BlueCross BlueShield of Oklahoma

Your BlueCare Dental℠ Program

Certificate of Benefits

BLUECARE DENTAL[SM] DOKLR07
SCHEDULE OF BENEFITS

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 Certificate.

The Deductibles, Coinsurance and/or Benefit Period Maximums 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	90% of Allowable Charge
Preventive Services (Deductible waived)	90% of Allowable Charge	90% of Allowable Charge
Diagnostic Radiographs (Deductible waived)	90% of Allowable Charge	90% of Allowable Charge
Miscellaneous Preventive Services	70% of Allowable Charge	70% of Allowable Charge
Basic Restorative Services	70% of Allowable Charge	70% of Allowable Charge
Non-Surgical Extractions	70% of Allowable Charge	70% of Allowable Charge
Non-Surgical Periodontal Services	70% of Allowable Charge	70% of Allowable Charge
Adjunctive General Services	70% of Allowable Charge	70% of Allowable Charge
Endodontic Services	50% of Allowable Charge	50% of Allowable Charge
Oral Surgery Services	50% of Allowable Charge	50% of Allowable Charge
Surgical Periodontal Services	50% of Allowable Charge	50% of Allowable Charge
Major Restorative Services	50% of Allowable Charge	50% of Allowable Charge
Prosthodontic Services	50% of Allowable Charge	50% of Allowable Charge
Miscellaneous Restorative and Prosthodontic Services	50% of Allowable Charge	50% of Allowable Charge
Implant Services	Not Covered	
Orthodontic Services	Not Covered	

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
Deductible		
Individual	$75	
Family	$225	
Benefit Period Maximum	$1,000	

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

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Certificate

This Certificate is issued according to the terms of your Group Dental Plan.

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

Your Group has contracted with **Blue Cross and Blue Shield of Oklahoma** (called the Plan, we, us, or our) to provide the Benefits described in this Certificate. Blue Cross and Blue Shield of Oklahoma, having issued a Group Contract to the Group, certifies that all persons who have:

- applied for coverage through the Plan;
- paid for the coverage;
- satisfied the conditions specified in the ***Eligibility*** section; and
- been approved by the Plan;

are covered by this Certificate. Covered persons are called Subscribers (or you, your).

Beginning on your Effective Date, we agree to provide you the Benefits described in this Certificate.

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

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.

How Your Dental Coverage Works

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 Certificate 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 Certificate 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 this Certificate;
- 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" for the Covered Services.

BENEFIT PERIOD

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

Your Benefit Period is a 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.

BENEFIT PERIOD MAXIMUM

The Benefit Period Maximum is the maximum dollar amount the Plan will pay for Covered Services for each Subscriber during a Benefit Period, according to the terms of this Certificate 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 Certificate, 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 dental coverage 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 dental Certificate 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 is also responsible for the amount charged by the Out-of-Network Provider that exceeds the Allowable Charge for the Covered Service.

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 Certificate 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 Certificate

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.

AMENDMENTS

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

Because of changes in federal or state laws, or changes in your dental coverage or the special needs of your Group, provisions called amendments may be added to your Certificate.

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

IDENTIFICATION CARD

You will get an Identification Card to show the Dentist when you need to use your coverage.

Your Identification Card shows the coverage through which you are enrolled and includes your own personal identification number. All of your covered Dependents share your identification number. Duplicate cards can be obtained for each Subscriber of your family.

Carry your card at all times. If you lose your card, you can still use your coverage. You can replace your card faster, however, if you know your identification number. The ***Certificate*** page has a space to record it.

Legal requirements govern the use of your card. You cannot let anyone who is not enrolled in your coverage use your card or receive your Benefits.

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 Certificate. 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

Eligibility

This section tells:

- How and when you become eligible for coverage;
- Who is considered an Eligible Dependent;
- How and when your coverage becomes effective;
- How to add Dependents to your coverage; and
- How and when your coverage stops.

WHO IS AN ELIGIBLE PERSON

Unless otherwise specified in the Group Contract, the Benefits described in this Certificate will be provided to persons who:

- Meet the definition of an Eligible Person as specified by the Group Contract;
- Have applied for this coverage and received an eligibility determination from the Group and/or the Plan; and
- Have received a Blue Cross and Blue Shield of Oklahoma Identification Card.

