STATE OF TEXAS
DENTAL CHOICE PLAN

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

State of Texas Dental Choice Plan℠
Master Benefit Plan Document

Administered by HumanaDental

Plan Year 2027

www.ERSdentalplans.com

Group No: 424504

Effective Date: September 1, 2026

ERS Employees Retirement System of Texas | Humana

TX ERS PPO MBPD 9-26

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TABLE OF CONTENTS

ARTICLE I – GENERAL INFORMATION 1

ARTICLE II - ELIGIBILITY FOR COVERAGE 2

ARTICLE III - PAYMENT OF BENEFITS; ALLOWABLE AMOUNT; PARTICIPANT/DENTAL PROVIDER RELATIONSHIP; COORDINATION OF BENEFITS 4

ARTICLE IV – BENEFITS PROVIDED 7

ARTICLE V - SCHEDULE OF DENTAL BENEFITS 12

ARTICLE VI - LIMITATIONS AND EXCLUSIONS 13

ARTICLE VII - TERMINATION OF COVERAGE 15

ARTICLE VIII - WHEN COVERAGE ENDS: CONTINUATION OF COVERED DENTAL SERVICES IN PROGRESS 16

ARTICLE IX - OPTION TO CONTINUE GROUP COVERAGE 17

ARTICLE X - CLAIM PROVISIONS 18

ARTICLE XI - GENERAL PROVISIONS 21

ARTICLE XII – DEFINITIONS 25

INTRODUCTION

We are pleased to welcome you to the State of Texas Dental Choice Plan (Dental Choice Plan) for the **Employees Retirement System of Texas (ERS)**. Your plan is self-funded by ERS and your claims are administered by HumanaDental Insurance Company (HumanaDental). Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see your Provider, but to see your provider on a regular basis.

This Master Benefit Plan Document (MBPD) describes your dental benefit program. It provides the detailed provisions of the Dental Choice Plan.

Using This Master Benefit Plan Document

This MBPD discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this MBPD completely and carefully. In addition, please read the Definitions section which will explain any words that have special or technical meanings within the MBPD.

The benefit explanations contained in this MBPD are subject to all provisions of the Contractual Agreement between ERS and HumanaDental and do not modify the terms and conditions of the Contractual Agreement in any way, nor shall you accrue any rights because of any statement in or omission from this MBPD.

Notice: ***This MBPD is your group dental plan and must be in effect at the time Covered Dental Services, as defined below, are provided. This information is not a guarantee of covered benefits, services or payments.***

Contact Information

For more information, please visit our website at www.ERSdentalplans.com or contact our Customer Service Center. A Customer Service Representative can assist with questions regarding dental care, locating a Dental Provider, explaining benefits, checking the status of a claim, and filing a claim.

You may call Customer Service toll-free at (855) 756-6580 (TTY: 711) to speak with a representative during business hours, Monday through Friday, 8 a.m. to 7 p.m. (CT).

If you prefer to submit your questions in writing, please mail your inquiry to:

HumanaDental Insurance Company
P.O. Box 14359
Lexington, KY 40512-4359

ARTICLE I – GENERAL INFORMATION

A. **Name of Dental Choice Plan**

The name of the dental Preferred Provider Organization (PPO) plan under the Texas Employees Group Benefits Program (GBP) is the State of Texas Dental Choice Plan for the Employees Retirement System of Texas (ERS).

B. **Type of Plan**

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

C. **Claims Administrator**

Benefits administered by HumanaDental Insurance Company (HumanaDental).

D. **Address for Dental Choice Plan Administration**

HumanaDental Insurance Company
PO Box 14359
Lexington, KY 40512-4359
Toll-free (855) 756-6580

E. **Dental Choice Group Number:** 424504

F. **Choice of Dental Provider**

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

G. **Entire Contract; Changes**

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

ARTICLE II - ELIGIBILITY FOR COVERAGE EFFECTIVE DATES

A. **Authority**

Any Employee or Retiree who is an appointed or elected State officer or Employee in the service of the State of Texas, including an Employee of an Institution of Higher Education and other individuals eligible under Subchapter C, Chapter 1551 of the Act, and their eligible Dependents shall be eligible to apply for coverage under this Dental Choice Plan. The following eligibility and Effective Date provisions shall apply.

B. **Eligibility for Coverage**

1. Any Employee or Retiree may, upon the date they become eligible, enroll in coverage under the Dental Choice Plan as the Subscriber or as the Subscriber and their Dependents. A Dependent, who is covered as an Employee or Retiree in the GBP, is not eligible for coverage as a Dependent in the GBP. A Dependent may not be covered by more than one Employee or Retiree in the GBP. The Subscriber's Dependents may not enroll in the Dental Choice Plan unless the Subscriber is also enrolled in the Dental Choice Plan. An eligible Dependent is:

   • Subscriber's spouse – an individual to whom the Subscriber is legally married. This includes a ceremonially married spouse whose marriage is documented by a valid marriage license or an informally married spouse whose marriage is documented by a valid Declaration of Informal Marriage filed with the appropriate governmental authority;

   • Subscriber's child who is under age 26, including a natural child, a stepchild, a foster child, a legally adopted child, and a child placed for adoption or ward, as defined in Section 1002.030, Texas Estates Code;

   • a child who is not a Subscriber's child referenced in the immediately preceding bullet point and who is related to the Subscriber by blood or marriage and was claimed as the Subscriber's dependent on his/her federal income tax return for the year prior to enrolling the child and for each subsequent year in which the child is enrolled, unless the child is born in the year first enrolled, or the Subscriber has shown good cause for not claiming the child (Good cause means that a person's failure to act was not because of a lack of due diligence the exercise of which would have caused a reasonable person to take prompt and timely action. A failure to act based on ignorance of the law or facts reasonably discoverable through the exercise of due diligence does not constitute good cause); or

   • a child age 26 or over who (i) is certified by an approved practitioner to be mentally or physically incapacitated from gainful employment and (ii) either earns less than the monthly wage standard for enrolling in Children's Health Insurance Program in Texas for a family of one at the time of application or reevaluation or earns more than this wage standard for a period of six months or longer in any Calendar Year and demonstrates that he/she is dependent on the Subscriber for care or support and either lives with the Subscriber or has care provided by the Subscriber on a regular basis.

