BlueCross BlueShield of Oklahoma

Your Health Care Benefits Program

Dental Benefits

Current Dental Terminology© American Dental Association

City of Oklahoma City by and through the Oklahoma City Municipal Facilities Authority (OCMFA)

Group #K19574 – Low Plan

K195740003.0122

104709.0919

CERTIFICATE OF COVERAGE

Blue Cross and Blue Shield of Oklahoma
(herein called "BCBSOK" or "Carrier")

Hereby certifies that it has issued a **Group Dental Benefits** Contract (herein called the "Plan"). Subject to the provisions of the Plan, each Employee (Subscriber) to whom a Blue Cross and Blue Shield of Oklahoma Identification Card is issued, together with their eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date, if the Employer makes timely payment of total premium due to the Carrier. Issuance of this Benefit Booklet by BCBSOK does not waive the eligibility and Effective Date provisions stated in the Plan.

President of Blue Cross and Blue Shield of Oklahoma

The Dental Schedule of Coverage enclosed with this Benefit Booklet indicates benefit percentages, Deductibles, maximums, and other benefit and payment issues that apply to the Plan.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

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Dental Schedule of Coverage

BlueCross BlueShield of Oklahoma

The Deductibles, and Coinsurance Amount, and Annual Maximum below are subject to change as permitted by applicable law.

BlueCare Dental℠

Covered Services	Contracting Dentist	Non-Contracting Dentist
Diagnostic Evaluations *(Deductible waived)*	100%	100%
Preventive Services *(Deductible waived)*	100%	100%
Miscellaneous Preventive Services	100%	100%
Restorative Services	80%	60%
General Services	80%	60%
Periodontal Services	50%	30%
Endodontic Services	50%	30%
Oral Surgery Services	50%	30%
Crowns, Inlays/Onlays	50%	30%
Prosthodontic Services	50%	30%
Implants	50%	50%
Orthodontia *(Deductible waived)*	50%	30%
All Participants		
Maximum Lifetime Benefits per individual for Orthodontia	$1,000	
Deductible	$50 individual	$50 individual
	$150 family	
Annual Maximum	$1,000	

All benefits are based upon the Allowable Amount, which is the amount determined by BCBSOK as the maximum amount eligible for payment of benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for covered services provided by a Non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the Non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your dental care expenses for Dentally Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affects your dental care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee.

Benefits available under the Plan are explained in the **COVERED DENTAL SERVICES** section. The benefits available to you are indicated on the Dental Schedule of Coverage in this Benefit Booklet.

You are covered only for those benefit categories of services selected by your Employer and shown on your Dental Schedule of Coverage.

The benefit percentage to be applied to each category of service is shown on your Dental Schedule of Coverage.

Important Contact Information

Resource	Contact Information	Accessible Hours
Dental Customer Service Helpline	**1–800–942–5837**	**Monday – Friday 8:00 a.m. – 6:00 p.m. (hours are subject to change)**
Website	**www.bcbsok.com**	**24 hours a day 7 days a week**

Dental Customer Service Helpline

Dental Customer Service Representatives can:

- Give you information about Contracting Dentists;
- Distribute claim forms;
- Answer your questions on claims;
- Assist you in identifying a Contracting Dentist (but will not recommend specific Dentists);
- Provide information on the features of the Plan.

BCBSOK Website

Visit the BCBSOK website at www.bcbsok.com for information about BCBSOK, access to forms referenced in this Benefit Booklet, and much more.

WHO GETS BENEFITS

Eligibility

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when the person becomes an Eligible Employee or a Dependent under the Plan. The Eligibility Date is:

- The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
- For a new Dependent of an Employee already having coverage under the Plan, the date the Employee acquired the Dependent (date of marriage, birth, Court Order, placement of a foster child, adoption, or suit for adoption).

Any person eligible under this Contract and covered by the Employer's previous dental care Plan on the date prior to the Contract Date, including any person who has continued group coverage under applicable federal or state law is eligible on the Contract Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Eligible Employee.

Dependent Eligibility
If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse;
2. A child under the limiting age shown in the definition of Dependent;
3. A child of any age who is medically certified as *Disabled* and dependent on you;
4. Any other child included as an eligible Dependent under the Contract. A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet.

An Employee must be covered first in order to cover their eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date.

Applying For Coverage

You may apply for coverage for yourself and your eligible Dependents by submitting an *Enrollment Application/Change form* to your Employer or BCBSOK.

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

Effective Dates of Coverage

The Effective Date is the date the coverage for a Participant actually begins.

It is important that your application for coverage under the Plan is received timely by the Carrier. If you apply for coverage and pay any required premium for yourself and your eligible Dependents and if you:

1. Are eligible on the Contract Date and the application is received by the Carrier prior to or within 31 days following such date, your coverage will become effective on the Contract Date;

2. Enroll for coverage for yourself or your Dependents during an Open Enrollment Period, coverage shall become effective on the Contract Anniversary Date, provided your application is received timely by the Carrier.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Late Applications
If you apply for coverage for yourself or for yourself and any Dependents and your application is not received within 31 days from your Eligibility Date, you will not be eligible to apply for coverage until the next Open Enrollment Period unless qualified for a Special Enrollment Period.