The date you become eligible is the date you satisfy the eligibility provisions specified by your Group and/or the Plan. **Check with your Group Administrator for specific eligibility requirements which apply to your coverage.**

WHO IS AN ELIGIBLE DEPENDENT

Unless otherwise specified in the Group Contract, an Eligible Dependent is defined as:

- your spouse or Domestic Partner. NOTE: Domestic Partner coverage is available at your Group's discretion. Contact your Group Administrator for information on whether Domestic Partner coverage is available for your Group.
- your Dependent child. Wherever used in this Certificate, "Dependent child" means your natural child, a stepchild, an eligible foster child, an adopted child or child Placed for Adoption (including a child for whom you or your spouse or your Domestic Partner (provided your Group covers Domestic Partners) 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 the Member or his/her spouse or Domestic Partner is also considered a Dependent child under this Certificate, provided proof of dependency is provided to the Plan.

  A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse or 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 reserves the right to request verification of a Dependent child's age, dependency, and/or disability status upon initial enrollment and from time to time thereafter as the Plan may require.

If two Eligible Persons are married to each other, or in a Domestic Partnership (provided the Group covers Domestic Partners), one may enroll as a Member and the other as a Dependent, or both may enroll as Members. Their child or children may be covered as Dependents under either person's coverage, but not under both.

APPLYING FOR COVERAGE

You may apply for dental coverage through the Group for yourself and/or your Dependents. Your and/or your Dependents' Effective Date will be determined by the Plan according to the provisions of the Contract in effect for your Group, and depending upon the date your application is received, payment of the initial premiums no later than the day before the Effective Date, and other determining factors.

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 Certificate 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.

The Plan 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 Certificate.

HOW TO ADD DEPENDENTS

You can apply to add Dependents to your coverage if we receive your "Request for Change in Membership" form within 31 days after you acquire an Eligible Dependent. The Effective Date for the Eligible Dependent will be the date the Dependent was acquired.

If your coverage already includes Dependent children, no application will be required to add a newborn child. However, you must notify the Plan of the child's birth. The Effective Date for the newborn will be the child's birth date.

An adopted child or a child Placed for Adoption may be added to your coverage, provided your "Request for Change in Membership" form is received by the Plan within 31 days of the date the child is placed in your custody. The Effective Date for the child will be the date you assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. A copy of the court order or adoption papers must be submitted to the Plan with the change form.

SPECIAL ENROLLMENT PERIOD

Individuals who previously declined enrollment under this dental program may apply for coverage within 31 days following the addition of a new Dependent, or within 31 days following the loss of other coverage. Determination of an individual's eligibility for coverage will be made by the Plan in accordance with the special enrollment guidelines applicable to group health plans, as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OPEN ENROLLMENT PERIOD

If you do not apply for coverage for yourself or for your Eligible Dependent(s) when first eligible to do so, or during a special enrollment period, then you may submit an application to the Plan during the Group's next open enrollment period. An open enrollment period will be held each year during the 31-day period immediately before the Group's Contract Date Anniversary (renewal date), or during another period agreed to between the Group and the Plan. Check with your Group Administrator for specific dates. If the application is accepted, the Effective Date will coincide with the Group's Contract Date Anniversary.

QUALIFIED COURT ORDERS FOR DENTAL COVERAGE FOR DEPENDENT CHILDREN

The Plan will honor certain qualified medical child support orders (QMCSO). To be qualified, a court of competent jurisdiction must enter an order for child support requiring dental coverage on behalf of your children.

An order or notice issued through a state administrative process that has the force of law may also provide for such coverage and be a QMCSO.

The order must include specific information such as:

- your name and address;
- the name and address of any child covered by the order;
- a reasonable description of the type of coverage to be provided to the child or the manner by which the coverage is to be determined;
- the period to which the order applies; and
- each dental plan to which the order applies.

To be a qualified order, the order cannot require the Plan to provide any type or form of Benefits or any option not otherwise provided by the dental plan, except as otherwise required by law. You will be responsible for paying all applicable premium contributions, and any Deductible, Copayment and/or Coinsurance or other cost sharing provisions which apply to your and your Dependent's coverage.

The Plan has to follow certain procedures with respect to qualified medical child support orders. If such an order is issued concerning your child, you should contact a Customer Service Representative at the number shown on your Identification Card.

