BlueCross BlueShield of Oklahoma

Your Health Care Benefits Program

For Employees of
City of Oklahoma City by and through the Oklahoma City Municipal Facilities Authority (OCMFA)
Dental Plan – Low Plan
January 1, 2026

70260.0516

Schedule of Benefits

COVERED SERVICES	**BENEFIT PAYABLE**	
Benefit Period: Calendar Year	**Services Obtained From:**	
	Participating Providers	**Out-of-Network Providers***
Diagnostic and Preventive Dental Services (Deductible waived)	**100%** of Allowable Charge	**100%** of Allowable Charge
Miscellaneous Dental Services	**100%** of Allowable Charge after Deductible	**100%** of Allowable Charge after Deductible
Restorative Dental Services	**80%** of Allowable Charge after Deductible	**60%** of Allowable Charge after Deductible
General Dental Services	**80%** of Allowable Charge after Deductible	**60%** of Allowable Charge after Deductible
Endodontic Services	**50%** of Allowable Charge after Deductible	**30%** of Allowable Charge after Deductible
Periodontic Services	**50%** of Allowable Charge after Deductible	**30%** of Allowable Charge after Deductible
Oral Surgery Services	**50%** of Allowable Charge after Deductible	**30%** of Allowable Charge after Deductible
Crowns, Inlays/Onlays Services	**50%** of Allowable Charge after Deductible	**30%** of Allowable Charge after Deductible
Prosthodontic Services	**50%** of Allowable Charge after Deductible	**30%** of Allowable Charge after Deductible
Implant Services	**50%** of Allowable Charge after Deductible	**30%** of Allowable Charge after Deductible
Orthodontic Services (Deductible waived)	**50%** of Allowable Charge	**30%** of Allowable Charge
Orthodontic Lifetime Maximum	**$1,000**	
Individual Deductible**	**$50**	**$50**
Family Deductible	**$150**	
Benefit Period Maximum	**$1,000**	

If you have separate Deductibles for Participating and Out-of-Network Dentist services, the Deductibles cross-apply to each other.

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

****Note:** If your Plan changed carriers during your Benefit Period, expenses you Incurred and which were applied toward your Deductible during the last partial Benefit Period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under this Plan.

Table of Contents

Certificate

This Certificate is issued according to the terms of your Group Dental Plan. It contains the principal provisions of the Group Contract. In the event of conflict between the Contract and this Certificate, the terms of the Contract will prevail.

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

are covered by the Group Contract. 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 Dentist 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.
- For Covered Services, you only have to pay your shared payment amount. **If your Participating Dentist charges more than our allowance for Covered Services, you aren't responsible for the difference.**

Subscribers living or traveling outside the state of Oklahoma may show their Identification Card to receive full, in-network Benefits from any Participating Dentist nationwide.

To locate a Participating Dentist, please call one of our Customer Service Representatives at 1-888-381-9727. 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.

HOW YOUR DENTAL NETWORK WORKS

This dental program 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, the program offers considerable financial advantages to Subscribers whenever they use a Participating Dentist.

If you need services which cannot be performed by your Participating Dentist, ask your Dentist to refer you to a specialist within the Participating Dental Network to assure you receive the highest level of Benefits under this program.

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 must 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 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.***

Blue Cross and Blue Shield of Oklahoma 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 any 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 or Coinsurance amounts that are applicable to your coverage; and
- The difference, if any, between your Dentist's "billed charges" and the "Allowable Charge" determined by the Plan.

Depending on the dental Benefit program under which you are enrolled, your coverage may include a higher Coinsurance percentage for services you receive out-of-network (check the ***Schedule of Benefits***).

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.

Benefit Period Maximum

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

The amounts applied to the Benefit Period Maximum are based on the Allowable Charges for all Covered Services for which Benefits were received. The Benefit Period Maximum does ***not*** include your Deductible or Coinsurance amounts.

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 Benefit program 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. Depending on the dental Benefit program under which you are enrolled, there may be a single combined Deductible to meet for the Covered Services from Participating and Out-of-Network Providers, or you may have two separate Deductibles for Participating and Out-of-Network Provider services. If you have two Deductible amounts, they may also either cross-apply or not cross-apply to each other. **It is always important to refer to your *Schedule of Benefits* for such variables in coverage.**

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 Benefit program pays 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, the Coinsurance and any amount in excess of the Allowable Charge (or in excess of the maximum lifetime orthodontic benefit). When a Covered Service is received from an Out-of-Network Provider, the Subscriber also is responsible for the amount charged by the Out-of-Network Provider that exceeds the Allowable Charge for the Covered Service.

Special Notices

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

Because of changes in federal or state laws, changes in your health care program, or the special needs of your Group, provisions called "special notices" may be added to your Certificate.

