BlueCross BlueShield of Oklahoma

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

BLUECARE DENTAL[SM] INDIVIDUAL DENTAL CONTRACT

YOU, THE MEMBER, HAVE THE RIGHT TO RETURN THIS CONTRACT FOR ANY REASON WITHIN 10 DAYS OF ITS DELIVERY AND HAVE ANY PAID PREMIUMS REFUNDED. If we do not return your premiums within 30 days from the date of cancellation, we must pay you interest on the proceeds. The interest we pay will be the same rate of interest as the average United States Treasury Bill rate of the preceding Calendar Year, as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage points which shall accrue from the date of cancellation until the premiums are returned. In such event, the Contract shall be deemed to have been cancelled on the date the Contract was placed in the United States Mail in a properly addressed, postpaid envelope; or if not so posted, on the date of delivery of such Contract in a properly addressed, postpaid envelope; or if not so posted, on the date of delivery of such Contract to us. **If you return the Contract, we will have no liability for any Benefits for dental care or service which you have received.**

THIS IS YOUR CONTRACT OF DENTAL CARE BENEFITS PROVIDED TO YOU BY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA. PLEASE READ IT NOW, AS IT IS VALUABLE IN ASSISTING YOU TO FULLY UNDERSTAND YOUR BENEFITS.

IN THIS CONTRACT, "WE", "US", AND "OUR" MEAN BLUE CROSS AND BLUE SHIELD OF OKLAHOMA. COVERED PERSONS ARE CALLED "SUBSCRIBERS", "YOU", OR "YOUR".

YOU ARE ELIGIBLE FOR COVERAGE UNDER THIS CONTRACT IF YOU ARE A MEMBER, AS DEFINED. YOUR DEPENDENTS, AS DEFINED, ARE ALSO ELIGIBLE PROVIDED YOU ARE COVERED.

COVERAGE UNDER THIS CONTRACT WILL CONTINUE IN FORCE AT THE OPTION OF YOU, THE MEMBER. HOWEVER, THE PLAN MAY NON-RENEW OR DISCONTINUE COVERAGE FOR YOU AND YOUR DEPENDENTS FOR THE FOLLOWING REASONS:

- YOU ARE NO LONGER ELIGIBLE FOR AN EXCHANGE-CERTIFIED DENTAL PLAN THROUGH THE EXCHANGE (ALSO KNOWN AS "HEALTH INSURANCE MARKETPLACE" OR "MARKETPLACE"), IF APPLICABLE;
- NON-PAYMENT OF PREMIUMS;
- FRAUD;
- TERMINATION BY THE PLAN OF THE PARTICULAR TYPE OF COVERAGE, OR ALL COVERAGE, IN THE INDIVIDUAL MARKET; OR
- RELOCATION OUTSIDE THE GEOGRAPHIC AREA ("NETWORK SERVICE AREA") DESIGNATED BY 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.

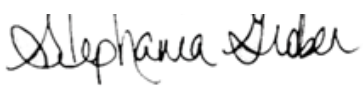
THIS CONTRACT IS NOT CANCELABLE BY YOU OR THE PLAN DURING A COVERAGE PERIOD, EXCEPT FOR NON-PAYMENT OF PREMIUMS, OR FOR FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT MADE IN ANY STATEMENT, APPLICATION, CLAIM OR OTHER FORM SUBMITTED TO OBTAIN THIS CONTRACT OR ANY OF ITS BENEFITS.

THE COVERAGE PERIOD IS THE PERIOD OF TIME COVERED BY YOUR MEMBER BILLING NOTICE, WHICH WAS ESTABLISHED AT THE BEGINNING OF YOUR FIRST COVERAGE PERIOD UNDER THIS CONTRACT.

Please notify the Plan of any change in your address. You should also notify the Plan immediately if you become eligible to enroll for dental coverage through another Contract underwritten by Blue Cross and Blue Shield of Oklahoma or any subsidiaries or affiliates of Health Care Service Corporation.

In corresponding with the Plan, always refer to your identification number and group number which appear on your Identification Card.

The issuance of this Contract to you certifies that the Plan and/or Exchange, (also known as Health Insurance Marketplace, hereinafter referred to as "Exchange") has accepted your application and that you, the Member named on the Identification Card, and your Dependents, if any, listed in your application or any supplemental application, along with any exhibits, appendices, addenda and/or other required information, accepted by the Plan and/or Exchange, as appropriate, are entitled to the Benefits set forth in this Contract.



Stephania Grober

President of Blue Cross and Blue Shield of Oklahoma

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BLUECARE DENTAL℠ 1B
SCHEDULE OF BENEFITS
For Subscribers Age 19 and Over

Your dental Benefits are highlighted below. To fully understand all the terms, conditions, limitations and exclusions which apply to your Benefits, please read your entire Contract.

The Deductibles, Coinsurance, Benefit Period Maximums and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
Diagnostic Evaluations (Deductible waived)	90% of Allowable Charge	70% of Allowable Charge
Preventive Services (Deductible waived)	90% of Allowable Charge	70% of Allowable Charge
Diagnostic Radiographs (Deductible waived)	90% of Allowable Charge	70% of Allowable Charge
Miscellaneous Preventive Services	90% of Allowable Charge	70% of Allowable Charge
Basic Restorative Services	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Extractions	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Periodontal Services	70% of Allowable Charge	50% of Allowable Charge
Adjunctive General Services	70% of Allowable Charge	50% of Allowable Charge
Endodontic Services	50% of Allowable Charge	30% of Allowable Charge
Oral Surgery Services	50% of Allowable Charge	30% of Allowable Charge
Surgical Periodontal Services* **	50% of Allowable Charge	30% of Allowable Charge
Major Restorative Services* **	50% of Allowable Charge	30% of Allowable Charge
Prosthodontic Services* **	50% of Allowable Charge	30% of Allowable Charge
Miscellaneous Restorative and Prosthodontic Services* **	50% of Allowable Charge	30% of Allowable Charge
Orthodontic Services	Not Covered	
Deductible		
Individual	$50	$50
Family	$150	$150
Benefit Period Maximum	$1,000	
Out-of-Pocket Maximum per Benefit Period	None	

* For Out-of-Network Dentist services, the Allowable Charge is the Dentist's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.

*** 12-month waiting period applies.

BLUECARE DENTAL SM 1B SCHEDULE OF BENEFITS
For Subscribers Under Age 19

Your dental Benefits are highlighted below. To fully understand all the terms, conditions, limitations and exclusions which apply to your Benefits, please read your entire Contract.

The Deductibles, Coinsurance, Benefit Period Maximums and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
Diagnostic Evaluations (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
Preventive Services (Periodic Oral Evaluation and Topical Fluoride Application covered at 100%, Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
Diagnostic Radiographs (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
Miscellaneous Preventive Services	80% of Allowable Charge	60% of Allowable Charge
Basic Restorative Services	50% of Allowable Charge	30% of Allowable Charge
Non-Surgical Extractions	50% of Allowable Charge	30% of Allowable Charge
Non-Surgical Periodontal Services	50% of Allowable Charge	30% of Allowable Charge
Adjunctive General Services	50% of Allowable Charge	30% of Allowable Charge
Endodontic Services	50% of Allowable Charge	30% of Allowable Charge
Oral Surgery Services	50% of Allowable Charge	30% of Allowable Charge
Surgical Periodontal Services	50% of Allowable Charge	30% of Allowable Charge
Major Restorative Services	50% of Allowable Charge	30% of Allowable Charge
Prosthodontic Services	50% of Allowable Charge	30% of Allowable Charge
Miscellaneous Restorative and Prosthodontic Services	50% of Allowable Charge	30% of Allowable Charge
Orthodontic Services (Deductible waived) Pediatric Orthodontic Services: Coverage limited to Subscribers under age 19 with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	50% of Allowable Charge	30% of Allowable Charge
Deductible		
Individual	$50	
Family	$150	
Benefit Period Maximum	Unlimited	
Out-of-Pocket Maximum per Benefit Period		

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
1 Child	$400	
2+ Children	$800	

* For Out-of-Network Dentist services, the Allowable Charge is the Dentist's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.

