AcademicBlue℠

University of Oklahoma Student Dental Insurance Plan 2024-2025

Underwritten by:
Blue Cross and Blue Shield of Oklahoma

Please review to fully understand your coverage.

Dental Account Number: 115548

AcademicBlue℠

Notice: This Policy is subject to: (1) Annual Maximums, for other than Pediatric Services; (2) the right to adjust the premium upon 60 days' notice to You. Such adjustments in rates shall become effective on the date specified in said notice; (3) termination of coverage in accordance with Termination of Coverage provision as specified in this Policy.

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

Within ten days after its delivery to You, this Policy may be surrendered by delivering or mailing it to Us at Our Administrative Office, branch office, or agent through whom it was purchased. Upon such surrender, any premiums paid will be returned.

Blue Cross and Blue Shield of Oklahoma

Herein called (BCBSOK, We, Us, Our)

Has issued this

Student Dental Insurance

Policy to

University of Oklahoma

This Policy describes the terms and conditions of coverage as issued to the Policyholder named above. This Policy is issued in the state of Oklahoma and is governed by its laws. This Policy becomes effective at 12:01 A.M. on the Policy Effective Date at the Policyholder's address.

Blue Cross and Blue Shield of Oklahoma ("The Plan"), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (the Insurer) and the Policyholder have agreed to all of the terms of this Policy as stated herein. In this Policy, "We", "Us", "Our" and the "Plan" mean Blue Cross and Blue Shield of Oklahoma.

Policyholder has confirmed to Us that it is an Institution of higher education as defined in the Higher Education Act of 1965. This Policy does not make dental insurance available other than in connection with enrollment as a Student or a Dependent of a Student in the Policyholder's Institution. If Covered Persons have any questions once they have read this Policy, they can call Us at the number shown on their Identification Card. It is important to all of Us that Covered Persons understand the protection this coverage gives them.

Signed for Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company by:

Stephania Grober

Stephania Grober
President, Blue Cross and Blue Shield of Oklahoma

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

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BLUECARE DENTAL[SM]
SCHEDULE OF BENEFITS
For Covered Persons Age 19 and Over

The dental Benefits are highlighted below. To fully understand all the terms, conditions, limitations, and exclusions which apply to these Benefits, please read the entire Policy.

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

BLUECARE DENTAL[SM] 1A

Covered Services	Benefit Payable In Network	Benefit Payable Out of Network*
Diagnostic Evaluations (Deductible waived)	100%	70%
Preventive Services (Deductible waived)	100%	70%
Diagnostic Radiographs (Deductible waived)	100%	70%
Miscellaneous Preventive Services	80%	50%
Basic Restorative Services	80%	50%
Non-Surgical Extractions	80%	50%
Non-Surgical Periodontal Services	80%	50%
Adjunctive General Services	80%	50%
Endodontic Services	80%	50%
Oral Surgery Services	80%	50%
Surgical Periodontal Services**	80%	50%
Major Restorative Services**	50%	30%
Prosthodontic Services**	50%	30%
Miscellaneous Restorative and Prosthodontic Services**	50%	30%
Orthodontic services	Not Covered	
Deductible	$50 Individual/$150 Family	
Benefit Period Maximum	$1,500	
Benefit Period Out-of-Pocket Maximum	None	

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

How This Dental Coverage Works

Please read this section carefully! It explains the role the Plan's Participating Dental Network plays in the Student's dental coverage.

THE PARTICIPATING DENTIST NETWORK

Covered Persons have access to thousands of Participating Dentists nationwide. Here's how using a Participating Dentist can benefit a Covered Person:

- A Participating Dentist will file a Covered Person's claims;
- Payment for Covered Services a Covered Person receives will be sent directly to the Participating Dentist; and
- A Covered Person pays only the Deductible and/or Coinsurance amount (if any) that applies to their Covered Services. **If a Covered Person's Participating Dentist charges more than the Allowable Charge for Covered Services, the Covered Person is not responsible for the difference.**

HOW THIS DENTAL COVERAGE WORKS

This dental coverage is designed to give Covered Persons some control over the cost of their own dental care. Covered Persons continue to have complete freedom of choice as to the Dentist they wish to use. However, this coverage offers considerable financial advantages to Covered Persons 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 Covered Persons use these Participating Dentists, they will have less out-of-pocket expense. **In contrast, when care is received from an Out-of-Network Dentist, a Covered Person's coverage may be subject to a reduction in Benefits. Refer to the *Schedule of Benefits* in the front of this Policy for additional details regarding this coverage.**

SELECTING A DENTIST

To locate a Participating Dentist, a Covered Person can call one of our Customer Service Representatives at the number shown on their Identification Card. A Covered Persons may also look up in-state (Oklahoma) and out-of-state Dentists on the "Provider Directory" section of the Plan's Web site at www.bcbsok.com.