Special Enrollment Periods
Special enrollment periods have been designated during which you may apply for or request a change in coverage for yourself and/or your eligible Dependents. You must apply for coverage within 31 days from the date of a triggering event in order to qualify for the changes described in this ***Special Enrollment Period*** subsection, including the following:

1. **Birth, Adoption, or Party to a Suit for Adoption, Placement of a Foster Child or Court-Ordered Dependent Coverage**
   The Effective Date of coverage will be the date of birth, adoption, or party to a suit for adoption or date of placement of a foster child. The Effective Date of coverage for Court-Ordered Dependent coverage will be determined by BCBSOK in accordance with the provisions of the Court Order.
2. **Marriage**
   The Effective Date of coverage will be no later than the first day of the month following your marriage date.

BCBSOK **must** receive notification from you on an *Enrollment Application/Change Form* during the 31-day period after the event. If you wait until after this 31-day period, the coverage will become effective on the Contract Anniversary Date following your Employer's next Open Enrollment Period.

Enrollment Application/Change Form

Use this form to…

- Notify the Plan and BCBSOK of a change to your name;
- Add Dependents (other than a newborn child where notification only is required);
- Drop Dependents;
- Cancel all or a portion of your coverage;
- Notify BCBSOK of all changes in address for yourself and your Dependents.

You may obtain this form from your Employer, by calling the BCBSOK Dental Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSOK website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

Changes in Your Family

You should promptly notify the Carrier, as appropriate, in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage or placement of a foster child, adoption, or a child being involved in a suit for which an adoption of a child is sought, or your Employer receives a Court

Order to provide health or dental coverage for a Participant's child or your spouse, you must submit an *Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in this **WHO GETS BENEFITS** section.

- When you divorce, your child reaches the Dependent child age limit or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions.

Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, premium refunds will not be made for any period before the date of notification. If benefits are paid prior to notification to BCBSOK, refunds will be requested.

Please refer to the **Continuation of Group Coverage - Federal** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSOK will pay for Eligible Dental Expenses you incur under the Plan. The portion of the charges by your Dentist that exceeds the Allowable Amount of BCBSOK will be your responsibility to pay to your Dentist, except when you have used a Contracting Dentist. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan and any applicable Deductibles and Coinsurance Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by BCBSOK.

Course of Treatment

Your Dentist may decide on a planned series of dental procedures which a dental exam shows you need. In cases where there is more than one professionally acceptable covered procedure or Course of Treatment, benefits will be covered for the least costly covered procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the person is responsible for expenses that exceed the amount covered for the least costly service.

Current Dental Terminology (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled "Current Dental Terminology and Procedure Codes (CDT)" is used when classifying dental services.

The Allowable Amount for an Eligible Dental Expense will be based on the most inclusive procedure codes.

Freedom of Choice

Each time you need dental care, you can choose to:	
See a Contracting Dentist	***See a Non-Contracting Dentist***
• Your out-of-pocket cost will generally be the least amount because Contracting Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses; • You are not required to file claim forms; • You are not balance billed for costs exceeding the BCBSOK Allowable Amount for Contracting Dentists.	• Your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSOK to accept the maximum Allowable Amount as payment in full for Eligible Dental Expenses; • You are required to file claim forms; • You may be balanced billed by Non-Contracting Dentists for costs exceeding the BCBSOK Allowable Amount.

In each event as described above, you will be responsible for the following:

- Any applicable Deductibles;
- Coinsurance Amounts;
- Services that are limited or not covered under the Plan.

If your Dentist is not a Contracting Dentist, you may be responsible for filing your claim, as described in the **CLAIM FILING AND APPEALS PROCEDURES** portion of this Benefit Booklet. You may also be responsible for payment in full at the time services are rendered.

To find a Contracting Dentist, you may look up a dental Provider in the Dental Directory, log on to the Blue Cross and Blue Shield of Oklahoma website at www.bcbsok.com and search for a Dentist using Provider

Finder, or call the Dental Customer Service Helpline number located in this Benefit Booklet or on your Identification Card.

How Benefits are Calculated

Your benefits are based on a percentage of the Dentist's Allowable Amount. To determine your benefits, subtract the Deductible (if applicable and not previously satisfied) from your Eligible Dental Expenses, then, multiply the difference by the Coinsurance Amount percentage applicable to the benefit category of services shown on your Dental Schedule of Coverage. The resulting total is the amount of benefits available.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, except when you have used a Contracting Dentist, any Deductible, and your Coinsurance Amount will be your responsibility to pay to your Dentist.

When using a Non-Contracting Dentist, your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSOK to accept the maximum Allowable Amount as payment in full for Eligible Dental Expenses. You may be balanced billed by Non-Contracting Dentists for costs exceeding the BCBSOK Allowable Amount.

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's dental care plan with BCBSOK. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Oklahoma as your Carrier.
- ***Your group number.*** This is the number assigned to identify your Employer's dental care Plan with BCBSOK.
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Dentist when receiving dental care services or supplies. Do not let anyone who is not named in your coverage use your Identification Card to receive benefits.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Carrier will provide a new Identification Card.

Predetermination of Benefits

If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of $300, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with and predetermined by BCBSOK prior to the commencement of treatment.

BCBSOK may request copies of existing radiographic images, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. BCBSOK will review the reports and materials, taking into consideration alternative Courses of Treatment. BCBSOK will notify you and the Dentist of the benefits to be provided under the Plan within 30 days of the date a request is submitted by a Dentist. Predetermination gives you and your Dentist the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

CLAIM FILING AND APPEALS PROCEDURES

Filing of Claims Required

Notice and Properly Filed Claim
BCBSOK will not be liable under this Benefit Booklet unless proper notice is furnished to BCBSOK that covered services have been rendered to you. Upon receipt of written notice, BCBSOK will furnish claim forms to you for submitting a properly filed claim. If the forms are not furnished within 15 days after BCBSOK receives your notice, you can comply with the properly filed claim requirements by forwarding to BCBSOK, within the time period set forth below, written proof covering the occurrence, character and extent of loss for which the claim is made.