Section I – How Your Dental Coverage Works

This Contract may be purchased through the Exchange (also known as Health Insurance Marketplace, hereinafter referred to as "Exchange") or in the commercial marketplace. If this Contract is not purchased through the Exchange, any references to the Exchange are not applicable.

Please read this section carefully! It explains the role the Blue Cross and Blue Shield of Oklahoma Participating Dental Network plays in your dental coverage.

YOUR PARTICIPATING DENTIST NETWORK

Blue Cross and Blue Shield of Oklahoma Subscribers have access to thousands of Participating Dentists nationwide. Here's how using a Participating Dentist can benefit you:

- A Participating Dentist will file your claims for you.
- Payment for Covered Services you receive will be sent directly to the Participating Dentist.
- You pay only the Deductible and/or Coinsurance amount (if any) that apply to your Covered Services. **If your Participating Dentist charges more than the Allowable Charge for Covered Services, you are not responsible for the difference.**

HOW YOUR DENTAL COVERAGE WORKS

This dental coverage is designed to give Subscribers some control over the cost of their own dental care. Subscribers continue to have complete freedom of choice as to the Dentist they wish to use. However, your coverage offers considerable financial advantages to Subscribers whenever they use a Participating Dentist.

This coverage operates around a group of Dentists who have agreed to charge no more than a reasonable, predetermined fee for their services. When Subscribers use these Participating Dentists, they will have less out-of-pocket expense. **In contrast, when care is received from an Out-of-Network Dentist, your coverage may be subject to a reduction in Benefits. Refer to the *Schedule of Benefits* in the front of this Contract for additional details regarding your coverage.**

SELECTING A DENTIST

To locate a Participating Dentist, please call one of our Customer Service Representatives at the number shown on your Identification Card. You may also look up in-state (Oklahoma) and out-of-state Dentists on the "Provider Directory" section of the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com.

ALLOWABLE CHARGE

To take full advantage of the negotiated pricing arrangements in effect between Blue Cross and Blue Shield of Oklahoma and our network of Participating Dentists, you should use Participating Dentists whenever possible.

Participating Dentists have agreed to hold the line on dental care costs by providing special prices for our Subscribers. A Participating Dentist will accept this negotiated price (called the **"Allowable Charge"**) as payment for Covered Services. This means that, if a Participating Dentist bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference.***

The Plan will calculate your Benefits based on this "Allowable Charge". We will deduct any charges for services which aren't eligible under your coverage, then subtract your Deductible and/or Coinsurance amounts which may be applicable to your ***Covered Dental Services***, as set forth in the ***Schedule of Benefits***. We will then determine your Benefits under this Contract and direct any payment to your Participating Dentist.

If you use an Out-of-Network Dentist, you will be responsible for the following:

- Charges for any services which are not covered under your Contract;
- Any Deductible and/or Coinsurance amounts which are applicable to your coverage; and

- The difference, if any, between your Dentist's "billed charges" and the "Allowable Charge".

Your coverage may include a higher Deductible and/or Coinsurance percentage for services you receive from an Out-of-Network Provider (check the *Schedule of Benefits* issued with this Contract).

BENEFIT PERIOD/POLICY YEAR

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

Your Benefit Period is a Calendar Year, which begins on January 1st and ends on December 31st of the same year. The initial Benefit Period begins on your Effective Date and ends on December 31st, which may be less than 12 months.

Your Policy Year and Benefit Period run concurrently.

BENEFIT PERIOD MAXIMUM

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

Each Subscriber's Benefit Period Maximum amount is given on the ***Schedule of Benefits***.

Orthodontic Services, if covered under this Contract, do not apply to the Benefit Period Maximum.

DEDUCTIBLE REQUIREMENTS

The Deductible amounts for each Subscriber are shown on the ***Schedule of Benefits***. The Deductible is the amount that each Subscriber must pay for Covered Services received during a Benefit Period before this Contract begins paying its percentage of the Allowable Charge for Covered Services. The amount applied to the Deductible for a Covered Service cannot exceed the Allowable Charge for the Covered Service.

COINSURANCE REQUIREMENTS

Your Coinsurance amount is the percentage of the Allowable Charges you are required to pay for a Covered Service after the Deductible, if applicable, has been met.

For each Covered Service, and after the Subscriber has met the Deductible (if applicable), this Contract covers a certain percentage (specified on the Subscriber's ***Schedule of Benefits***) of the Allowable Charge for the Covered Service. When a Covered Service is received from a Participating Provider, the Subscriber pays only the Deductible and/or Coinsurance amount applicable to that service. When a Covered Service is received from an Out-of-Network Provider, the Subscriber also is responsible for the amount charged by the Out-of-Network Provider that exceeds the Allowable Charge for the Covered Service.

AMENDMENTS

The Plan reserves the right to amend the provisions, language and Benefits set forth in this Contract.

Because of changes in federal or state laws, or changes in your dental coverage, provisions called amendments may be added to your Contract.

Be sure to check for an amendment. It amends provisions or Benefits in your Contract.

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLAN

If your Dentist recommends a Course of Treatment, your Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Plan will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated Benefits which will be provided under this Contract within 30 days of the date a request is submitted by a Dentist. This is an estimate of the Benefits available for the proposed services to be rendered. The Plan's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Contract requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, you are responsible

for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by the Plan.

BENEFIT PAYMENT FOR DENTAL SERVICES

The Benefits provided by the Plan and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating Dentist or Out-of-Network Dentist.

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield of Oklahoma to accept the Allowable Charge as payment in full, less any Deductible and/or Coinsurance. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Allowable Charge. Therefore, you will be responsible only for any Coinsurance and/or Deductible amounts applicable to your Covered Services.

Out-of-Network Dentists are Dentists who have not signed an agreement with Blue Cross and Blue Shield of Oklahoma to accept the Allowable Charge as payment in full. Therefore, you are responsible to these Dentists for the difference between the Plan's Benefit and such Dentist's charge to you, in addition to any Coinsurance and/or Deductible amounts applicable to your services.

If you need an estimate of the Allowable Charge for a particular procedure or whether a particular Dentist is a Participating Dentist, contact the Dentist or the Plan at the number listed on your Identification Card.

QUESTIONS

Whenever you call our offices for assistance, please have your Identification Card with you.

You usually will be able to answer your dental care Benefit questions by referring to this Contract. If you need more help, please 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

Section II – Eligibility

This section explains who is eligible for Benefits under this Contract. It tells:

- ***Who*** is eligible for coverage;
- ***How*** to obtain coverage for Dependents*;*
- ***How*** and ***when*** your coverage becomes effective;
- ***When*** your coverage under this Contract ends.

WHO IS AN ELIGIBLE PERSON

Oklahoma Residents who reside or live in the geographic area ("Network Service Area") designated by the Plan, and who meet the eligibility requirements stated in the application as determined by the Plan and/or Exchange, are eligible to apply for coverage under this Contract. A Subscriber may contact the Customer Service Department at the number shown on their Identification Card or access the Web site at www.bcbsok.com to determine if he/she is in the Network Service Area.

The Plan and/or Exchange reserves the right to request proof of residency upon initial enrollment and from time to time thereafter as the Plan and/or Exchange may require.

An individual who is currently enrolled under any other dental coverage underwritten by Blue Cross and Blue Shield of Oklahoma or any subsidiaries or affiliates of Health Care Service Corporation is not eligible for coverage under this Contract.

