

A&M Dental PPO Plan

Updated July 2023



THE TEXAS A&M
UNIVERSITY SYSTEM

Introduction

The Texas A&M University System provides dental benefits to help you and your family maintain good dental health.

The A&M Dental plan emphasizes preventive care — to help avoid those painful and expensive procedures that can result from not getting good care on a continuous basis. But recognizing that dental problems can occur even with regular care, the plan also covers most other types of dental treatment.

The A&M Dental plan is funded by The Texas A&M University System, and claims are administered by Delta Dental Insurance Company (Delta Dental).

If you elect coverage, you pay the cost of coverage. Your premiums will be paid on a before-tax basis. This booklet provides a summary of your dental coverage in everyday language. Most of your questions can be answered by referring to this booklet.

Administrative plan details are included in the contract between The Texas A&M University System and Delta Dental.

In the event of a discrepancy between this summary and the contract between the A&M System and Delta Dental, the contract prevails.

This booklet is neither a contract of current or future employment nor a guarantee of payment of benefits. The A&M System reserves the right to change or end the benefits described in this booklet at any time for any reason.

Clerical or enrollment errors do not obligate the plan to pay benefits. Errors, when discovered, will be corrected according to the provisions of the plan description and published procedures of the A&M System.

The A&M System will, in all cases, determine eligibility for coverage and effective dates of coverage in accordance with its rules and procedures. If these rules and procedures differ from the Policy or Certificate, it is understood that the A&M System's determination will prevail.

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Participation

All full-time and some part-time employees and retirees and their eligible dependents are eligible for A&M Dental coverage. Coverage can begin on your first day of work. Participation is voluntary.

You and your dependents are eligible to participate in the dental plan if you:

- are eligible to participate in the Teacher Retirement System of Texas (TRS) or Optional Retirement Program (ORP), and
- work at least 50% time for at least 4½ months.

You and your dependents are also eligible if you are a graduate student employee who works at least 50% time for at least 4½ months, or if you are a postdoctoral fellow. To be eligible for coverage as a retiree, you must meet the criteria listed in the Retiree Eligibility section. Eligibility for this plan is subject to change by the A&M System or the Texas Legislature.

Eligible Dependents

You may choose to cover any or all of your eligible dependents in addition to yourself. Dependents eligible for coverage include:

- your spouse, and
- your unmarried dependent children younger than 26*.

Dependent children include:

- a natural child,
- an adopted child,
- a stepchild who has a regular parent/child relationship with you,
- a foster child under a legally supervised foster care program,
- a legally adopted child,
- a grandchild you claim on your income tax,
- a dependent for which you have received a court order to provide coverage, and

- *managing conservatorship/legal guardianship dependents up to age 18 unless accepted court order states otherwise.

You will be asked to provide documents to verify eligibility for the dependent(s) you wish to cover under this plan. If the child is mentally or physically unable to earn a living and is dependent on you for support, you must notify your Human Resources office of the child's disability before the child's 26th birthday. This will allow time for you to obtain and complete the necessary forms for coverage to continue. Periodically, you may be required to provide evidence of the child's continuing disability and your support.

Enrolling in the Plan

You must enroll in benefits within 31 days from the date you become eligible. You have some options on when your coverage begins:

- You can elect coverage for you and your dependents to start on your hire/initial eligibility date if you enroll before, on, or within 7 days after your hire/initial eligibility date.
- You can elect for coverage to begin on the first of the month following hire/initial eligibility if you enroll before the end of the month of your hire/initial eligibility.
- If you enroll beyond the 7th day after your hire/initial eligibility date, but during your 31-day initial enrollment period, your coverage will start on your employer contribution eligibility date (the first of the month after your 60th day of employment).

You may also choose to have your coverage begin before your employer contribution eligibility date but have your dependents' coverage begin on your employer contribution eligibility date.

If you do not enroll yourself or a dependent during your initial enrollment period, you must wait until the next Open Enrollment period (coverage effective September 1) to enroll. Likewise, if you gain a new dependent, you must enroll that dependent within 31-days or wait until the next Open Enrollment period. You must be actively at

work on the day your coverage is to begin. If you are not, coverage will be delayed until you return to work.

Retiree Eligibility

If you were retired from or employed in a benefits-eligible position with the A&M System on August 31, 2003, you are eligible for dental coverage as a retiree when:

- you are at least age 55 and have at least 5 years of service credit, or your age plus years of service equal at least 80, or you have at least 30-years of service, and
- you have 3-years of service with the A&M System, and
- the A&M System is your last state employer.

If you left A&M System employment before September 1, 2003, but you met the above criteria as of August 31, 2003, you qualify for retiree benefit coverage under these criteria.

If you are in TRS, you must also provide documentation that you are receiving or have applied to receive your TRS annuity payments.

If you were hired by the A&M System in a benefits-eligible position after August 31, 2003, or if you left A&M System employment before August 31, 2003, and did not meet the criteria listed above as of August 31, 2003, you are eligible for dental coverage as a retiree when:

- you are at least age 65 and have at least 10-years of service credit, or your age plus years of service equal at least 80 and you have 10 years of service credit, and
- you have 10 years of service with the A&M System, and
- the A&M System is your last state employer.