Your properly filed claim must be furnished to BCBSOK within 180 days after the end of the benefit period for which the claim is made. Failure to provide a properly filed claim to BCBSOK within the time specified above will not reduce any benefit if you show that the claim was given as soon as reasonably possible.

Who Files Claims

Provider-filed claims
Contracting Dentists have agreed to submit claims directly to BCBSOK for you. When you receive covered services from a Contracting Dentist, simply show your Identification Card, and claims submission will be handled for you. If you must use a Non-Contracting Dentist, you should follow the guidelines below in submitting your claims.

Participant-filed claims
In order to obtain your dental benefits under this Benefit Booklet, it is necessary for a claim to be filed with BCBSOK. Usually all you have to do is show your BCBSOK Identification Card to your Dentist. They will file your claim for you. Remember, however, it is your responsibility to ensure that the necessary claim information has been provided to BCBSOK.

If you use a Non-Contracting Dentist and have to file a claim yourself, you may call customer service at the number on your Identification Card for a claim form. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement. Once you complete the claim form and attach the Attending Dentist's Statement, you may send the claim to:

Blue Cross and Blue Shield of Oklahoma
c/o Dental Network of America, Inc.
P. O. Box 23100
Belleville, Illinois 62223-0100

It is important that all information requested on the claim form be given; otherwise, the claim form may be returned to you for additional information before we can process your claim for benefits.

A separate claim form must be filled out for each Participant, along with that person's expenses. A separate claim form must accompany each group of statements (if filed at different times).

IMPORTANT: Remember to send the itemized statement with all your claims. It gives the following necessary information:

- Full name of patient;
- Dental service(s) performed;
- Date of service(s);
- Who rendered service(s);
- Charge for service(s).

Cancelled checks, cash register receipts, personalized itemizations and statements that show only the balance due are not acceptable.

When you file claims, be sure to keep copies of all bills and receipts for your own personal records.

Remember, we must receive your claims for covered services within 365 days of the date of service for which the claim is made.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

Once BCBSOK receives a properly filed claim from you or your Provider, a benefit determination will be made within 30 days. This period may be extended one time for up to 15 additional days, if BCBSOK determines that additional time is necessary due to defects or improprieties in the claim, including a lack of any required substantiating documentation, beyond our control.

If we determine that additional time is necessary, you will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which BCBSOK expects to make the determination.

Upon receipt of your claim, if BCBSOK determines that additional information is necessary in order for it to be a properly filed claim, we will provide written notice to you, prior to the expiration of the initial 30-day period, of the specific information needed. You will have 45 days from receipt of the notice to provide the additional information. BCBSOK will notify you of its benefit determination within 15 days following receipt of the additional information.

The procedure for appealing an adverse benefit determination is set forth under the **Claim Appeal Procedures** section below.

Benefits for a properly filed claim will not be denied for procedures specifically included in the predetermination estimate unless at least one of the following circumstances applies for each procedure denied:

- Benefit limitations such as annual maximums, benefit period maximums or lifetime maximums not applicable at the time or the predetermination estimate due to utilization after the predetermination estimate was issued;
- The claim clearly fails to support the predetermination estimate as originally authorized; if after the predetermination estimate was issued, new procedures are provided to the patient or a change in the condition of the patient occurs such that the predetermination estimate procedure would no longer be considered Medically Necessary, based on the prevailing standard of care;
- If after the predetermination estimate was issued, new procedures or a change in the condition of the patient occurred, such that the procedure for which the predetermination estimate was submitted would, at the time that it was submitted, have required disapproval based on the terms and conditions for coverage under the Plan which was in effect at the time the predetermination estimate was used; or
- The denial of the dental service contractor was due to one of the following:
    - another payor is responsible for payment,
    - the Dentist has already been paid for the procedures identified on the claim,
    - the claim was submitted fraudulently, or the predetermination estimate was based in whole or material part on erroneous information provided to the Plan by the Dentist, patient, or other person not related to the Plan, or
    - the person receiving the procedure was not eligible to receive the procedure on the date of service and the Plan did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

CLAIM FILING AND APPEALS PROCEDURES

Claim Appeal Procedures

If your claim has been denied in whole or in part, you may have your claim reviewed. BCBSOK will review its decision in accordance with the following procedure.

If your claim has been denied in whole or in part for lack of Medical Necessity, you may appeal BCBSOK's decision.

Within 180 days after you receive notice of a denial or partial denial, you may write to BCBSOK. BCBSOK will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of Oklahoma

P. O. Box 23100

Belleville, Illinois 62223-0100

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing, as it is necessary to protect against disclosure of information about you except to your authorized representative.

While BCBSOK will honor telephone requests for information, such inquiries will not constitute a request for review. You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. BCBSOK will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the claims procedures or the review procedure, you may call a customer service representative at the number shown on your Identification Card.

Or you can write to:

Blue Cross and Blue Shield of Oklahoma

c/o Dental Network of America, Inc.

P. O. Box 23100

Belleville, Illinois 62223-0100

If you have a claim for benefits which is denied, in whole or in part, you may file suit in a state or federal court.

Actions Against BCBSOK

No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of 60 days after Proof of Loss has been filed in accordance with the requirement of the Plan and no such action will be brought at all unless brought within three years from the expiration of the time within which Proof of Loss is required by the Plan.