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- The Member's spouse or Domestic Partner; or
- Your Dependent child. Wherever used in this Contract, "Dependent child" means your natural child, a stepchild, an eligible foster child, an adopted child or a child Placed for Adoption (including a child for whom you or your spouse or your Domestic Partner is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon you or your spouse or your Domestic Partner is also considered a Dependent child under this Contract, provided proof of dependency is provided with the child's application.

A Dependent child who is medically certified as disabled and dependent upon you or your spouse or your Domestic Partner is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

The Plan and/or Exchange reserves the right to request verification of a Dependent child's age or disability status upon initial enrollment and from time to time thereafter as the Plan may require.

The Plan and/or Exchange also reserves the right to review a Physician's certificate of disability and/or request medical records or require a medical examination by an independent Physician to verify disability at the Subscriber's expense. The Plan and/or Exchange will make the final determination regarding the Dependent's disability status.

CHILD-ONLY COVERAGE

An Eligible Person who has not attained age 19 prior to his/her Effective Date may enroll as the sole Subscriber under this Contract. In such event, this Contract is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole Subscriber; the parent or legal guardian is not covered and is not eligible for Benefits under this Contract.
- Eligible Dependents of the Member, who have not attained age 19 prior to his/her Effective Date, may be added to the Member's coverage.
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Plan and/or the Exchange, as appropriate. For any child under the age of 18 covered under this Contract, any obligations set forth in this Contract, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for child-only coverage will not be accepted for an adult child that has attained age 19 prior to his/her Effective Date as of the beginning of the Policy Year. Adult children (at least 18 years of age) who are applying as the sole Subscriber under this Contract must apply for their own individual coverage and must sign or authorize the application(s).

APPLYING FOR COVERAGE

You may apply for dental coverage for yourself and/or your Dependents.

No eligibility rules or variations in premium will be imposed based upon 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. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or Benefits of this Contract 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.

You may enroll in or change dental coverage for yourself and/or your Dependents during one of the following enrollment periods. Your and/or your Dependents' Effective Date will be determined by the Plan and the Exchange, as appropriate, depending upon the date your application is received, payment of the initial premiums no later than the day before the Effective Date of coverage, and other determining factors.

The Plan and the Exchange, as appropriate, may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a Dependent under this Contract.

ANNUAL OPEN ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

You may apply for or change dental coverage for yourself and/or your Dependents during the annual open enrollment period designated by the Exchange and/or the Plan, as appropriate.

When you enroll during the annual open enrollment period, your and/or your Dependents' Effective Date will be the following January 1, unless otherwise designated by the Exchange and/or the Plan, as appropriate.

This section *"Annual Open Enrollment Periods/Effective Date of Coverage"* is subject to change by the Exchange, the Plan and/or applicable law, as appropriate.

SPECIAL ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

Special enrollment periods have been designated during which you may change dental coverage for yourself and/or your Dependents. You must apply for dental coverage within 60 days from the date of a Special Enrollment Event detailed below.

Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your Effective Date will be no later than the 1st day of the following month, or if you apply between the 16th day and the end of the month, your and/or your Dependents' Effective Date will be no later than the 1st day of the second following month.

You must provide acceptable proof of a special enrollment event. *"Special Enrollment Events"* are described in detail below. The Plan will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a special enrollment event will delay or prevent enrollment under this Contract. Please call the Customer Service number shown on your Identification Card for additional information.

Special Enrollment Events:

- You experience a loss of Minimum Essential Coverage. New coverage for you and/or your Dependents will be effective no later than the first day of the month following the loss.
- You gain a Dependent or become a Dependent through marriage. New coverage for you and/or your Dependents will be effective no later than the first day of the following month.
- You gain a Dependent through birth, adoption or Placement for Adoption or court-ordered Dependent coverage. New coverage for you and/or your Dependents will be effective on the date of birth, adoption, or Placement for Adoption.

  If your membership includes at least one Dependent, coverage for a newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, your application to add coverage for the newborn must be received within 31 days following the child's birth; and you must make the required contribution for such coverage from the date of birth.
- Your enrollment or non-enrollment in an Exchange-Certified Dental Plan is unintentional, inadvertent, or erroneous as evaluated and determined by the Exchange and/or the Plan, as appropriate.
- You adequately demonstrate to the Exchange that the Exchange-Certified Dental Plan in which you are enrolled substantially violated a material provision of its Contract in relation to you.
- You are determined newly eligible or newly ineligible for Advance Premium Tax Credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in an Exchange-Certified Dental Plan.
- You gain access to new Exchange-Certified Dental Plans or other individual coverage as a result of a permanent move.

In addition to the "*Special Enrollment Events*" outlined above, if you have purchased this coverage through the Exchange, the following Special Enrollment Events apply:

- You are an Indian, as defined by section 4 of the Indian Health Care Improvement Act. You may enroll yourself or your Dependents in an Exchange-Certified Dental Plan or change from one Exchange-Certified Dental Plan to another one time per month.
- You demonstrate to the Exchange, in accordance with the guidelines issued by Health and Human Services (HHS), that you meet other exceptional circumstances as the Exchange may provide.

Coverage resulting from any of the "*Special Enrollment Events*" outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Exchange and/or the Plan, as appropriate.

This section *"Special Enrollment Periods/Effective Date of Coverage"* is subject to change by the Exchange, the Plan and/or applicable law, as appropriate.

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Member's responsibility to notify the Exchange and/or the Plan, as appropriate, of any change to a Subscriber's name or address. An address change may result in Benefit changes for you and your Dependents if you move out of the Plan's Network Service Area. You may call Customer Service at the number shown on your Identification Card or visit our Web site at www.bcbsok.com.

DELETING A DEPENDENT

You can change your coverage to delete Dependents. The change will be effective at the end of the month and/or billing period during which eligibility ceases.

WHEN COVERAGE UNDER THIS CONTRACT ENDS

When a Subscriber is no longer an Eligible Person or Eligible Dependent, as determined by the Exchange, coverage stops the last day of the month following the month in which a termination notice is sent by the Exchange, except that, when a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will terminate on the date of death.

In the event a Subscriber becomes eligible to enroll under another dental Contract underwritten by Blue Cross and Blue Shield of Oklahoma or any subsidiaries or affiliates of Health Care Service Corporation, the Subscriber may transfer his or her membership to the other coverage in accordance with the applicable underwriting and enrollment guidelines. A Subscriber may not be covered under more than one dental Contract underwritten by Blue Cross and Blue Shield of Oklahoma and/or any subsidiaries or affiliates of Health Care Service Corporation.

If applicable, payment made for coverage beyond the termination date specified above will be refunded to the Member.

A Member's coverage (including coverage for his or her Dependents, if any) shall be terminated retroactive to the Effective Date if the Member commits fraud or intentional misrepresentation of material fact in applying for or obtaining coverage under this Contract. A Subscriber's coverage shall terminate immediately if he or she files a fraudulent claim.

If your premiums are not paid, your coverage will stop at the end of the coverage month and/or billing period for which your premiums have been paid, subject to the *"Grace Period"* set forth under the ***General Provisions*** section.

CONVERSION PRIVILEGES

When an individual ceases to be an eligible Dependent under this Contract, the individual may apply for dental coverage in his or her own name. In order for the coverage to be continuous, application must be received by the Plan within 60 days after the date eligibility under this Contract has ended.

Upon the death of the Member, a surviving Subscriber may apply to the Plan for membership in his or her own name. The application must be submitted to the Plan within 60 days following the death of the Member for continuous coverage.