If you are in TRS, you must also provide documentation that you are receiving or have applied to receive your TRS annuity payments.

Former Employees (Return to Retire)

You are eligible for coverage as a retiree if you are a former employee who meets the eligibility criteria listed under Retiree Eligibility. You may apply for coverage within 60 days of meeting these criteria or within 60 days of leaving a TRS-eligible position with another state employer after meeting the eligibility criteria. In these cases, you may choose to have your coverage become effective on the first of the month following the date the Human Resources office receives your application or on your employer contribution eligibility date (the first of the month after 90 days after the Human Resources office receives your application).

If you do not enroll on one of these dates, you may enroll during a later Open Enrollment period. In that case, you can choose to have your coverage become effective on the next September 1 or December 1 (90-day employer contribution waiting period still applies).

Your Options

You also have a choice of four levels of coverage:

- employee/retiree only,
- employee/retiree and spouse,
- employee/retiree and children, or
- employee/retiree and family (spouse and children).

If you enroll your dependents, you must enroll them in the same plan in which you enrolled yourself. Once you enroll in the dental plan, you can only drop change or drop coverage during Open Enrollment or within 31-days of a Qualifying Life Event.

Changing Your Coverage

You can enroll in or drop Dental coverage only during Open Enrollment (changes effective September 1). However, you can add or drop dental coverage for yourself and/or your dependents within 31-days of a Qualified Life Event if you or your dependents are affected by the change.

Qualifying Life Events include:

- Employee's marriage or divorce or death of employee's spouse. A divorce is considered official when the trial court announces its decision in open court or by written memorandum filed with the clerk.
- Birth, adoption or death of a dependent child.
- Change in employee's, spouse's or dependent child's employment status that affects benefit eligibility, such as leave without pay.
- Child becoming ineligible for coverage due to reaching age 26.
- Changes in the employee's, spouse's or a dependent child's residence that would affect eligibility for coverage.
- Changes made by a spouse or dependent child during his/her Open Enrollment period with another employer.
- The employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid.
- Significant employer- or carrier-initiated changes in or cancellation of the

employee's, spouse's or dependent child's coverage.

- Employee's receipt of a qualified medical child support order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) medical coverage for a child,

Changes in coverage must be consistent with the Life Event. For example, if you have a baby, you may add that child to your coverage, but you may not drop your other children.

You must provide Qualifying Life Event documentation for approval to make changes to your coverage during the plan year.

ID Cards

Delta Dental will mail each enrolled employee/retiree a membership letter. The letter includes:

- ID cards
- Customer care contact information
- Information on how to use your benefit.

Coverage Cost

You pay the cost of Dental coverage. You pay your premiums on a before-tax basis.

You must pay premiums for dental coverage. If coverage for you or your dependents begins in the middle of a month, you must pay your share of the premium for the entire month.

Through the Pretax Premiums Plan, your premium will automatically be deducted from your paycheck on a before-tax basis. This means you never pay federal income tax or Social Security tax on the money you pay for your Dental coverage.

When you pay premiums on a before-tax basis, your taxable income is reduced. This may mean that your eventual Social Security benefit could be reduced. However, the reduction is quite small. Your base pay, for purposes of pay increases and benefits based on pay, is not reduced.

If you are retired or paying your premiums through billing (ex. leave of absence, summer billing, etc.), you are not eligible for before-tax deductions since your premiums are paid through billing, ACH or TRS annuity deduction.

If you do not enroll in an A&M System medical plan, but certify that you have other medical coverage, you may receive one-half of the employee-only employer contribution to pay for other coverages. You may apply this toward your Dental premium.

How Dental Coverage Works

The dental plan covers preventive, basic, major and orthodontic care. The plan pays up to \$1,500 per year in dental benefits, with a \$1,500 lifetime maximum on orthodontic care.

Your dental plan covers most types of dental care, but at different benefit levels. In general, here's how the plan works:

The plan pays 100% of Delta Dental's allowed amount for certain preventive care. You must meet a \$75 deductible each plan year (September 1 – August 31) before the plan pays benefits for basic, major, or orthodontic care.

Once you meet your annual deductible, the plan pays 80% of basic and 50% of major and orthodontic care. When you have received \$1,500 in dental benefits for basic and major services combined in a plan year, the plan pays no additional benefits for that plan year. Each covered person can receive a lifetime maximum benefit of \$1,500 for orthodontic care.

Annual Deductible

You must first meet an annual deductible before you receive dental benefits, except for preventive care. This means you pay the first dental expenses (other than preventive) you have for yourself and your covered dependents each year. If you have dependent coverage, the maximum annual deductible for all family members is three times the individual deductible. All expenses incurred by any combination of three or more family members will go toward meeting the family deductible. Preventive care expenses do not count toward the deductible or annual maximum, since the allowable amount is paid at 100%.

