not contracted with BCBSNM as a Network Provider. You are responsible for paying all billed charges to the Provider, which includes this benefit program's benefit payment, amounts greater than BCBSNM's Maximum Allowance, applicable Deductibles and Coinsurance, and any expenses for non-covered services. Members may have to file their own claims. Payment for Covered Services is usually made directly to you.

Physician -means a Physician duly licensed to practice medicine in all of its branches. A Physician also includes a Practitioner of the Healing Arts.

Practitioner of the Healing Arts- Any person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, or operate on, or prescribe for any human pain, injury, disease, deformity, physical, or mental condition pursuant to:

- the Chiropractic Physician Practice Act
- the Dental Health Act
- the Medical Practice Act
- the Acupuncture and Oriental Medicine Practice Act

Pretreatment Estimate -a Pretreatment Estimate identifies BCBSNM's estimated financial liability before treatment is started. This estimate may include some or all of the following information: patient's eligibility, Covered Services, benefit amounts payable, Deductible amounts, Coinsurance, and/or maximum benefit limitations. Such estimates are subject to change, according to the terms of the Member's coverage, and may include an allowance for alternate benefits. Final determination of benefits is made upon submission of a claim to BCBSNM for actual payment.

Provider -means a hospital, other facility, Dentist, Physician, or other health care Provider that BCBSNM recognizes as a health and/or dental care professional or medical facility. The Provider must be licensed, certified, or registered by the state or jurisdiction where services are provided to perform designated health and dental care services. Services of such a Provider must be among those covered by this dental benefit program and are subject to review by a medical or dental authority appointed by BCBSNM. A professional supplier of medical and dental supplies and equipment is considered an "other health care provider."

Subscriber -means the person in whose name the dental benefit program coverage is established and to whom the Identification Card is issued.

THINGS YOU SHOULD KNOW

This Benefit Booklet describes the benefits available to Members of this Dental Plan and benefit limitations and exclusions. It also describes optional benefits that **may or may not** have been chosen by the Member's Group.

SUMMARY OF BENEFITS

In addition to this Benefit Booklet, Members should have a *Schedule of Benefits* that shows the Annual Maximum Benefit amount, Deductible requirements, the percentage of the Maximum Allowance that the benefit program will pay for a Covered Service, and specific benefit options and/or coverage variables chosen by the Group. (If you do not have a schedule, please contact a BCBSNM Dental Customer Advocate.) Members will receive a new *Schedule of Benefits* if changes are made to this benefit program.

LOOKING UP INFORMATION

This Benefit Booklet is designed to make it easy for Members to determine their benefits. For example, if you need to know the benefit for an x-ray, turn to *Covered Services*. The "Diagnostic Radiographs" subsection defines the benefits for an x-ray. The subsection also lists the most important limitations and exclusions to that particular service. *General Exclusions* lists other limitations and exclusions which **apply to all services, whether or not these items are listed separately within any subsection of the *Covered Services* section.**

CURRENT DENTAL TERMINOLOGY (CDT)

When classifying a certain dental service, BCBSNM Benefit Booklet language reflects the most recent edition of a manual published by the American Dental Association entitled *Current Dental Terminology and Procedure Codes*. The Maximum Allowance for a Covered Service will be based on the most inclusive code, determined by BCBSNM, in *Current Dental Terminology and Procedure Codes*. The Maximum Allowance for a Covered Service will be based on the most recent edition of a manual published by the American Dental Association entitled *Current Dental Terminology and Procedure Codes*. (No benefits will be provided for procedures which are components of a more inclusive code.) BCBSNM's dental processing procedures will be automatically updated as new codes are implemented by the American Dental Association.

CUSTOMER SERVICE

If you have any questions about your coverage, call BCBSNM's Dental Customer Advocate department. For your convenience, the toll-free customer service numbers are printed at the bottom of every page in this benefit booklet.

Dental Administrative Offices

P.O. Box 23090 Belleville, IL 62223-0090

Hours: 8:30 A.M. to 5:00 P.M. Central Time Monday-Friday

Phone number: 1-877-723-5697

ENROLLMENT AND TERMINATION INFORMATION

Unless otherwise specified in the Contract, all active employees who have completed the employee probationary period and are regularly working the minimum number of hours specified in the Contract are eligible for coverage. Employers may request coverage for regular part-time employees expected to work an average of at least 20 hours per week over a six-month period. Each employer may choose whether or not to offer health insurance to those part-time employees. (This optional coverage for part-time employees is not available to temporary or seasonal workers.) To find out the number of hours you must work per week and to learn of any other eligibility criteria specified by your Group, contact your Group administrator.

BCBSNM may request proof that a valid employer-employee relationship exists, if applicable, and/or that the applicant meets the eligibility requirements stated in the Contract and the Member's application. The Group also agrees to permit BCBSNM to perform payroll audits. See "Reenrollment" for important information if you or a Dependent were previously enrolled in a benefit program administered by BCBSNM.

IF YOUR EMPLOYER OFFERS RETIREE BENEFITS

If your employer's Plan also covers retirees, then retirees under the age of 65 who meet the eligibility requirements for dental benefit program participation are also eligible. If you are covered under this benefit program and anticipating retirement, please contact your Group administrator for eligibility criteria applicable to you.

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The Subscriber must notify BCBSNM **within 31 days** following any changes that may affect his/her or a Dependent's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to BCBSNM. (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.) You can obtain this form at the BCBSNM Web site at **www.bcbsnm.com** from the Group administrator or by calling the BCBSNM Dental Customer Advocate.

APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her eligible Dependents, by submitting an enrollment/change form to BCBSNM **within 31 days** after becoming eligible according to the terms of the Contract.

BCBSNM will determine your Effective Date of Coverage according to the provisions of the Contract. Depending upon the provision of the Contract, if you and/or your Dependents do **not** apply for coverage **within 31 days** of becoming eligible, you will have to wait until the Group's next annual open enrollment period before enrolling. See "Late Applicant Provision" later in this section for details.

This benefit program does not cover any service received before your Effective Date of Coverage (which, for eligible Dependents, may be later than the Subscriber's effective date). Also, if your prior coverage has an extension of benefits provision, this benefit program will not cover those charges incurred after your effective date that are covered under the prior plan.

WHO IS ELIGIBLE

Subject to the other terms and conditions of the Contract, the Benefits described in this Benefit Booklet will be provided to persons who:

- Are active employees who have completed the employee probationary period, if any, and who are regularly working the minimum number of hours specified in the Contract and their Eligible Family Members (No such probationary period may exceed 90 days unless permitted by applicable law. If BCBSNM records show that your Group has a probationary period that exceeds the time period permitted by applicable law, then BCBSNM reserves the right to begin your coverage on a date that BCBSNM believes is within the required period. Regardless of whether BCBSNM exercises that right,

your Group is responsible for your probationary period. If you have questions about your probationary period or the number of hours you must work per week or to learn of any other eligibility criteria specified by your Group, contact your Group's benefits administrator.);

- Have applied for coverage in this Dental Plan through BCBSNM;
- Have received a BCBSNM Identification Card; and
- Reside or work in the geographic Network Service Area served by BCBSNM's network of Participating Dentists for this Benefit Booklet. You may call Customer Service at the number shown on the back of your Identification Card to determine if you reside or work in the Network Service Area or log on to the website at *www.bcbsnm.com*.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor. You will not be discriminated against for coverage under this Dental Plan on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or Benefits of this Dental Plan that are based on clinically indicated, reasonable dental management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

BCBS may request proof that a valid employer-employee relationship exists, if applicable, and/or that the applicant meets the eligibility requirements stated above and/or in the Contract and the Member's application. The Group also agrees to permit BCBSNM to perform payroll audits.

See "Re-Enrollment" in this section for important information if you or an Eligible Family Member were previously enrolled in a dental care benefit plan administered by BCBSNM.

ELIGIBLE FAMILY MEMBERS

Covered family member, covered spouse, covered Child – An eligible spouse or Eligible Child (as defined below) who has applied for and been granted coverage under the Subscriber's policy based on his/her family relationship to the Subscriber.

Eligible Family Members – Family Members of the Subscriber, limited to the following persons:

- the Subscriber's legal **Spouse**
- the Subscriber's Eligible Child through the end of the month in which the Child reaches **age 26** (Once a covered Child reaches age 26, the child is automatically removed from coverage – unless the Child is an Eligible Family Member under this Dental Plan due to a disability as described below.)
- the Subscriber's **unmarried** Child age 26 or older who was enrolled as the Subscriber's covered child in this Dental Plan at the time of reaching the age limit, and who is medically certified as **disabled**, chiefly dependent upon the Subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability (Such condition must be certified by a Physician and BCBSNM. Also, a Child may continue to be eligible for coverage beyond age 25 only if the condition began before or during the month in which the Child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month during which the child's coverage would otherwise end.)
- the Subscriber's **Domestic Partner** (NOTE: Domestic Partner coverage is available at your employer's discretion. Contact your employer for information on whether Domestic partner coverage is available for your Group.)

Eligible child – The following family member of the Subscriber through the end of the month during which the Child turns age 26:

- natural or legally adopted Child of the Subscriber
- Child placed in the Subscriber's home for purposes of adoption (including a Child for whole the Subscriber is a party in a suit in which the adoption of the child by the Subscriber is being sought)

- stepchild of the Subscriber (or otherwise Eligible Child of a Domestic Partner, provided your employer covers Domestic Partners and the Eligible Child(ren) of a Domestic Partner
- Child for whom the Subscriber must provide coverage because of a court order or administrative order pursuant to state law
- eligible foster Child

A Child meeting the criteria above is an "Eligible child" whether or not the Subscriber is the custodial or noncustodial parent, and whether or not the Eligible Child is claimed on income tax, employed, married, attending school or residing in the Subscriber's home, **except** that once the Subscriber is no longer a legal guardian of a Child or there is no longer a court order to provide coverage to a child, the Child must be eligible as a natural Child, legally adopted Child, eligible foster child, or stepchild of the Subscriber in order to retain eligibility as a family member under this Dental Plan.

A **Domestic Partner** is a person of the same or opposite sex who meets all of the following criteria:

- shares your permanent residence and has resided with you for no less than one year;
- is not less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or, if none of the documents enumerated are available, by providing other documentation as is needed to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to BCBSNM on request.