   A child who is at least 26 years of age on the date of and following the expiration of the child's continuation coverage under COBRA ceases to be a Dependent and may continue coverage as a Subscriber who is a Former COBRA Dependent Child.

   A Former COBRA Dependent Child may enroll a newly acquired dependent child within 30 days of the child's date of birth or placement for adoption, but the Former COBRA Dependent Child may not enroll any other Dependents.

   Coverage for a disabled child - While you are a Subscriber under this Plan, if an enrolled Dependent child with a mental or physical disability reaches 26 years of age, the Plan will continue to cover the Dependent child, as long as the Dependent child is mentally or physically incapacitated to such an extent that he or she is dependent upon you for care or support.

2. Eligible Dependents acquired after the Effective Date of the Employee's or Retiree's coverage shall become eligible in accordance with the Rules.

3. A Participant should contact their Benefits Coordinator if an Employee, or ERS if a Retiree, for information regarding how and when a Participant may:
   - Add Dependents to coverage;
   - Drop Dependents from coverage; or
   - Obtain more information on when Dependents are no longer eligible for coverage.

C. **Election for Coverage**

Coverage of each eligible Employee or Retiree and their eligible Dependents shall be contingent upon the Employee or Retiree making an election for coverage in accordance with the Rules.

D. **Effective Dates – Timely Enrollment**

If the enrollment is for the initial coverage of an Employee or Retiree and their eligible Dependents and if the enrollment is received by the Employer's Benefits Coordinator or ERS within the first thirty (30) days following the Employee's or Retiree's date of eligibility, the coverage will become effective in accordance with the Rules. If the enrollment is received on or before the first day of eligibility, coverage will become effective on the first day of eligibility.

E. **Effective Dates – Late Enrollment**

If an enrollment for coverage for those eligible in accordance with Article II is received by the Employer's Benefits Coordinator or ERS more than thirty (30) days after the date such Employee or Retiree or Dependent becomes eligible, no coverage shall become effective unless a qualifying event occurs or until the next open Enrollment Period.

ARTICLE III - PAYMENT OF BENEFITS; ALLOWABLE AMOUNT; PARTICIPANT/DENTAL PROVIDER RELATIONSHIP; COORDINATION OF BENEFITS

A. Payment of Benefits

1. Payment of benefits to the Dental Provider furnishing the service or to the Subscriber, as the Claims Administrator may elect, shall constitute full discharge of all responsibility to the Employee or Retiree on account of benefits available to any Participant under the Dental Choice Plan, subject to Dental Choice Plan provisions.

2. Notwithstanding Subsection 1, above, of this Section A, if payment in full or part has not been made to either the Dental Provider furnishing the service or to the Subscriber for services or supplies provided to a minor child who is a Dependent of the Subscriber, benefits may be paid on behalf of such child to a person other than the Dental Provider or Subscriber if an order by a court of competent jurisdiction names such person the managing conservator of such child and such person has paid for the services or supplies provided to the child.

3. The rights and benefits of the Dental Choice Plan shall not be assignable, either before or after services and supplies are provided, except for direct payment that the Participant may assign to Dental Providers.

4. It is understood and agreed that the allowances set out in Article III for services and supplies furnished by a Dental Provider are not intended to and do not fix the value of the services of the Dental Provider nor in any way relate to or regulate such value; that such Dental Provider is privileged to make its regular charges and that the stipulated amounts are merely to apply credits thereon.

5. A Covered Dental Service appropriately provided through Teledentistry is covered on the same basis and to the same extent that the Covered Dental Service is provided through in-person diagnosis, consultation, or treatment.

B. Allowable Amount

- **In-Network Dental Provider:**
  Allowable Amount is based on the provisions of the Dental Provider's contract and the payment methodology in effect on the date of service.

- **Out-of-Network Dental Provider:**
  Allowable Amount shall be determined by the Claims Administrator. The Claims Administrator determines the Allowable Amount, when possible, by using standard industry guides, such as national charge table of prevailing health care charges using the 80th percentile. This means that out of every 100 claims, 20 charged amounts may be more, but 80 charged amounts will be the Allowable Amount or less.

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

C. **Participant/Dental Provider Relationship**

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

D. **Dental Services Performed Outside of the United States**

Covered Dental Services, including Emergency care performed in Canada or Mexico will be processed as an Out-of-Network Benefit. If you are traveling outside of the United States, Canada or Mexico and need a Covered Dental Service on an Emergency basis, the Emergency Covered Dental Service will be processed as an Out-of-Network Benefit. Non-Emergency Covered Dental Services performed outside of the United States, Canada, or Mexico are not reimbursable by the plan. Reimbursable Covered Dental Services performed outside of the United States are reimbursed in US currency, at the rate of exchange on the date of the service.