In the event of a divorce or dissolution of a Domestic Partnership, the spouse or Domestic Partner may apply for membership in his or her own name. To assure continuous coverage, the application must be submitted to the Plan within 60 days of the date the divorce is granted. The spouse or Domestic Partner may purchase dental coverage to include the Dependents.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Contract terminates, Benefits will continue for any dental Covered Services described in this Contract, as long as the Covered Service began prior to the date your coverage terminated and is completed within 30 days of your termination date. **NOTE: If you terminate coverage under this Contract, you will not be eligible to re-enroll for dental coverage until the next annual open enrollment period or during a special enrollment period, if applicable.**

REINSTATEMENT

When coverage lapses for failure to pay premiums for this Contract, the subsequent acceptance of such premium payments by the Plan or its duly authorized agents or the Exchange shall reinstate the Contract. For purposes of this reinstatement provision, mere receipt and/or negotiation of a late premium payment does not constitute acceptance. The reinstated Contract shall cover only loss resulting from accidental injury sustained after the date of reinstatement and loss due to sickness beginning more than 10 days after such date. In all other respects, the Subscriber and the Plan shall have the same rights hereunder as they had under the Contract immediately before the due date of the defaulted premiums, including the right of the Subscriber to apply the period of time this Contract was in effect immediately before the due date of the defaulted premiums toward satisfaction of any waiting periods for Benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

If you are not receiving a Premium Tax Credit under the Affordable Care Act, you and your covered Dependents, if applicable, may apply for reinstatement of coverage by sending in the appropriate premium due no later than 60 days after termination for nonpayment of premium. If more than 60 days have elapsed since coverage was

terminated, you and/or your Dependents may reapply for coverage only during an annual open enrollment period or special enrollment period as previously described in this section.

In the event you are receiving a Premium Tax Credit under the Affordable Care Act, you may be eligible for an extended grace period for paying premiums (refer to the *"Grace Period"* provisions set forth in the ***General Provisions*** section of this Contract). If full payment of your premium is not received within the grace period and coverage is terminated, you and/or your Dependents may reapply for coverage only during an annual open enrollment period or special enrollment period as previously described in this section.

RESCISSION OF COVERAGE

Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact with the intent to deceive the Plan on the Member's application, may result in the cancellation of the Member's coverage (and/or coverage of any Dependents), retroactive to the Effective Date, subject to 30 days' prior notification. A rescission does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates. In the event of a rescission, the Plan may deduct from the premium refund any amounts made in claim payments during this period, and the Member may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which rescission is affected. At any time when the Plan is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Contract, the Plan may at its option make an offer to reform the policy already in force or is otherwise permitted to make retroactive changes to this policy and/or change in the rating category/level. In the event of reformation, the Contract will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

Section III – Covered Dental Services

The Benefits of this section are subject to all the terms and conditions of your Contract. Benefits are available only for services and supplies that are determined by the Plan to be "Medically Necessary", unless otherwise specified. All Covered Services listed in this section are subject to the ***Exclusions and Limitations*** section of this Contract, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your *Schedule of Benefits* to find out what your Deductible, Coinsurance and Benefit Period Maximum will be for a Covered Service. If you do not have a *Schedule of Benefits*, please call a Customer Service Representative at the number shown on your Identification Card.

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Contract, it will mean Dentist or Physician**.**

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 oral evaluations, 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 the age of three, including counseling with primary caregiver.
- Oral Examinations – The initial oral examination and periodic routine oral examinations. However, your Benefits are limited to one comprehensive and one periodic examination every Benefit Period in the dental office.

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

PREVENTIVE SERVICES

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

- Prophylaxis – Professional cleaning, scaling and polishing of the teeth. Benefits are limited to two cleanings every 12 months.
- Topical Fluoride Application – Benefits for Fluoride Application are only available to Subscribers under age 19 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Following active periodontal treatment, the benefit of a combination of two prophylaxes and two periodontal maintenance treatments (see "*Non-Surgical Periodontal Services*") every 12 months.

DIAGNOSTIC RADIOGRAPHS

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films – Benefits are limited to four horizontal films or eight vertical films once every 12 months for adults. Benefits are limited to two sets every 12 months for Subscribers under age 19. However, Benefits are not available for bitewing films taken on the same date as full-mouth films or within 6 months of a complete series of radiographic images.

- Periapical films, as Medically Necessary for diagnosis – Benefits are limited to six films every 12 months for adults. Frequency limitation does not apply to Subscribers under age 19.

MISCELLANEOUS PREVENTIVE SERVICES

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

- Sealants – Benefits for sealants are limited to Subscribers under age 19 and are limited to permanent unrestored molars only.
- Space Maintainers – Benefits for space maintainers are limited to a lifetime maximum of one Appliance per quadrant for posterior primary teeth for Subscribers under age 19.

BASIC RESTORATIVE SERVICES

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Covered Services include:

- Amalgam restorations – Benefits are limited to one restoration per tooth every 12 months for adults. Frequency limitation does not apply to Subscribers under age 19.
- Resin-based composite restorations – Benefits are limited to one restoration per tooth every 12 months for adults. Frequency limitation does not apply to Subscribers under age 19.

Benefits will not be provided for restorations placed within 12 months of the initial placement by the same Dentist.

NON-SURGICAL EXTRACTIONS

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

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

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 one per quadrant every 24 months.
- Scaling in the presence of generalized moderate to severe gingival inflammation full mouth.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
- Periodontal maintenance procedures – Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services include:

- Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Medically Necessary for documented Subscribers with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.
- Therapeutic parenteral drugs—Therapeutic parenteral drugs will be covered for Eligible Persons under age 19.

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 Provider 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.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Contract.

Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

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 one per quadrant every 24 months.
- Clinical crown lengthening once per lifetime.
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.
- Osseous grafts – Benefits are limited to one per site every 36 months. Benefits are not available for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 36 months.
- Distal or proximal wedge procedure.
- Anatomical crown exposures are not covered.

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 and onlay restorations.

- Labial veneer restorations.

Benefits will not be provided for dentures, crowns, inlays, onlays, bridgework, or other Appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

Benefits for major restorations are limited to one per tooth every 60 months for adults, whether placement was provided under this Contract or under any prior dental coverage, even if the original crown was stainless steel. Frequency limitation does not apply to Subscribers under age 19. Crowns placed over implants are covered.

PROSTHODONTIC SERVICES

Prosthodontics involves procedures Medically 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 60-month for adults, whether placement was provided under this Contract or under any prior dental coverage. Frequency limitation does not apply to Subscribers under age 19. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures are limited to one in a 36-month period after the initial 6-month period following initial placement.
- Fixed bridgework – Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months for adults, whether placement was under this Contract or under any prior dental coverage. Frequency limitation does not apply to Subscribers under age 19.
- Maxillofacial prosthetics—Benefits will be provided for maxillofacial prosthetics to Eligible Persons under the age of 19.

Prosthetics placed over implants will be covered.

Note: Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services include:

- Prefabricated crowns – Benefits are provided for stainless steel and resin-based crowns. Benefits are limited to one per tooth every 60 months for adults. Frequency limitation does not apply to Subscribers under age 19. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect is considered part of the restorative procedure.
- Adjustments – Benefits will be limited to three times per Appliance every 12 months.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (unless additions are completed on the same date as replacement partials/dentures) are limited to a lifetime maximum of once per tooth or clasp.

MEDICALLY NECESSARY ORTHODONTIC SERVICES

Benefits for Medically Necessary orthodontic services are limited to Subscribers who meet the Plan's criteria related to a medical condition including but are not limited to:

- Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
- Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services.

- Skeletal anomaly involving maxillary and/or mandibular structures.

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Subscribers under age 19, covered for orthodontics as shown on your ***Schedule of Benefits.*** Coverage is limited to Subscribers under age 19 with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion). Covered Services include:

- Diagnostic orthodontic records and radiographs **limited to once every 60 months per Subscriber.**
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention, **limited to one Appliance every 60 months per Subscriber.**

Special Provisions Regarding Orthodontic Services:

- Orthodontic services are paid over the Course of Treatment. Benefits cease when the Subscriber is no longer covered.
- 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.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- If the Subscriber's coverage is terminated prior to the completion of the orthodontic treatment plan, the Subscriber is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic Appliance by the same Provider who placed the Appliance and/or who is responsible for the ongoing care of the Subscriber 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 other benefits paid prior to this coverage beginning.