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.

COBRA CONTINUATION COVERAGE

THIS PROVISION MAY NOT APPLY TO YOUR GROUP'S COVERAGE. PLEASE CHECK WITH YOUR GROUP ADMINISTRATOR TO DETERMINE IF YOUR GROUP IS SUBJECT TO COBRA* REGULATIONS.

- **Eligibility for Continuation Coverage**

  When a Qualifying Event occurs, eligibility under this Certificate may continue for you and/or your Eligible Dependents (including your widow/widower, your divorced or legally separated spouse, and your children) who were covered on the date of the Qualifying Event. A child who is born to you, or Placed for Adoption with you, during the period of COBRA Continuation Coverage is also eligible to elect COBRA Continuation Coverage.

  You or your Eligible Dependent is responsible for notifying the Employer within 60 days of the occurrence of any of the following events:

  – your divorce or legal separation; or
  – your Dependent child ceasing to be an Eligible Dependent under the Plan; or
  – the birth, adoption or Placement of Adoption of a child while you are covered under COBRA Continuation Coverage.

  For the purposes of this Certificate, Domestic Partners are not qualified beneficiaries for COBRA Continuation Coverage.

* *Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.*

- **Election of Continuation Coverage**

  You or your Eligible Dependent must elect COBRA Continuation Coverage within 60 days after the later to occur of:

  – the date of the Qualifying Event would cause you or your Dependent to lose coverage; or

  – the date your Employer notifies you, or your Eligible Dependent, of your COBRA Continuation Coverage rights.

- **COBRA Continuation Coverage Period**

  You or your Eligible Dependents are eligible for coverage to continue under your Group's coverage for a period not to exceed:

  – 18 months from the date of a loss in coverage resulting from a Qualifying Event involving your termination of employment or reduction in working hours; or

  – 36 months from the date of a loss in coverage resulting from a Qualifying Event involving:

    o your death, divorce or legal separation, or your loss of coverage due to becoming entitled to Medicare; or

    o the ineligibility of a Dependent child;

    provided the premiums are paid for the coverage as required.

- **Disability Extension**

  – COBRA Continuation Coverage may be extended from 18 months to 29 months for you or an Eligible Dependent who is determined by the Social Security Administration to have been disabled on the date of a Qualifying Event, or within the first 60 days of COBRA Continuation Coverage. This 11-month disability extension is also available to nondisabled family members who are entitled to COBRA Continuation Coverage.

  – To request the 11-month disability extension, you or your Dependent must give notice of the disability determination to the Employer before the end of the initial 18-month COBRA Continuation Coverage period, and no later than 60 days after the date of the Social Security Administration's determination. In addition, you or your Dependent must notify the Employer within 30 days after the Social Security Administration makes a determination that you or your Dependent is no longer disabled.

- **Multiple Qualifying Events**

  In the event an Eligible Dependent experiences a second Qualifying Event after onset of COBRA Continuation Coverage resulting from your termination or reduction in work hours, the maximum period of coverage is 36 months from the date of a loss in coverage resulting from the first Qualifying Event. This extension is available to the Eligible Dependent only.

- **Special TAA/ATAA Election Period**

  An Employee who loses his/her job due to a trade-related reason may be entitled to a second 60-day COBRA election period if the Employee did not elect COBRA Continuation Coverage when initially eligible to do so. In order to qualify for this election period, the U.S. Department of Labor (or a state labor agency) must issue a certification showing that the job loss was due to trade-related reasons and that the Employee is entitled to "trade adjustment assistance" (TAA) or "alternate trade adjustment assistance" (ATAA). The special 60-day election period begins on the first day of the month in which the Employee becomes eligible for trade adjustment assistance, as determined by the Department of Labor or state labor agency. The Employee is not eligible for the special election period if the TAA/ATAA eligibility determination is made more than six months after termination of employment.