In addition, you and your Domestic partner will meet the terms of this definition as long as neither of you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within 12 months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, souse, or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners if you reside in a state that provides for such registration. In any case, if your employer allows coverage for Domestic Partners and their children, BCBSNM will require a notarized *Affidavit of Domestic Partnership* and at least three corroborating documents:

- joint lease/mortgage or ownership of property
- jointly owned motor vehicle, bank or credit account (only one qualifies)
- Domestic Partner named as beneficiary of the employee's life insurance and/or retirement benefits, and/or as primary beneficiary under employee's will
- Domestic Partner assigned as power of attorney or legal designee by the employee
- Both names on a utility bill and/or on an investment account

The federal government does not recognize Domestic Partners as qualified eligible family members and therefore, the premium paid for the coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the employer for the Domestic Partner and his/her covered children. Employees wanting to change benefit elections involving a Domestic Partner must adhere to the same rules regarding Special Enrollment Events.

Within 31 days of hire, you must submit all required forms to your benefits administrator. Once you have

made an election during your initial enrollment period of 31 days from your date of hire, you are locked into that decision until the next annual open enrollment period.

BCBSNM may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Family Member under this coverage. Unless listed as an Eligible Family Member, no other family member, relative or person is eligible for coverage as a family member. Common-law spouses are **not** considered legal spouses; in order to be considered eligible for coverage, a common-law spouse must meet the definition of "Domestic Partner."

Information for Noncustodial Parents

When a child is covered by the Dental Plan through the Child's noncustodial parent, then the Dental Plan will:

- provide such information to the custodial parent as may be necessary for the Child to obtain Benefits through the Dental Plan;
- permit the custodial parent or the Provider (with the custodial parent's approval) to submit Claims for Covered Services with the approval of the noncustodial parent; and
- make payments on Claims submitted in accordance with the above provision directly to the custodial parent, the Provider, or the state Medicaid agency as applicable.

ADDING DEPENDENTS

NOTE: If your employer provides coverage for retirees, retirees may or may not be able to add Dependents to coverage following retirement. Usually, only those Dependents who were covered at the time of the employee's retirement are eligible to continue coverage under this dental benefit program. However, please contact your Group administrator for guidelines that apply to you.

You may apply for coverage of a Dependent (such as a spouse or a child). **Within 31 days** of acquiring the new Dependent or before adding a spouse to coverage, you must:

- request that the Group notify BCBSNM of the change,
- complete and submit all necessary enrollment/change forms and legal documentation of proof of dependency and
- pay any additional premium or other employee contribution for coverage, which may mean changing, for example, from Individual to Two-Person, Employee/Children or Family coverage.

Adding a New Spouse

If a Subscriber adds coverage for a new spouse **within 31 days** of marriage, the effective date of the spouse's coverage will be the first of the month following the date of marriage. If not enrolled **within 31 days** of the marriage, the spouse may not be added to coverage except as a late applicant.

Adding a Dependent Child

If Family or if available, Employee/Children coverage is in effect, a newborn, natural child is covered from birth. (You should, however, submit an application to add the newborn as a Dependent as soon as possible after birth.) Also, Subscribers may apply for coverage for a Dependent child under **three** years of age any time after the child becomes initially eligible for coverage. The enrollment change form must be submitted **within 31 days of the Dependent child's third birthday. If not added within 31 days of the child's third birthday** (or any time prior), the child may not be added to coverage except as a late applicant.

Note: If the parent of the newborn is a Dependent child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), benefits are not available for the newborn.

Adding Adopted Children

A child under age 18 placed in the Subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage should be made no later than **within 31 days** following legal adoption. Depending on when you submit the application, the

Effective Date of Coverage will be the date of placement in the home or the date of legal adoption if you submit the application **within 31 days** of the applicable event. (Although a child over the age of 18 is not eligible for adoption, an adopted child is covered as any other child, subject to the same Dependent age limitations and restrictions.) If not added **within 31 days** of legal adoption or **within 31 days** of the child's third birthday, whichever occurs first, the child will be considered a late applicant.

Legal Guardianship

Application for coverage must be made for a child for whom the Subscriber or the Subscriber's spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship. If not specified in the court order, the Dependent's Effective Date of Coverage will be the date the order has been filed as public record with the State or the effective date of Family coverage, whichever is later. If not added **within 31 days** of the court order or administrative order, the child will be considered a late applicant.

Court Ordered Dependent Coverage

When an employee or employer is required by a court or administrative order to provide coverage for a Dependent child, the Dependent may be enrolled in the Subscriber's Family or if available, Employee/Children coverage. (If the Subscriber has Individual or Two-Person coverage, he/she may be required to pay additional premium in order for the Dependent to be added.) If not specified in the court or administrative order, the Dependent's Effective Date of Coverage will be the date the order has been filed as public record with the State or the effective date of Family coverage or Employee/Children coverage if available, whichever is later. BCBSNM must receive a copy of the court or administrative order.

Information for Noncustodial Parents

When a child is covered by the benefit program through the child's noncustodial parent, then BCBSNM will:

a. Provide such information to the custodial parent as may be necessary for the child to obtain benefits through the benefit program;
b. Permit the custodial parent or the Provider (with the custodial parent's approval) to submit claims for Covered Services without the approval of the noncustodial parent; and
c. Make payments on claims submitted in accordance with the above provision directly to the custodial parent, the Provider, or the state Medicaid agency, as applicable.

LATE APPLICANT PROVISION

Unless eligible for "special enrollment," applications from the following will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this benefit program (e.g. an employee applying for coverage **more than 31 days** after becoming eligible for coverage, a new spouse or stepchild or stepchild added **more than 31 days** after marriage or any child enrolled **more than 31 days** following his/her third birthday;
- anyone eligible but not enrolled during the Group's initial enrollment under the dental benefit program;
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994).

If you and/or your Dependents do **not** apply for coverage **within 31 days** of becoming eligible, you will have to wait until the Group's next annual open enrollment period before enrolling.

Late applications are not accepted from retirees. If the retiree does not choose dental benefit coverage upon retirement, coverage may not be chosen at a later date. Late applications are also not accepted from persons applying for coverage under one of the continuation provisions listed under "How To Continue Coverage," later in this section. (There are federal and state regulations regarding the amount of time that a terminating plan member has to apply for continued coverage when first eligible. See "How To Continue Coverage" for more information.

OPEN ENROLLMENT

If you did not enroll in the dental benefit program when initially eligible or make application to add a Dependent (other than a newborn for whom no additional premium is required) to your coverage within 31 days of acquiring the new Dependent, you must wait until the Group's next annual open enrollment period to apply for the dental benefit program coverage. If you must change your coverage type (for example, from Individual to Family) you must also pay any additional premium or other employee contribution for coverage. Please ask your employer when your Group's annual open enrollment period begins each year for the dental benefit program.

WAITING PERIOD

The Benefit Waiting Period is the number of months that you must be continuously covered under this dental benefit program before you are eligible to receive benefits for certain Covered Services *(listed on your Schedule of Benefits)*.

SPECIAL ENROLLMENT FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

There are two instances ("qualifying events") in which an eligible person can obtain a "special enrollment" right and enroll in this Group plan **more than 31 days** after becoming eligible without being considered a late applicant. You have a limited amount of time during which you may request a special enrollment. If you do not request special enrollment within the time frame described below, you will be considered a late applicant. There are no "special enrollments" for persons applying for any extension of benefits or continuation coverage offered under this group plan or to retirees who declined coverage. You must timely enroll in these coverages.

Other Special Enrollment Events / Effective Dates of Coverage:

You must apply for or request a change in coverage within 30 days from the date of the below Other Special Enrollment Events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section. Coverage for you and your eligible spouse or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective no later than the 1st day of the month beginning after the date the Plan receives the request for other Special Enrollment.

Special Enrollment events:

- The employee or Dependent had COBRA continuation coverage and the COBRA continuation coverage has expired;
- The employee or Dependent had a loss of eligibility for the coverage. Loss of eligibility for coverage includes a loss coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the forgoing. However, loss of eligibility does not include a loss of coverage due to failure of the individual or the Beneficiary Member to pay premiums on a timely basis or termination of coverage for cause;
- A situation in which The Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or
- The employee is not enrolled because of an election to not enroll during a previous enrollment period, and a person becomes a Dependent of the eligible employee through marriage, birth, or adoption or placement for adoption.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Plan and BCBSNM, as appropriate.

This section "Other Special Enrollment Events/Effective Dates of Coverage" is subject to change by the Plan, BCBSNM, and/or applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, as appropriate.

Waiver of Coverage − If you and your Dependents decline to enroll in this group dental benefit program when initially eligible to do so, you must sign a waiver of coverage for yourself and your Dependents and submit it to your employer. **It is very important that you indicate the reason for declining coverage.** If you declined coverage due to having other dental coverage and later involuntarily lose the other coverage you and your Dependents may be eligible to enroll in your employer's Group dental benefit program as ''special enrollees." Waivers of coverage must be submitted to your employer **within 31 days** of becoming eligible for coverage. If you decline coverage and later request a special enrollment without providing the waiver, or the reason for declining coverage was not due to having other coverage, then you will be ineligible for special enrollment. If you then enroll you will be considered a late applicant.

Coverage Effective Date − If you are granted a special enrollment due to involuntary loss of coverage or due to marriage, coverage will begin no later than the first day of the month after BCBSNM or the employer received the request for special enrollment. For a change in family status due to birth of a newborn or adoption, coverage will begin on the date of the birth or adoption.

QUALIFYING EVENTS

The qualifying events for special enrollment are:

- **Loss of Prior Coverage** − If you decline coverage when initially eligible because of having other dental plan coverage and later involuntarily lose the other coverage or you reach a lifetime maximum under the prior plan, you may apply for coverage. If application is made **within 31 days** of losing the other coverage or **within 31days** of receiving the first dental notice informing you that you have reached a lifetime maximum, then your application will **not** be considered late. If application is **not** made **within 31 days,** you and your Dependents will be considered late applicants and no special enrollment right will be available. BCBSNM reserves the right to verify your eligibility for coverage by requesting proof of loss of coverage or proof of the date of the event.
- **Change in Family Status** − If you acquire a new Dependent due to marriage, birth, adoption or placement for adoption then you may apply for coverage. Your application for special enrollment will not be considered late if submitted **within 31 days** of the day you acquire the new Dependent. If your application is submitted more than 31 days following the change in family status, special enrollment is not available.