You pay your \$75 annual deductible					
Basic		Major		Orthodontic	
You pay 20%	The plan pays 80%*	You pay 50%	The plan pays 50%*	You pay 50%	The plan pays 50%*
Once you have received \$1,500 in benefits in a plan year, you pay all remaining dental expenses for that plan year.				Once you have received \$1,500 in benefits in your lifetime, you pay all remaining orthodontic expenses.	
*Of Delta Dental's allowed amount.					

Cost Sharing

You and the plan share many costs on a percentage basis. For basic services, after you meet your annual deductible, you pay 20% and the plan pays 80% of expenses. You and the plan each pay 50% for major and orthodontic care, after you meet your annual deductible.

Plan Limits

The plan pays up to \$1,500 per person per plan year for basic and major services combined. The plan also pays up to \$1,500 in each person's lifetime for orthodontic care. Any orthodontic benefits previously received under this plan count toward this lifetime maximum.

Choice of Dentist

You can choose a Delta Dental PPO Dentist (PPO Dentist), a Delta Dental Premier® Dentist (Premier Dentist) or a non-Delta Dental Dentist:

- Choosing a PPO Dentist gives you the greatest reduction in your out-of-pocket cost because these dentists have contracted with Delta Dental to charge less than what most dentists in your area charge.
- Choosing a Premier Dentist allows you to receive dental care at a cost that is usually lower than a non-Delta Dental Dentist's charges but more than a PPO Dentist's charges. Premier Dentists charge either their regular fees, the Premier contracted fee or the maximum plan allowance (see below), whichever is less.
- If you choose a non-Delta Dental Dentist, Delta Dental will pay the dentist's charge or the maximum plan allowance (see below), whichever is less. You must pay any remaining charges.

In addition, a PPO Dentist or Premier Dentist will file claims for you. You pay only the deductible and your coinsurance. Delta Dental will pay the dentist directly for the remaining cost up to the maximum benefit (see Plan Limits, previous page).

Dental providers can be located through the A&M System dedicated website at <http://www.deltadentalins.com/tamus>, or your Human Resources office.

Dentists are regularly added to or deleted from the network, so a new dentist may not be listed, and you should always verify with Delta Dental that a listed dentist is still in the network.

Pre-Treatment Estimates

If your dentist recommends treatment that will cost more than \$300, you should submit a treatment plan to Delta Dental in advance. Delta Dental will figure your benefit under this plan before you receive treatment. This will allow you and your dentist to

know, before you agree to treatment, exactly how much the plan will pay and how much you will have to pay.

Many dental problems can be treated in more than one way. The plan will pay benefits based on the generally accepted treatment that provides adequate care at the lowest cost. For example, veneer materials may be used for front teeth or bicuspids. The plan will pay benefits based on the least expensive adequate veneer material.

If the treatment your dentist proposes is not the least expensive acceptable treatment, a pretreatment estimate will let you know that in advance. You can then discuss with your dentist the alternative treatments and make your decision based on your benefits allowed by the plan.

Pre-treatment estimates are valid for 60 days from the date of the pre-treatment estimate, until you become ineligible for dental coverage or until the plan ends, whichever occurs first.

Maximum Plan Allowance

The Maximum Plan Allowance (MPA) is the highest amount Delta Dental will reimburse for a covered procedure. Delta Dental sets MPAs each year based on actual claims submitted by providers in the same geographic area with similar professional standing. The MPA may vary by the type of dentist.

Covered Dental Expenses

The Dental plan covers regular checkups and routine care such as fillings, x-rays, cleanings and extractions. Other treatments also are covered, including orthodontic care.

Your dental plan covers most medically necessary, reasonable and customary charges for services provided by:

- licensed dentists,
- doctors operating within the scope of their licenses, and
- licensed dental hygienists operating within the scope of their licenses and under the supervision and direction of dentists or doctors.

This section lists the expenses covered by the plan. Some limitations may apply to specific services as noted in this list. Expenses that are not covered are listed beginning on page 13.

If you cannot find a service or supply in either section, call Delta Dental's Customer Service department at 1 (800) 521-2651 to find out if the expense is covered.

Preventive Care

For in-network services, the plan pays 100%, with no deductible, for:

- oral exams, up to three each plan year,
- prophylaxis (cleaning), including periodontal prophylaxis, up to three each plan year,
- topical application of fluoride for children younger than 15, up to twice each plan year,
- full-mouth x-rays, including panoramic once every three years,
- bitewing x-rays, up to twice each plan year,
- space maintainers for children younger than 14,

- sealants, limited to once per tooth within 24 months; up to age 16 for first and second molars, and

Basic Care

For in-network services, the plan pays 80% after the deductible for:

- extractions,
- restorative fillings, including amalgam, acrylic, or composite fillings,
- oral surgery,
- general and local anesthetic for covered oral surgery procedures,
- administration of nitrous oxide for use as sedation and/or analgesic for children up to age 14,
- treatment of periodontal and other diseases of the gums and tissues supporting the teeth (except periodontal cleanings, which are covered as preventive care if proof of prior root planning and scaling or osseous surgery is provided),
- endodontic treatment, including root canals, if the tooth is opened while the patient is covered by the plan,
- injection of antibiotic drugs,
- re-cementing of crowns, inlays and bridgework (certain limitations may apply)
- realignment of dentures, up to once every two plan years, and
- emergency palliative (pain) treatment.
- night guards for correction of harmful habits such as teeth grinding.