WHEN COVERAGE UNDER THIS CERTIFICATE ENDS

When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the month and/or billing period during which eligibility ceases, except in the following cases:

- When a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will cease on the date of death.
- A Subscriber's COBRA Continuation Coverage, when applicable, will cease on the earliest to occur of the following dates:
  - the date the billing period ends following expiration of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period, whichever is applicable;
  - the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Subscriber is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);
  - the date on which the Group stops providing any Group Dental Plan to any Employee;
  - the date on which coverage stops because of a Subscriber's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;
  - the date on which the Subscriber first becomes (after the date of the election) covered under any other Group Dental Plan; or
  - the date on which the Subscriber becomes (after the date of election) entitled to benefits under Medicare.

Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or intentional misrepresentation of material fact in applying for or obtaining coverage under this Certificate. Your coverage will end immediately if you file a fraudulent claim.

If your premiums are not paid, your coverage will stop at the end of the month and/or billing period for which your premiums have been paid.

Termination of the Group Contract automatically ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of such termination.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

After the date you stop being a Subscriber, we will not pay for any procedures or services which you receive after your coverage ends.

Covered Dental Services

This section describes the services and supplies covered by this Certificate. Benefits are available only for services and supplies that are determined by the Plan to be "Medically Necessary". All Covered Services listed in this section are subject to the ***Exclusions & Limitations*** section of this Certificate, 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 Certificate, 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, including counseling with primary caregiver.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months.

Benefits will not be provided for 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.

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. Additional Benefits will not be provided for prophylaxis based on degree of difficulty.
- 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.

Combination of prophylaxes and periodontal maintenance treatments (see "*Non-Surgical Periodontal Services*") are limited to two 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. However, Benefits are not available for bitewing films taken on the same date as full-mouth films.
- Periapical films, as Medically Necessary for diagnosis – Benefits are limited to six films every 12 months

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

MISCELLANEOUS PREVENTIVE SERVICES

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

- Sealants – Benefits for sealants are limited to one per permanent molar per lifetime and are available to Subscribers under age 16.
- Space Maintainers – Benefits for space maintainers are limited to a lifetime maximum of one appliance per missing tooth site for Subscribers under age 19.

Benefits are not available for nutritional, tobacco or oral hygiene counseling.

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

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 the following services:

- Periodontal scaling and root planing – Benefits are limited to one per quadrant every 24 months.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once every 12 months.
- 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.

Benefits will not be provided 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.

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.

Separate Benefits will not be provided for local anesthesia, nitrous oxide analgesia, therapeutic parenteral drugs, or other drugs or medicaments and/or their application.

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.

Benefits will not be provided for the following *"Endodontic Services"*:

- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants or intentional reimplantations, canal preparation, fitting of preformed dowel and post or post removal.
- Endodontic therapy if you discontinue endodontic treatment.

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 Certificate.

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.

Benefits will not be provided for the following Oral Surgery procedures:

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- 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.

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 the following services.

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one per quadrant every 24 months.
- Clinical crown lengthening.
- 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 24 months.
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 24 months.
- Distal or proximal wedge procedure.
- Anatomical crown exposures – Benefits are limited to one per quadrant every 24 months.

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.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

MAJOR RESTORATIVE SERVICES

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

- Single crown restorations.
- Gold foil and inlay/onlay restorations.
- Labial veneer restorations.

Benefits will be provided for the replacement of a lost or defective crown. However, Benefits will not be provided for the restoration of occlusion or incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Certificate or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

PROSTHODONTIC SERVICES

Prosthodontics involves procedures 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 period whether placement was provided under this Certificate or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures – Benefits will be limited to one procedure every 36 months.
- 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 whether placement was under this Certificate or under any prior dental coverage.

Prosthetics placed over implants will be covered.

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

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Effective Date, except those teeth missing due to congenital malformation.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

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. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to two recementations every 12 months. However, any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect.
- Adjustments – Benefits will be limited to 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.

IMPLANT SERVICES

Implant procedures and treatment include services for Subscribers as shown on your ***Schedule of Benefits,*** if your Group chose this optional implant service. Covered Services include an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth.

ORTHODONTIC SERVICES

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

Covered Services include:

- Diagnostic orthodontic records and radiographs **limited to a lifetime maximum of once per Subscriber.**
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention, **limited to a lifetime maximum of one appliance per Subscriber.**

Special Provisions Regarding Orthodontic Services:

- Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic Benefit, if applicable. Benefits cease when the Subscriber is no longer covered, whether or not the entire Benefit has been paid out, if applicable.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the maximum for orthodontic services, if applicable.
- 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.