ELIGIBLE DENTAL EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Dental Expenses

The Plan provides coverage for services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each category of service is shown on the Dental Schedule of Coverage.

For benefits available for Eligible Dental Expenses, please refer to the Dental Schedule of Coverage in this Benefit Booklet. Your benefits are calculated on a Calendar Year basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Dental Schedule of Coverage. The Deductibles are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under "Deductible" on your Dental Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of services, before benefits are available under the Plan.

The following are exceptions to the Deductibles described above.

If you have several covered Dependents, all charges used to apply toward a "per individual" amount will be applied toward the "per family" amount shown on your Dental Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the family Deductible amount.

Maximum Dental Benefits

Annual Maximum Benefit
The total amount of benefits available to any one Participant for all combined categories of services for a Calendar Year shall not exceed the "Annual Maximum Benefit" amount shown on your Dental Schedule of Coverage.

This Annual Maximum Benefit amount includes:

1. All payments made by BCBSOK under the benefit provisions of the Plan except for and Orthodontic Services, when indicated on your Dental Schedule of Coverage; and
2. Any benefits provided to a Participant under a dental care plan held by the Employer with BCBSOK immediately prior to the Participant's Effective Date of coverage under this Plan.

Maximum Lifetime Benefits
The total amount of benefits available to any one Participant under the Plan shall not exceed the "Maximum Lifetime Benefits" amount as shown on your Dental Schedule of Coverage.

This Maximum Lifetime Benefits amount includes all payments made by BCBSOK under the Orthodontic Services provision of the Plan as indicated on your Dental Schedule of Coverage.

Changes in Benefits

Benefits for Eligible Dental Expenses incurred during a Course of Treatment that begins before the change will be those benefits in effect on the day the Course of Treatment was started.

COVERED DENTAL SERVICES

The Plan will provide benefits for the following Eligible Dental Expenses, subject to the limitations and exclusions described in this Benefit Booklet, only if the category of service is shown on your Dental Schedule of Coverage. The benefit percentage applicable to each category of service is also shown on your Dental Schedule of Coverage.

You are covered only for those categories of services shown on the Dental Schedule of Coverage issued with this Benefit Booklet.

Diagnostic Evaluations

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

- Periodic oral evaluations for established patients.
- Problem focused exam, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children under three years of age, including counseling with primary caregiver.

Benefits for periodic, extensive, and detailed oral evaluations are limited to a combined maximum of two exam(s) every Calendar Year. Comprehensive oral evaluations are limited to one every 36 months when performed by the same Dentist.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations when Eligible Dental Expenses are rendered on the same date as any other oral evaluation by the same Dentist.

Preventive Services

Preventive services are performed to prevent dental disease. Eligible Dental Expenses include:

- Prophylaxis – Professional cleaning and polishing of the teeth. Benefits are limited to two cleaning(s) every Calendar Year.
- Scaling in presence of generalized moderate or severe gingival inflammation. Benefits are limited to one per Calendar Year. If this benefit is utilized, only one prophylaxis is allowed in a Calendar Year in combination.
- Topical application of fluoride – Benefits for topical application of fluoride are available for Participants under age 16 and are limited to two applications every Calendar Year.

Combination of prophylaxes and periodontal maintenance treatments are limited to a combination of two every Calendar Year.

Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

- Sealants – Benefits for sealants are limited to one per permanent (first and second) molar per lifetime and are available for Participants under age 15.
- Space Maintainers – Benefits for space maintainers are limited to a lifetime maximum of one appliance per arch for Participants up to age 15.

Basic Restorative Services

Basic restorative services are restorations necessary to repair dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Eligible Dental Expenses include:

- Amalgam restorations – Benefits are limited to one restorative service per tooth every 12 months.
- Resin-based composite restorations – Benefits are limited to one restorative service per tooth every 12 months.

Non-Surgical Periodontal Services

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- Periodontal scaling and root planing – Benefits are limited to once per quadrant every 36 months.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
- Periodontal maintenance procedures – Benefits are limited to two every Calendar Year in combination with oral prophylaxis following active periodontal treatment.

General Services

General services include:

- Palliative treatment (emergency) of dental pain, when treatment is not performed in conjunction with a definitive treatment or service.
- Deep sedation/general anesthesia and intravenous/non–intravenous conscious sedation – By report only and when determined to be Medically Necessary by the Plan for Participants with documented medical or dental conditions. A person's apprehension does not constitute a Medical Necessity.

Endodontic Services

Endodontics is the treatment of dental disease of the tooth pulp and includes:

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.
- Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Pulpal debridement is considered part of endodontic therapy when performed by the same Dentist and not associated with a definitive emergency visit.

Oral Surgery Services

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

- Surgical tooth extractions.
- Alveoloplasty and vestibuloplasty.
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess. Intraoral soft tissue incision and drainage is covered only when provided as the definitive treatment for an abscess. Routine follow–up care is considered part of the procedure.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Contract.

Surgical Periodontal Services

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to no more than one surgical periodontal procedure (periodontal surgery, osseous surgery, gingivectomy or gingivoplasty) per quadrant every 36 months.
- Clinical crown lengthening once per lifetime per tooth.
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 36 months. In addition, osseous surgery performed in conjunction with crown lengthening on the same date of service and in the same area of the mouth, will receive the benefit of crown lengthening in the absence of periodontal disease.
- Osseous grafts – Benefits are limited to one per quadrant every 36 months.
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per quadrant every 36 months.
- Distal or proximal wedge procedure, limited to one per quadrant every 36 months, not in conjunction with osseous surgery.
- Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

Major Restorative Services

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

- Single crown restorations.
- Inlay/onlay restorations.
- Labial veneer restorations not performed for cosmetic reasons.