Major Care

For in-network services, the plan pays 50% after the deductible for:

- implants (prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis),
- inlays, onlays, gold fillings or crowns,
- initial installation of fixed bridge-work, including inlays and crowns, or replacement of existing bridge-work or the addition of teeth on existing bridge-work, and
- initial installation of partial or full removable dentures, the replacement of an

existing partial or full removable denture or the addition of teeth to a partial removable denture. However, initial installation and replacements or additions to existing dentures or bridge-work will be covered only if the work cannot be repaired and were installed at least five years before replacement.

If your dental coverage ends while you are in the middle of treatment for major services, coverage may be extended for that service. If you are not entitled to benefits under any other dental plan and installation of a dental appliance, crown, bridge or gold restoration is performed within 30-days of the end of your coverage, benefits for the installation will be paid if:

- an impression for the appliance was taken before coverage ended, or
- the tooth was prepared for the crown, bridge or gold restoration before coverage ended.

Orthodontic Care

The plan will pay 50% after the deductible for treatment, materials and supplies related to orthodontic treatment. The plan will pay 50% of your down payment, which may not exceed one third of the total cost or \$700, whichever is less, for

orthodontic treatment. The remaining cost will be divided by the number of months of expected service (generally 24-months). You will be reimbursed 50% of this monthly cost each month. Orthodontic benefits are limited to \$1,500 per covered person per lifetime.

If you or a covered dependent begins orthodontic treatment before becoming covered under this plan, this plan may pay for part of the treatment. The plan will pay no benefits for the placement of the appliance if that step pre-dated plan coverage. However, the plan will pay for the ongoing treatment that occurs after coverage begins. In this case, Delta Dental will make monthly payments on the first payment due date after your coverage becomes effective.

If coverage ends before your treatment is finished, Delta Dental will make its last orthodontic payment on the first payment due date after your coverage ends or on the last payment due date before the plan terminates, whichever occurs first.

If an interceptive appliance, such as an expander, is placed before the orthodontic work begins, benefits for the related charges would be considered part of the \$1,500 maximum orthodontic benefit.

Dental Expenses Not Covered

Charges for cosmetic work, charges that are not medically necessary, charges above the maximum plan allowance and certain other items are not covered by the Dental plan.

While most dental expenses are covered by this plan, some dental expenses are not covered. Most of these are listed below. Others that are specific to a certain service are listed in the section “Covered Dental Expenses.”

If you cannot find a specific expense listed in this section or in the list of covered expenses beginning on page 11, call Delta Dental’s Customer Service department at 1 (800) 521-2651.

Expenses that are not covered include, but are not limited to:

- for any treatment, including materials and supplies, not begun and completed while the patient is covered by the plan, except as explained on page 11,
- for repair and/or replacement of lost, missing or stolen prosthetic or orthodontic appliances,
- for prescription drugs, although these may be covered by your health plan,
- for any treatment, material or supplies that are for orthodontic treatment except as explained on page 11.
- Re-cementations within six months by the same dentist/dental office,
- Re-cementations in excess of one re-cementation by the same dentist/ dental office.
- for dentures, crowns, inlays, onlays, bridge-work or other treatment, material or supplies provided to alter vertical dimension or alter occlusion,
- for failure to keep a scheduled appointment with a dentist,
- for services restoring tooth structure lost from wear, erosion, or abrasion, for

- rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth including equilibration and periodontal splinting.
- for sealants except as explained on page 11, or other materials to prevent decay other than fluorides,
- for accidental injury or illness related to any employment or for which the patient is entitled to or has received benefits or a settlement from any workers’ compensation or occupational disease law,
- due to war or any act of war, whether declared or undeclared,
- for telephone consultations, records or x-rays necessary for Delta Dental to make a benefit determination, that would not have been made if you did not have coverage,
- that you are not legally obligated to pay, except charges from a tax-supported institution of the State of Texas for care of mental illness or retardation and charges for services or materials provided under the Texas Medical Assistance Act of 1967,
- for services or supplies furnished by an agency of the U.S. or a foreign government, unless excluding the charges is illegal,
- for services while you are not under the direct care of a dentist, for treatment by a dentist that is not within the scope of his/her license,
- for services of a person who is a member of your or your spouse’s immediate family or who lives with you,
- for personalized complete or partial dentures, overdentures and their related procedures,
- for treatment that is not medically necessary, except those preventive benefits described on page 11,
- for services and materials in excess of the maximum plan allowance as described on page 10, for which benefits are not provided under this plan,
- for expenses charged by a hospital or surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility,

- for cosmetic surgery or treatment, unless due to:
 - an accident that occurred while you were covered by the plan,
 - a birth defect if your child is continuously covered by this plan from date of birth, or
 - surgical reconstruction or correction of a defect resulting from surgery while you were covered by the plan,
- for extraoral grafts (grafting of tissues from outside the mouth to oral tissues),
- for scholastic education or vocational training,
- for care, treatment, services or supplies that are experimental or investigative in terms of generally accepted medical and dental standards,
- for travel, even if recommended by a dentist,
- for adjustment of a denture or bridgework within six months after installation by the same dentist who installed it,
- for instruction for oral care, such as hygiene or diet,
- for charges made by a dentist for completing dental forms,
- for more than one consultation in a plan year,
- for the administration or cost of drugs and/or gases used for sedation or as an analgesic for adults and children over age 14, unless medically necessary,
- and charges related to temporomandibular joint problems (however, these may be covered under your health plan).