REENROLLMENT

Members who voluntarily terminate their coverage (including Dependents who are terminated from coverage by the Subscriber) and who are not paying premium may reenroll under this dental benefit program as late applicants.

Members reenrolling because they involuntarily lost their eligibility under this dental benefit program or because their prior group's coverage was involuntarily terminated will be treated as new applicants and may reenroll **within 31 days** of regaining eligibility under this benefit program.

COVERAGE TERMINATION

Except for nonpayment of premium or termination of the Contract, BCBSNM will not terminate your coverage without giving you 30 days' written notice. Unless stated otherwise, coverage ends at the end of the month following the earliest of the following dates:

- You **terminate employment** or **otherwise lose eligibility according** to the terms of the Contract. If you or the Group fails to notify BCBSNM **within 31 days** to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person's behalf.
- When your **premium payment** or other employee contribution for coverage is not received on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received **within 31 days** after its due date, you or the Group will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 31-day grace period will be billed both to you and to the Group or, in the case of continuation coverage, to you.)
- When you begin a **leave of absence** or enter the **armed forces** for **more than 31 days** or as provided by law. (See "Leave of Absence or Military Service.")
- When you **materially fail to abide by the rules,** policies or procedures of this benefit program or fraudulently provide or materially misrepresent information affecting coverage. If you knowingly give false material information in connection with your eligibility or enrollment, BCBSNM may terminate your coverage retroactively to the Effective date of Coverage. You are liable for any benefit payments made as a result of such improper actions.
- When you **die**. (Surviving eligible Dependents remain covered through the last-paid billing period.)
- When **Group coverage is discontinued** for the entire Group or for the employee's enrollment classification.
    - BCBS will notify the group contract holder of the date the group contract will discontinue and that, unless otherwise provided in the group contract, BCBS shall not be liable for claims for losses incurred after the date of discontinuance.
    - BCBS will also be responsible for notifying all persons covered by the group contract of the discontinuance within ten working days of notice to the group contract holder in whatever manner BCBS customarily uses to provide such notice.
- When the Group gives BCBSNM or BCBSNM gives the Group a minimum 30 **days' advance written notice**.

If BCBSNM ceases operations, BCBSNM will be obligated for Covered Services for the rest of the period for which premiums were already paid.

Additional Dependent Termination Reasons

In addition, coverage will end for any Dependent on the earliest of the above dates or the earliest of the following dates:

- At the end of the **last-paid billing period** for Dependent coverage.
- At the end of the month when a child **no longer qualifies as a Dependent** under the benefit program (e.g., a child is removed from placement in the home, marries or reaches the Dependent age limit). At the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse.
- At the end of the month when you give a minimum **30 days' advance notice** in writing to end coverage for a Dependent(s), according to the rules of your benefit program as established by your Group.

If a Dependent is being removed from coverage because of loss of eligibility under the benefit program (for reasons other than reaching the Dependent child age limit), the enrollment/change form must be received by BCBSNM **within 31 days** following the effective date of the change. In these cases, the

Member will be removed from coverage as of the end of the month following the change in his/her eligibility status. BCBSNM and the Providers of care may recover benefits erroneously paid on behalf of the removed Member.

Note: If enrolled under federal continuation, send enrollment/change forms to the COBRA administrator.

Voluntary Termination of Coverage

To remove a Dependent from coverage before loss of eligibility or to voluntarily terminate your coverage, you must submit a completed enrollment/change form to your Group administrator. If voluntary termination is allowed under your benefit program outside the annual renewal period, coverage will end the first of the month following receipt of the enrollment/change form.

Note: If enrolled under federal continuation, send enrollment/change forms to the COBRA administrator.

Leave of Absence or Military Service

Coverage will end for you and your eligible Dependents at the end of the month during which the leave began. During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact your Group administrator for information.

NOTIFICATION

If the Contract is terminated or premiums are not submitted, coverage will terminate for all affected Members as of the end of the last-paid billing period. The affected Members will be notified of such terminations by BCBSNM. (If your Group fails to submit premium payments to BCBSNM, BCBSNM will advise you of the benefit program termination.)

The required premiums are determined and established by BCBSNM. The percentage of the total premium that you pay is established by your Group. BCBSNM may change premium amounts according to any of the following:

- changes in federal and state law; or
- changes to coverage classifications (for example, to a new age category or geographic location or from an individual coverage to family coverage type); or
- after giving the Group and/or you **60 days** written notice.

PREMIUM REFUNDS

BCBSNM may not refund membership premiums paid in advance on behalf of a terminated Member if:

- the enrollment/change form is not received **within 31 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated Member during the period for which premiums have been paid.

HOW TO CONTINUE COVERAGE

If you lose coverage under this benefit program, you may be able to continue coverage for a limited period of time. **Note:** There is no special enrollment under these provisions. You must reenroll timely to qualify for continued coverage.

Continuation Coverage

Your Group may be subject to the provisions for continuation of plan coverage under Federal law (COBRA or USERRA) or state law (six-month continuation). If so, you and your covered dependents who lose eligibility under this benefit program may be able to continue as Members for a limited period of time by purchasing the continuation coverage described below. You must pay premiums from the date of loss of Group coverage.

You are not eligible to enroll for continuation coverage if:

- the Group stops offering this coverage to its employees or
- you do not elect continuation coverage in a timely fashion.

In addition, if you elect state continuation coverage, you may not later enroll in federal continuation coverage. Contact your Group administrator for details about enrolling in continuation coverage.

Continuation coverage is identical to the coverage a similarly situated regular Member has. However, if the coverage for regular Members changes, your continuation coverage will reflect the same change. For example, if the benefit program's Deductible or other cost-sharing amounts change for regular Members, yours will change by the same amount.

Federal Continuation (COBRA)

COBRA continuation coverage may be available to you and to other members of your family who are covered under this dental benefit program when you would otherwise lose your group dental benefit program coverage. Contact the employer to determine if you or your Group are eligible for COBRA continuation coverage.

Unless approved in writing by BCBSNM, the following persons may **not** enroll in this continued coverage option:

- one who **voluntarily** terminated coverage while still eligible;
- a Dependent who was removed from coverage by the Subscriber while the Dependent was still eligible;
- any Member whose BCBSNM dental care coverage was terminated for Good Cause.

Continuation coverage under federal law ends on the **earliest** of the following dates or any of the applicable dates listed under "Coverage Termination" earlier in this section:

- the first of the month when you become entitled to Medicare;
- when the Group discontinues offering this benefit program to employees. (If this benefit program is replaced by another health care plan, continuation coverage will also be replaced by the new plan.) **Exception:** If your Group declares bankruptcy and you are covered under this benefit program as a retiree, you and your Dependents may be eligible for continued coverage;
- when you become covered under another Group Health Care Plan;
- when the continuation period expires.

State Continuation Coverage

You and your Dependents may continue plan coverage for **6 months** after losing coverage for any reason other than nonpayment of premium or termination of the entire Group. BCBSNM must receive the application for state continuation coverage **within 31 days** after Group coverage is lost. If you choose this coverage, you are not later eligible for federal continuation coverage. This state continuation provision was designed to protect Members whose employers are not subject to federal COBRA continuation provisions (i.e. groups under 20).

State continuation coverage ends on the **earliest** of the following dates or of the applicable dates listed under "Coverage Termination" earlier in this section:

- when the Group discontinues offering this benefit program to employees (If this benefit program is replaced by another dental care plan, continuation coverage will also be replaced by the new plan.);
- when the dental continuation period expires.

USERRA Continuation Coverage

You and your covered Dependents who lose Group coverage because you are absent from work due to military service may be able to continue coverage for **up to 24 months** after the absence begins. Contact

your Group administrator for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Direct-Pay Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA administrator. Subscribers under state continuation coverage pay premiums to BCBSNM. Contact your Group administrator for an application for coverage and details.

Premiums for coverage may change on your Group's renewal date or on any date that the plan is amended. Written notice of any such change will be given to the Group or Subscriber **at least 60 days** before the effective date of the premium change.

HOW THIS DENTAL PROGRAM WORKS

PROVIDER CHOICES

This dental benefit program offers its Members freedom of choice and comprehensive coverage from BCBSNM. The services that a Provider may perform depend upon what the Provider is licensed or certified to do, and whether this dental benefit program recognizes the Provider as eligible for payments.

Members may choose to visit one of the many Dentists who participate in the benefit program as a Network Provider or visit Dentists outside this network. Network Providers have agreed to accept the benefit program's benefit payment plus the Member's share (Deductible and/or Coinsurance) as payment in full. This means Members won't be billed for the difference between a Network Provider's regular fee for a Covered Service and BCBSNM's Maximum Allowance for the same service. (Remember to ask your Dentist whether he or she participates in the BCBSNM dental benefit program or contact your BCBSNM Dental Customer Advocate.)

Network Providers − If a Member chooses a Network Provider, this dental benefit program will pay the Provider directly for Covered Services. Network Providers will also complete and file all claims for the Member.

As previously stated, Network Providers agree to accept BCBSNM's benefit payment plus the Member's share (Deductible and/or Coinsurance) as payment in full for Covered Services. For Covered Services, the Member pays only the Deductible and/or Coinsurance amounts, and charges that exceed the Annual Maximum Benefit or the maximum lifetime orthodontic benefit (if applicable). A Network Provider may request payment for Deductible and/or Coinsurance amounts from the Member at the time services are performed.

Non-Network Providers − Depending on the dental benefit program under which you are enrolled, benefits may also be reduced for receiving services out-of-network and/or you may need to pay a higher Deductible. Check your *Schedule of Benefits*. In any case, you will be responsible to the Provider of services for all charges, regardless of BCBSNM's Maximum Allowance or the amount of the benefit payment to you.

Choosing a Provider − Before choosing a dental care Provider, you may want to check your *Dental Network Provider Directory* or visit the BCBSNM Web site at **www.bcbsnm.com**. If you do not have a current directory and would like a hard copy, contact a BCBSNM Dental Customer Advocate for a list of Network Providers.