ALLOWABLE CHARGE

To take full advantage of the negotiated pricing arrangements in effect between the Plan and the Plan's network of Participating Dentists, Covered Persons should use Participating Dentists whenever possible.

Participating Dentists have agreed to hold the line on dental care costs by providing special prices for our Covered Persons. 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 Covered Persons more than the Allowable Charge for Covered Services, ***they are not responsible for the difference.***

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

If a Covered Person uses an Out-of-Network Dentist, they will be responsible for the following:

- Charges for any services which are not covered under this Policy;
- Any Deductible and/or Coinsurance amounts which are applicable to a Covered Person's coverage; and
- The difference, if any, between their Dentist's "billed charges" and the "Allowable Charge".

This coverage may include a higher Deductible and/or Coinsurance percentage for services a Covered Person receives from an Out-of-Network Provider (check the *Schedule of Benefits* issued with this Policy).

BENEFIT PERIOD

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

The Benefit Period is a period of time, which begins on the Policy Effective Date through the Termination Date as shown on the face page of the Policy.

BENEFIT PERIOD MAXIMUM

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

Each Covered Person's Benefit Period Maximum amount is given on the ***Schedule of Benefits***. Orthodontic Services, if covered under this Policy, do not apply to the Benefit Period Maximum.

DEDUCTIBLE REQUIREMENTS

The Deductible amounts for each Covered Person are shown on the ***Schedule of Benefits***. The Deductible is the amount that each Covered Person must pay for Covered Services received during a Benefit Period before this Policy 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

A Covered Person's Coinsurance amount is the percentage of the Allowable Charges a Covered Person is required to pay for a Covered Service after the Deductible, if applicable, has been met.

For each Covered Service, and after the Covered Person has met the Deductible (if applicable), this Policy covers a certain percentage (specified on the ***Schedule of Benefits***) of the Allowable Charge for the Covered Service. When a Covered Service is received from a Participating Provider, the Covered Person 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 Covered Person also is responsible for the amount charged by the Out-of-Network Provider that exceeds the Allowable Charge for the Covered Service.

AMENDMENTS

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

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

Be sure to check for an amendment. It amends provisions or Benefits in this Policy.

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLAN

If a Covered Person's Dentist recommends a Course of Treatment, their 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 the Covered Person 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 a Covered Person and their Dentist of the estimated Benefits which will be provided under this Policy.

This is not a guarantee of payment, but 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 Policy requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, a Covered Person is 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 a Covered Person's responsibility for Covered Services will depend on whether they receive services from a Participating Dentist or Out-of-Network Dentist.

Participating Dentists are Dentists who have signed an agreement with the Plan to accept the Allowable Charge as payment in full. Such Participating Dentists have agreed not to bill a Covered Person for Covered Service amounts in excess of the Allowable Charge. Therefore, a Covered Person will be responsible only for any Coinsurance and/or Deductible amounts applicable to their Covered Services.

Out-of-Network Dentists are Dentists who have not signed an agreement with the Plan to accept the Allowable Charge as payment in full. Therefore, a Covered Person is responsible to these Dentists for the difference between the Plan's Benefit and such Dentist's charge to a Covered Person, in addition to any Coinsurance and/or Deductible amounts applicable to Covered Services.

If a Covered Person needs an estimate of the Allowable Charge for a particular procedure or whether a particular Dentist is a Participating Dentist, they can contact the Dentist or the Plan at the number listed on their Identification Card.

QUESTIONS

Whenever Covered Persons call our offices for assistance, they should have their Identification Card with them.

A Covered Person usually will be able to answer dental care Benefit questions by referring to this Policy. If they need more help, they may call a Customer Service Representative at the number shown on their Identification Card. Or they may 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 is section explains who is eligible for Benefits under this Policy. It tells:

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

WHO IS AN ELIGIBLE PERSON

Each person in the *"Classes of Eligible Persons"* shown below is eligible to be insured as a Student under this Policy. This includes anyone who is eligible on the Policy Effective Date and may become eligible after the Policy Effective Date while the Policy is in force. Students must meet the Institution's requirements for maintaining their status as an active and enrolled Student. Students must actively attend classes for at least the first 31 consecutive days after the date for which coverage is purchased. Some courses may not fulfill the eligibility requirements, check with your Institution for more information. We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, our only obligation is to refund any premium paid for that person.