Filing Claims

Whether you need to file a claim depend on whether you use an in-network or out-of-network provider.

To file a claim for dental benefits, you must complete a claim form (pictured on the following page) and mail it with a copy of your itemized bill to the address shown on the claim form.

Claim forms are available from your Human Resources office or at Delta Dental's web site: www.deltadentalins.com/tamus.

PPO Dentists and Premier Dentists will be paid directly by Delta Dental for services provided under the plan. You may request, in writing, when filing proof of loss that payment be made directly to an out-of-network dentist. All benefits not paid to the dentist will be paid to you or your estate, except if the person receiving payment is a minor or otherwise not competent to give a valid release. In such event, benefits may be paid to that person's parent, guardian or other person supporting him or her.

Be sure to keep a copy of your claim for your records. You must send the original claim form and bill to:

Delta Dental Insurance Company Claims
Department
P.O. Box #1809
Alpharetta, Georgia 30023

Be sure to fill out the claim form completely. If information is missing, payment of your benefits may be delayed.

For orthodontic claims, you should first submit the bill for your down payment with a claim form. Then you must submit claims for each of your monthly bills.

You need to file all claims for a plan year soon after the end of that plan year (August 31). All claims must be received by January 31 of the next plan

year. The plan is not obligated to pay claims received after that date.

Overpayments

If Delta Dental overpays a claim for any reason, the plan has the right to recover the overpaid amount from you.

How to Appeal a Claim

If your claim for benefits is denied in whole or in part, Delta Dental will notify you in writing within 90-days of receipt of your claim.

The written notice will give specific reasons for the denial and reference the specific plan provisions on which the denial is based. It will also describe any additional material you must submit and explain the plan's claim review procedures.

In special circumstances, a response to your claim may take more than 90-days. If an extension is needed, you will receive written notice before the end of the 90-day period. In no event will the extension be more than 90-days.

Within 60-days of receiving written notice of a claim denial, you or your authorized representative may submit a written request for reconsideration to Delta Dental. Be sure to state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. You may also review any pertinent plan documents. Your appeal will be reviewed by the claim administrator.

A decision on the appeal will be made by Delta Dental within 60-days after receipt of your request for review unless special circumstances require additional time. A decision will be made no more than 120-days after receipt of your request. The decision on the review will be in writing and will include the specific reasons for the decision as well as specific references to the appropriate plan provisions on which the decision is based.

A&M System Review

If you are not satisfied with the decision reached by the claims review process, you may request a review by the A&M System Review Panel within

30-days of your receipt of the final written decision from Delta Dental. To request a review, you must send written notification of your desire to have your claim reviewed, with a copy of Delta Dental's decision, to:

The Texas A&M University System
Attn: Director of System Benefits Administration
Moore/Connally Building
301 Tarrow St., 5th Floor
College Station, TX 77840
Mail Stop: 1117 TAMU

If you or any of your witnesses or representatives wish to meet with the Review Panel from outside College Station using a virtual meeting method, your notification letter must state that preference. Within five working days of receiving your letter, the Director of System Benefits Administration will mail you an acknowledgment of your request. This mailing will include release forms that you must sign to authorize the release of relevant information about the problem to members of the Review Panel and to release panel members from any and all liability arising from the panel's conclusions.

You must return the release forms to the Director of System Benefits Administration within 30-days of receiving the forms. Within 10 working days of receiving the release forms, the Director of System Benefits Administration will contact the Review Panel members and set a review date. This group will meet to review the case within 30-days of the

Director of System Benefits Administration's notification to the panel.

Within 30-days of the meeting, the panel will make a decision on the case, unless special circumstances require additional time. You may address the panel and submit relevant information and expert opinions and/or witnesses. You must submit at least 10 copies of all documentation on your claim problem to the Director of System Benefits Administration at least 72-hours before the meeting with the panel.

You also must inform the Director of System Benefits Administration at least 72-hours in advance of the meeting of any witnesses or representatives you will have at the meeting. You are responsible for any expenses arising from use of witnesses or representatives.

The Director of System Benefits Administration will notify you and Delta Dental of the panel's decision. This will be the final decision on your case, and the panel will not review it again.

If the review panel's decision would require the plan to violate state or federal law or A&M System policy or regulation, the plan administrator, after consulting with the General Counsel, may prohibit implementation of the panel's decision. You may cancel a review of your case at any time by written request to the Director of System Benefits Administration.

Coordination of Benefits

Your Dental benefits are coordinated with other group plans so your combined benefits are not more than 100% of the expense.