For more information on the process of filing a claim for international reimbursement please contact us at – (855) 756-6580 (TTY: 711).

E. **Coordination of Benefits**

Availability of benefits specified herein shall be subject to coordination of benefits as described below. A Participant must tell the Claims Administrator if the Participant or a covered Dependent has Other Dental Coverage. This is called "double coverage."

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

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

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

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

Other Dental Coverage does not include:

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

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

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

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

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

ARTICLE IV – BENEFITS PROVIDED

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

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

Charges will be covered only to the extent that they:

- Do not exceed the amount allowed under the Alternative Benefit Provision; and
- Do not exceed the Maximum Allowable Charge.

A Covered Dental Service is considered incurred on the date in which:

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

The service must be completed in order to be considered a Covered Dental Service. Special conditions apply to Orthodontic treatment. See the Orthodontic Services section below for additional detail.

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

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

THE COVERED DENTAL SERVICES ARE:

DIAGNOSTIC AND PREVENTIVE SERVICES

- Routine oral examinations, limited to 2 per Calendar Year.
- Emergency (problem focused) examinations.
- Office Visits, limited to 2 per Calendar Year.
- The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not a separately payable service.
- Consultations.
- Routine cleaning of teeth, limited to 2 per Calendar Year.
- Fluoride applied on teeth of your Dependent children under age 19, limited to 2 per Calendar Year.
- Space Maintainers, except fixed distal shoe Space Maintainers, for your Dependent children under age 19, to replace teeth prematurely removed or missing.
- Fixed distal shoe Space Maintainers for your Dependent children under age 19, to replace teeth prematurely removed or missing. Limited to one maintainer per 3 years.

- Dental X-rays:
  - Full mouth or panoramic (single or multiple films), limited to one every 36 months, unless due to an Accidental Injury;
  - Bitewings. Limited to one set per Calendar Year for Participants under age 10 and 2 sets per Calendar Year for Participants age 10 and older; or
  - Other X-rays when needed to diagnose and treat a specific covered condition.
  - When the fees submitted for any combination of intraoral radiographic images in a single treatment series meet or exceed the fee for a Comprehensive Intraoral Series, The Claims Administrator considers the radiographic images to be the equivalent of a Comprehensive Intraoral Series.

- Cone Beam Images, limited to once per 12-month period.

- Palliative (Emergency) treatment to relieve pain, but not on the same day as any other service except X-rays and Emergency (problem focused) examinations.

- Topical application of Sealant is covered only for Dependent children on permanent first molars to age 9 and second permanent molars to age 16 if they are without Caries or Restorations on the occlusal surface. The repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement. This coverage applies to In-Network and Out-of-Network Dental Providers.

BASIC SERVICES

- Amalgam and Composite fillings for decayed or fractured teeth except as listed under Major Services. Benefit is limited to once per surface per tooth within a 24-month period.

- Full mouth Scaling (in the presence of moderate or severe gingival inflammation upon oral examination). Limited to one per 3 years. The Participant must have no prior periodontal history and pocket depths are 4mm or greater with no bone loss. If full mouth Scaling is a Covered Dental Service, services for routine cleanings, periodontal Scaling and root planning, and full mouth debridement procedures performed on the same date of service will not be a Covered Dental Service.

MAJOR SERVICES

- Extraction (removal) of teeth.

- Oral surgery (extractions and certain other surgical procedures, including pre- and post-operative care).

- General Anesthesia and intravenous sedation, when Dentally Necessary and when administered by a Dentist for a Covered Oral Surgery, or for gingivectomy, gingivoplasty or osseous surgery.

- Periodontal examinations, cleanings, Scaling and root planing, or surgery (including 3 months post-surgical care) to remove diseased gum tissue or bone. Benefits are not coordinated between a medical plan and the Dental Choice Plan; therefore, benefits will be processed as though the Dental Choice Plan is primary.

  i. Benefits for periodontal Scaling and root planing in the same quadrant are limited to once in every 24-month period.

  ii. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or Scaling and root planing.

  .

  iii. Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or Implants.

  iv. If in the same quadrant, Scaling and root planing must be performed at least four (4) weeks prior to the periodontal surgery.

v. Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal Scaling and root planing if performed by the same Dentist's office.

- Full mouth debridement, limited to once per lifetime.

- Site therapy (localized delivery of antimicrobial agents) when the Participant has had prior periodontal therapy performed and pocket depths are 5mm or greater. Site therapy must be performed a minimum of 4 weeks following active periodontal therapy. Site therapy is limited to once per tooth per 12 months to a maximum of 3 tooth sites per quadrant.

- Endodontic Therapy, including pulpotomies and Root Canal Therapy.

- Antibiotic injections when given by the Dental Provider in conjunction with Covered Oral Surgery.

- Repairs/maintenance and recementing of Crowns, Inlays, Onlays, Bridgework, Partial Denture or full Denture.

- Post/core build-ups for Crowns and Bridgework.

- Relining or Rebasing of Partial Dentures and full Dentures, but not within 6 months of initial placement and not more than one of either in a 36-month period.

- Stainless steel Crowns on primary (baby) teeth.

- Porcelain on the upper or lower Anterior and bicuspid teeth.

- Tissue conditioning, but not within 6 months of the initial placement.

- Implants, including the prosthesis placed over the Implant and adjustments of the prosthesis but only to replace teeth that are congenitally missing or extracted. No Alternative Benefit Provision will apply. Includes 6 months post-installation care. Replacement of an Implant or prosthesis over the Implant will be a Covered Dental Service if installed at least 5 years prior to its replacement and cannot be made serviceable, or if replaced as the result of an Accidental Injury.