A person may be insured under only one Class (see *"Classes of Eligible Persons"* below), even though the person may be eligible under more than one Class.

Dependents of all Students are eligible for coverage under this Policy.

A Student's Dependent is eligible on the date:

- the Student is eligible if the Student has Dependents on that date; or
- the date the person becomes a Dependent of the Student, if later.

A person may not be insured as a Dependent and a Student at the same time.
The Plan, as appropriate, may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a Dependent under this Policy.

No eligibility rules or variations in premium will be imposed based on a Covered Person's health status, medical condition, claims experience, receipt of health care, medical or dental history, genetic information, evidence of insurability, disability, quality of life, life expectancy, or any other health status related factor. A Covered Person will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or political affiliation expression. Coverage does not require documentation certifying a COVID-19 Vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving Benefits. Variations in the administration, processes or Benefits of this Policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

CLASSES OF ELIGIBLE PERSONS

Class 1: All enrolled Students and their Dependents are eligible for coverage under this Policy.

An individual who is currently enrolled under any other dental coverage underwritten by the Plan or any subsidiaries or affiliates of Health Care Service Corporation is not eligible for coverage under this Policy.

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- the Student's spouse; or
- a Student's Dependent child. Wherever used in this Policy, "Dependent child" means a Student's natural child, a stepchild, an eligible foster child, an adopted child or a child Placed for Adoption (including a child for whom a Student or a Student's spouse is a party in a legal action in which the adoption of the child is sought), or a grandchild(ren), 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 a Student or a Student's spouse is also considered a Dependent child under this Policy, provided proof of dependency is provided with the child's application.

  A Dependent child who is medically certified as disabled and dependent upon a Student or a Student's 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 or disability status upon initial enrollment and from time to time thereafter as the Plan may require.

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

ANNUAL OPEN ENROLLMENT PERIODS

The Plan along with the Institution will designate annual open enrollment periods during which Students may apply for or change coverage for themselves and/or their eligible spouse and/or Dependents.

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

QUALIFYING EVENT

Eligible Students and eligible Dependents who have a change in status and lose coverage under another dental care plan are eligible to enroll for coverage under the Policy. Within 30 days of the qualifying event, such Student or Dependent must complete supporting documentation. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment, legal separation, gain of a Dependent whether by birth, adoption, or suit for adoption or court-ordered Dependent coverage, or loss of Dependent status because of age. The premium will be the same as what it would have been at the beginning of the semester or quarter, whichever applies. However, the Effective Date of Coverage will be the later of the date the Student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. Please contact your Institution for further information.

EFFECTIVE DATE OF INSURANCE

The Policy begins on the Policy Effective Date at 12:01 AM, Standard Time at the address of the Policyholder.

Insurance for an Eligible Person who enrolls during the program's enrollment period, as established by the Institution, is effective on the latest of the following dates:

- the Policy Effective Date;
- the date We receive the completed enrollment form;
- the date the required premium is paid; and
- the date the Student enters the Eligible Class.

Coverage for a Student's eligible Dependent who enrolls:

- during the enrollment period established by the Policyholder; or
- within 31 days after the Student acquires a new Dependent; or
- within 31 days after a Dependent terminates coverage under another dental care plan,

is effective on the latest of the following dates:

- the first day of the Coverage Period;
- the date the Student enters the Eligible Class;
- the date We receive the completed enrollment form; and
- the date the required premium is paid.

After the time periods described above, the Student or Dependent must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another dental care plan. We will pay Benefits for a newborn child of a Student until that child is 31 days old. Coverage may be continued beyond the 31 days if the Student notifies Us of the child's birth and pays the required premium, if any.

Adopted children, as defined by the Policy, will be covered on the same basis as a newborn child from the date the child is Placed for Adoption with the Student or the date the Student becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the Student’s legal obligation terminates.

DELETING A DEPENDENT

Students can change their coverage to delete Dependents. The change will be effective at the end of the coverage period during which eligibility ceases.

WHEN COVERAGE UNDER THIS POLICY ENDS

When a Covered Person is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except that, when a Covered Person ceases to be an Eligible Dependent by reason of death, coverage for that Covered Person will terminate on the date of death.

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

A Student's coverage will end on the earliest of the date:

- the Policy terminates;
- the Student is no longer eligible; or
- the period ends for which premium is paid.

A Dependent's coverage will end on the earliest of the date:

- he or she is no longer a Dependent;
- the Student's coverage ends;
- the period ends for which premium is paid; or
- the Policy terminates.

We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either We or the Policyholder may terminate this Policy on any Premium Due Date by giving 31 days advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and the Plan.