In many families, especially if both spouses work, family members may be covered by more than one dental plan. Each plan pays benefits, but the plans coordinate their payments so that the total payments are not more than 100% of the allowable expenses. Coordination of benefits (COB) rules determine the sequence of payments.

One plan has primary responsibility and pays first; the other plan has secondary responsibility and pays benefits for any additional covered expenses. When A&M Dental is the secondary payor, the A&M Dental benefit is based on the total billed charge, subject to the maximum plan allowance limits (see page 10). A plan that has no coordination of benefits provision is always primary. If both spouses cover the family under plans through their respective employers and both plans have COB provisions, the chart below shows which plan is designated as primary or secondary under COB rules.

If the parents of a covered dependent child are divorced, the plan of the parent who has financial responsibility for that child’s dental care expenses under a court decree is primary. If no decree establishes financial responsibility, the plan of the parent with custody is primary. If there is no financial decree and the parent with custody remarries, that parent’s plan is primary, the stepparent’s plan is secondary and the other natural parent’s plan pays third.

If you or your spouse are covered under one employer’s plan as a retired or laid-off employee and under another plan as an active employee, the plan that covers you as an active employee pays first. If none of these rules apply, the plan that has covered the person for the longest period will pay first.

These rules apply to any other group coverage or government program, except Medicaid. Any personal dental care policies you may have are not affected by the COB rules.

Claimant	Primary Plan	Secondary Plan
Spouse #1	Spouse #1	Spouse #2
Spouse #2	Spouse #2	Spouse #1
Child	Parent’s whose birthday is earliest in the calendar year	Other parent’s
<i>* This assumes both plans have this rule. If not, the other plan’s rules determine which plan is primary.</i>		

When Coverage Ends

In most cases, coverage ends on the last day of the month in which your employment ends. You can continue your coverage under COBRA for a limited time.

Your coverage will end on the earliest of the following dates:

- the last day of the month in which your employment ends or you become ineligible for coverage.
- the last day of the last month for which you pay your full premium,
- the last day of the plan year if you elect during Open Enrollment not to continue coverage,
- the last day of the month in which you elect to terminate coverage due to a Qualifying Life Event, or
- the day this plan ends.

Coverage for your dependents ends on the earliest of the following dates:

- the day your coverage ends,
- the last day of the month in which the dependent no longer meets the eligibility requirements,
- the last day of the month for which you pay your full premium for dependent dental coverage,
- the last day of the plan year if you elect during Open Enrollment not to continue dependent dental coverage,
- the last day of the month after you ask that your family coverage be dropped,
- the last day of the month in which you elect to drop dependent coverage due to a Qualifying Life Event, or
- the day the A&M System stops offering dependent coverage.

When Coverage is Extended

In some cases, your coverage can be extended due to changes in you're A&M System employment.

Approved Leave of Absence: If you take a paid leave of absence, including a paid military leave, your coverage can continue, and your premiums will continue to be deducted from your pay.

If you pay part or all of your premiums with the employer contribution, you will continue to receive the contribution while on leave during any month in which you receive some pay from the state.

If your leave is unpaid, including an unpaid military leave, you may make arrangements to pay your premiums. Should you drop coverage while on an unpaid leave of absence, you can elect to reinstate your coverage when you return to work regardless of the plan year. You have 31-days after you return from your leave of absence to change your election.

Family or Medical Leave: If you take an unpaid leave of absence, any employer contribution toward your dental coverage normally will end. However, if you take a family or medical leave under the Family and Medical Leave Act, the employer contribution toward your coverage will continue for up to 12-weeks.

If you do not pay your share, if any, of the premiums for coverage while on a family or medical leave, your dependents' coverage will be dropped and, if the employer contribution does not fully cover premiums for your coverage, your coverage will be dropped. You can elect to reinstate your coverage when you return to work, and you have 31-days after your return to change your election.

Total Disability: If you become disabled while covered by the Dental plan, your coverage will continue, if you continue to pay the premiums, while you are on paid sick leave or vacation. You can also continue coverage by paying the premiums while you are on leave without pay non-FMLA or workers' compensation leave, but you will not

receive any employer contribution.

If you qualify for disability retirement as defined by TRS, regardless of whether you participate in TRS, you may continue benefits for a period of time as described below. These rules are subject to change by the Texas Legislature.

If you were employed in a benefit-eligible position with the A&M System on August 31, 2003:

- and you have at least 10 years of TRS, ORP or ERS service credit and three years of A&M System service, you can keep your A&M System insurance coverages and the employer contribution indefinitely as a disability retiree.
- and you have less than 10 years of TRS, ORP or ERS service credit but three years of A&M System service, you can keep your coverages and employer contribution for the number of months equal to your months of service credit.

The above rules apply if you were on an approved leave on August 31, 2003 and if you were employed in a benefit-eligible position with the A&M System on August 31, 2003, later left employment and then returned to A&M System employment.