- Removable or Fixed Bridgework and Partial or full Dentures, but only to replace teeth (excluding third molars) that are congenitally missing or extracted. No benefits will be allowed for adjustments during the first 6 months after placement.

- Add teeth to an existing Partial or full Denture, but only to replace teeth that are extracted.

- Replacement of an existing fixed bridge with a new bridge, replacement of an existing removable Partial Denture with a new Partial Denture, or replacement of an existing full Denture with a new Denture, are all subject to the following conditions:
  a) The replacement is needed to replace teeth that are extracted;
  b) The existing Partial Denture or full Denture or Bridgework is certified by the Dental Provider to be at least 5 years old at the time of replacement and cannot be made serviceable, or if replaced as the result of an Accidental Injury; or
  c) The existing Partial Denture or full Denture is certified by the Dental Provider to be an immediate temporary full Denture that cannot be made permanent and is replaced with a permanent Denture within 12 months of the date it was installed.

- Crowns, Inlays or Onlays to restore teeth, but only when:
  a) The tooth is fractured or has major decay; and
  b) The tooth cannot be restored with fillings such as Amalgam, plastic or Composite resin. Replacement of a Crown, Inlay or Onlay will be a Covered Dental Service if installed at least 5 years prior to its replacement and cannot be made serviceable, or if replaced as the result of an Accidental Injury.

ORTHODONTIC SERVICES

- Covered Dental Services will include examinations, X-rays, surgical exposure of erupted teeth, placement of a device to facilitate eruption of impacted teeth, active Appliances and adjustments of the Appliances. The Dental Provider must submit to the Claims Administrator a complete outline of the Orthodontic problem, the proposed treatment, the charges for the treatment and the length of time for completion of the treatment.

- Charges will be considered, subject to other Dental Choice Plan conditions, as follows:

  a) The lesser of 25% of the total case fee or the Dental Provider's fee will be allowed and considered as being incurred on the date the initial active Appliance is placed; and
  b) The remainder of the total case fee will be divided by the number of months for the total treatment plan and the resulting portion will be considered to be incurred on a monthly basis until the Dental Choice Plan Maximum Benefit is paid, treatment is completed, or eligibility ends.

  Orthodontic services started prior to the Effective Date of coverage under this Plan are not a Covered Dental Service if the Participant did not have dental coverage in effect when the Orthodontic services began.

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

A. **Dental Necessity**

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

B. **Deductibles**

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

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

C. **Coinsurance**

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

D. **Alternative Benefits**

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

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

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

E. **Assignment of Benefits**

Benefits may not be assigned to a third party except for direct payments, which the Participant may assign to a Dental Provider or a provider of health care services. Any assignment will be effective on the date it is assigned, subject to any actions the Claims Administrator may take prior to receipt of the assignment. An assignment does not provide a coverage or benefit that is not otherwise available under the Plan. The Claims Administrator assumes no responsibility for the validity of an assignment. The Claims Administrator has the right to pay the Participant or the Dental Provider, whether or not the Claims Administrator received an assignment of benefits. If the Claims Administrator pays benefits under the Plan directly to a Dental Provider or other provider of health care services pursuant to an assignment that is delivered to the Claims Administrator with the claim for benefits, the Plan is relieved of the obligation to pay, and for any liability for paying, those benefits to the Participant. The payment of benefits pursuant to an assignment does not relieve the Participant of any contractual obligation under the Plan to pay a Deductible or Coinsurance, and a Dental Provider or other provider of health care services may not waive a Deductible or Copayment by the acceptance of such an assignment.

ARTICLE V - SCHEDULE OF DENTAL BENEFITS

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

Covered Dental Services are classified as:

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

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

SCHEDULE OF DENTAL BENEFITS		
	In-Network Dental Providers	**Out-of-Network Dental Providers**
Individual Maximum Benefit	Basic and Major Services: $2,000 per Calendar Year*	
Diagnostic and Preventive Calendar Year Deductible	Individual: $0 Family: $0	Individual: $50 Family: $150 aggregate
Diagnostic and Preventive Services	The Plan pays 100% of the allowable amount for Covered Dental Service, not subject to a Deductible.	After Diagnostic and Preventive Services Deductible, the Plan pays 90% of the allowable amount for Covered Dental Service.
Basic and Major Services Calendar Year Deductible	Individual: $50 Family: $150 aggregate	Individual: $100 Family: $300 aggregate
Basic Services	After the Deductible, the Plan pays 90% of the allowable amount for Basic Covered Dental Services.	After the Deductible, the Plan pays 70% of the allowable amount for Basic Covered Dental Services.
Major Services	After the Deductible, the Plan pays 50% of the allowable amount for Major Covered Dental Services.	After the Deductible, the Plan pays 40% of the allowable amount for Major Covered Dental Services.
Individual Lifetime Maximum Benefit for Orthodontic Services	$2,000 per Participant	
Orthodontic Services	The Plan pays 50% of the allowable amount for Covered Dental Services, not subject to a Deductible.	The Plan pays 50% of the allowable amount for Covered Dental Services, not subject to a Deductible.

*Once a Participant meets the $2,000 per Calendar Year Maximum Benefit for Basic and Major Services, the Dental Choice Plan will pay 40% of Covered Dental Services for the remainder of the Calendar Year for In-Network Dental Providers. The Participant will be responsible for the remaining 60% of Covered Dental Services. This is also referred to as the Extended Benefit. Diagnostic and Preventive Services do not apply to the $2,000 per Calendar Year Maximum Benefit.