Section IV – Exclusions and Limitations

These general ***Exclusions and Limitations*** apply to all services described in this dental Contract. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (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 Covered Services for eligible dental treatment that are determined by the Plan to be Medically Necessary.

No Benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to you is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you, as determined by the Plan.

The fact that a Physician or 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

If more than one Covered Service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment, as determined by the Plan. If you or your Dentist requests or you accept a costlier Covered Service, you are responsible for expenses that exceed the amount covered for the least costly service.

Non-Compliance with Prescribed Care

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

EXCLUSIONS — WHAT IS NOT COVERED

No Benefits will be provided under this Contract for:

1. Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Charge, 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, lack of tooth enamel and grafts to improve aesthetics, except as included in the pediatric orthodontic Benefit as shown in ***Medically Necessary Orthodontic Services***.
4. Dental services or Appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Contract or if resulting from accidental injury.
5. Dental services or Appliances to increase vertical dimension, unless specifically mentioned in this Contract.
6. 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.

7. Services and supplies for any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
8. Services or supplies that do not meet accepted standards of dental practice.
9. Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
10. Hospital and ancillary charges.
11. Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
12. 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.
13. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
14. Services rendered by a Dentist related to you by blood or marriage.
15. 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.
16. Claims for duplicate services performed on the same date for the same Subscriber.
17. Services or supplies received for behavior management or consultation purposes.
18. Any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
    - You agree to:
        a. pursue your rights under the workers' compensation laws;
        b. take no action prejudicing the rights and interests of the Plan; and
        c. cooperate and furnish information and assistance the Plan requires to help enforce its rights.
    - If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
        a. hold the money in trust for the Benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
        b. repay the Plan any money recovered from the employer or insurance carrier.
19. Any services or supplies to the extent payment has been made under Medicare or to the extent governmental units provide benefits or would have provided benefits if you had applied for and claimed those benefits (some state or federal laws may affect how we apply this exclusion).
20. Charges for nutritional or oral hygiene counseling.
21. For tobacco counseling for Subscribers age 19 and over.
22. Charges for local, state, or territorial taxes on dental services or procedures.
23. Charges for the administration of infection control procedures as required by local, state, or federal mandates.
24. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional Appliances.
25. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
26. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers.

27. Charges for personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than professionally accepted, necessary and appropriate treatment except this exclusion will not apply to the Benefits provided for the Covered Services subject to the Alternate Benefit provision.
28. 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.
29. 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 if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Effective Date.
30. Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
31. Case presentations or detailed and extensive treatment planning when billed for separately.
32. Charges for occlusion analysis, diagnostic casts, or occlusal adjustments.
33. Gold foil restorations.
34. Cone beam imaging and cone beam MRI procedures.
35. Sealants for teeth other than permanent molars.
36. Orthodontic care for Dependent children age 19 and over.
37. Localized delivery of antimicrobial agents or chemotherapeutic agents.
38. Comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.
39. Tests and oral pathology procedures, or for re-evaluations.
40. Any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
41. Restorations placed within 12 months of the initial placement by the same Dentist.
42. For chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.
43. Separate Benefits will not be provided for local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application for adults.
44. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
45. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.
46. Endodontic therapy if you discontinue endodontic treatment.
47. Surgical services related to a congenital malformation.
48. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
49. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
50. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); 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.
51. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
52. Bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.

53. The replacement of lost, missing or stolen Appliances and those for replacement of Appliances that have been damaged due to abuse, misuse, or neglect. Benefits will not be provided for dentures, crowns, inlays, onlays, bridgework, or other Appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
54. To restore occlusion on incisal edges due to bruxism or harmful habits.
55. Treatment to replace teeth which were missing prior to the Effective Date.
56. Congenitally missing teeth.
57. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
58. Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

The Plan may, without waiving these "Exclusions", elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the "Exclusions" listed above. If it is later determined that the care and services are excluded from the Subscriber's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Contract (see "Plan's Right of Recoupment" in the ***General Provisions*** section). The Subscriber must provide the Plan with all documents it needs to enforce its rights under this provision.

Section V – General Provisions

This section explains:

- Your responsibilities under this Contract;
- When your premiums for coverage must be paid;
- Deadline for claims filing;
- How Benefits are determined and how payment is made;
- How Benefits are affected when you have coverage through a government program or you are injured by a third party.

ENTIRE CONTRACT; CHANGES

This Contract, with the application and the Identification Card, is the entire Contract between you and the Plan. No change in this Contract will be effective until approved by an authorized Plan officer. This approval must be noted on or attached to this Contract. No agent or representative of the Plan other than a Plan officer may otherwise change this Contract or waive any of its provisions. All statements made by the Subscriber or by an individual Member shall, in the absence of fraud, be deemed representatives and not warranties.

BENEFITS TO WHICH SUBSCRIBERS ARE ENTITLED

The liability of the Plan is limited to the Benefits for Covered Services specified in this Contract.

No person other than a Subscriber is entitled to receive Benefits under this Contract. Such right to Benefits and coverage is not transferable.

Benefits for Covered Services specified in this Contract will be provided only for services and supplies provided by a Dentist, as specified in the ***Definitions*** section of this Contract and regularly included in such Dentist's charges.

PRIOR APPROVAL

The Plan does not give prior approval or guarantee Benefits for any services through its preauthorization process, or in any oral or written communication to Subscribers or other persons or entities requesting such information or approval.

RECORDS OF SUBSCRIBER ELIGIBILITY AND CHANGE IN SUBSCRIBER ELIGIBILITY

The Member must furnish the Plan with any data required by the Plan for coverage of Subscribers under this Contract. In addition, the Member must provide prompt notification to the Plan of the effective date of any changes in a Subscriber's coverage status under this Contract.

All notification by the Member to the Plan must be furnished on forms approved by the Plan. The notification must include all information reasonably required by the Plan to effect changes.

PREMIUMS AND CONTRACT CHANGES

The amount of premium shall be the amount determined by the Plan for the Benefits of this Contract.

The Plan is hereby granted discretionary authority to determine, alter and interpret the provisions, language and Benefits set forth in this Contract or the payment of premiums therefor. The Plan may change premiums upon 31 days' notice to the Member prior to the Policy Year renewal, or as permitted by applicable law.

All premiums for coverage shall be paid to the Plan and/or Exchange and shall be payable on or before each Member's Effective Date. All further premiums shall be due and payable in advance of and no later than the due date for the month and/or billing period as stated in the periodic Member billing notice.

When you renew Blue Cross and Blue Shield of Oklahoma coverage or reenroll by selecting a new product, you will need to be current on your premium payments. Any past due premium payments for coverage we provided will be due at the beginning of the new plan year in addition to the current premium charges. New coverage will not be effective until all such payments are made.

Failure of the Member to submit premiums or other payment required by this Contract to the Plan and/or Exchange on or before the due date described above shall automatically and without notice terminate and cancel coverage for all Subscribers at the end of the month and/or billing period for which premiums are paid, subject to the *"Grace Period"* provisions set forth below. The Plan and/or Exchange shall have no liability for any care and services occurring after the date of such termination and cancellation. The Plan and/or Exchange reserves the right to reinstate coverage for the Member upon such terms and conditions as the Plan and/or Exchange determines to be acceptable.

Coverage under this Contract is renewable at expiration of any coverage period for an additional coverage period at the option of the Plan and/or Exchange by its acceptance of any premiums determined to be due and payable. For purposes of this Contract, the coverage period is that period of time covered by the periodic Member billing notice, as mutually established by the Plan and/or Exchange and the Member.