Benefits for major restorations are limited to one per tooth every 8 years whether placement was provided under this Contract or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

Prosthodontic Services

Prosthodontics involves procedures necessary for providing artificial replacements for missing natural teeth and includes:

- Complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 8 year period, whether placement was provided under this Contract or under any prior dental coverage.
- Denture reline/rebase procedures – Benefits will be limited to one procedure every 36 months.
- Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the prosthetic delivery.
- Fixed bridgework – Benefits will be provided for the initial installation of an eligible bridgework, including inlays/onlays and crowns. Benefits will be limited to one every 8 years whether placement was under this Contract or under any prior dental coverage.
- Prosthetics placed over implants will be covered.

Crowns, Inlays/Onlays

Crowns, Inlays/Onlays include:

- Prefabricated crowns – Benefits for stainless steel and resin–based crowns are limited to one per tooth every 8 years. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to two recementations per Calendar Year. Recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect.
- Adjustments – Benefits will be limited to two time(s) per appliance per Calendar Year.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of a missing or broken tooth or clasp (unless additions are completed on the same date as replacement partials/dentures) - Benefits are limited to a lifetime maximum of once per tooth or clasp.

Orthodontic Services

Orthodontic procedures and treatment include examination, records, tooth guidance repositioning (straightening) and retention of the teeth for Participants covered for orthodontics as shown on your Dental Schedule of Coverage. Covered services include:

- Limited**,** interceptive and comprehensive orthodontic treatment, which all accumulate to the Participant's lifetime maximum.

***Special Provisions Regarding Orthodontic Services*:**

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

Implant Services

Depending on the dental Plan chosen, benefits may be available for covered services incurred for an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth. See your Dental Schedule of Coverage for more information.

DENTAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to all services described in this dental Contract. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, (as defined in the **DEFINITIONS** section) licensed to perform services covered under this dental Contract.

Important Information About Your Dental Benefits

- ***Dental Procedures Which Are Not Medically Necessary***

  Please note that in order to provide you with dental care benefits at a reasonable cost, this Contract provides benefits only for those Eligible Dental Expenses that are determined by the Plan to be Medically Necessary.

  No benefits will be provided for procedures which are not Medically Necessary.

  The fact that a Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

- ***Care By More Than One Dentist***

  If you change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

- ***Alternate Benefits***

  In all cases in which there is more than one covered procedure or Course of Treatment possible to treat a covered dental condition, the benefit will be based upon the least costly covered procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the Participant is responsible for expenses that exceed the amount covered for the least costly service.

  If you and your Dentist decide on:

  - personalized restorations; or
  - personalized complete or partial dentures and overdentures; or
  - to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as determined by the Plan.

- ***Non-Compliance with Prescribed Care***

  Any additional treatment and resulting liability which is caused by the lack of a Participant's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Participant.

Exclusions and Limitations

No benefits will be provided under this Contract for:

1. Services or supplies not specifically listed as an Eligible Dental Expense, or when they are related to a non-covered service.

2. Amounts which are in excess of the Allowable Amount, as determined by the Plan.

3. Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to:

   - bleaching teeth; and
   - grafts to improve aesthetics.

4. Dental services, radiographic images, or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Benefit Booklet or if resulting from an Accidental Injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Benefit Booklet.
5. Dental services which are performed due to an Accidental Injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an Accidental Injury.
6. Services and supplies for any illness or injury suffered after the Participant's Effective Date as a result of war or any act of war, declared or undeclared while on active or reserve duty in the armed forces of any country or international authority.
7. Services or supplies that are not Dentally Necessary or do not meet accepted standards of dental practice.
8. Services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the American Dental Association.
9. Hospital and ancillary charges.
10. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
11. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance Amounts are offered.
12. Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
13. Services or supplies received for behavior management or consultation purposes.
14. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
15. Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
16. Charges for nutritional, tobacco or oral hygiene counseling.
17. Charges for local, state or territorial taxes on dental services or procedures.
18. Charges for the administration of infection control procedures as required by OSHA, local, state or federal mandates.
19. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
20. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or radiographic images.
21. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
22. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
23. Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
24. Chemical treatments or localized delivery of chemotherapeutic agents.
25. Charges for local anesthesia, nitrous oxide analgesia, therapeutic, parenteral drugs, or other drugs or medicaments and/or their application.

26. Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Effective Date under this Contract; except this exclusion will not apply to:
    - Any Participant who has been continuously covered for 24 months under a group dental care contract with BCBSOK or a combination of coverage of BCBSOK and the previous group dental care contract by the Employer, which included prosthetic benefits.
    - A partial or full denture or fixed bridge which includes replacement of a missing tooth which was extracted after your Effective Date.
27. Replacement of an extracted or missing third molar and/or congenitally missing teeth.
28. Any services, treatments or supplies included as Eligible Dental Expenses under other hospital, medical and/or surgical coverage.
29. Case presentations or detailed and extensive treatment planning when billed for separately.
30. Charges for occlusion analysis or occlusal adjustments.
31. Endodontic retreatment provided within 12 months of the initial endodontic therapy by the same Dentist.
32. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparations, fitting of preformed dowel and post, or post removal.
33. Endodontic therapy if you discontinue endodontic treatment.
34. Surgical services related to congenital or developmental malformation.
35. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological) or for bony impactions covered by another benefit plan.
36. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
37. Anatomical crown exposure.
38. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prosthesis); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
39. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
40. Charges for replacement of stolen, lost, or defective dentures, crowns or other appliances.
41. Splinting of teeth including double retainers for removable partial dentures and fixed bridgework.
42. Any procedure, service, or appliance for the purpose of altering or maintenance of vertical dimension of occlusion.
43. Appliances or restoration of teeth due to lost vertical dimension of occlusion, erosion, attrition, abrasion, or abfraction. Benefits are not provided for the appliances or restorations to restore occlusion or incisal edges due to bruxism or harmful habits.
44. Any procedure, service, or appliance provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall be considered cosmetic.
45. Precision or semiprecision attachments.
46. Gold foil restorations.
47. Tests and oral pathology procedures, or for re-evaluations.
48. The replacement of a lost or defective crown.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes.

Allowable Amount means the maximum amount determined by BCBSOK to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Dentists contracting with BCBSOK*** – The Allowable Amount is based on the terms of the Dentist's contract and BCBSOK's methodology in effect on the date of service.
- ***For Dentists not contracting with BCBSOK*** – The Allowable Amount is based on the amount BCBSOK would have paid for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and BCBSOK:

- ***For services performed in Oklahoma*** – The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.
- ***For services performed outside of Oklahoma*** – The Allowable Amount will be established by identifying Dentists with similar experience or skills in order to establish the applicable amount for the procedure, services, or supplies.
- ***For multiple surgical procedures performed in the same operative area*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
- ***When a less expensive professionally acceptable service, supply, or procedure is available*** – The Allowable Amount will be based upon the least expensive services. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

The Allowable Amount for all Eligible Dental Expenses also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

Calendar Year means the period commencing each January 1 and ending on the next succeeding December 31, inclusive.

Coinsurance Amount means the dollar amount (expressed as a percentage) of Eligible Dental Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Contract Anniversary Date means the corresponding date in each year after the Contract Date for as long as the Contract is in force.

Contract Date means the date on which coverage for the Employer's Contract with BCBSOK commences.

Contracting Dentist means a Dentist who has entered into a written agreement with BCBSOK, who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC) and/or who has entered into an agreement with another entity with which HCSC or any of its subsidiaries has contracted.

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

Court Order means a direction issued by a court or a judge requiring a Participant to do or not do something. A Court Order may also include an administrative order.

Deductible means the dollar amount of Eligible Dental Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dentally Necessary or Dental Necessity means those services, supplies, or appliances covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. Not primarily for the convenience of the Participant or the Participant's Dentist; and
4. The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

Dentist means a person, when acting within the scope of their license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

Dependent means your spouse or any *child* who has been determined to be eligible for coverage, if applicable, and who is covered under the Plan.

Child means a natural child, a stepchild, an eligible foster child, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status or any combination of those factors. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States, is also considered a Dependent *child* under the Plan.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the applicable Oklahoma law, if applicable.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligible Dental Expenses means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant has an obligation to pay.

Eligible Employee means an Employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a Large Employer.

The term does not include an Employee who:

1. Works on a part-time, temporary, seasonal, or substitute basis, or
2. Is covered under (a) another Health Benefit Plan, or (b) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974, or

3. Elects not to be covered under the Small Employer's Health Benefit Plan and is covered under (a) the Medicaid program; (b) another federal program, including the TRICARE program or Medicare program; or (c) a benefit plan established in another country.

Employee means an individual employed by a Large Employer.

For purposes of this plan, the term *Employee* may also include those individuals who are no longer an Employee of the Large Employer, but who are Participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the applicable Oklahoma law, if applicable.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or Provider in which they were performed; and
- the Dentist has had the appropriate training and experience to provide the treatment or procedure.

The medical/dental staff of BCBSOK shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Dentist may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSOK still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Identification Card means the card issued to the Employee by the Carrier indicating pertinent information applicable to the Participant's dental coverage.

Large Employer (Employer) means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least 51 Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Calendar year.

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

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

Non-Contracting Dentist means a Dentist who is not a Contracting Dentist as defined herein.

Open Enrollment Period means the 31-day period, selected by the Employer, preceding the next Contract Anniversary Date during which Employees and Dependents may enroll for coverage.

Participant means an Employee or Dependent whose coverage has become effective under this Contract.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Provider means a physician, Dentist or any other person, company, or institution furnishing to a Participant, when acting within their scope of their license, an item of service or supply listed as an Eligible Dental Expenses.

Waiting Period means the number of days of continuous employment required by the Employer that must pass before an individual, who is a potential enrollee under the Plan, is eligible to be covered for benefits.

Agent

The Employer is not the agent of the Carrier.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and BCBSOK.

Assignment and Payment of Benefits

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

Blue Cross and Blue Shield of Oklahoma as an Independent Plan

The Employer, on behalf of itself and its Employees, hereby expresses acknowledges its understanding that the Plan constitutes a contract solely between the Employer and BCBSOK, that BCBSOK is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting BCBSOK to use the Blue Cross and Blue Shield Service Mark in the state of Oklahoma, and that BCBSOK is not contracting as the agent of the Association. The Employer further acknowledges and agrees that it has not entered into the Plan based upon representations by any person other than BCBSOK and that no person, entity, or organization other than BCBSOK shall be held accountable or liable to the Employer for any of BCBSOK's obligations to the Employer created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of BCBSOK other than those obligations created under other provisions of the Plan.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any Dentist, insurance carrier, or other entity to furnish BCBSOK all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Participant/Dentist Relationship

The choice of a Dentist should be made solely by you or your Dependents. BCBSOK does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. BCBSOK is not liable for any act or omission by any Dentist. BCBSOK does not have any responsibility for a Dentist's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the Dentist selected and are available only for treatment acceptable to the Dentist.