NOTE: If services are covered under the HealthSelect of Texas® or Consumer Directed HealthSelect℠ medical plans, then no coverage is available under this Plan.

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

ARTICLE VI - LIMITATIONS AND EXCLUSIONS

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

1. Covered Dental Services incurred prior to your Effective Date under the Dental Choice Plan or after the date of coverage under the Dental Choice Plan ceases for a Participant for any reason.
2. Services or supplies from anyone other than a Dental Provider. Routine cleaning of teeth and Fluoride application when performed by a licensed dental hygienist under the direct supervision of, and billed by the Dental Provider will be covered.
3. Porcelain or similar material placed on molar Crowns or Pontics (teeth or spaces to the rear of the second bicuspid). An Alternative Benefit Provision may be applied.
4. Services or supplies that are partially or wholly Cosmetic in nature, or directed toward a Cosmetic end. This exclusion shall not apply to: (a) operations necessary to repair disfigurement due to an accident occurring while covered for Covered Dental Service benefits under the Dental Choice Plan, and (b) treatment of a congenital anomaly in a child who is covered for Covered Dental Service benefits under the Dental Choice Plan.
5. Replacing a lost, broken, missing or stolen Prosthetic Appliance.
6. Charges billed to a Participant for missing a scheduled appointment.
7. Any services received from a medical department, clinic or any facility provided or furnished by a Participant's Employer.
8. Any service that is not Dentally Necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending Dental Provider.
9. Services or supplies that do not meet accepted standards of dental practice including Experimental and Investigational services or supplies.
10. Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
11. Any duplicate Prosthetic Appliance except as specifically provided under the Dental Choice Plan.
12. Claim form completion, including fees.
13. Preventive control programs, including but not limited to, oral hygiene or dietary instruction, take home items or plaque control programs.
14. Any Splinting procedure, including but not limited to, multiple Abutments or any service to stabilize periodontally weakened teeth.
15. An injury or illness covered by workers' compensation.
16. Services or supplies for which a Participant is not required to pay.
17. Appliances, Restorations, or any procedures to alter Vertical Dimension, or restore Occlusion.
18. Any service or supply that is covered in whole, or in part, by another plan provided, or sponsored by the GBP.
19. Nitrous oxide.
20. Speech or myofunctional therapy.
21. Occlusal guards, including their Reline/repair/adjustment, or athletic mouth guards.
22. Veneers and their maintenance/repairs.
23. Caries susceptibility testing, lab tests, anaerobic cultures and sensitivity testing.
24. Sterilization/infection control fees.
25. Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), including but not limited to charges for: TMJ X-rays and consultations; TMJ surgery, kinesiographic analysis and muscle testing; TMJ splints and Appliances; splint equilibration and adjustments or physical therapy for symptoms including but not limited to headaches.

26. Osteotomies.
27. Harmful habit Appliance.
28. Stressbreakers.
29. Pulp vitality tests.
30. Occlusal adjustments.
31. Gold foil fillings and their maintenance/repairs. An Alternative Benefit Provision will be applied allowing benefits for an Amalgam Restoration.
32. Precious (gold) Crowns and their maintenance/repairs. An Alternative Benefit Provision will be applied allowing benefits for a semi-precious Crown.
33. Overdentures and their maintenance/repairs.
34. Precision or semi-precision attachments.
35. Major Services performed on other than permanent teeth.
36. Prescription drugs or pre-medications.
37. Any hospital charges or for services of any anesthesiologist.
38. The extent the expense exceeds the Maximum Allowable Charge for the service, treatment or supply in the locality where furnished.
39. Services or supplies not specifically listed under Covered Dental Services.
40. Any Covered Dental Services to the extent of any amount received from others for the Accidental Injuries or losses which necessitate such benefits.
41. Claims for direct-to-consumer Orthodontics not provided by a Dental Provider authorized to deliver care in the patient's state.
42. Services and Appliances for, and related to, the treatment of sleep apnea.

ARTICLE VII - TERMINATION OF COVERAGE

A. The coverage of all Participants under the Dental Choice Plan shall automatically terminate when the Dental Choice Plan is terminated in writing by the Trustee, such termination to be effective on the first day of the month immediately following notification of termination.

B. The coverage of any Subscriber and their Dependents included under the Dental Choice Plan shall automatically terminate:

1. On the last day of the month in which the Employee's employment terminates;

2. The day following the last day of the last period for which the Participant's Premium is paid to the Plan Administrator;

3. The Effective Date of an amendment to the Plan which terminates the coverage of any class of Subscriber or Dependent to which the Participant belongs;

4. The last day of the month in which the Subscriber or Dependent's death occurs;

5. The date the Subscriber or Dependent is expelled from the GBP for misrepresentation, fraud or attempted fraud;

6. The end of the month in which a Participant ceases to be a Participant as defined in Article I, except;

   a. An eligible member of the Texas Legislature
      1) Who held office on or after May 17, 1979, and
      2) Who, on ending service as a member of the Legislature, has established the minimum amount of creditable service required of an elective official for eligibility for service requirement benefits at 60 years of age, and
      3) Who notified the Plan Administrator within 30 days of leaving office of their intent to continue coverage and remit the necessary Premiums therefore, or
   b. Persons who have at least ten years of creditable service in ERS as an Employee of the Texas Legislature as defined in Texas state statutes and the Rules of the ERS Board of Trustees may continue coverage under the Dental Choice Plan for the Subscriber or for the Subscriber and their family members as Dependents.