Although a directory is current as of the date published, it is subject to change without notice. To verify a Provider's current status with your dental benefit program, contact a BCBSNM Dental Customer Advocate. Your Provider choice − Network or Non-Network − may make a difference in the amount you pay.

BENEFIT PERIOD

Some benefits are limited to a specific dollar amount or number of services or visits allowed during a Benefit Period.

Your Benefit Period is a period of one year which begins on January 1 and ends on December 31 of the same

year. The initial Benefit Period is from your Effective Date of Coverage and ends on December 31, which may be less than 12 months.

MAXIMUM ALLOWANCE

Amounts applied to the Deductible and benefits for covered dental services and supplies are based on BCBSNM's Maximum Allowance. After a Member pays the required Deductible, if any, this benefit program pays the applicable percentage (listed on the *Schedule of Benefits*) of the Maximum Allowance determined for the service (not to exceed the Annual Maximum Benefit).

ANNUAL MAXIMUM BENEFIT

The Annual Maximum Benefit is the maximum dollar amount BCBSNM will pay for all Covered Services for each Member during a Benefit Period, according to the terms of this Benefit Booklet and the coverage outlined in the *Schedule of Benefits*.

Each Member's Annual Maximum Benefit amount is given on the *Schedule of Benefits*. Benefits for services covered under the **optional** "Orthodontic Services" provision are **not** included in the Annual Maximum Benefit calculation but are subject to a separate lifetime maximum orthodontic benefit amount.

The amounts applied to the Annual Maximum Benefit are based on the Maximum Allowances for all Covered Services for which benefits were received. The Annual Maximum Benefit does **not** include your Deductible or Coinsurance amounts.

DEDUCTIBLE REQUIREMENTS

Network Deductible − The amount that each Member must pay for Covered Services received from Network Providers during a Benefit Period before this dental benefit program begins paying its percentage of the Maximum Allowance for Covered Services received from Network Providers. The amount applied to the Deductible for a Covered Service cannot exceed the Maximum Allowance for the Covered Service.

Non-Network Deductible - The amount that each Member must pay for Covered Services received from Non−Network Providers during a Benefit Period before this Dental benefit program begins paying its percentage of the Maximum Allowance for services received from Non−Network Providers. The amount applied to the Deductible for a Covered Service cannot exceed the Maximum Allowance for the Covered Service.

COINSURANCE PERCENTAGE

Member Coinsurance - The percentage of the Maximum Allowance **the Member** pays for a Covered Service after the Deductible, if applicable, has been met.

For each Covered Service, and after the Member has met the Deductible (if applicable), the dental benefit program pays a certain percentage (specified on the Member's *Schedule of Benefits*) of the Maximum Allowance for the Covered Service. When a Covered Service is received from a Network Provider, the Member pays only the Deductible, the Coinsurance, and any amount in excess of the Annual Maximum Benefit (or in excess of the maximum lifetime orthodontic benefit). When a Covered Service is received from a Non−Network Provider, the Member also pays the amount charged by the Non-Network Provider that is over BCBSNM's Maximum Allowance for the Covered Service.

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLANS

Pretreatment Estimate of Benefits − A determination by BCBSNM before you receive certain specified services, that such services are Medically Necessary and/or in compliance with the provisions of this dental benefit program. It identifies this dental benefit program's **estimated** financial liability **before** treatment is started. Such estimates are subject to change, according to the terms of your coverage, and may include an allowance for alternate benefits (see "Alternate Benefits'' later in this section).

If your Dentist recommends a Course of Treatment that will cost more than $300 your Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs

and models and an estimate of the charges prior to your beginning the Course of Treatment. BCBSNM will review the report and materials, taking into consideration alternative adequate Courses of Treatment, and will notify you and your Dentist of the estimated benefits that will be provided (i.e. a "Pretreatment Estimate of Benefits"). This is **not** a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered. BCBSNM's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and contract requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, you are responsible for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by BCBSNM. Mail the Pretreatment Estimate of Benefits requests and Treatment Plan forms to:

Blue Cross and Blue Shield of New Mexico
Dental Administrative Offices P.O. Box 23090
Belleville, IL 62223-0090

ALTERNATE BENEFITS

In all cases in which there is more than one Course of Treatment possible, the Claim Payment will be based upon the Course of Treatment bearing the lesser cost. If you and your Dentist or Physician decide on a personalized restoration, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by BCBSNM. Even if the Provider is a Network Provider, you may be charged the difference between the less costly procedure and BCBSNM's Maximum Allowance for the service or supply actually provided, plus any applicable Deductible and Coinsurance.

COVERED SERVICES

This section describes the services and supplies covered by this dental benefit program. Benefits are payable only for services and supplies that are considered "Medically Necessary." All benefit items listed in this section are subject to the *General Exclusions* section of the Benefit Booklet, which lists the services, supplies, situations, or related expenses that are not covered.

It is important for you to refer to your *Schedule of Benefits* to find out what your Deductible, Coinsurance percentage, and Annual Maximum Benefit will be for a Covered Service, and to determine what optional benefits and variable coverage features were chosen by your Group. If you do not have a *Schedule of Benefits*, please call a Dental Customer Advocate immediately.

1. DIAGNOSTIC EVALUATIONS

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease. Covered Services include:

a. Periodic oral evaluations for established patients.
b. Problem-focused oral evaluations, whether limited, detailed or extensive.
c. Comprehensive oral evaluations for new or established patients.
d. Comprehensive periodontal evaluations for new or established patients.

Special Provisions

- The combination of periodic routine and comprehensive evaluations **are limited to two every 12 months.**
- The combination of problem-focused oral evaluations and comprehensive periodontal evaluations **are limited to two every 12 months**.
- Benefits are **not** available for comprehensive periodontal evaluations or problem-focused evaluations if provided on the same date as any other oral evaluation by the same Provider.
- Benefits are **not** available for tests and oral pathology procedures or for re-evaluations.

2. DIAGNOSTIC RADIOGRAPHS (X-RAYS)

Dental radiographs including interpretation, are x-rays taken to diagnose dental disease. Covered Services include:

a. Full mouth (intraoral complete series) and panoramic films, **limited to a combined total of one every 36 months**.
b. Bitewing films, **limited to 4** horizontal films or **8** vertical films **once every 12 months.**
c. Periapical films, as necessary for diagnosis limited to six every 12 months.

Special Provisions

- The cost of any radiographs taken in conjunction with orthodontic treatment is classified under ''Orthodontic Services," and benefits are available **for such services only** if orthodontic services are covered and are subject to the benefit maximum for orthodontic services. See your *Schedule of Benefits* to find out if your benefit program covers Orthodontic Services.
- Benefits are **not** available for bitewings taken on the same date as full mouth films.

3. PREVENTIVE SERVICES

Preventive services are performed to prevent dental disease. Covered Services include:

- Prophylaxis - Professional cleaning and polishing of the teeth. Benefits are limited to two cleanings every 12 months. Additional benefits will not be provided for prophylaxis based on degree of difficulty.

- Scaling in presence of generalized moderate or severe gingival inflammation. Benefits are limited to one every 12 months
- Topical fluoride application - Benefits for fluoride application are only available for Participants under age 16 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

- Cleanings include associated scaling and polishing procedures.
- Combination of prophylaxes, scaling in the presence of inflammation and periodontal maintenance treatments (see "*Non-Surgical Periodontic Services*") are limited to two every 12 months.

Enhanced Benefit

Participants diagnosed with specified medical conditions – pregnancy, diabetes, and heart disease – will receive the following benefits:

- One additional oral exam, in addition to that standardly offered, all to be delivered at 100% benefit. Such exams are comprehensive and periodic oral exams.
- One additional comprehensive periodontal exam, in addition to that standardly offered, all to be delivered at 100% benefit.
- One additional cleaning, in addition to that standardly offered, all to be delivered at 100% benefit. Cleaning procedures include standard prophylaxis, periodontal maintenance and scaling in the presence of inflammation.
- All standardly offered periodontal scale and root plane procedures delivered at 100% benefit.

In the case of pregnancy, duration will be 9 months beyond first diagnosis. Duration for other covered medical conditions will be indefinite.

All benefits afforded here will apply to the standard annual benefit maximum. No deductible will be applied to these procedures**.**

4. MISCELLANEOUS PREVENTIVE SERVICES

Miscellaneous preventive services are other services used to prevent dental disease. Covered Services include:

a. Sealants − Benefits for sealants are **limited to once per permanent molar per lifetime** for Members **up to age 16.**
b. Space maintainers − Benefits for space maintainers are **limited to a lifetime maximum of one appliance per missing tooth site(s)** for Members **up to age 19**.

Special Provisions

- Benefits are **not** available for nutritional, tobacco, and oral hygiene counseling.

5. BASIC RESTORATIVE SERVICES

Basic restorative services repair basic dental decay (e.g. cavities) by replacing a part of a tooth that has been damaged by the decay and Covered Services include:

a. Amalgam restorations − Benefits for amalgam restorations are **limited to one per tooth surface every 12 months.**
b. Resin-based composite restorations − Benefits are **limited to one per tooth surface every 24 months.**

Special Provisions

- The Maximum Allowance for basic restorations includes tooth preparation, all adhesives, bases, liners, and polishing.
- Benefits are **not** provided for restorations placed **within 12 months** of the initial placement by the same Provider.

6. ENDODONTIC SERVICES

Endodontic services treat dental disease and injury of the tooth pulp, tooth root and periradicular tissue. Covered Services include:

a. Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.

b. Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.

c. Apexification/recalcification procedures, and apicoectomy/periradicular services including surgery, retrograde filling, root amputation, and hemisection.

Special Provisions

- Pulpal debridement is considered part of endodontic therapy when performed by the same Provider and not associated with a definitive emergency visit.
- Benefits are **not** available for endodontic retreatments provided **within 12 months** of the initial endodontic therapy by the same Provider.
- Incomplete endodontic therapy is **not** a Covered Service if you discontinue treatment.
- Benefits are **not** available for pulp vitality tests, endodontic endosseous implants, or intentional reimplantations.
- Benefits are **not** available for canal preparation, fitting of preformed dowel and post, or post removal.