This Policy terminates automatically on the earlier of:

- the Policy Termination Date shown in the Policy; or
- the Premium Due Date if premiums are not paid when due.

Termination takes effect at 12:00 AM, Central Time at the address of the Policyholder on the date of termination.

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

If a Student's premiums are not paid, their coverage will stop at the end of the coverage period for which the premiums have been paid, subject to the *"Grace Period"* set forth under the ***General Provisions*** section.

REFUND OF PREMIUM

A refund of premium will be made only in the event:

- of a Covered Person's death; or
- the Covered Person enters full-time active duty in any Armed Forces; and We receive proof of such active-duty service.

EXTENSION OF A COVERED PERSON'S DENTAL BENEFITS IN CASE OF TERMINATION

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

RESCISSION OF COVERAGE

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

Covered Dental Services

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

It is important to refer to the *Schedule of Benefits* to find out what a Covered Person's Deductible, Coinsurance and Benefit Period Maximum will be for a Covered Service. To obtain a *Schedule of Benefits*, the Covered Person may call a Customer Service Representative at the number shown on the Identification Card.

A Covered Person's Dental Benefits include coverage for the following Covered Services as long as these services are rendered to a Covered Person by a Dentist or a Physician. When the term "Dentist" is used in this Policy, 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 is covered for a child under the age of three.
- Oral Examinations – The initial oral examination and periodic routine oral examinations. However, your Benefits are limited to one comprehensive and one periodic examination every Benefit Period in the dental office.

Benefits will not be provided for 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; and
- Topical Fluoride Application – Benefits for Fluoride Application is only available to Covered Persons under age 19 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

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

DIAGNOSTIC RADIOGRAPHS

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

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months;
- Bitewing films – Benefits are limited to four horizontal films or eight vertical films once every 12 months for adults. Benefits are limited to two every 12 months for Covered Persons under age 19. However, Benefits are not available for bitewing films taken on the same date as full-mouth films or within 6 months of a complete series of radiographic images; and
- Periapical films, as Medically Necessary for diagnosis – Benefits are limited to six films every 12 months for adults. Frequency limitation does not apply to Covered Persons under age 19.

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 Covered Persons under age 19 and are limited to permanent unrestored molars only.

Benefits are not available for nutritional or oral hygiene counseling. Tobacco counseling is not available to Covered Persons age 19 and over.

BASIC RESTORATIVE SERVICES

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

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

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

NON-SURGICAL EXTRACTIONS

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

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

NON-SURGICAL PERIODONTAL SERVICES

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

- Periodontal scaling and root planing – Benefits are limited to one per quadrant every 24 months, however, this limit does not apply to Covered Persons under the age of 19;
- Scaling in the presence of generalized moderate to severe gingival inflammation is limited to once every 6 months combined with prophylaxes and periodontal maintenance; and
- 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 Covered Persons with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity; and
- Therapeutic parenteral drugs - Therapeutic parenteral drugs will be covered for Eligible Persons under age 19.

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

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; and
- 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; and
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post or post removal.

Endodontic therapy if a Covered Person discontinues 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; and
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Policy.

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; and
- 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:

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one per quadrant every 24 months;
- Clinical crown lengthening once per lifetime for Covered Persons over the age of 19, however, this limit does not apply to Covered Persons under the age of 19;
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease;
- Osseous grafts – Benefits are limited to one per site every 36 months. Bone grafts are excluded in conjunction with extractions, apicoectomy or any non-covered service or non-eligible implants;
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 36 months;
- Distal or proximal wedge procedure; and
- Anatomical crown exposures – is not covered.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered part of the restoration.

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;
- Inlay/onlay restorations; and
- Labial veneer restorations.

Benefits will not be provided for the replacement of a lost, missing, or stolen Appliances and those for replacement of Appliances that have been damaged due to abuse, misuse, or neglect. Benefits will not be provided for dentures, crowns, inlays, onlays, bridgework, or other Appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions. Benefits will not be provided to restore occlusion on incisal edges due to bruxism or harmful habits.

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

PROSTHODONTIC SERVICES

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

- Complete and removable partial dentures - Benefits will be provided for the initial installation of removable complete, immediate, or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month period for adults, whether placement was provided under this Policy or under any prior dental coverage. Frequency limitation does not apply to Covered Persons under age 19. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement, or loss;
- Denture reline/rebase procedures - Benefits will be limited to one procedure every 36 months after the initial 6 months period following initial placement;
- Fixed bridgework - Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months for adults, whether placement was under this Policy or under any prior dental coverage. Frequency limitation does not apply to Covered Persons under age 19; and
- Maxillofacial prosthetics - Benefits will be provided for maxillofacial prosthetics to Eligible Persons under the age 19.