7. The last day of the month during which an Employee is on an approved leave of absence without pay status; or,

8. When this MBPD is terminated.

C. The coverage of any Dependent of a Subscriber included under the Dental Choice Plan shall automatically terminate at the end of the month in which such Dependent ceases to be a Dependent as defined in Article I.

D. In the event coverage for a Subscriber, who meets the age and service credit requirements to qualify for a retirement benefit or a survivor's annuity, ends by reason of death, a surviving Dependent of the deceased shall have the right to continue coverage under the Dental Choice Plan provided: (1) each Dependent continues to be an eligible Dependent as defined herein; and (2) payment of Premiums is made to ERS according to its administrative Rules and practices.

E. Under no circumstances shall the Claims Administrator be obligated to notify any Participant of the termination of the Dental Choice Plan or of the Participant's coverage under the Dental Choice Plan.

ARTICLE VIII - WHEN COVERAGE ENDS: CONTINUATION OF COVERED DENTAL SERVICES IN PROGRESS

If a Participant is incurring Covered Dental Services and coverage under the Plan ends, benefits will be considered as follows:

Charges for Dentures will be considered Covered Dental Services if:
- the Impression was made prior to the date coverage ends; and
- the Denture was ordered prior to the date coverage ends.

Charges for Fixed Bridgework, Crowns and Inlays will be considered Covered Dental Services if:
- the tooth or teeth were prepared prior to the date coverage ends;
- the Impression was taken prior to the date coverage ends; and
- the Fixed Bridgework, Crown or Inlay was ordered prior to the date coverage ends.

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

ARTICLE IX - OPTION TO CONTINUE GROUP COVERAGE

A. **Continuation of Group Coverage**

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

B. **Conversion Privilege**

1. When coverage for any Participant is terminated under Article VII or Section A of this Article IX, the Participant shall have the right of conversion to new individual coverage as provided in Subsection 2, below.

2. Any Participant becoming eligible for conversion as provided for in the preceding Subsection 1 may, within 31 days after termination of the Participant's coverage under the Dental Choice Plan, submit application for a HumanaDental individual dental plan.

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

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

   If you have any questions about your conversion privilege or need an application, please call (855) 756-6580 (TTY: 711).

ARTICLE X - CLAIM PROVISIONS

A. Examination

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

B. Payment of Benefits

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

- To the State of Texas Dental Choice PPO Network of Dental Providers; otherwise
- To any assignee of record; otherwise
- To the Subscriber, if living; otherwise
- To the Subscriber's estate.

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

C. Predetermination of Benefits

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

If treatment is to commence more than 180 days after the issuance of a Predetermination of Benefits, the Claims Administrator will require the Participant to submit another treatment plan.

D. Facility of Payment

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

E. Proof of Loss

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

F. **Notification of Claim Decision**

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

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

G. **Claim Denial and Appeal**

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

HumanaDental – ERS
P.O. Box 14163
Lexington KY 40512-4163

The first level appeal must be filed with the Claims Administrator within 180 days from the date of the letter issued by the Claims Administrator notifying you of the denial or reduction.

Following the first level appeal, if the claim is again denied, the Claims Administrator will send the Participant an Explanation of Benefits with instructions on how to file a second level appeal with ERS.

To file a second level appeal with ERS, the Participant must send a written request, along with copies of all correspondence from the Claims Administrator, give reasons why the denial was wrong, and any other related information to:

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

A request to ERS for a second level appeal must be postmarked or received within 90 days of the date of the Claims Administrator's notice of the Participant's right to a second level appeal. The Participant will receive a decision in writing from ERS.

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

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

H. **Loss of Benefits Due to Fraud**

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

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

I. **Legal Actions**

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

J. **Dental Provider Change**

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

K. **Provisions Applicable to All Coverage**

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

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

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

L. **Timely Payment of Claims**

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

ARTICLE XI - GENERAL PROVISIONS

A. Applicable Law and Remedies

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

B. Copies; Dental Choice Plan Information

Copies of this MBPD, any future amendments to the MBPD, and other Dental Choice Plan information is available at www.ERSdentalplans.com. A Participant may obtain copies of this MBPD and other Dental Choice Plan information related to the Participant's coverage upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Such copies will be supplied within 30 days. Any Participant may also inspect copies of all Dental Choice Plan documents at any time during normal working hours.

C. Networks

The State of Texas Dental Choice PPO Network is subject to change. It is the Participant's responsibility to verify that the Dental Provider currently participates in the Claims Administrator's Network before care is received.

The Claims Administrator does not guarantee that the Claims Administrator's In-Network Dental Providers are available for all specialties, are available in all areas or that the Claims Administrator's Maximum Allowable Charge is less than what can be obtained from Out-of-Network Dental Providers.

Information on In-Network Dental Providers can be obtained free of charge from the Claims Administrator's website which is linked from the ERS website at www.ERSdentalplans.com by using the "Find Care" function on the State of Texas Dental Choice PPO tab , or by calling (855) 756-6580 (TTY: 711).

D. Coverage Data

The Plan Administrator shall furnish the Claims Administrator all information needed to effect coverage of Participants under the Dental Choice Plan and termination and changes in such coverage on a timely basis.

E. Disclaimer

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

F. Funding

The Dental Choice Plan is funded by participating Subscribers in accordance with the Act.

G. **Master Benefit Plan Document; Amendments**

1. The MBPD shall constitute the entire document governing the provision of benefits under the Dental Choice Plan. ERS and the Claims Administrator have also entered into a Contractual Agreement regarding the relationship and respective obligations between them, and have also entered into a Business Associates Agreement (BAA) with regard to each party's respective obligations related to the requirements of HIPAA and the regulations adopted pursuant to HIPAA. The Contractual Agreement and BAA control with regard to matters not specifically addressed in the MBPD.