7. NON-SURGICAL PERIODONTAL SERVICES

Non-surgical periodontal services treat dental disease in the supporting and surrounding tissues of the teeth (gums). Covered Services include:

a. Periodontal scaling and root planing, **limited to once per quadrant every 24 months.**

b. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis **limited to one time every 12 months.**

c. Periodontal maintenance when performed following active periodontal treatment and **limited to two cleanings every 12 months** in combination with routine oral prophylaxes. (See "Preventive Services").

Special Provisions

- Benefits are **not** available for localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

8. SURGICAL PERIODONTAL SERVICES

Surgical periodontal services also treat dental disease in the supporting and surrounding tissues of the teeth (gums) and supporting bone, and Covered Services include:

a. Gingivectomy or gingivoplasty and gingival flap procedures (includes root planing) **limited to once per quadrant every 24 months.**

b. Clinical crown lengthening.

c. Osseous surgery, including flap entry with closure **limited to once per quadrant every 24 months**. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same provider, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.

d. Osseous grafts, limited to one per site every 24 months.

e. Soft tissue grafts/allografts (includes donor site) **limited to one per site every 24 months**.

f. Distal or proximal wedge procedure.

g. Anatomical crown exposures, limited to once per quadrant every 24 months.

Special Provisions

- Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered part of the restoration and no additional benefits are provided for such periodontal services.
- Procedures related to the placement of an implant (e.g., bone re-contouring and excision of gingival tissue) are **not** covered (unless the additional ‘‘Implant Placement Surgery” benefit is included in your benefit design and displayed on your *Schedule of Benefits*.)
- Benefits are **not** available for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

9. NON−SURGICAL EXTRACTIONS

Non-surgical removal of tooth and tooth structures are covered, and Covered Services include:

a. Removal of retained coronal remnants – deciduous tooth.
b. Removal of erupted tooth or exposed root.

10. ORAL SURGERY SERVICES

Oral surgery services mean surgical removal of tooth and tooth structures. Covered Services include:

a. Surgical tooth extractions.
b. Alveoloplasty and vestibuloplasty.
c. Excision of benign odontogenic tumor/cysts.
d. Excision of bone tissue.
e. Incision and drainage of intraoral abscess.
f. Other necessary surgical and repair procedures not listed as an exclusion.

Special Provisions

- Intraoral soft tissue incision and drainage is **only** covered when it is provided as the definitive treatment of an abscess.
- Routine post-operative care is considered part of the procedure.
- Benefits are not **available** for prophylactic removal of third molars or impacted teeth (i.e. removal of asymptomatic, nonpathological teeth), or for complete bony impactions covered by another benefit plan.
- Benefits are **not** available for surgical services related to a congenital malformation.
- Benefits are **not** available for the excision of malignant or nonodontogenic tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Benefits are **not** available for excision of exostoses of the jaws and hard palate (unless done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts.

11. MAJOR RESTORATIVE SERVICES

Major restorations repair major dental decay or tooth fractures that cannot be restored with amalgam or composite-type filing material. Covered Services include:

a. Single crown restorations.
b. Gold foil and inlay/onlay restorations.
c. Labial veneer restorations.

Special Provisions

- Major restorations, including replacements of lost or defective crowns are **limited to one per tooth in a 60-month period** whether placement was under this benefit program or under any prior dental coverage, even if the original crown was stainless steel.
- Crowns placed over implants will be covered.
- Benefits are **not** available to restore occlusion or incisal edges due to bruxism or harmful habits.

12. PROSTHODONTIC SERVICES

Prosthodontic services restore and maintain the oral function, comfort and health of a patient by replacing missing natural teeth and surrounding tissue with artificial substitute. Covered Services include:

a. Complete and removable partial dentures. Initial installation of removable complete, immediate or partial dentures includes any adjustments, relines or rebases **during the six-month period** following installation. Replacements are **limited to once in any 60-month period**, whether placement was under this benefit program or under any prior coverage.

b. Denture reline/rebase procedures are **limited to once in any 24-month period.**

c. Fixed bridgework. Installation of bridgework (including inlays/onlays and crowns as retainers) is **limited to once per tooth in any 60-month period**, whether placement was under this benefit program or under any prior coverage.

Special Provisions

- Services or treatment to replace teeth that were missing prior to the Effective Date of Coverage are **not** eligible for coverage, except for those teeth missing due to congenital defects.
- Benefits will **not** be provided for replacement of complete or partial dentures due to theft, misplacement, or loss.
- Prosthetics placed over implants will be covered.
- Tissue conditioning is considered part of the procedure when performed on the same day as the delivery of a denture or a reline/rebase.
- Benefits are **not** available for splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

13. MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services that are covered include:

a. Prefabricated crowns – stainless steel and resin, **limited to once per tooth every 60 months** but only when not used as a temporary crown.

b. Recementation of inlays/onlays, crowns, bridges, and post and core **limited to two times every 12 months**. Recementation provided within six months of initial placement by the same Provider is considered part of the procedure and no additional benefits will be provided for such charges.

c. Post and core, pin retention, and crown and bridge repair services.

d. Pulp cap – direct and indirect.

e. Adjustments **limited to three times per appliance every 12 months**.

f. Repairs of crowns and fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (unless additions are completed on the same date as replacement partials or dentures) are **limited to a lifetime maximum of once per tooth or clasp**.

14. ADJUNCTIVE GENERAL SERVICES

Covered Services include:

a. Emergency palliative treatment of dental pain, but **only** when not performed in conjunction with a definitive treatment.

b. Deep sedation/general anesthesia and intravenous conscious sedation – By report **only** and when Medically Necessary for documented handicapped Members or for justifiable medical or dental conditions. Patient apprehension does **not** constitute necessity.

Special Provisions

- Benefits are **not** provided for local anesthesia or nitrous oxide analgesia.
- Benefits are **not** provided for therapeutic parenteral drugs, or other drugs and/or their application.

15. ORTHODONTICS

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Members covered for orthodontics as shown on your *Schedule of Benefits* if your Group chose this optional orthodontic service. Covered Services include:

a. Diagnostic orthodontic records and radiographs **limited to a lifetime maximum of once per Member**.

b. **Limited**, interceptive and comprehensive orthodontic treatment.

c. Orthodontic retention, **limited to a lifetime maximum of one appliance** per Member.

Special Provisions

- Orthodontic services are paid over the Course of Treatment, **up to the lifetime maximum orthodontic** benefit. Benefit payments cease when the Member is no longer covered, whether or not the entire benefit has been paid out.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic benefit and **subject to the calendar year maximum** for orthodontic services.
- If orthodontic treatment is terminated for any reason before completion, plan benefits will cease on the date of termination.
- If the Member's coverage is terminated prior to the completion of the orthodontic treatment plan, the Member is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Member is **not** covered.
- Benefits are **not** available for replacement or repair of an orthodontic appliance.
- For services in progress on the Effective Date of Coverage, benefits will be **reduced** based on benefits paid prior to this coverage beginning.

16. TMJ/CMJ SERVICES

This plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders. Related orthodontic appliances and treatment, crowns, bridges and dentures are covered only if the disorder is the result of trauma.

GENERAL EXCLUSIONS

These general limitations and exclusions apply to all services described in this Dental Benefit Booklet. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the *Definitions*) licensed to perform services covered under this dental benefit program.

This dental benefit program does not provide benefits for any of the following services, supplies, situations, or related expenses:

ACCIDENTAL INJURIES

For Covered Services related to accidental injury, this benefit program is secondary to any health care or medical plan coverage (see *Coordination of Benefits* for more information). **This benefit program does not cover** services performed due to an accidental injury when caused by an external force. (External force means any outside strength producing damage to the dentition and/or oral structures.

ACUPUNCTURE

This benefit program does not cover services related to acupuncture, whether for dental or anesthesia purposes.

COSMETIC SERVICES

This benefit program does not cover cosmetic services (beautification or aesthetic services to improve an individual's appearance by alteration of a physical characteristic, for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging or incisal wear). Cosmetic services include, but are not limited to, bleaching teeth, grafts to improve aesthetics and the cosmetic replacement of serviceable amalgam restorations with silicate, plastic, or composite material.

To prevent doubt or confusion regarding the medical necessity of a possibly "cosmetic service," BCBSNM may give written determination of such benefits before the services are received. For details, see "Pretreatment Estimates and Treatment Plans" in the *How This Dental Benefit Program Works* section. Also, see "Restorative or Reconstructive Surgery" in this section.

DUPLICATE (DOUBLE) COVERAGE

This benefit program does not cover services that are payable under your hospital or medical-surgical health care plan, including services or supplies that are furnished by the local, state or federal government and services and supplies covered by, provided by, or available from the local, state or federal government (for example, Medicare), whether or not that payment or benefit is received. (This exclusion shall not be applicable to medical assistance benefits or similar legislation of any state benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law). If a Member is covered by more than one dental plan, total benefit payments cannot be more than 100 percent of the Maximum Allowance for Covered Services. (See *Coordination of Benefits (COB)* for more information.)

DUPLICATE PROSTHETIC DEVICES OR APPLIANCES

This benefit program does not cover charges for any duplicate, temporary, or provisional prosthetic device or other appliance, or for a "spare" set of dentures or any other duplicate appliance such as, but not limited to, removable orthodontic retaining devices.

EXPERIMENTAL, UNPROVEN OR INVESTIGATIONAL PROCEDURES

This benefit program does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard dental practice, as defined below, or those considered experimental, investigational, or unproven. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U. S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatments, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. The service must be Medically Necessary and not excluded by any other benefit program exclusion.

Standard dental practice means the services or supplies that are in general use in the dental community in the United States, and;

- have been demonstrated in standard dental and/or medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established dental and/or medical value for curing or alleviating the condition being treated;
- if applicable, are appropriate for the hospital or other facility provider in which they were performed; and
- the attending Physician or dentist has had the appropriate training and experience to provide the treatment or procedure.