Prosthetics placed over implants will be covered.

Benefits will not be provided for the following Prosthodontic Services:

- Tissue conditioning (is a part of a denture or a reline/rebase when performed the same day as the delivery);
- Treatment to replace teeth which were missing prior to the Effective Date of Coverage;
- Congenitally missing teeth in Covered Persons over the age of 19; and
- 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 for stainless steel and resin-based crowns. Benefits are limited to one per tooth every 60 months for adults. Frequency limitation does not apply to Covered Persons under age 19. These crowns are not intended to be used as temporary crowns;
- Recementation of inlays/onlays, crowns, bridges, and post and core;
- Post and core, pin retention, and crown and bridge repair services;
- Pulp cap – direct and indirect is considered part of the restorative procedure;
- Adjustments – Benefits will be limited to three times per Appliance every 12 months; and
- 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).

MEDICALLY NECESSARY ORTHODONTIC SERVICES

Medically Necessary orthodontic services are limited to members who meet the Plan's criteria related to a medical condition such as:

- Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
- Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services; and
- Skeletal anomaly involving maxillary and/or mandibular structures.

Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment does not meet the definition of Medical Necessity.

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

- Diagnostic orthodontic records and radiographs **limited to once every 60 months per Covered Person;**
- Limited, interceptive, and comprehensive orthodontic treatment; and
- Orthodontic retention limited to one Appliance every 60 months per Covered Person. Special Provisions Regarding Orthodontic Services:
- Orthodontic services are paid over the Course of Treatment. Benefits cease when the Covered Person is no longer covered;
- Orthodontic treatment is started on the date the bands or Appliances are inserted;
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit;
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination;
- If the Covered Person's coverage is terminated prior to the completion of the orthodontic treatment plan, the Covered Person 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 Covered Person is not covered;
- Benefits are not available for replacement or repair of an orthodontic Appliance; and
- For services in progress on the Effective Date of Coverage, Benefits will be reduced based on other benefits paid prior to this coverage beginning.

Exclusions and Limitations

These general ***Exclusions and Limitations*** apply to all services described in this dental Policy. 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 Policy.

IMPORTANT INFORMATION ABOUT THIS DENTAL COVERAGE

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

Please note that in order to provide Covered Persons with dental care Benefits at a reasonable cost, this Policy 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 a Covered Person 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 a Covered Person, 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 a Covered Person changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if the Covered Person had stayed with the same Dentist until their treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

In all cases in which there is more than one service or Course of Treatment to treat a Covered Person's dental condition, the benefit will be based on the less costly Covered Service or Course of Treatment.

The alternate benefit copayment will be based on the less costly service plus the difference in cost between the less costly service and more costly elected service.

If a Covered Person and their 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 least costly Course of Treatment or 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 Covered Person's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Covered Person.

EXCLUSIONS - WHAT IS NOT COVERED

No Benefits will be provided under this Policy 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, lack of tooth enamel and grafts to improve aesthetics, except as included in the pediatric orthodontic Benefit;

- Dental services or Appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Policy or if resulting from accidental injury. Dental services or Appliances to increase vertical dimension, unless specifically mentioned in this Policy;
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in a Covered Person's mouth is not considered an accidental injury;
- Dental services which are performed due to injuries arising from Interscholastic Activities and Intercollegiate Sports;
- Services and supplies for any illness or injury suffered after the Covered Person's Effective Date of Coverage 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;
- Services or supplies for which Covered Persons are not required to make payment or would have no legal obligation to pay if they 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 a Covered Person 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 submitted by a Dentist, which is for the same services performed on the same date for the same member by another Dentist;
- Services or supplies received for behavior management or consultation purposes;
- Services or supplies 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; 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 Covered Persons claim the benefits or compensation or recover the losses from a third party;
- Covered Persons agree to:
  - pursue their 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 Covered Persons receive any money in settlement of their employer's liability, regardless of whether the settlement includes a provision for payment of their medical bills, they 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 or oral hygiene counseling;
- Charges for tobacco counseling for Covered Persons age 19 and over;
- 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;
- 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 a Covered Person's Effective Date of Coverage under this Policy; 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 a Covered Person's Effective Date of Coverage;
- 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, diagnostic casts, or occlusal adjustments;
- Gold foil restorations;
- Cone beam imaging and cone beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Orthodontic care for Dependent children age 19 and over; and
- Localized delivery of antimicrobial agents or chemotherapeutic agents.