2. This MBPD may be amended or changed at any time by ERS upon 30 days prior written notice to the Claims Administrator, subject to Texas law, without the consent of the Participants covered under the Dental Choice Plan or of their beneficiaries.

H. **Medicare/Primary Carrier Determinations**

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

I. **Not a Contract**

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

J. **Refund of Benefit Payments**

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

K. **State Government Programs**

1. Benefits for services or supplies under the Dental Choice Plan will not be excluded solely because benefits are paid or payable for such services or supplies under a state plan for medical assistance (Medicaid) made pursuant to 42 U.S.C., Section 1346 et seq., as amended. Any benefits payable under such state plan for medical assistance shall be payable to the Texas State Department of Health and Human Services Commission to the extent required by Chapter 1204, Subchapter D or its successor statute of the *Texas Insurance Code*.
2. All benefits paid on behalf of a child or children under the Dental Choice Plan must be paid to the Texas Department of Human Services where:
    a. The Texas Department of Health and Human Services Commission is paying benefits pursuant to Chapter 31 or 32 of the Texas Human Resources Code, and

b. The parent who is covered by the Dental Choice Plan has possession or access to the child pursuant to a court order, or is not entitled to access or have possession of the child and is required by the court to pay child support, and
c. The Claims Administrator receives written notice at its home office, affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Health and Human Services Commission.

L. **State or Federal Law**

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

M. **Right to Reimbursement**

The right to reimbursement means that if a third-party is or may be responsible to pay for the Participant's sickness or injury for which the Participant receives a settlement, judgment, or other recovery from any third-party, the Participant must use those proceeds to return to the Plan, to the maximum extent allowed by Texas law, the amount of any benefits the Participant received for such sickness or injury.

N. **Third-Parties**

The following persons and entities are considered third-parties:

- a person or entity alleged to have caused the Participant to suffer a sickness, injury or medical damages, or who is legally responsible to pay for the sickness, injury or medical damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or medical damages; or
- any other persons or entities who are responsible for paying losses caused by the Participant's sickness or injury when such payments are subject to subrogation under Texas law.

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

1. Complete a third-party information report, naming among other things:
   a. The party who may be considered responsible for the injury or sickness;
   b. Any current or anticipated third-party litigation, settlement negotiations, or other coverage;
   c. The name, address, and telephone number of any attorney retained by the Participant to prosecute a third-party claim; and, the name, address, and telephone number, claim number, or policy number, as known to the Participant of any insurance companies insuring either the Participant, the third-party or others liable for payment to the Participant on account of the Participant's injury or sickness;
2. Give statements and provide information about the other parties or the injury or sickness when requested by the Dental Choice Plan;
3. Execute and deliver any other documents or do whatever the Dental Choice Plan reasonably requires to secure its rights of subrogation;
4. Obtain the Dental Choice Plan's consent prior to releasing the third party from any liability for payment of medical or dental expenses; or
5. Reimburse the Dental Choice Plan to the maximum extent allowed under Texas law when a recovery is made as a consequence of third-party negligence or other actions.

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

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

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

O. **Workers' Compensation Insurance**

The Dental Choice Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by workers' compensation insurance.

P. **Right to Receive and Release Needed Information**

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

Any Participant claiming benefits must furnish the Claims Administrator with the necessary information needed to determine Other Dental Coverage benefit payments.

ARTICLE XII – DEFINITIONS

As Used Herein:

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

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

Act - The Texas Employees Group Benefits Act, Texas Insurance Code, Chapter 1551, as amended.

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

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

- Contracted Fee amount for the most economical Covered Dental Service or material which meets broadly accepted standards of dental care as determined by the Claims Administrator if a State of Texas Dental Choice PPO Dental Provider provides the service or supply, or

- The Maximum Allowable Charge for the most economical service or material which meets broadly accepted standards of dental care as determined by the Claims Administrator if an Out-of-Network Dental Provider provides the service or supply.

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

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

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

Amalgam Restoration - A direct restorative dental procedure using an Amalgam material to repair and restore a tooth that has been damaged by decay or fracture.

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

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

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

Benefits Coordinator - A person employed by the Employer to provide assistance for Participants with various benefit programs, including the Plan. ERS is the Benefits Coordinator for Retirees.

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

Bridgework or Prosthetic Appliance -

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

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

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

Claims Administrator - HumanaDental Insurance Company.

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

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

Comprehensive Intraoral Series - A two dimensional radiographic survey of the whole mouth intended to display the Crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including endentulous areas.

Cone Beam Images - An X-ray image of the head and neck which permits those structures to be seen in three dimensions (3D).

Contracted Fee - The total compensation that a State of Texas Dental Choice PPO Network Dental Provider has agreed to accept as payment in full for Covered Dental Services.

Contractual Agreement - A formal, legally binding document between HumanaDental Insurance Company and ERS outlining the terms, conditions, and obligations governing the provision of dental benefits to ERS Participants.

Cosmetic - Involving or relating to treatment intended primarily to improve physical appearance or performed for psychological purposes.

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

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

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

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

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

Dental Choice Plan or **Plan -** State of Texas Dental Choice Plan[SM].

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

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

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

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

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

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

Dependent - An individual who, because of a statutorily defined relationship with a Subscriber, meets the eligibility requirements specified in the Plan, as described under Article II, Eligibility for Coverage, and is enrolled as a Participant in the Plan. A Dependent does not include anyone who is enrolled in the Plan as a Subscriber. No one can be enrolled as a Dependent of more than one Subscriber.