Exclusions & Limitations

These general ***Exclusions & Limitations*** apply to all services described in this dental Certificate. 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 Certificate.

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 Certificate 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**

  In all cases in which there is more than one Course of Treatment possible, the Benefit will be based upon the most efficient Course of Treatment, as determined by the Plan.

  If you and your Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the standard procedures for dental services, as determined by the Plan.

- **Non-Compliance with Prescribed Care**

  Any additional treatment and resulting liability which is caused by the lack of a 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 Certificate for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Charge, as determined by the Plan.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.

- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Certificate or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Certificate.
- 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.
- 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.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants, unless your ***Schedule of Benefits*** shows that the dental plan chosen provides coverage for Implant Services.
- 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.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- 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.
- Services or supplies received for behavior management or consultation purposes.
- 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:
    - pursue your rights under the workers' compensation laws;
    - take no action prejudicing the rights and interests of the Plan; and
    - 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:
    - 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
    - repay the Plan any money recovered from the employer or insurance carrier.
- 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).
- Charges for nutritional, tobacco or oral hygiene counseling.

- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Orthodontic services and supplies, if your Group did not purchase the optional Orthodontic Services Benefit.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
- 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.
- 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 Certificate; 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.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis or occlusal adjustments.

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 Certificate (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.

General Provisions

This section explains:

- The Benefits to which you are entitled;
- How to get Benefits;
- Your relationship with Dentists;
- Your relationship with us;
- Coordination of Benefits when you have other coverage.

BENEFITS TO WHICH SUBSCRIBERS ARE ENTITLED

We provide only the Benefits specified in this Certificate.

Only Subscribers are entitled to Benefits from us and they may not transfer their rights to Benefits to anyone else.

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

NOTICE AND PROPERLY FILED CLAIM

The Plan will not be liable under this Certificate 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 can 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.

LIMITATIONS OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after a Properly Filed Claim has been made. No such action may be taken later than three years after the expiration of the time within which a Properly Filed Claim is required by this Certificate.

PAYMENT OF BENEFITS

You authorize us to make payments directly to Dentists furnishing Covered Services for which we provide Benefits under this Certificate. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, either before or after Covered Services are received.

Once a Dentist performs a Covered Service, we will not honor a request not to pay the claims submitted.

Benefits under this Certificate will be based upon the Allowable Charge (as we determine) for Covered Services. A Participating Dentist may collect any Deductible and/or Coinsurance amounts applicable to your coverage, but you will not be responsible for any amounts that exceed the Allowable Charge for Covered Services. However, if you receive Covered Services from Out-of-Network Dentists, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts which may apply.

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

- an Out-of-Network Dentist and the Plan's allowance for the Covered Services; and
- a Dentist for non-covered services performed in conjunction with Covered Services and the allowance for the Covered Services; and
- a Dentist for personalized, characterized or unusual procedures or techniques being used and our allowance for any portion of those services which may be Covered Services.

If you use the services of any practitioner 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 Certificate, then Benefits will be provided regardless of which practitioner 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 Certificate and to determine its Benefits.

The Plan's medical staff may conduct a medical review of your 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 Certificate.**

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

- you arrange for medical or dental records to be provided to the Plan; and/or
- you submit to a professional evaluation by a Dentist or Physician selected by the Plan, at the Plan's expense; and/or
- a Dentist consultant or 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 or dental records or evaluation may result in Benefits being partially or wholly denied.

SUBSCRIBER/PROVIDER RELATIONSHIP

The choice of a Dentist is solely yours.

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 you receive from Dentists. We are not liable for any act or omission of any Dentist. We have no responsibility for a Dentist's failure or refusal to render Covered Services to you.

The Plan's reference to Dentists or other Providers as "Participating" or "Out-of-Network" is not a statement or warranty about their abilities or professional competency.

GROUP RELATIONSHIPS

The Group is your agent, not our agent.

COORDINATION OF BENEFITS

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

- **Definitions**

  In addition to the ***Definitions*** of this Certificate, 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

Certificate are an indebtedness which we may recover. Our acceptance of your premiums or payment of Benefits under this Certificate 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 Certificate, 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 any excess or erroneous payment made under this Certificate more than 24 months after the payment is made, unless:

- the payment was made because of fraud committed by the Subscriber or the Provider; or
- 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.