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

General Provisions

This section explains:

- A Covered Person's responsibilities under this Policy;
- When a Student's premiums for coverage must be paid;
- Deadline for claims filing;
- How Benefits are determined and how payment is made; and
- Coordination of Benefits when Covered Persons have other coverage.

ENTIRE CONTRACT

The entire contract consists of the Policy (including any endorsements or amendments), the signed application of the Policyholder, the Student enrollment form, Benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the Benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Policy, or to extend the time for payment of premiums, or to waive any of the Plan's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Plan's officers and delivered to the Policyholder.

BENEFITS TO WHICH COVERED PERSONS ARE ENTITLED

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

No person other than a Covered Person is entitled to receive Benefits under this Policy. Such right to Benefits and coverage is not transferable.

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

PRIOR APPROVAL

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

RECORDS OF COVERED PERSON ELIGIBILITY AND CHANGE IN COVERED PERSON ELIGIBILITY

The Policyholder must furnish the Plan with any data required by the Plan for coverage of Covered Persons under this Policy. In addition, the Policyholder must provide prompt notification to the Plan of the effective date of any changes in a Covered Person's coverage status under this Policy.

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

PREMIUMS AND POLICY CHANGES

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

The Plan is hereby granted discretionary authority to determine, alter and interpret the provisions, language and Benefits set forth in this Policy or the payment of premiums therefor. Any changes in Benefits or premiums shall not affect any Covered Persons during the coverage period for which premiums have been paid. Any increase in premiums shall be made only upon 31 days' notice to the Policyholder prior to the effective date of the premium increase.

All premiums for coverage shall be paid to the Plan and shall be payable on or before each Student's Effective Date of Coverage. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

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

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

Premium rates are based upon the amount of taxes, fees, surcharges or other amounts currently in effect by various governmental agencies. If the amount of taxes, fees, surcharges or other amounts which the Plan is required to pay or remit are increased during the Calendar Year, the Plan reserves the right, at its option, to charge the Policyholder for such amounts or to adjust the premium rates to reflect such increase, on the effective date of such increase. Upon request, the Policyholder agrees to furnish to the Plan in a timely manner all information necessary for the calculation or administration of any such taxes, fees, surcharges or amounts.

GRACE PERIOD

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period, the Policy shall continue in force. However, claim payments for Covered Services received during the grace period may be pended until full premium payment is made, and during the grace period your Providers and pharmacies may require you to pay for your health care and Prescription Drug expenses in full. After a grace period of 31 days, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid. The Policyholder will be liable to the Plan for any unpaid premium for the time the Policy was in force.

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

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

REINSTATEMENT

If this Policy terminates due to default in premium payment(s), the subsequent acceptance of such defaulted premium by Us or any duly authorized agents shall fully reinstate the Policy. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of the Policy shall not be deemed a waiver of either the requirement of timely premium payment or the right of termination for default in premium payment in the event of any future failure to make timely premium payments.

TIME LIMIT ON CERTAIN DEFENSES

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

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

NOTICE AND PROPERLY FILED CLAIM

The Plan will not be liable under the Policy unless proper notice is furnished to the Plan that Covered Services have been rendered to the Covered Person. Upon receipt of written notice, the Plan will furnish claim forms to the Covered Person for submitting a Properly Filed Claim. If the forms are not furnished within 15 days after the Plan receives the Covered Person's notice, the Covered Person may comply with the Properly Filed Claim requirements by forwarding to the Plan, within the time period set forth below, written proof covering the occurrence, character and extent of loss for which the claim is made.

The Covered Person's Properly Filed Claim must be furnished to the Plan within 180 days after the end of 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 the Covered Person shows that the claim was given as soon as reasonably possible.

RELEASE OF INFORMATION

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

LIMITATIONS OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after a Properly Filed Claim has been made as specified above, and 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 Policy.

PAYMENT OF BENEFITS

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

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

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

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

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

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

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

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

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

The Plan's medical staff may conduct a medical review of Covered Persons' 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 Policy.

To assist the Plan in its review of Covered Persons' claims, the Plan may request that:

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

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

COVERED PERSON/PROVIDER RELATIONSHIP

The choice of a Dentist is solely the Covered Person's.

Dentists and other Providers are not Employees, agents or other legal representatives of the Plan.

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

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

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

IDENTIFICATION CARD

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

COVERED PERSON RIGHTS

A Covered Person shall have no rights or privileges except as specifically provided in this Policy.

BALANCE BILLING AND OTHER PROTECTIONS

I. Continuity of Care

If you are under the care of a participating Provider as defined in the Policy who stops participating in the Plan’s network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider’s Covered Services at the participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the Provider’s termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider’s termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Policy.