If you were not in a benefit-eligible position with the A&M System on August 31, 2003:

- and you have at least 10 years of TRS, ORP or ERS service credit and 10 years of A&M System service, you can keep your A&M System insurance coverages and the employer contribution indefinitely as a disability retiree.
- and you have less than 10 years of TRS, ORP or ERS service credit but at least 10-years of A&M System service, you can keep your coverages and employer contribution for the number of months equal to your months of service credit.

In all cases, a physician's certification of disability may be required periodically, but no more than once a year. Your Vision coverage and employer contribution will end when you are no longer

disabled, unless you return to work or meet the requirements for retiree insurance coverage.

If you don't qualify for disability retirement, you may continue benefits under COBRA for 18 months. You are not eligible for the employer contribution. You may be able to continue COBRA coverage for 11 months beyond the initial COBRA period if you are approved for Social Security disability benefits while on COBRA.

Retirement: You may continue Vision coverage or enroll during any Open Enrollment period if you meet the requirements for retirement outlined in section Retiree Eligibility.

Survivors: If your dependents were covered at the time of your death, your spouse can continue coverage indefinitely and your children can continue coverage until they no longer meet the dependent requirements if:

- you were any age and had at least five years of TRS or ORP creditable service, including at least three years of service with the A&M System, and your last state employment was with the A&M System,
- your age and service combined totals at least 80-years,
- you were any age and had at least 30-years of service, or
- you were a retiree of the A&M System.

Your dependents must pay to continue coverage. If your dependents do not qualify under this provision to continue coverage, they may qualify for COBRA coverage as explained later in this section.

COBRA Coverage Continuation

In some cases, you, your spouse (including a former spouse) and your children have the option to extend coverage beyond the time it would normally end by paying the full cost of coverage. The chart on the next page describes these cases.

COBRA Qualifying Events & Continuation Periods

If...	Then...
<ul style="list-style-type: none"> • Your employment ends for any reason (other than gross misconduct), or • You go on leave without pay, or • Your hours are reduced so that you are no longer eligible 	Coverage for you and/or your covered family members can be extended for up to 18 months.
<ul style="list-style-type: none"> • You die, or • You divorce or legally separate 	Coverage for your covered family members can be extended for up to 36 months.
<ul style="list-style-type: none"> • Your covered child no longer qualifies for coverage 	Coverage for the child can be extended for up to 36 months.
<ul style="list-style-type: none"> • You elect extended coverage due to employment termination, leave without pay or reduction in hours and you or a covered family member qualifies for Social Security disability benefits within 60 days of the date coverage ends 	Coverage for the disabled person and all covered family members can be extended for up to 29 months.

If, in anticipation of a divorce, you drop your spouse’s dental coverage during Open Enrollment or due to a Qualifying Life Event, under certain circumstances your spouse will be offered COBRA continuation coverage from the date of the divorce if you or your ex-spouse notifies your Human Resources office of the divorce. Coverage will not be available for the time between the date you first dropped your spouse’s coverage and the divorce date.

You must notify the A&M System when you or family members experience certain life events that would cause coverage to end. In other cases, you will not have to provide notification. Failure to meet these deadlines will cause you or your dependents to lose your right to continue Dental coverage.

After you notify the A&M System of an event or after an event not requiring notification, the A&M System (through our COBRA administrator P&A Group) will send enrollment forms within 14 days directly to the person eligible for extended coverage. Included with the enrollment forms will be information about rights to extended coverage and the costs of this coverage.

You and/or your dependents then must make your election and pay premiums within the times outlined in the chart, COBRA Timelines. Thereafter, premiums for continuing coverage must be paid by the date specified by P&A Group.

To continue coverage, you and/or your covered family members must pay the full premium plus an additional 2% to cover administrative costs. If you and covered family members elect extended coverage due to your termination of employment or reduction in hours, your covered family members may elect an additional extension period of up to 18 months (for an overall total of 36 months) if during the initial extension period:

- you die, or
- you divorce.

If your child no longer qualifies for coverage (because they reach age 26 or age 18 if managing conservatorship or legal guardianship) during the initial extension period, that child may extend coverage for an additional 18 months for a total extension of 36 months.

To be eligible for the additional extended coverage, your covered family members must notify the A&M System within 31-days of the occurrence of one of these events.

When a person on 18 months of COBRA coverage becomes disabled within the first 60 days of COBRA coverage, that person and other covered family members may extend COBRA coverage for an additional 11 months. To do so, the disabled person or a family member must notify your Human Resources office of the disabled person's eligibility for Social Security disability benefits. This notification must be made within 60 days of the disabled person receiving the determination from the Social Security Administration and before the end of the initial 18-month COBRA period. The cost of coverage will be approximately 50% higher during the final 11 months of COBRA coverage due to a Social Security-eligible disability if the disabled person alone or the disabled person and other family members elect to extend coverage during that period. The cost will remain 2% higher if the disabled person does not extend coverage but family members do.

Coverage stops before the end of the extension period if:

- the required premium is not paid,
- you or a family member becomes covered under another group vision plan, unless that plan has a pre-existing condition provision that limits your benefits, or
- the System no longer offers vision coverage to its employees.