PLAN/ASSOCIATION RELATIONSHIP

Each Subscriber hereby expressly acknowledges his/her understanding that the Group Contract constitutes a contract solely between the Group 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 Group has not entered into the Group Contract based upon representations by any person other than Blue Cross and Blue Shield of Oklahoma. No person, entity, or organization other than Blue Cross and Blue Shield of Oklahoma shall be held accountable or liable to the Group or its Subscribers for any of Blue Cross and Blue Shield of Oklahoma's obligations to the Group or Subscribers created under the Group 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 the Group Contract.

Claims Filing Procedures

The Benefits begin to pay only after the Deductible amount you incur toward eligible expenses shows on our records. When your Dentist or other Provider of dental care services submits bills for you, your Deductible will be recorded automatically and then your coverage will begin its share of the payment, if any. If you file your own claims, you must submit copies of all your bills, even those you must pay to meet your Deductible. Then our records will show that you have incurred the Deductible amount, and your dental care coverage will begin to help pay the balance of your eligible expenses.

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, 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.

MEMBER-FILED CLAIMS

In order to obtain your dental Benefits under this Certificate, 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
c/o Dental Network of America, Inc.
P.O. Box 23100
Belleville, IL 62223-0100

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

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

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

- Full name of patient;
- Dental service(s) performed;
- Date of service(s);

- Who rendered service(s);
- Charge for service(s).

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

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

Remember, we must receive your claims for Covered Services within 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 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, 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.

The procedure for appealing an adverse Benefit determination is set forth under *"Dental Claim Review Procedures"*, below.

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 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 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.

DIRECT CLAIMS LINE

For questions regarding your dental coverage, you may call a Customer Service Representative at the number shown on your Identification Card.

Your ERISA Rights

As a participant in this dental program, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Check with your Group Administrator to see if your dental plan is governed by ERISA.

ERISA RIGHTS

If your claim for Benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator (your Employer) to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

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

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.

ALLOWABLE CHARGE

The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under this Certificate. 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 for Covered Services, 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.

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 Certificate 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 and through the Plan under this Certificate.

CALENDAR YEAR

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

CERTIFICATE

This document which explains the Benefits, limitations, exclusions, terms and conditions of this dental coverage and all endorsements, amendments and riders attached hereto, now and in the future.

COBRA CONTINUATION COVERAGE

Coverage under the Group Contract for you and your Eligible Dependents with respect to whom a Qualifying Event has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Group Contract to Subscribers to whom a Qualifying Event has not occurred.

COINSURANCE

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

CONTRACT/GROUP CONTRACT

The agreement including, but not limited to, the Group's application (if applicable) and any amendments between your Group and us.

CONTRACT DATE ANNIVERSARY

The date the Group Contract will renew and each 12-consecutive-month renewal date thereafter.

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 Certificate and given by a Dentist or other Provider for which we will provide Benefits.

DEDUCTIBLE

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

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 in accordance with the Employer's guidelines. All provisions of this Certificate (with the exception of COBRA Continuation Coverage), that pertain to a spouse also pertain to a Domestic Partner once eligibility is determined. Check with your Group Administrator for Domestic Partner provisions unique to your Group's coverage.

NOTE: For purposes of this Certificate, Domestic Partners are not qualified beneficiaries for COBRA Continuation Coverage.

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.

EMPLOYEE

An Eligible Person as specified in the ***Eligibility*** section.

EMPLOYER

A Group, as defined, in which there exists an employment relationship between a Member and the Group.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product, or dental treatment or procedure is Experimental, Investigational and/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.

GROUP

A classification of coverage whereby a corporation or other legal entity has agreed to establish a premium collection and payment system in order to provide an opportunity for its employees to acquire Plan coverage for health and dental care expenses.

GROUP DENTAL PLAN

A plan of, or contributed to by, an employer (including a self-employed person) or employee organization to provide dental care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

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.

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 for such Covered Services. 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.

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 Determinations 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, substantiating 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.

QUALIFYING EVENT

Any one of the following events which, but for the COBRA Continuation Coverage provisions of this Certificate, would result in the loss of a Subscriber's coverage:

- The death of the covered Employee;
- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment;
- The divorce or legal separation of the covered Employee from the Employee's spouse;
- The covered Employee becoming entitled to benefits under Medicare;
- A Dependent child ceasing to be eligible as defined under this Certificate.