HOSPITAL AND ANCILLARY CHARGES

This benefit program does not cover hospitalization charges and any additional fees charged by the Dentist for hospital treatment, except when hospitalization is Medically Necessary and such charges are not covered under the Member's medical plan. If Medically Necessary, benefits for all professional services rendered during the hospitalization will be paid at the same percentage rate as if performed by a licensed Dentist, not to exceed the Annual Maximum Benefit identified on the separately issued *Schedule of Benefits.*

HYPNOSIS

This benefit program does not cover hypnosis or services related to hypnosis, whether for medical, dental, or anesthesia purposes.

MEDICALLY UNNECESSARY SERVICES

This benefit program does not cover services and supplies that are not, in the reasonable judgment of BCBSNM, Medically Necessary. The fact that a Provider may prescribe, order, recommend, or approve a service does not, of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.

MILITARY SERVICE

This benefit program does not cover care for disabilities, illnesses, or injuries received while in the military for which the Member is legally entitled to services and for which facilities are reasonably available to the Member.

MOUTH REHABILITATION

If the Member and the Dentist select a course of mouth rehabilitation, BCBSNM's obligation under this benefit program will be to cover only those services necessary to eliminate oral disease and replace covered missing teeth. The balance of the treatment, including costs of treatment and materials to increase vertical dimension or restore the occlusion, will remain the responsibility of the Member.

NO LEGAL OBLIGATIONS TO PAY

This benefit program does not cover services for which the Member has no legal obligation to pay, charges made only because benefits are available under this dental benefit program, services for which the Member has received a professional or courtesy discount or offer to waive Deductible and/or Coinsurance amounts, or services provided by the Member for him/herself, or by a family member (related to the Member by either blood or marriage).

NONCOVERED PROVIDERS

This benefit program does not cover services provided by the Member for him/herself, or by a family member (related to the Member by either blood or marriage), services provided by someone other than a Dentist, except those services that may be performed by a licensed dental hygienist under the supervision and guidance of the Dentist, where applicable, services provided by a hospital or other facility (except as specified under "Hospital Ancillary Charges", earlier in this section), or services provided through a medical department, clinic, or similar facility furnished or maintained by the employer.

NONCOVERED SERVICES

This dental benefit program does not cover services not specifically listed as covered, such as but not limited to:

- analgesics (includes nitrous oxide) when billed separately
- athletic mouth guards
- bacteriological studies for determination of pathologic agents
- behavior management
- bleaching of teeth
- caries susceptibility tests
- desensitizing medicaments and/or their application
- diagnostic photographs, casts, or models
- dietary instructions
- discing
- enamel microabrasion
- guided tissue regeneration
- histopathological examinations
- house/hospital calls
- isolation of tooth with rubber dam, metal copings, mobilization of erupted or malpositioned tooth
- local anesthetic when billed separately
- occlusal analysis or appliances, materials, restorations, or special equipment used to increase vertical dimension or correct or restore occlusion
- oral hygiene instructions
- OSHA fees and/or infection control fees when billed separately
- polishing of restorations
- precision attachments for partials and/or dentures, stress breakers, or personalized prosthetics or

appliances, related procedures, or other specialized techniques

- prescription or nonprescription drugs, mouthwashes, rinses, topical solutions or preparations
- prosthetic device including partial or full denture or fixed bridge, to replace a tooth lost or extracted before the Member's Effective Date of Coverage, unless the device also includes replacement for a tooth that was lost or extracted **after** the Member's Effective Date of Coverage. **This exclusion may not apply if your group purchased the "Missing Tooth Provision Waiver." Please refer to your *Schedule of Benefits* for a list of available benefits. You may also contact your Group administrator or a BCBSNM Dental Customer Advocate for more information.**
- pulp vitality tests
- recontouring
- restoration overhang removal
- sealants on restored teeth (occlusal surface)
- second professional opinions
- services that are dependent upon noncovered services
- therapeutic injections
- tissue conditioning procedures
- tobacco use counseling

ORTHODONTIC SERVICES

This benefit program does not cover orthodontic services or supplies if your Group did not purchase the optional "Orthodontic Services" benefit. Check your separately issued *Schedule of Benefits* and any attachments to determine which optional benefits are available to you.

POST-TERMINATION BENEFITS

This benefit program does not cover services or supplies received after your dental benefit program coverage ends, even if the services or supplies were made necessary by an accident, illness, or other event that occurred before or while coverage was in effect − even if a Pretreatment Estimate was received.

PRE-ENROLLMENT SERVICES

This benefit program does not cover any service or supply received before your Effective Date of Coverage.

PRIOR CARRIER AUTHORIZATIONS FOR PRE-EXISTING CONDITIONS

If a Member who was previously covered under another benefit program received a Pretreatment Estimate, benefit authorization, or prior approval from the prior carrier, such authorizations will **not** be honored by BCBSNM. In these cases, the Member may submit a Treatment Plan and Pretreatment Estimate request to BCBSNM **before** services are received or completed (if the Member began treatment before changing to BCBSNM). Incomplete services that were begun before the Member's Effective Date of Coverage that would otherwise be eligible for benefits may not be covered under this dental benefit program. The Member must submit a Treatment Plan before the incomplete services are received or completed.

REPORT PREPARATIONS/APPOINTMENT PENALTIES, AND OTHER NON-DENTAL SERVICES

This benefit program does not cover charges for preparing insurance reports, itemized bills, or claim forms. **This dental benefit program does not cover** charges made for telephone consultations; charges to forward records or x-rays needed to make a benefit determination; local, state or territorial taxes; administration of infection control procedures required by local, state, or federal mandates, or failure to keep a scheduled appointment with the Dentist or other Provider.

RESTORATIVE OR RECONSTRUCTIVE SURGERY

Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery (such surgery may have a coincidental cosmetic effect).

Benefits for restorative or reconstructive surgery and related expenses are allowed **only** when required as the result of accidental injury or disease process or its treatment. To qualify for coverage, the situation requiring such surgery must have occurred on or after the Member's Effective Date of Coverage. Also, continuous coverage must have been maintained since the Member's Effective Date of Coverage, date of accident, or start date of disease treatment.

BCBSNM must give a written Pretreatment Estimate for such benefits before the date of services. For more information, see "Pretreatment Estimates and Treatment Plans" in the *How This Dental Benefit Program Works* section.

When these procedures are eligible for benefits under the Member's medical plan, this dental benefit program pays secondary to the other coverage. See the *Coordination of Benefits (COB)* section for more information.

SERVICES NOT IDENTIFIED OR RELATED TO NONCOVERED SERVICES

This benefit program does not cover any service or supply not specifically identified as a benefit in this booklet or otherwise eligible for benefits under "Alternate Benefits" in the *How This Dental Benefit Program Works* section. **This benefit program also does not cover** services when they are related to a non-covered service.

TRAVEL EXPENSES

This benefit program does not cover travel expenses for the Member, Dentist, or other Provider.

VETERAN'S ADMINISTRATION FACILITY SERVICES

This benefit program does not cover services and supplies furnished by a Veterans Administration facility for a service-connected disability or while in active military service.

WAR-RELATED SERVICES

This benefit program does not cover services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

WORK-RELATED INJURIES OR ILLNESSES

This benefit program does not cover work-related injuries, illnesses, or conditions. This exclusion from coverage applies to all work-related illness or injury, and includes charges resulting from occupational accidents or sickness covered under:

- occupational disease laws
- employer's liability
- municipal, state, or federal law (except Medicaid)
- Workers' Compensation Act

In order to recover benefits for a work−related illness or injury, the Member must pursue his/her rights under the Workers' Compensation Act or any of the above provisions which apply, including filing an appeal. This benefit program may pay claims during that appeal process if the Member signs a reimbursement agreement with BCBSNM.

This benefit program does not cover charges for services resulting from a work-related illness or injury, even if:

- the Member fails to file a claim within the filing period allowed by the applicable law; *or*
- the Member obtains care which is not authorized by Workers' Compensation insurance; *or*
- the Member's employer fails to carry the required Workers' Compensation insurance; in this case, the

employer may be liable for any employee's work-related illness or injury expenses; *or*

- the Member fails to comply with any other provisions of the law.

Note: This "Work-Related Illnesses or Injuries" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation if under any applicable state law, the individual has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act or any similar provisions in his/her state of residence. You must provide documentation showing that you have waived Workers' Compensation and are eligible for the waiver. (The Workers' Compensation Act may also apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

COORDINATION OF BENEFITS (COB)

This dental benefit program contains a coordination of benefits (COB) provision that prevents duplication of payments. When a Member is eligible for benefits under any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of the Maximum Allowance. *(''Other valid coverage" − means all group and nongroup insurance policies, which may include Medicare [but excluding Indian Health Service and Medicaid coverages], that provide payments for dental services.)*

If you are also covered by Medicare, special COB rules may apply. Contact a BCBSNM Dental Customer Advocate for more information.

If you are currently covered under COBRA continuation coverage provisions, coverage ceases when you become eligible for any other valid coverage (unless a preexisting conditions limitation applies).

For a work-related injury or condition, see *"Work-Related Injuries or Conditions"* exclusion in *General Exclusions*.

The following rules determine which coverage pays first:

1. **No COB Provision** − If the other valid coverage does not include a COB provision, that coverage pays first, and this dental benefit program pays secondary benefits.
2. **Subscriber/Dependent** − If the Member who received care is covered as the Subscriber (i.e., active or retired employee or nongroup policyholder) under one coverage and as a Dependent under another, the Subscriber's coverage pays first. **Exception:** If Medicare is secondary to the benefit program of an *active* worker covering the Medicare beneficiary as a Dependent, then that benefit program determines its benefits first then Medicare and last, the benefit program covering the Medicare beneficiary as the Subscriber.

   If you have other valid coverage, contact the other carrier's customer service department to determine if the other coverage is primary or secondary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may or may not be subject to those provisions.
3. **Dependent Child** − If the Member who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other coverage does not follow the birthday rule, then the father's coverage pays first.
4. **Dependent Child, Parents Separated or Divorced** − If two or more plans cover a Member as a Dependent child of divorced or separated parents, benefits for the child are coordinated in the following order:
   (i) *Court-Decreed Obligations*. Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's dental expenses, the coverage of that parent pays first.
   (ii) *Custodial/Noncustodial.* The benefit program of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
   (iii) *Joint Custody.* When a court decree specifies that the parents share joint custody, without stating that one of the parents is responsible for the dental expenses of the child, the plan covering the child follow the rules that are applicable to children whose parents are not separated or divorced.
5. **Active/Inactive Employee** − If the Member who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active employee under one coverage and as the Dependent of the *same* but *inactive* employee under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

6. **Longer/Shorter Length of Coverage** − When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in the entity that pays, provides, or administers the plan's benefits, or a change from one type of plan to another.)