THIRD PARTY PAYMENTS

Blue Cross and Blue Shield of Oklahoma follows the premium payment process established by the Affordable Care Act in accordance with all Federal requirements. Blue Cross and Blue Shield of Oklahoma only accepts premium and cost sharing payments from:

A. The Member.

B. The Member's family.

C. Blue Cross and Blue Shield of Oklahoma accepts premium payments from the following third-party entities on behalf of enrollees:

   i. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

   ii. An Indian tribe, tribal organization or urban Indian organization; and

   iii. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

D. Blue Cross and Blue Shield of Oklahoma may accept premium payments on behalf of enrollees from private, not-for-profit foundations, if the payments are:

   i. For the entire coverage period of the enrollee's policy;

   ii. Based solely on the financial status of the enrollees;

   iii. Regardless of the coverage the enrollee chooses; and

   iv. Regardless of the enrollee's health status.

E. Blue Cross and Blue Shield of Oklahoma may accept premium payments on behalf of enrollees from a Trust, Power of Attorney or Legal Guardian.

F. Blue Cross and Blue Shield of Oklahoma will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (ERISA) group health plan and either:

   i. The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or

   ii. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA), or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.

G. Blue Cross and Blue Shield of Oklahoma will accept payments on behalf of an enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

Blue Cross and Blue Shield of Oklahoma does not accept premium and cost-sharing payments from any other third party. Unauthorized premium and cost-sharing payments will not be credited to the Member's account and will be refunded to the unauthorized payer. If Blue Cross and Blue Shield of Oklahoma fails to receive payment in full from an authorized source by the end of any premium grace period, Blue Cross and Blue Shield of Oklahoma will retroactively terminate or cancel this coverage in accordance with the termination provision of this Contract.

GRACE PERIOD

A period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the Contract shall continue in force, however, claim payments for Covered Services received during the grace period may be pended until full premium payment is made, and during the grace period your Providers and pharmacies may require you to pay for your health care and Prescription Drug expenses in full. After a grace period of 31 days, coverage under this Contract will automatically terminate on the last day of the month and/or billing period for which premiums have been paid, unless coverage is extended as described below.

If you pay your premium in full during the 31-day grace period, then you may submit a claim to the Plan for any expenses that you paid to your Providers and pharmacies during the grace period. See the ***Claims Filing Procedures*** section for additional information.

If you fail to pay premiums due to the Plan and/or the Exchange within 31 days of the premium due date, this Contract will automatically terminate. Benefits will not be provided for expenses incurred during this 31-day grace period. You will be required to pay the full amount to the health Provider for services received. If you pay your past due premium during the 31 days grace period, you may submit the claims to the Plan. We will process these claims and pay for those services that are covered under the terms this Contract. **If coverage is terminated for non-payment of premium, any claims received and paid for during the 31-day grace period will be billed to you.**

In the event you are receiving an Advance Premium Tax Credit, you have a three-month grace period, or such other grace period, if any, permitted by applicable law or regulatory guidance. If full premium is not paid within one month of the premium due date, claim payments for Covered Services received during the second and third months grace period under this Contract will be pended until full premium payment is made. If full payment of the premium is not made within the three-month grace period, then coverage under this Contract will automatically terminate on the last day of the first month of the three-month grace period.

During the grace period, in the event you are receiving an Advance Premium Tax Credit, the Plan will:

- Pay all appropriate claims for services rendered during the first month of the grace period and may pend claims for services rendered in the second and third months of the grace period;
- Notify the Department of Health and Human Services of such non-payment; and
- Notify Providers of the possibility of denied claims during the second and third months of your grace period.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the Effective Date of coverage for any Subscriber, no misstatements, or omissions, except fraudulent misstatements or omissions, made in the application for coverage shall be used to void this Contract or to deny a claim for loss incurred after the expiration of such two-year period.

No claim for loss incurred after two years from the Effective Date of this Contract shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Subscriber's Effective Date. However, this provision shall not apply to a disease or physical condition for which a fraudulent misstatement or omission was made by the Subscriber in his/her application for coverage.

NOTICE AND PROPERLY FILED CLAIM

The Plan will not be liable under this Contract unless proper notice is furnished to the Plan that Covered Services have been rendered to you. Upon receipt of written notice, the Plan will furnish claim forms to you for submitting a Properly Filed Claim. If the forms are not furnished within 15 days after the Plan receives your notice, you may

comply with the Properly Filed Claim requirements by forwarding to the Plan, 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 the Plan within 180 days after the end of the Benefit Period for which the claim is made.

Failure to provide a Properly Filed Claim to the Plan within the time specified above will not reduce any Benefit if you show that the claim was given as soon as reasonably possible.

RELEASE OF INFORMATION

Each Subscriber agrees that any person or entity having information relating to an illness or injury for which Benefits are claimed under this Contract may furnish it to the Plan (including copies of records). In addition, the Plan may furnish such information to other entities providing similar Benefits at their request.

LIMITATIONS OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after Proof of Loss has been given as specified above, and no such action may be taken later than three years after the expiration of the time within which Proof of Loss is required by this Contract.

PAYMENT OF BENEFITS

The Plan is authorized by the Member to make payments directly to Dentists furnishing Covered Services for which Benefits are provided under this Contract. However, the Plan reserves the right to make the payments directly to the Member.

The right of a Member to receive payment is not assignable nor may the Benefits of this Contract be transferred, either before or after Covered Services are rendered.

Once Covered Services are rendered by a Dentist, the Plan will not honor Subscriber requests not to pay the claims submitted by the Dentist. The Plan will have no liability to any person because of its rejection of the request.

For Covered Services provided to a Subscriber under this Contract, Benefits will be based upon the Allowable Charge for such services, as determined by the Plan. Participating Dentists have agreed to charge Plan Subscribers no more than the Allowable Charge for Covered Services, less any Deductible and/or Coinsurance. However, Subscribers who receive Covered Services from Out-of-Network Dentists may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

Subscribers will be responsible for the difference, if any, between the charges actually made by:

- An Out-of-Network Dentist and the Allowable Charge determined by the Plan for the Covered Services; and
- A Dentist for non-covered services performed in conjunction with Covered Services and the Allowable Charge determined by the Plan for the Covered Services; and
- A Dentist for costlier Covered Services when the Alternative Benefit provision applies and our Allowable Charge for any portion of those services which may be Covered Services.

If the Subscriber receives services from any member of the healing arts who is licensed by any state of the United States or its territories to perform services within the scope of his or her license which, if performed by a Dentist, would be considered eligible for Benefits under this Contract, then Benefits will be provided regardless of which healing art performs the service.

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

The Plan, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of this Contract and to determine its Benefits.

The Plan's medical staff may conduct a medical review of Subscriber claims to determine that the care and services received were Medically Necessary.

The fact that a Dentist, Physician or other Provider prescribes, orders, recommends or approves a service or supply does not, of itself, make it Medically Necessary or a Covered Service, even if it is not specifically listed as an exclusion under this Contract.

To assist the Plan in its review of Subscriber claims, the Plan may request that:

- The Subscriber arrange for medical or dental records to be provided to the Plan; and/or
- The Subscriber submit to a professional evaluation by a Dentist selected by the Plan, at the Plan's expense; and/or
- A Dentist consultant or a panel of Dentists or other Physicians appointed by the Plan review the claim.

Failure of the Subscriber to comply with the Plan's request for medical records or medical evaluation may result in Benefits being partially or wholly denied.

SUBSCRIBER/PROVIDER RELATIONSHIP

The choice of a Dentist is solely the Subscriber's.

Dentists and other Providers are not Employees, agents or other legal representatives of Blue Cross and Blue Shield of Oklahoma.

The Plan does not furnish Covered Services but only provides Benefits for Covered Services received by Subscribers.