Refund Of Benefit Payments

If BCBSOK pays benefits for Eligible Dental Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSOK has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, BCBSOK may deduct any refund due from any future benefit payment.

Reimbursement

When BCBSOK pays benefits under the Contract and it is determined that a negligent third party is liable for the same expenses, BCBSOK has the right to receive reimbursement from the monies payable from the

negligent third party equal to the amount BCBSOK has paid for such expenses. The Participant hereby agrees to reimburse BCBSOK on a first-priority basis from any monies recovered from a negligent third party as a result of a judgment against, settlement with, or otherwise paid by the third party regardless of whether or not the Participant is made whole. The Participant agrees to take action against the third party, furnish all information, and provide assistance to BCBSOK regarding the action taken, and execute and deliver all documents and information necessary for BCBSOK to enforce our rights of reimbursement.

BCBSOK's process to recover by subrogation or reimbursement will be conducted in accordance with Oklahoma law.

Coordination of Benefits

All benefits provided under this Benefit Booklet are subject to this provision.

Definitions
In addition to the **DEFINITIONS** section of this Benefit Booklet, the following definitions apply to this provision.

Other Contract means any arrangement providing dental care benefits or services through:

- Group, group-type, non-group, individual, blanket or franchise insurance coverage;
- Blue Cross Plan, Blue Shield Plan, health maintenance organization, and other prepayment coverage;
- Coverage under labor-management trusteed plans, union welfare plans, Employer organization plans, or Employee benefit organization plans;
- Coverage toward the cost of which any Employer has contributed, or with respect to which any Employer has made payroll deduction;
- Group or individual automobile insurance coverage; and
- Coverage under any tax supported or government program, including Medicare, to the extent permitted by law.

Comprehensive health benefit plans shall not be included in the definition of "Other Contract" herein.

Covered Service means a service or supply furnished by a Dentist or other Provider for which benefits are provided under at least one contract covering the person for whom claim is made or service provided.

Dependent additionally means a person who qualifies as a Dependent under an Other Contract.

Effect on Benefits
If the total benefits for Covered Services to which you would be entitled under the Contract and all Other Contracts exceed the Covered Services you receive in any benefit period, then the benefits we provide for that benefit period will be determined according to this provision.

When we are primary, we will pay benefits for Covered Services without regard to your coverage under any Other Contract.

When we are secondary, the benefits we provide for Covered Services may be reduced because of benefits received from the Other Contracts.

Order of Benefit Determination
When a person who received care is covered as an Employee under one group contract, and as a Dependent under another, then the Employee coverage pays first.

When a Dependent child is covered under two group contracts, the contract covering the child as a Dependent of the parent whose birthday falls earliest in the Calendar Year pays first. (If one contract does not follow the "birthday rule" provision, then the rule followed by that contract is used to determine the order of benefits.)

However, when the Dependent child's parents are separated or divorced, the following rules apply:

- If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
- When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent's coverage pays second before the coverage of the parent who does not have custody.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

When none of the above circumstances applies, the coverage you have had for the longest time pays first, except that a contract which covers you as a laid-off or retired Employee or as a Dependent of such person pays after a contract which covers you as other than a laid-off or retired Employee or Dependent of such person.

When BCBSOK requests information from another carrier to determine the extent or order of your benefits under an Other Contract, and such information is not furnished after a reasonable time, then BCBSOK shall:

- Assume the Other Contract is required to determine its benefits first;
- Assume the benefits of the Other Contract are identical to the benefits of this coverage and pay its benefits accordingly.

Once BCBSOK receives the necessary information to determine your benefits under the Other Contract and to establish the order of the benefit determination under the rules listed above, prior payments under this coverage will be adjusted accordingly (if the above rules require it).

If the other carrier reduces your benefits because of payment you received under this coverage and the above rules do not allow such reduction, then BCBSOK will advance the remainder of its full benefits under this coverage as if your benefits had been determined in absence of an Other Contract. **However, BCBSOK shall be subrogated to all of your rights under the Other Contract.** You must furnish all information reasonably required by BCBSOK in such event, and you must cooperate and assist BCBSOK in recovery of such sums from the other carrier.

If the other carrier later provides benefits to you for which BCBSOK has made payments or advances under this Coordination of Benefits provision, you must hold all such payments in trust for BCBSOK and must pay such amount to BCBSOK upon receipt.

Facility of Payment

If payment is made under any Other Contract which we should have made under this provision, then we have the right to pay whoever paid under the Other Contract the amount we determine is necessary under this provision. Amounts so paid are benefits under the Contract and we are discharged from liability to the extent of such amounts paid for Covered Services.

Right of Recovery

If we pay more for Covered Services than this provision requires, we have the right to recover the excess from anyone to or from whom the payment was made. You agree to do whatever is necessary to secure our right to recover the excess payment.

The Plan will not seek recovery of a claim solely due to a loss of coverage of a patient or ineligibility if, at the time of treatment, the Plan erroneously confirms coverage and eligibility, but had sufficient information available indicating that the patient was no longer covered or was ineligible for coverage.