Be sure to check for a "special notice." It changes 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 Group 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 member 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 health care Benefit questions by referring to this Certificate. If you need more help, please call a Customer Service Representative at 1-888-381-9727 between 8:00 a.m. and 6:00 p.m., Monday through Friday. Or, you can write:

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, you are an Eligible Person if you are an Employee who works on a full-time basis with a normal work week of 24 or more hours. If you work on a part-time, temporary or substitute basis, you are not considered an Eligible Person.

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

Who Is an Eligible Dependent

An Eligible Dependent is defined as:

- your spouse.
- a natural child, a stepchild, an adopted child or child Placed for Adoption (including a child for whom the Member of spouse 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 spouse is also considered a Dependent child under the Group Dental Plan, provided proof of dependency is provided with the child's application.

  A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse 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 status as a disabled Dependent child upon initial enrollment and from time to time thereafter as the Plan may require.

When Coverage Begins

Your coverage begins on the Effective Date assigned by the Plan according to the provisions of the Contract in effect for your Group. You may select coverage for yourself, or coverage to include your Dependents.

How to Add Dependents

You can apply to add Dependents to your coverage if we receive your application 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 application 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). Your application for coverage must be received by the Plan within this time period. **(Check with your Group Administrator for specific dates.)** If the application is accepted, the Effective Date will be the Group's Contract Date Anniversary.

Deleting a Dependent

You can change your coverage to delete Dependents. The change will be effective at the end of the coverage 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 for Adoption of a child while you are covered under 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 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 and/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:

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

    ○ 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 coverage period during which eligibility ceases, except in the following cases:

- In the case of an Employee whose coverage is terminated, such Employee and his/her Dependents shall remain insured under the Contract for a period of 31 days after such termination, unless during such period the Employee and his/her Dependents shall otherwise become entitled to similar insurance from some other source.

- 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 coverage 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 health 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 health plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the Subscriber (or the date the Subscriber has satisfied the preexisting condition exclusion period under that plan); or

  — the date on which the Subscriber becomes (after the date of the election) entitled to benefits under Medicare.

Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or material misrepresentation in applying for or obtaining coverage under the Group Contract. 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 coverage 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, including orthodontic procedures or services, which you receive after your coverage ends.

Covered Dental Services

This section describes the services and supplies covered by this Group Dental Plan. Benefits are payable only for services and supplies that are considered "Medically Necessary." All Covered Services listed in this section are subject to the ***Exclusions and Limitations*** section of this Certificate, which lists the 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 percentage and Benefit Period Maximum will be for a Covered Service, and to determine what optional Benefits and variable coverage features were chosen by your Group.

Diagnostic and Preventive Dental Services

Your Benefits for Diagnostic and Preventive Dental Services are designed to help you keep dental disease from starting or to detect it in its early stages. Your Diagnostic and Preventive Dental Services are as follows:

- Oral Examinations – The initial oral examination and periodic routine oral examinations. However, your Benefits are limited to two examinations every Benefit Period.
- Dental X-rays – Benefits for panoramic and routine full-mouth X-rays are limited to one full-mouth series every 36 months. Routine bitewing X-rays are limited to one set per Benefit Period. Additional full-mouth X-rays are covered only if Medically Necessary.
- Prophylaxis/Periodontal Maintenance – The routine scaling and polishing of your teeth. However, your Benefits are limited to two cleanings each Benefit Period.
- Topical Fluoride Application – Benefits for this application are only available to persons under age19 and are limited to two applications each Benefit Period.
- Sealants – Benefits for sealants are only available to persons under age 15 and are limited to first and second molars once per tooth in a 60 month period.
- Space Maintainers – Benefits for space maintainers are only available to persons under age 15 when not part of orthodontic treatment.

Miscellaneous Dental Services

- Labs and Tests – Pulp vitality tests.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Restorative Dental Services

- Amalgam (fillings).
- Pin retention.
- Composites.
- Simple extractions.

General Dental Services

- General Anesthesia/Intravenous Sedation – If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits – Visits by a Dentist to your home when medically required to render a Covered Dental Service.
- Stainless steel crowns.

Endodontic Services

- Root canal therapy.
- Pulp cap.
- Apicoectomy.
- Apexification.
- Retrograde filling.
- Root amputation/hemisection.
- Therapeutic pulpotomy.
- Pulpal debridement.

Periodontic Services

- Periodontal scaling and root planing.
- Full-mouth debridement.
- Gingivectomy/gingivoplasty. Your Benefits are limited to one full-mouth treatment per Benefit Period.
- Gingival flap procedure.
- Osseous surgery. Your Benefits are limited to one full-mouth treatment per Benefit Period.
- Osseous grafts.
- Soft tissue grafts.
- Periodontal maintenance is covered under preventive services and in combination with prophylaxis two per Benefit Period.

Oral Surgery Services

- Surgical tooth extraction.
- Alveoloplasty.
- Vestibuloplasty.
- Other necessary dental surgical procedures.

Crowns, Inlays/Onlays Services

- Prefabricated post and cores.
- Cast post and cores.