The Plan is not liable for any act or omission of any Dentist. The Plan has no responsibility for a Dentist's failure or refusal to render Covered Services to a Subscriber.

The use or nonuse of an adjective such as "Participating" or "Out-of-Network", in modifying the term "Dentist" is not a statement or warranty as to the professional competency or ability of the Dentist.

IDENTIFICATION CARD

The Plan will provide an Identification Card to each Member bearing the Member's name, identification number and group number.

SUBSCRIBER RIGHTS

A Subscriber shall have no rights or privileges except as specifically provided in this Contract.

NOTICE

Any notice required under this Contract must be in writing. Notice given to you will be sent to your address as it appears on our records. Notice given to Blue Cross and Blue Shield of Oklahoma should be addressed as follows:

- **Claims Submission and Customer Service Inquiries:**

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

- **Premium Payments:**

  Blue Cross and Blue Shield of Oklahoma
  c/o Dental Network of America, Inc.
  75 Remittance Drive, Suite 6987
  Chicago, IL 60675-6987

- **Application and Membership Updates:**

  Blue Cross and Blue Shield of Oklahoma
  c/o Dental Network of America, Inc.
  Attention: Data Management

2 Trans Am Plaza Drive, Suite 500
Oakbrook Terrace, IL 60181-4288

You or Blue Cross and Blue Shield of Oklahoma may, by written notice, indicate a new address for giving notice.

COORDINATION OF BENEFITS

All Benefits provided under this Contract are subject to this provision.

Definitions

In addition to the ***Definitions*** of this Contract, 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" additionally 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 Group 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 the Plan 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 the Plan 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 the Plan 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 the Plan 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, the Plan shall be subrogated to all of your rights under the Other Contract.** You must furnish all information reasonably required by the Plan in such event, and you must cooperate and assist the Plan in recovery of such sums from the other carrier.
- If the other carrier later provides benefits to you for which the Plan has made payments or advances under this Coordination of Benefits provision, you must hold all such payments in trust for the Plan and must pay such amount to the Plan 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.

PLAN'S RIGHT OF RECOUPMENT

You agree to reimburse us for Benefits we have paid and for which you were not eligible under the terms of the Contract. This payment is due and payable immediately when you are notified by the Plan. Also, we have the sole right to determine that any overpayments, wrong payments or any excess payments made for you under this Contract are an indebtedness which we may recover. Our acceptance of your premiums or payment of Benefits under this Contract does not waive our rights to enforce these provisions in the future.

Plan's Right of Recoupment for Overpayments

If the Plan pays Benefits for eligible 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 ("Overpayment"), Blue Cross Blue Shield of Oklahoma has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such Benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities or organizations, including, but not limited to, Participating Providers or Out-of-Network Providers.

If no refund is received, the Plan (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

- Any future Benefit payment made to any person or entity under this Contract, whether for the same or a different Subscriber; or
- Any future benefit payment made to any person or entity under a self-funded benefit program administered by the Plan; or

- Any future benefit payment made to any person or entity under another group benefit plan or individual policy insured by the Plan; or
- Any future benefit payment, or other payment, made to any person or entity; or
- Any future payment owed to one or more Participating Providers or Out-of-Network Providers.

Further, Blue Cross Blue Shield of Oklahoma has the right to reduce your Benefit plan's or policy's payment to a Provider by the amount necessary to recover another Blue Cross Blue Shield plan's or policy's overpayment to the same Provider and to remit the recovered amount to the other Blue Cross Blue Shield plan or policy.

Plan's Right of Recoupment for Third Party Proceeds

To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, each Subscriber agrees that the Plan shall have a first lien on any settlement proceeds, and the Subscriber shall reimburse and pay the Plan, on a first-priority basis, from any money recovered by suit, settlement, judgment or otherwise from another party or his/her insurer or from any carrier providing uninsured/underinsured motorist coverage. Each Subscriber shall reimburse the Plan on a first-priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not he or she is made whole or is fully compensated for any injuries. The Plan expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with the Plan's rights herein.

You must hold in trust for us any money (up to the amount of Benefits we have paid) you recover, as described above. You must give us information and assistance and sign necessary documents to help us enforce our rights.

LIMITATION ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

The Plan will not seek recovery of all or a portion of a payment of a claim made to a Subscriber more than twelve (12) months or a Provider more than eighteen (18) months after the payment is made. This paragraph will shall not apply;

• If the payment was made because of fraud committed by the Subscriber or the Provider; or

• If the Subscriber or Provider has otherwise agreed to make a refund to the Plan for overpayment of a claim.

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.

DISCLOSURE AND RELEASE OF INFORMATION

If this coverage is purchased through the Exchange, in no event shall the Plan be considered the agent of the Exchange or be responsible for the Exchange. All information you provide to the Exchange and received by the Plan from the Exchange will be relied upon as accurate and complete. The Subscriber will promptly notify the Exchange and the Plan of any changes to such information.

PLAN/ASSOCIATION RELATIONSHIP

Each Member hereby expressly acknowledges its understanding that this Contract constitutes a Contract solely between the Member and Blue Cross and Blue Shield of Oklahoma. Blue Cross and Blue Shield of Oklahoma is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"). The license from the Association permits Blue Cross and Blue Shield of Oklahoma to use the Blue Cross and Blue Shield Service Marks in the State of Oklahoma. Blue Cross and Blue Shield of Oklahoma is not contracting as the agent of the Association. It is further understood that the Member has not entered into this Contract based upon representations by any person other than Blue Cross and Blue Shield of Oklahoma and that no person, entity, or organization other than Blue Cross and Blue Shield of Oklahoma shall be held accountable or liable to the Member for any of Blue Cross and Blue Shield of Oklahoma's obligations to the Member created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Oklahoma other than those obligations created under other provisions of this Contract.

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), and you are entitled to vote in person, or by proxy, at all meetings of HCSC. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term "Member" as used above refers only to the person to whom this Contract is issued. It does not include any other family members covered under family coverage unless such family member is acting on your behalf.

Section VI – Claims Filing Procedures

PARTICIPATING DENTISTS

Participating Dentists have agreed to submit claims directly to the Plan for you. When you receive Covered Services from a Participating Dentist, simply show your Identification Card, and claims submission will be handled for you. If you must use an Out-of-Network Dentist who is not a member of the Plan's Participating Dentist Network, you may have to file a claim yourself. If so, you should follow the guidelines below in submitting your claims.

REMEMBER: To receive the maximum Benefits under your dental coverage, you must receive treatment from Participating Dentists.

FILING DENTAL CLAIMS

In order to obtain your dental Benefits under your Contract, it is necessary for a claim to be filed with the Plan. Usually all you have to do is show your Blue Cross and Blue Shield of Oklahoma 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 the Plan.

If you use an Out-of-Network 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
P.O. Box 23100
Belleville, IL 62223-0100

Claims must be filed with the Plan within 180 days after the end of the Benefit Period for which the claim is made.

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

Once the Plan 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 the Plan determines that additional time is necessary due to matters beyond our control.

If we determine that additional time is necessary, you and/or your Provider 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 the Plan expects to make the determination.

Upon receipt of your claim, if the Plan determines that additional information is necessary in order for it to be a Properly Filed Claim, we will provide written notice to you and/or your Provider, 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. The Plan will notify you of its Benefit determination within 15 days following receipt of the additional information.

Benefits for a Properly Filed Claim will not be denied for procedures specifically included in the Pretreatment 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 Pretreatment Estimate due to utilization after the Pretreatment Estimate was issued;

- the claim clearly fails to support the Pretreatment Estimate as originally authorized; if after the Pretreatment Estimate was issued, new procedures are provided to the patient or a change in the condition of the patient occurs such that the Pretreatment Estimate procedure would no longer be considered Medically Necessary, based on the prevailing standard of care;
- if after the Pretreatment Estimate was issued, new procedures or a change in the condition of the patient occurred, such that the procedure for which the Pretreatment 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 Pretreatment 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 Pretreatment 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.