SUBSCRIBER

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

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 मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

BlueCross BlueShield of Oklahoma

Health care coverage is important for everyone.

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

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

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

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

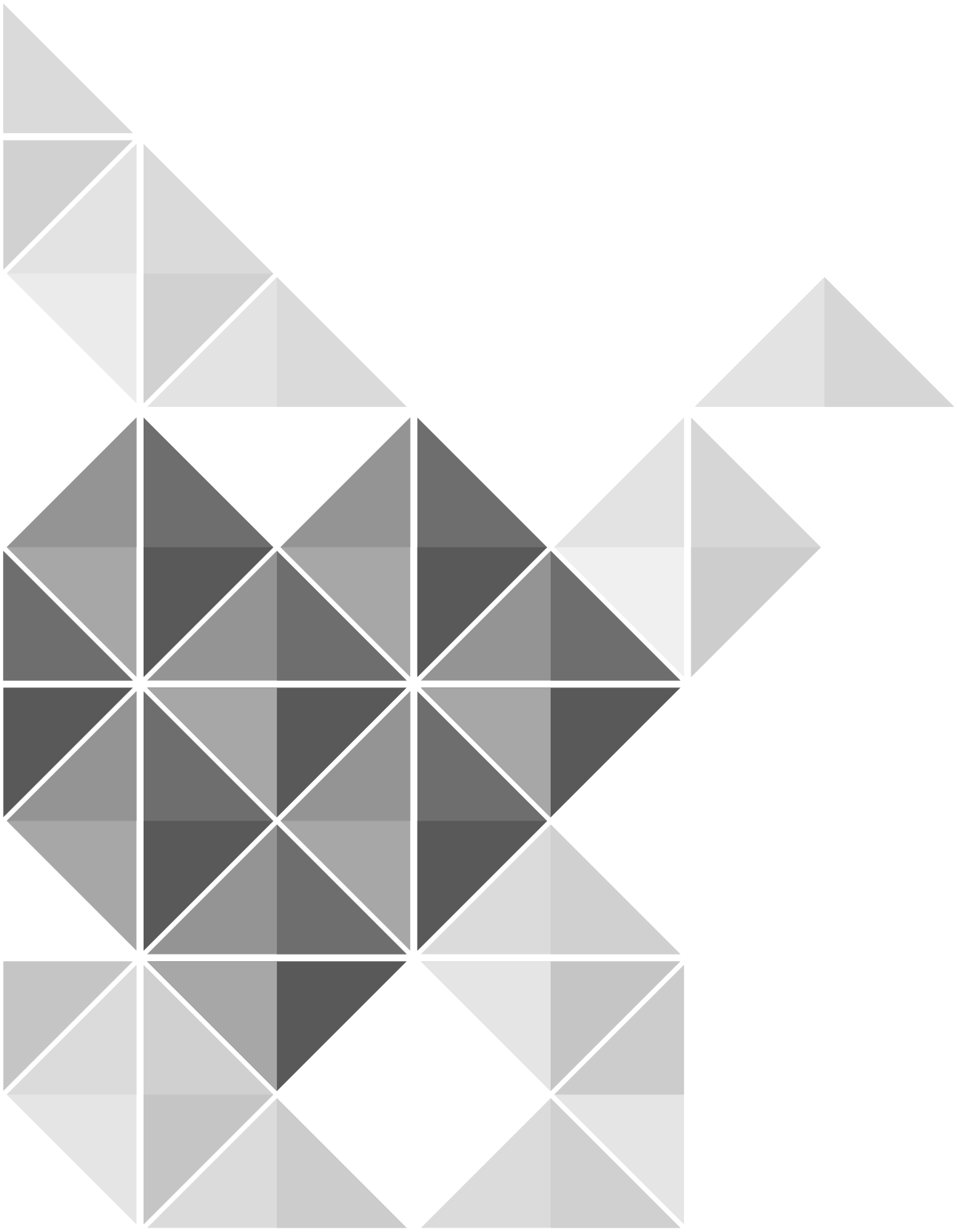
Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

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

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

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

BlueCross BlueShield of Oklahoma



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