COBRA Billing Administrator

P&A Group
17 Court Street, Suite 500
Buffalo, NY 14202

COBRA Timelines

If...	Then...
<ul style="list-style-type: none"> • You divorce, or • Your child becomes ineligible for coverage 	<p>You and/or your dependents have 31 days after the event to notify Human Resources of the event.</p> <p>P&A Group has 14 days after your notification to send you and/or your dependents a COBRA enrollment form.</p> <p>You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.</p> <p>You and/or your dependents have 45 days after making your election to pay back premiums.</p>
<ul style="list-style-type: none"> • You leave employment, • Your hours are reduced, • You go on leave without pay, or • You die 	<p>P&A Group has 14 days after the event (or notification of your death) to send you and/or your dependents a COBRA enrollment form.</p> <p>You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.</p> <p>You and/or your dependents have 45 days after making your election to pay back premiums.</p>
<p>If you or your dependent becomes eligible for Social Security disability benefits within 60 days of the date your coverage ended, you or your dependent must notify your Human Resources office within 60 days of receiving notice from the Social Security Administration and before the end of the initial 18-month COBRA period. If you and/or your dependents miss any of these deadlines, you and/or your dependents forfeit your rights to continue coverage.</p>	

COBRA Timelines

If...	Then...
<ul style="list-style-type: none"> • You divorce, or • Your child becomes ineligible for coverage 	<p>You and/or your dependents have 31 days after the event to notify Human Resources of the event.</p> <p>P&A Group has 14 days after your notification to send you and/or your dependents a COBRA enrollment form.</p> <p>You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.</p> <p>You and/or your dependents have 45 days after making your election to pay back premiums.</p>
<ul style="list-style-type: none"> • You leave employment, • Your hours are reduced, • You go on leave without pay, or • You die 	<p>P&A Group has 14 days after the event (or notification of your death) to send you and/or your dependents a COBRA enrollment form.</p> <p>You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.</p> <p>You and/or your dependents have 45 days after making your election to pay back premiums.</p>
<p>If you or your dependent becomes eligible for Social Security disability benefits within 60 days of the date your coverage ended, you or your dependent must notify your Human Resources office within 60 days of receiving notice from the Social Security Administration and before the end of the initial 18-month COBRA period. If you and/or your dependents miss any of these deadlines, you and/or your dependents forfeit your rights to continue coverage.</p>	

Administrative and Privacy Information

Plan Name

The official name of this plan is The Texas A&M University System Group Dental Program. This booklet also describes The Texas A&M University System Pre-Tax Premium Plan.

Plan Sponsor

The Texas A&M University System
c/o Director of Benefits Administration
Moore/Connally Building
301 Tarrow St., 5th Floor
College Station, TX 77840
Mail Stop: 1117 TAMU
Phone: (979) 458-6330

Plan Administrator

The plan administrator is Benefits Administration at the Texas A&M University System. Contact at the address shown for the Plan Sponsor.

Type of Plan

The A&M Dental plan is a group plan providing dental benefits. The Pretax Premiums Plan is a flexible benefit plan under section 125 of the IRS tax code.

Claims Administrator

The Texas A&M University System is liable for all benefits under this plan. However, Delta Dental, in accordance with an administrative services contract between Delta Dental and The Texas A&M University System, supervises and administers the payment of claims.

Claims should be sent to:

Delta Dental Insurance Company Claims Department
P.O. Box #1809
Alpharetta, Georgia 30023

The Pre-Tax Premium Plan claims administrator is the Plan Administrator. The A&M Dental and Pre-Tax Premium Plan legal documents govern all plan benefits. You may examine a copy of the documents or obtain a copy for a copying fee by contacting the Plan Sponsor.

Plan Funding

The A&M Dental and Pre-Tax Premium Plan are self-funded primarily through employee contributions. This means the money you put into the plans is the same money that is used to pay benefits.

Plan Year

September 1 - August 31

Employer Identification Number

74-2648747

Group Number

4170-0001

Agent For Service of Legal Process

Plan Administrator

Privacy Information

Benefits Administration at The Texas A&M University System (Benefits Administration) is committed to protecting your personal health information. Benefits Administration's Notice of Privacy Practices explains the circumstances under which this type of information can be disclosed, and it explains the rights you have regarding how the information is used. This document is available online at <https://www.tamus.edu/business/benefits-administration/booklets-brochures/> or from your Human Resources office.

Delta Dental collects certain personal information to administer your health benefits. It typically obtains this information from your application, claims, health care providers, and other forms or sources used in administering your health benefits. Unless you give permission for your personal information to be used and disclosed in a particular circumstance, Delta Dental does not use or disclose your personal information except where permitted or required by law and the A&M System's administrative services contract with Delta Dental. Delta Dental also must maintain administrative, physical, and technical safeguards to protect the confidentiality of your personal information.

If you have questions about the Delta Dental privacy policy, please write to:

Delta Dental Insurance Company Regulatory Department
Attn: Privacy Officer
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Future of the Plan

While The Texas A&M University System intends to continue the plan indefinitely, it may change, suspend or end the plan at any time for any reason.

Delta Dental Customer Service

1 (800) 521-2651

8:00AM – 8:00PM EST Monday –Friday