HOW BENEFITS ARE PAID

When this benefit program is the primary plan, benefits will be paid according to the terms of this Benefit Booklet. When this benefit program is the secondary plan, the primary plan's benefits will be subtracted from this benefit program's usual benefit and the resulting balance, if any, paid as secondary benefits, whether or not a claim has been filed with the primary plan. This rule applies even if a claim was submitted but benefits were refused because the claim was not sent to the other plan on a timely basis. In no case will this benefit program's payment, when combined with the primary plan's payment, exceed the total benefit under this benefit program.

RESPONSIBILITY FOR TIMELY NOTICE

BCBSNM is not responsible for coordination of benefits if timely information has not been provided by the Member regarding the application of this provision.

FACILITY OF PAYMENT

Whenever any other plan makes benefit payments that should have been made under this benefit program, BCBSNM has the right to pay the other plan any amount BCBSNM determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this benefit program, and with that payment BCBSNM will fully satisfy its liability under this provision.

OVERPAYMENTS

Regardless of who was paid, whenever benefit payments made by BCBSNM exceed the amount necessary to satisfy the intent of this provision, BCBSNM has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service benefit program, or any other organizations or persons.

CLAIM PAYMENTS AND APPEALS

This section explains how to file claims to obtain benefits, how claims are processed, and what to do if you disagree with the action taken on your claim.

In order to obtain your dental benefits under this benefit program, it is necessary for a claim to be filed with BCBSNM. If you use a Network Dentist, he or she will file your claims for you, and payment will be sent directly to the Dentist. You will receive an Explanation of Benefits (EOB) form BCBSNM showing the benefits provided.

If you use a Non-Network Dentist, it is your responsibility to file the claim. Payment for Covered Services will be sent to you.

You will receive an EOB whether we send payment to you or the Dentist. Benefit payment is subject to any applicable Deductible and/or Coinsurance requirements.

BCBSNM will pay all claims **within 30 days** of receipt of all information required to process a claim. If the claim is denied in whole or in part, you will receive a notice from BCBSNM with:

1. the reason for denial;
2. a reference to the benefit program provisions on which the denial is based;
3. a description of additional information which may be necessary to perfect the appeal; and
4. an explanation of how you may have the claim reviewed by BCBSNM if you do not agree with the denial.

IF YOU HAVE OTHER VALID COVERAGE

If this dental benefit program is secondary to another plan you need to file your claim with the other carrier first (see

Coordination of Benefits).

If a Provider normally files claims to BCBSNM and the other carrier does not pay the Provider directly, the Provider will need, from you, a copy of the other carrier's explanation of benefits to include with the claim sent to BCBSNM.

If a Non-Network Provider does not file claims for you, attach a copy of the Non-Network Provider's explanation of benefits to the claim that you send to BCBSNM.

HOW TO FILE CLAIMS

Most Providers will bill BCBSNM on the Member's behalf using the proper claim forms. When you must file your own claim, however, request the appropriate claim form from the Dental Administrative Offices, **1-877-723-5697** or obtain an *Attending Dentist's Statement* from BCBSNM before going to your Dentist. The *Attending Dentist's Statement* is also used for requesting Pretreatment Estimates. It is your responsibility to ensure that the necessary claim information has been provided.

You must complete and sign the Subscriber/Insured Information of the *Attending Dentist's Statement*. As soon as treatment has ended, ask your Dentist to complete and sign the *Attending Dentist's Statement,* and file it with:

Blue Cross and Blue Shield of New Mexico

P.O. Box 23090 Belleville, IL 62223-0090

If a Provider will not complete the *Attending Dentist's Statement* or does not bill BCBSNM directly, it is the Member's responsibility to attach to the claim form, and submit to BCBSNM, itemized bills that include all necessary information (balance due statements, cash register receipts, and canceled checks are **not** acceptable).

TIMELY FILING LIMITS

All claims must be filed **within 180 days** after the date of service. Any claims filed after this time limit may be denied, unless BCBSNM is satisfied that there is a valid reason why the Member could not submit his/her claim within this time limit. In no case will claims be paid that are filed **later than 365** days after the date of service.

If a claim must be returned to the Subscriber for additional information, the claim must be resubmitted to BCBSNM **within 45 days** of the date the claim was returned to the Subscriber.

If a Member's coverage under this dental benefit program ends, claims for Covered Services **must** be filed **within 180 days** after the date of the coverage termination. Failure to file a claim **within the 180 days** will result in loss of benefits otherwise provided by this dental benefit program if, as a result of such failure by the Member, BCBSNM is unable to perform adequate claims review.

CLAIM FORMS AND ITEMIZED BILLS

All information on the claim form and itemized statements must be readable. If information is missing on the claim form or it is not readable, then BCBSNM will return it to the Subscriber or to the Provider. **Handwritten entries added to a typed or computerized claim form that change or add procedure codes are considered fraudulent and will require the Subscriber's and the Provider's signatures acknowledging approval of such information.**

The information on the itemized bills is used to determine benefits, so it must support information reported on the submitted claim form. All claims must include:

- Subscriber's benefit program ID number
- Subscriber's name and address
- Member's name
- Member's age and relationship to the Subscriber
- other dental coverage in effect
- date of service
- type of treatment
- itemization of charges
- accident or surgery date (when applicable)
- name and address of Provider
- Provider's tax ID number or social security number
- Member's signature
- Provider's signature

If an itemized bill from the Provider is not attached to a claim form, the Dentist must complete the "Dentist Information Section" and the "Examination and Treatment Record" of the *Attending Dentist's Statement* and **must** sign the claim form.

Benefits cannot be determined if documentation is missing or radiographs submitted are not of sufficient diagnostic quality to determine benefits.

Separate Claim Forms Required - A separate claim form is required for each Provider for which you are requesting reimbursement. A separate claim form is also required for each Member when charges for more than one family member are being submitted.

ASSIGNMENT OF BENEFITS

All benefits under this dental benefit program will be paid directly to Network Providers. Except as provided by law, BCBSNM specifically reserves the right to pay the Subscriber directly and to refuse to honor an assignment of benefits in any circumstances. A Member may not execute any power of attorney to interfere with BCBSNM's right to pay the Subscriber instead of anyone else.

Benefit payments for Members eligible for Medicaid are paid to the New Mexico Human Services Department or Providers when required by law.

WHERE TO SEND CLAIM FORMS

Send claims to:

Blue Cross and Blue Shield of New Mexico

Dental Administrative Office P.O. Box 23090

Belleville, IL 62223-0090

PAYMENT IN ERROR

If BCBSNM makes an erroneous benefit payment, you or the ineligible person may be required to refund the amount paid in error. BCBSNM reserves the right to correct payments made in error by offsetting the amount paid in error against new claims. BCBSNM also reserves the right to take legal action to collect payments made in error.

CLAIM AND PRETREATMENT ESTIMATE APPEAL PROCEDURES

If your claim or Pretreatment Estimate has been denied in whole or in part, you may have your claim reviewed. BCBSNM will review its decision in accordance with the following procedure. **Within 180 days** after you receive notice of a denial or partial denial, write to BCBSNM. BCBSNM will need to know the reason why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of New Mexico

Dental Administrative Office

P.O. Box 23090 Belleville, IL 62223-0090

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. While BCBSNM will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional dental information **within 180 days** after you receive notice of a denial or partial denial. BCBSNM will give you a written decision within 60 days after receiving your request for review.

If you have any questions about the claims procedures or the review procedure, write or call BCBSNM. BCBSNM offices are open from 7:45 A.M. to 3:45 P.M., Mountain Time, Monday through Friday.

Blue Cross and Blue Shield of New Mexico

300 East Randolph Chicago, IL 606011

1 866-431-1604

Arbitration for Non-ERISA Plans

The "Arbitration for non-ERISA Plans" provision applies to all Government Plans, Church Plans and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens. If a dispute about coverage, benefits or handling of claims or Prior Approval requests

continues after the Member has followed and exhausted the reconsideration or appeal process administered by BCBSNM, the issue or claims shall be submitted to arbitration upon agreement by the Member. The rules for arbitration shall be the "Commercial Arbitration Rules" developed by the American Arbitration Association. You may obtain a copy of these rules from a Dental Customer Advocate. The rules are also available from the American Arbitration Association's Web site (www.adr.org). The use of arbitration does not limit your ability to seek other means by which to resolve your dispute but is an avenue available to you.

External Appeal for ERISA Plans

This benefit program provided by your Group may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The "External Appeal of ERISA Plans" right is applicable to all Group plans except Government Plans, Church Plans and plans maintained outside of the United States primarily for the benefit of persons substantially all whom are nonresident aliens. Therefore, if this benefit program is governed by ERISA and you are still not satisfied after having completed the reconsideration or appeal process administered by BCBSNM, you may have a right to bring a civil action under ERISA section 502(a).

GENERAL PROVISIONS

AVAILABILITY OF PROVIDER SERVICES

BCBSNM makes no guarantee that the services of a Provider will be available at any given time.

CATASTROPHIC EVENTS

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond the control of BCBSNM, BCBSNM may be unable to process claims on a timely basis. No suit or action in law or equity may be taken against BCBSNM because of a delay caused by any of these events.

CHANGES TO THE BENEFIT BOOKLET

BCBSNM may amend this Benefit Booklet when authorized by an officer of BCBSNM. BCBSNM will give an employer **at least 30 days'** prior written notice of an amendment to this Benefit Booklet or a new coverage.

No employee of BCBSNM may change this Benefit Booklet by giving incomplete or incorrect information, or by contradicting the terms of this Benefit Booklet. Any such situation will not prevent BCBSNM from administering this dental benefit program in strict accordance with its terms.