Termination of Coverage

BCBSOK is not required to give you prior notice of termination of coverage. BCBSOK will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage
Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your portion of the group premium is not received timely by BCBSOK; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Carrier may refuse to renew the coverage of an Eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on you will not terminate upon reaching the limiting age shown in the definition of Dependent if the child continues to be both:

1. *Disabled;* and
2. Dependent upon you for support and maintenance as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Employer to the Carrier within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Carrier may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group
The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Continuation of Group Coverage - Federal

The following "events" **may** provide you or your Dependents an option to continue group coverage:

1. Your death, divorce, retirement, or eligibility for Medicare;
2. The termination of your status as an Employee (except for reason of gross misconduct) or retirement;
3. If you are covered as a retired Employee, the filing of a Title XI bankruptcy proceeding by the group; or
4. Your child's marriage or reaching the "Dependent child age limit".

If such an event occurs, you or your Dependents should immediately contact your Employer to determine your rights.

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within a prescribed time period. You or your Dependents may be required to pay your own premium rates. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Dental Schedule of Coverage). Hence, changes in the group premium rates or benefits will change the premium rates or benefits for any continued coverage.

The continued coverage automatically terminates after a period of time (never to exceed three years) but will be terminated earlier upon the occurrence of certain circumstances. These circumstances include, but are not limited to, nonpayment of premium, entitlement to or coverage under Medicare and coverage under any other group health coverage which does not contain a limitation with respect to a preexisting condition of the Participant (even if such coverage is less valuable than your current health plan). Your Employer will give you more detailed information upon your request.

AMENDMENTS

NOTICES

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

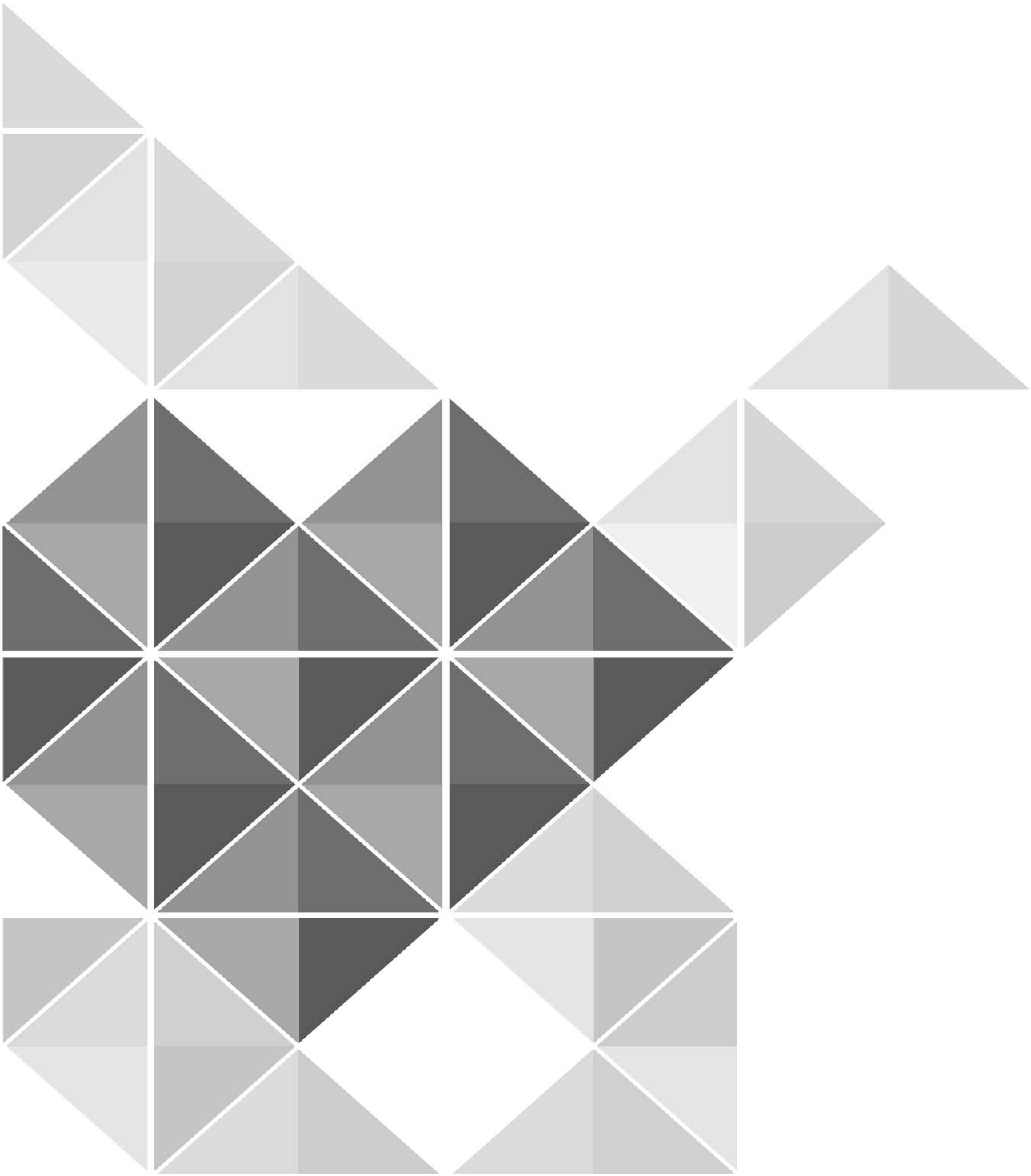
Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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



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