DENTAL CLAIM REVIEW PROCEDURES

If your claim has been denied in whole or in part, you may have your claim reviewed. The Plan 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 the Plan's decision.

Within 180 days after you receive notice of a denial or partial denial, you may write to the Plan. The Plan 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, IL 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 the Plan 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. The Plan 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 listed on your Identification Card between 8:00 a.m. and 6:00 p.m., Monday through Friday. Or you can write to:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 23060
Belleville, IL 62223-0060

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.

Section VII – Definitions

This section defines terms that have special meanings in this Contract.

If a word or phrase starts with a capital letter, it has a special meaning. It is defined in this section or where used in the text or it is a title.

ADVANCE PREMIUM TAX CREDIT

The advance payment of a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, 2013, as provided for under applicable law where the advanced payment is used to offset all or a portion of the premium for coverage obtained by that individual through the Exchange.

ALLOWABLE CHARGE

The charge that the Plan will use as the basis for Benefit determination for Covered Services incurred by a Subscriber under this Contract. The Plan will use the following criteria to establish the Allowable Charge for Covered Dental Services:

- **Participating Dentists** – the amount the Dentist has agreed to accept as full payment for Covered Services.
- **Out-of-Network Dentists** – the Dentist's usual charge, not to exceed the Out-of-Network Allowance.

APPLIANCE

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

BENEFIT PERIOD

The period of time during which you receive Covered Services for which the Plan will provide Benefits. The Benefit Period is a period of one year which begins on January 1st of each year. When you first enroll under this dental coverage, your first Benefit Period begins on your Effective Date and ends on December 31st of the same year.

BENEFIT PERIOD MAXIMUM

The maximum dollar amount the Plan will pay for Covered Services for each Subscriber during a Benefit Period, according to the terms of this Contract and the coverage outlined on the Subscriber's ***Schedule of Benefits.*** The amounts applied to the Benefit Period Maximum are Benefit payments made, which are based on the Allowable Charge for all Covered Services for which Benefits were received. The Benefit Period Maximum does not include the Subscriber's Deductible and/or Coinsurance amounts, if any.

BENEFITS

The payment, reimbursement, and indemnification of any kind which you will receive from us under this Contract.

CALENDAR YEAR

The period of 12 months commencing on the first day of January and ending on the last day of the following December.

COINSURANCE

The percentage of Allowable Charges for Covered Services for which the Subscriber is responsible.

CONTRACT

This agreement, including the application and any amendments between you and the Plan.

COURSE OF TREATMENT

Any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERED SERVICE

A service or supply shown in this Contract and given by a Dentist for which we will provide Benefits.

DEDUCTIBLE

A specified amount of Covered Services that you must incur before Benefits are available for Covered Services.

DENTIST

A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

DEPENDENT

A Subscriber other than the Member as shown in the ***Eligibility*** section.

DOMESTIC PARTNER

A companion of the same sex or opposite sex with whom the Member has entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP

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

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

A person entitled to apply to be a Member as specified in the ***Eligibility*** section.

EXCHANGE (also known as "Health Insurance Marketplace")

A governmental agency or non-profit entity that meets the applicable Health Insurance Exchange standards, and other related standards established under the Affordable Care Act ("ACA") and makes Qualified Health Plans (QHPs) and Exchange-Certified Dental Plans available to qualified individuals and qualified employers. Unless otherwise identified, the term Exchange refers to State Exchanges, regional Exchanges, subsidiary Exchanges and a Federally facilitated Exchange on which Blue Cross and Blue Shield of Oklahoma offers this Exchange-Certified Dental Plan.

EXCHANGE-CERTIFIED DENTAL PLAN

A dental plan that has in effect a certification that it meets the applicable standards issued or recognized by each Exchange through which such plan is offered.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product, or dental treatment or procedure is Experimental, Investigational or Unproven if **the Plan determines** that:

- The drug, device, biological product, or dental treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or dental treatment or procedure is furnished; or
- The drug, device, biological product, or dental treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- The prevailing opinion among peer reviewed dental and scientific literature regarding the drug, device, biological product, or dental treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Approval by a governmental or regulatory agency will be taken into consideration by the Plan in assessing Experimental/Investigational/Unproven status of a drug, device, biological product, or medical treatment or procedure but will not be determinative.

IDENTIFICATION CARD

The card issued to the Member by the Plan, bearing the Member's name, identification number and group number.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

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 Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by 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.

MEDICARE

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

MEMBER

An Eligible Person who has enrolled for coverage.

MINIMUM ESSENTIAL COVERAGE

Health insurance coverage that is recognized as coverage that meets substantially all requirements under applicable law pertaining to adequate individual, group, or government health insurance coverage. For additional information on whether particular coverage is recognized as "Minimum Essential Coverage", please call Customer Service at the number shown on the back of your Identification Card or visit www.cms.gov.

NETWORK SERVICE AREA

The geographic area designated by the Plan, that the Subscribers must reside, live, or work in to be eligible to apply for coverage under this Contract. A Subscriber may call the Customer Service Department at the number shown on the Identification Card to determine if he or she is in the Network Service Area or visit the Website at www.bcbsok.com.

OKLAHOMA RESIDENT

A person domiciled in the state of Oklahoma. "Domicile" is the place established as your true, fixed and permanent home. It is the place you intend to return to whenever you are away (as on vacation abroad, business assignment, education leave or military assignment). A domicile, once established, remains until a new one is adopted.

OUT-OF-NETWORK ALLOWANCE

The amount determined by the Plan as the maximum Provider charge eligible for Benefits. The Subscriber will be responsible for the full amount by which the actual charges of an Out-of-Network Provider exceed the Out-of-Network Allowance.

OUT-OF-NETWORK DENTIST

A Dentist or Provider who has not entered into an agreement to be a Participating Dentist.

PARTICIPATING DENTIST

A Dentist who has entered into an agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's allowance as payment. Participating Dentists include the following:

- A Dentist who has entered into a Participating Provider Agreement with the Plan;
- A Dentist who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC);
- A Dentist who is a member of any other network with which Health Care Service Corporation or any of its subsidiaries has contracted.

PHYSICIAN

A person who is a professional practitioner of a Healing Art defined and recognized by law, and who holds a Physician license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or surgery or other procedures and provide services within the scope of such license.

PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)

The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person terminates upon the termination of such legal obligation.

PLAN

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

POLICY YEAR

The 12-month period beginning January 1 each year.

PRETREATMENT ESTIMATE

A Pretreatment Estimate identifies the Plan's estimated financial liability before treatment is started. This estimate may include some or all of the following information: patient's eligibility, Covered Services, Benefit amounts payable, Deductible amounts, Coinsurance and/or maximum Benefit limitations. Such estimates are subject to change, according to the terms of the Subscriber's coverage, as set forth in *"Benefit Determination for Properly Filed Claims"*, and may include an allowance for alternate Benefits. Final determination of Benefits is made upon submission of a claim to the Plan for actual payment determination, if any.

PROPERLY FILED CLAIM

A formal statement or claim regarding a loss which provides sufficient information to allow the Plan to determine its liability for Covered Services. This includes: a completed claim form; the Provider's itemized statement of services rendered and related charges; and medical records, when requested by the Plan.

PROVIDER

A hospital, Dentist, Physician, or other practitioner or Provider of medical or dental services or supplies licensed to render Covered Services and performing within the scope of such license.

SUBSCRIBER

The Member and each of his or her Dependents (if any) covered under this Contract.

Health care coverage is important for everyone.

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

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

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

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

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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

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

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

BlueCross BlueShield of Oklahoma

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

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