- Crowns, inlays/onlays repairs.
- Recementation of crowns, inlays/onlays.

Prosthodontic Services

- Bridges.
- Dentures.
- Implants.
- Adjustments to Bridges and Dentures – During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his/her in-office associates who provided or relined the dentures.
- Bridge and Denture repairs.
- Addition of tooth or clasp.
- Reline/Rebase.

Once you receive Benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until five years have elapsed. Also, Benefits are not available for the replacement of a bridge or denture which could have been made serviceable.

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 Benefit Period orthodontic Benefit. Benefit payments cease when the Subscriber is no longer covered, whether or not the entire Benefit has been paid out.
- 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 Benefit Period maximum for orthodontic services.
- 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 Benefits paid prior to this coverage beginning.

Exclusions & Limitations

These general exclusions and limitations apply to all services described in this Dental Certificate of Benefits. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the *Definitions*) licensed to perform services covered under this dental Benefit program.

Dental Procedures Which are Not Medically Necessary

PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THIS DENTAL BENEFIT PROGRAM PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT THE PLAN DETERMINES WERE NOT MEDICALLY NECESSARY.

No Benefits will be provided for procedures which are not, in the reasonable judgment of the Plan, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Plan, 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. 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 should 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 Benefit Program

In all cases in which there is more than one Course of Treatment possible, the Benefit payment will be based upon the Course of Treatment bearing the lesser cost.

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 reasonably determined by the Plan.

Special Limitations

No Benefits will be provided under this Dental Benefit program for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Dental services which are performed for cosmetic purposes, including but not limited to, bleaching teeth and grafts to improve esthetics.
- Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders or to increase vertical dimension.

- Dental services which are performed due to an accidental injury.
- Services and supplies for any illness or injury occurring on or after your Effective Date as a result of war or an 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.
- Services or supplies which the Plan determines are Experimental/Investigational in nature.
- Hospital and ancillary charges.
- 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 received from a member of your immediate family.
- 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.
- For 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; 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 your employer or insurance carrier.
- Any services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- Charges for nutritional, tobacco, and 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 or preparations.
- 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.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.

General Provisions

This section tells:

- 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 You 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, and regularly included in such Dentist's charges.

Prior Approval

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

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.

Limitation 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 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 giving 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 gives 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 will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services. However, if you receive Covered Services from an Out-of-Network Dentist, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

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 the Contract 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 are 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.

We do not furnish Covered Services but only pay 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 give 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.

Agency Relationships

The Group is your agent, not our agent.

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

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, except as specified below, providing dental care benefits or services through:

  — Group, 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;

  — 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 pay for Covered Services will 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 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 for 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 by deducting it from any future Benefits under this Certificate, or under any other coverage provided by the Plan. Our acceptance of your premiums or payment of Benefits under this Certificate does not waive our rights to enforce these provisions in the future.

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 or 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.

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.

Failure to comply with the above provisions may result in termination of your coverage and/or legal action to enforce collection.

Limitations 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.

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

This program begins 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 program will begin its share of the payment. 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 network 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 care program, you must receive treatment from Participating Dentists.

Member-Filed Claims

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Plan office.

Be sure to fill out the dental claim form completely, sign it, and attach the Dentist's itemized statement. Send the completed form 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, personal 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 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.

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.

Within 180 days after you receive notice of a denial or partial denial, 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 1-888-454-5590 between 8:00 a.m. and 6:00 p.m., Monday through Friday. Or, you can write:

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

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.

Direct Claims Line

For questions regarding your dental coverage, you may call a Customer Service Representative at 1-888-381-9727 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

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 the Contract. The Plan will use the following criteria to establish the Allowable Charge:

- **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.

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 Dependent 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 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

The agreement (including the Group Application and any endorsements) between your Group and us, referred to as the Master Contract or Group Contract.

Contract Date Anniversary

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

Course of Treatment

A planned series of dental procedures which an examination shows you need.

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 the Plan will start to pay its share of the remaining Covered Services.

Dentist

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

Dependent

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

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

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

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 care expenses.

Group Dental Plan

A plan (including a self-insured 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.

Incurred

A charge is Incurred on the date you receive a service or supply for which the charge is made.

Medically Necessary (or Medical Necessity)

A specific procedure or supply provided to you is reasonably required, in the judgment of the Plan, for the treatment or management of your specific dental symptom, injury, or condition and that the procedure performed 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.

Open Enrollment Period

A period of 31 days immediately before the Group's Contract Date Anniversary (renewal date) during which an individual who previously declined coverage may enroll for coverage under the Contract as a Late Enrollee.

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 who has not entered into an agreement to be a part of the Plan's Participating Dentist network.

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 Blue Cross and Blue Shield of Oklahoma;
- 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, 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.

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.

Special Enrollment Period

A period during which an individual who previously declined coverage is allowed to enroll under the Contract without having to wait until the Group's next regular Open Enrollment Period.

Subscriber

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


BlueCross BlueShield
of Oklahoma