DELIVERY OF DOCUMENTS

BCBSNM will issue to the employer, or mail to the Member's address as listed on the enrollment/change form, a Benefit Booklet setting forth the services to which Members are entitled, a BCBSNM Identification Card, and a *Schedule of Benefits.*

DISCLAIMER OF LIABILITY

BCBSNM has no control over any diagnosis, treatment, care, or other service provided to a Member by any Dentist or other Provider and is not liable for any loss or injury caused by any Dentist or other Provider by reason of negligence or otherwise.

DISCLOSURE AND RELEASE OF INFORMATION

BCBSNM will only disclose information as permitted or required under state and federal law.

You must provide BCBSNM with whatever information is necessary to determine benefits on your claims. BCBSNM may obtain information from any insurance company, organization, or person when such information is necessary to carry out the provisions of this Benefit Booklet. Such information may be exchanged without consent of, or notice to, the Member.

You agree to cooperate at all times by allowing BCBSNM access to your medical or dental records to investigate claims and verify information provided on the enrollment/change form. You also agree to execute whatever documents are necessary in order for BCBSNM to determine benefits under this benefit program. If you do not cooperate, you forfeit all rights to benefit payments on those claims subject to investigation and acknowledge that your coverage may be canceled.

To help BCBSNM determine which services qualify for benefits, you authorize all Providers of services or supplies to provide BCBSNM with any medical or dental-related information pertaining to your treatment.

You waive all provisions of law that are subject to waiver, and which otherwise restrict or prohibit Providers from disclosing or testifying to such information.

EXECUTION OF PAPERS

Upon request, the Subscriber must (on behalf of him/herself and his/her Dependents) execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this Benefit Booklet.

INDEPENDENT CONTRACTORS

The relationship between BCBSNM and its Network Providers is that of independent contractors; physicians and other Providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any Network Provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider.

The relationship between BCBSNM and the Group is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of the employer.

PAYMENT OF PREMIUM BY THE EMPLOYER

If an employer fails to submit premium payments when due, coverage will terminate as of the end of the last-paid billing period.

If an employer has contracted with BCBSNM to pay claims under a special financial arrangement, claims administration may be handled in one of the following ways:

- Funds for payment of claims are held by the employer and are used to pay submitted claims. If the claims funds agreed upon by the employer and BCBSNM are not maintained by the employer, payments for submitted claims will not be made.
- Funds for payment of claims are paid to BCBSNM by the employer. If the claims funds agreed upon by the employer and BCBSNM are not remitted by the employer, payments for submitted claims will not be made.

In such cases, claims not paid because of insufficient claims funds should be submitted for payment to and are the liability of the employer.

SENDING NOTICES

All notices to the Subscriber are considered to be sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either the Subscriber at the latest address appearing on BCBSNM's membership records or the Subscriber's employer.

TRANSFER OF BENEFITS

All benefits described in this Benefit Booklet are personal to you. Neither these benefits nor BCBSNM payments may be transferred or given to any person, corporation, or entity. Any attempted transfer will be void. Use of benefits by anyone other than a Member will be considered fraud or material misrepresentation in the use of services or facilities, which may result in cancellation of coverage for the Member and appropriate legal action by BCBSNM.

UTILIZATION REVIEW

Claims for Covered Services may be reviewed to establish that the services were Medically Necessary, consistent with the condition reported, with generally accepted standards of medical, dental, and surgical practice in the area where performed and according to the findings and opinions of BCBSNM's professional consultants.

FINANCIAL ARRANGEMENTS WITH PROVIDERS

BCBSNM has contracts with certain Providers (''Plan Providers") in its service area to provide and pay for dental care services to all persons entitled to dental care benefits under policies and contracts to which BCBSNM is a party, including all persons covered under this benefit program. Under certain circumstances described in its contracts with Plan Providers, BCBSNM may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider; or
- pay Plan Providers substantially less than their billed charges for services, by discount or otherwise; or
- receive from Plan Providers other substantial allowances under BCBSNM's contracts with them.

In the case of Dentists, the calculation of any maximum amounts of benefits payable by BCBSNM under this

benefit program and the calculation of all required Deductible and Coinsurance amounts payable by you under this benefit program shall be based on the lesser of the Maximum Allowance or Provider's billed charge for Covered Services rendered to you. BCBSNM may receive such payments, discounts, and/or other allowances during the term of this benefit program. You are not entitled to receive any portion of any such payments, discounts and/or other allowances.

ENTIRE CONTRACT

Acceptance of coverage under this Benefit Booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this Benefit Booklet. The legal agreement between the Subscriber and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this Benefit Booklet, the Group's *Schedule of Benefits*, and any amendments or endorsements
- the enrollment/change form(s) for the Subscriber and his/her Dependents
- the Identification Card

In addition, the employer has important documents that are part of the legal agreement:

- the Application from the employer
- the Contract between BCBSNM and the employer

The above documents constitute the entire legal agreement between BCBSNM and the Subscriber/Member. All statements made by the Subscriber shall, in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a claim under this benefit program unless it is contained in a written application.

LIMITATIONS OF ACTIONS

No action at law or in equity may be brought or arbitration demand made **less than 60 days** after BCBSNM has received the claim for benefits or Pretreatment Estimate request, or later than three years after the date that the claim for benefits should have been filed with BCBSNM.

PAYMENT OF CLAIMS

Once Covered Services are rendered by a Provider, you have no right to request BCBSNM to not pay the claim submitted by such Provider and no such request will be honored. In addition, BCBSNM will have no liability to you or any other person because of its rejection of such request.

Your claim for benefits under this dental benefit program is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to you. Coverage will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

YOUR PROVIDER RELATIONSHIPS

The choice of a Provider is solely your choice and BCBSNM will not interfere with your relationship with any Provider.

BCBSNM does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. BCBSNM is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render service to you. Professional services which can only be legally performed by a Provider are not provided by BCBSNM. Any contractual relationship between a Physician and a Hospital or other Provider shall not be construed to mean that BCBSNM is providing professional services.

The use of an adjective such as ''Network" in modifying a Provider, shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of ''Network" or any similar modifying or the use of a term such as

‘‘Non-Network” should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

APPLICABLE LAW

This dental benefit program shall be subject to and interpreted by the laws of the State of New Mexico.

SEVERABILITY

In case any one or more of the provisions contained in this Benefit Booklet shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of the dental benefit program, but this Benefit Booklet shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under this benefit program. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger Group employers. COBRA continuation coverage may be available to you and to other members of your family who are covered under the benefit program when you would otherwise lose your Group dental coverage. Contact your employer to determine if you or your Group are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage;
- When it may become available to you and your family if your Group is subject to the provisions of COBRA; and
- What you need to do to protect your right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the plan and under federal law, contact the Plan Administrator or see *Enrollment and Termination Information* of this Benefit Booklet.

The Plan Administrator of the plan is named by the employer or by the Group Dental Care Plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA Administrator for specific information for your plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens and if your Group is subject to the provisions of COBRA:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

If the plan provides dental care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Administrator **within 30 days** when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- With respect to a retired employee dental coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The plan requires you to notify the Plan Administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for **up to 36 months** when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B or both);
- Your divorce or legal separation; or
- A dependent child losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for **up to 18 months**. There are two ways in which this 18-month period of COBRA continuation can be extended:

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during **the first 60 days** of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan Administrator is notified of the Social Security Administration's determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, **up to a maximum of 36 months**. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the Plan Administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

REIMBURSEMENT PROVISION

If you or one of your Dependents incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this Benefit Booklet, you agree:

- BCBSNM has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total covered charges for Covered Services for which BCBSNM has provided benefits to you or your Dependents.
- BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.

BCBSNM shall have the right to first reimbursement out of all funds you, your covered Dependents or your legal representative, are or were able to obtain for the same expenses for which BCBSNM has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

Bluecare Dental PPO[SM]

DNMHR22

Blue Cross and Blue Shield of New Mexico

The following is a listing of common services available through your network of Participating Dentists.
The Member's share of the cost is determined by whether care is received from a Participating or Out-of-Network Dentist.
This information only provides highlights of this Dental Plan. Please refer to your Dental Benefit Booklet for additional Benefit information.

The Deductibles, Coinsurance and Benefit Period Maximum shown below are subject to change as permitted by applicable law.

SCHEDULE OF BENEFITS

Program Basics	Participating Dentist	Out-of-Network Dentist **
Benefit Period Maximum [1]	$1,000	$1,000
Deductible [1]	$50 Individual / $150 Family	$50 Individual / $150 Family
Covered Services		
Diagnostic Evaluations	No Charge (Deductible waived)	No Charge (Deductible waived)
Preventive Services	No Charge (Deductible waived)	No Charge (Deductible waived)
Diagnostic Radiographs	No Charge (Deductible waived)	No Charge (Deductible waived)
Miscellaneous Preventive Services	No Charge (Deductible waived)	No Charge (Deductible waived)
Basic Restorative Services	20%, after Deductible	20%, after Deductible
Non-Surgical Extractions	20%, after Deductible	20%, after Deductible
Non-Surgical Periodontal Services	20%, after Deductible	20%, after Deductible
Adjunctive Services	20%, after Deductible	20%, after Deductible
Endodontic Services	20%, after Deductible	20%, after Deductible
Oral Surgery Services	20%, after Deductible	20%, after Deductible
Surgical Periodontal Services[3]	20%, after Deductible*	20%, after Deductible*
Major Restorative Services[3]	50%, after Deductible*	50%, after Deductible*
Prosthodontic Services[3]	50%, after Deductible*	50%, after Deductible*
Miscellaneous Restorative and Prosthodontic Services[3]	50%, after Deductible*	50%, after Deductible*
Implants	Not Covered	Not Covered
Orthodontics [1, *]	50% of Allowable Charge, (Deductible waived) up to $1,000 Lifetime Maximum	50% of Allowable Charge, (Deductible waived) up to $1,000 Lifetime Maximum

[1] Participating and Out-of-Network accumulate together.
[3] 12 month waiting period
*Adult coverage and dependent children up to age 19
** Services from non-participating providers will be subject to the Maximum Allowable Amount, as determined by the Company. **Amounts in excess of these allowances will be the full responsibility of the insured.**

A Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

BlueCross BlueShield of New Mexico

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

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

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

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

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

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of New Mexico

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

BlueCross BlueShield of New Mexico