II. Federal No Surprises Act

Definitions

The definitions below apply only to Section II. Federal No Surprises Act. To the extent the same terms are defined in both the Policy and this , those terms will apply only to their use in the Policy or this Amendment, respectively.

“Air Ambulance Services” means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

“Emergency Medical Condition” means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

1. a medical screening examination performed in the emergency department of a hospital or a freestanding emergency department;
2. further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an emergency medical condition until your condition is stabilized; and
3. Covered Services you receive from a non-participating provider during the same visit after your emergency medical condition has stabilized unless:
4. Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport;
5. Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
6. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Oklahoma (BCBSOK) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSOK for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a Physician or other health care provider who has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network Benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out- of-network Benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

III. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. **Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. **Cost-Sharing**

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider deductible and/or Out-of-Pocket Maximum, if any.

2. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost- share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTICE

Any notice required under this Policy must be in writing. Notice given to the Policyholder will be sent to the address as it appears on our records. Notice given to the Plan should be addressed as follows:

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

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

The Policyholder or the Plan may, by written notice, indicate a new address for giving notice.

COORDINATION OF BENEFITS

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

- **Definitions**

In addition to the ***Definitions*** of this Policy, the following definitions apply to this provision.

"*Other Contract*" means any arrangement, except as specified below, 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 another Contract.

- **Effect on Benefits**

If the total Benefits for Covered Services to which a Covered Person would be entitled under this Policy and all Other Contracts exceed the Covered Services a Covered Person receives 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 a Covered Person's 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 a Covered Person has had for the longest time pays first, except that a contract which covers a Covered Person as a laid-off or retired employee or as a Dependent of such person pays after a contract which covers a Covered Person 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 a Covered Person's benefits under another 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 acc*or*dingly.

  Once the Plan receives the necessary information to determine a Covered Person's 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 a Covered Person's benefits because of payment they 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 a Covered Person's Benefits had been determined in absence of an Other Contract. **However, the Plan shall be subrogated to all of a Covered Person's rights under the Other Contract.** A Covered Person must furnish all information reasonably required by the Plan in such event, and they must cooperate and assist the Plan in recovery of such sums from the other carrier.
- If the other carrier later provides benefits to a Covered Person for which the Plan has made payments or advances under this Coordination of Benefits provision, the Covered Person 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 this Policy 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. The Covered Person agrees to do whatever is necessary to secure Our right to recover the excess payment.

PLAN'S RIGHT OF RECOUPMENT

The Covered Person agrees to reimburse the Plan for Benefits the Plan has paid and for which the Covered Person was not eligible under the terms of the Policy. This payment is due and payable immediately when the Covered Person is notified by the Plan. Also, the Plan has the sole right to determine that any overpayments, wrong payments, or any excess payments made for the Covered Person

under this Policy are an indebtedness which the Plan may recover. The Plan's acceptance of premiums or payment of Benefits under this Policy does not waive the Plan's 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 a Student or their 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 Policy, whether for the same or a different Covered Person; 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 a Covered Person's Benefit Plan's or Policy's payment to a Provider by the amount necessary to recover another Blue Cross Blue Shield plans 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 Covered Person agrees that the Plan shall have a first lien on any settlement proceeds, and the Covered Person 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 Covered Person 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.

The Covered Person must hold in trust for the Plan any money (up to the amount of Benefits the Plan has paid) the Covered Person recovers, as described above. The Covered Person must give the Plan information and assistance and sign necessary documents to help the Plan enforce its rights.

LIMITATION ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

The Plan will not seek recovery of all or a portion of a payment of a claim made to a Covered Person more than twelve (12) months or a provider more than eighteen (18) months after a payment is made. This paragraph will not apply if:

- the payment was made because of fraud committed by the Covered Person or the Provider; or
- the Covered Person or Provider has otherwise agreed to make a refund to the Plan for

overpayment of a claim.

PLAN/ASSOCIATION RELATIONSHIP

The Policyholder hereby expressly acknowledges its understanding that this Policy constitutes a contract solely between the Policyholder 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 Policyholder has not entered into this Policy based upon representations by any person other than Blue Cross and Blue Shield of Oklahoma and that no person, entity, or organization other than Blue Cross and Blue Shield of Oklahoma shall be held accountable or liable to the Policyholder for any of Blue Cross and Blue Shield of Oklahoma's obligations to the Policyholder created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Oklahoma other than those obligations created under other provisions of this Policy.

NOTICE OF ANNUAL MEETING

The Policyholder is hereby notified that it is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of members of said Company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m. For purposes of the aforementioned paragraph the term "Member" means the group, trust, association or other entity to which this Policy has been issued. It does not include Covered Persons under the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)".