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

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

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

If you have an Emergency, you can receive treatment from any Dental Provider, including an Out-of-Network Dental Provider. If you receive Covered Dental Services from an Out-of-Network Dental Provider as the result of an Emergency, the Plan pays a benefit at the In-Network Dental Provider level of coverage, subject to the terms and conditions of the Plan.

If you have an Emergency outside of the United States, Covered Dental Services claims will be processed pursuant to the section entitled "Dental Services Performed Outside of the United States."

Employee - A person eligible to participate in the GBP under §1551.101 of the Act, which includes an appointed state officer, judicial officer, or Employee in the service of the State of Texas. The term also includes an eligible Employee of an Institution of Higher Education and any persons required or permitted by the Act to enroll as Subscribers.

Employer - The State of Texas and all its agencies, certain political subdivisions or Institutions of Higher Education that employ or employed an Employee or Retiree.

Endodontic Therapy - Treatment of diseases of the dental pulp.

Enrollment Period - The time period which begins with a Participant(s)' eligibility date and ends when the Participant is no longer eligible to make benefit changes.

ERS - An acronym for Employees Retirement System of Texas.

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

Extended Benefit - The amount the Dental Choice Plan will pay for Covered Dental Services performed by In-Network Dental Providers for the remainder of the Calendar Year after the Calendar Year Maximum Benefit is met for Basic and Major Services

Former COBRA Dependent Child - A child of an Employee or Retiree who is eligible for and reinstates coverage under the Plan pursuant to Sec. 1551.158 of the Texas Insurance Code.

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

Fund - The insurance trust Fund created by the Act.

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

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

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

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

In-Network Dental Provider - A Dental Provider who participates in the Claims Administrator's State of Texas Dental Choice PPO Network and agrees to limit charges to the maximum amount determined by the Claims Administrator's Network.

Institution of Higher Education - A public junior college, a senior college or university, or any other agency of higher education within the meaning and jurisdiction of Chapter 61 of the Texas Education Code. "Institution of Higher Education" does not include The University of Texas System, as described by Section 65.02 of the Texas Education Code, or an entity in the Texas A&M University System, as described by Subtitle D, Title 3 of the Texas Education Code, including the Texas Veterinary Medical Diagnostic Laboratory.

Maximum Allowable Charge - The reimbursement under the Plan against which Claims Administrator calculates the Plan's payment and the Subscriber's applicable cost-sharing responsibilities, including Deductible, Coinsurance, and any other amounts the Subscriber is required to pay. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Allowable Charge for services provided:

- by an In-Network Dental Provider is the lesser of the Provider's actual charge or the Contracted Fee for Covered Dental services.
- by an Out-of-Network Provider it will not exceed:
  - The amount customarily charged by the Dental Provider for the service or supply; or
  - The charge for the service or supply made by Dental Providers for comparable services or supplies in the same locality.

Maximum Benefit - The maximum amount that may be payable for each Participant, for services. The applicable Maximum Benefit is shown on the Schedule of Dental Benefits.

Network - The State of Texas Dental Choice PPO Network of Dental Providers that has been established by the Claims Administrator and approved to provide services for the Dental Choice Plan.

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

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

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

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

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

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

Out-of-Network - Services or supplies rendered by a provider outside the State of Texas Dental Choice PPO Network of Dental Providers that has been established by the Claims Administrator.

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

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

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

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

Participant - An Employee, Retiree, or Dependent, as defined in the Act, including surviving Dependents of deceased Employees and Retirees, or any other individual eligible for coverage as provided under the Act while eligible for coverage and enrolled under the Plan. References to "you" and "your" throughout this Master Benefit Plan Document are references to a Participant.

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

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

Pontic - The part of a fixed bridge that replaces a missing tooth or teeth.

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

The Claims Administrator may request such information as:

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

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

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

Program - The Texas Employees Group Benefits Program as established by Chapter 1551 of the Texas Insurance Code and the ERS Board of Trustees.

Proof of Loss - The standard form used to file a claim or request reimbursement for treatment received by a Dental Provider.

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

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

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

Retiree - (also known as annuitant) an Employee who has retired as defined in the Act.

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

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

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

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

Space Maintainer - A fixed or removable Appliance placed to maintain the space of prematurely removed or missing teeth.

Splinting - Stabilizing or immobilizing teeth to gain strength.

State Agency - A commission, board, department, division, Institution of Higher Education or other agency of the State of Texas created by the constitution or statutes of the State of Texas.

Stressbreaker - A device that relieves the Abutment teeth, to which a fixed or removable Partial Denture is attached, of all or part of the forces generated by occlusal function.

Subscriber - An Employee, Retiree or other person eligible to participate in the GBP as provided under the Act and who is not a Dependent.

Teledentistry - Dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification. Teledentistry includes services delivered through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).

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

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

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

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Mail:
P.O. Box 14618
Lexington, KY 40512-4618

Phone: **877-320-1235 (TTY: 711),**

Email: **accessibility@humana.com**

If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Mail:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building, Washington, DC 20201

Email: **OCRComplaint@hhs.gov**

Phone: **800-368-1019**, **800-537-7697 (TTY/TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**

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English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean):** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Italiano (Italian): Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

اردو (Urdu): اوپر دیے گئے نمبر پر کال کریں۔ مفت زبان کی مدد کی خدمات حاصل کرنے کے لیے یہ نمبر

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