Claims Filing Procedures

PARTICIPATING DENTISTS

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

To receive the maximum Benefits under this dental coverage, Covered Persons must receive treatment from Participating Dentists.

FILING DENTAL CLAIMS

In order for Covered Persons to obtain dental Benefits, it is necessary for a claim to be filed with the Plan. Usually, all Covered Persons have to do is show their Blue Cross and Blue Shield of Oklahoma Identification Card to their Dentist. They will file a claim for the Covered Person. It is the Covered Person's responsibility to ensure that the necessary claim information has been provided to the Plan.

If Covered Persons use an Out-of-Network Dentist and have to file a claim themselves, they may call Customer Service at the number on their Identification Card for a claim form. As soon as treatment has ended, they should ask their Dentist to complete and sign the attending Dentist's Statement. Once a Covered Person completes the claim form and attaches the attending Dentist's Statement, they may send the claim to:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 23100
Belleville, IL 62223-0100

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

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

Once the Plan receives a Properly Filed Claim from a Covered Person or their 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, the Covered Person and/or their Provider will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Plan expects to make the determination.

Upon receipt of a Covered Person's 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 the Covered Person and/or their Provider, prior to the expiration of the initial 30-day period of the specific information needed. The Covered Person will have 45 days from receipt of the notice to provide the additional information. The Plan will notify the Covered Person of its Benefit determination within 15 days following receipt of the additional information.

DENTAL CLAIM REVIEW PROCEDURES

If a Covered Person's claim has been denied in whole or in part, they may have the claim reviewed. The Plan will review its decision in accordance with the following procedure.

If a Covered Person's claim has been denied in whole or in part for lack of Medical Necessity, they may appeal the Plan's decision.

Within 180 days after the Covered Person receives notice of an Adverse Benefit Determination, they may call or write to the Plan's Administrative Office. The Plan will need to know the reasons why the Covered Person does not agree with the Adverse Benefit Determination. Send the request to:

Appeal Coordinator – Customer Service Department
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283

- The Plan will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of the Covered Person's claim review, the Covered Person has the option of presenting evidence and testimony to the Plan. The Covered Person and their authorized representative may ask to review the Covered Person's file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after they receive notice of an Adverse Benefit Determination or at any time during the claim review process.

The Plan will provide the Covered Person or their authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of the Covered Person's claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to the Covered Person or their authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give the Covered Person a chance to respond. Clinical appeal determinations may be made by a Physician associated or contracted with the Plan and/or by external advisors, but who were not involved in making the initial denial of the Covered Person's claim. Before the Covered Person or their authorized representative may bring any action to recover Benefits, the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Plan.

- If the Covered Person has any questions about the claim's procedures or the review procedure, they may call our Administrative Office Customer Service Representative at the number shown on the Identification Card.

Timing of Appeal Determinations

Upon receipt of a non–urgent pre–service appeal, the Plan shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received the Plan.

Upon receipt of a non-urgent post-service appeal, the Plan shall render a determination of the appeal as soon as practical, but in no event more than 60 days (or 30 days if the determination involves a Medical Necessity/ appropriateness or Experimental, Investigational and/or Unproven decision) after the appeal has been received by the Plan.

Notice of Appeal Determination

The Plan will notify the party filing the appeal, the Covered Person, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to the Covered Person or their authorized representative will include:

- A reason for the determination;

- A reference to the Benefit provisions on which the determination is based, or the contractual or administrative basis or protocol for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used.

Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

- An explanation of the Plan's external review processes (and how to initiate an external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Plan;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and Contact information for applicable office of health insurance consumer assistance or ombudsman.

EXTERNAL REVIEW RIGHTS

If the Covered Person receives an Adverse Benefit Determination, they may have a right to have the Plan's decision reviewed by independent health care professionals who have no association with the Plan if the Plan's decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment. The request for a standard external review by an Independent Review Organization (IRO) must be submitted within four months after the Covered Person receives notice of the internal appeal determination unless the Covered Person's medical condition qualifies them for an expedited external review of the Plan's denial. For a standard external review, a decision will be made within 45 days of receiving the Covered Person's request. If the Covered Person has a medical condition that would seriously jeopardize their life or health or would jeopardize their ability to regain maximum function if treatment is delayed, they may be entitled to request an expedited external review of the Plan's denial before the Covered Person's internal review rights have been exhausted. If the Plan's denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental, Investigational or Unproven, the Covered Person also may be entitled to file a request for external review of the Plan's denial.

A Covered Person or their authorized representative may file a request for a standard or expedited external review by completing the required forms and submitting them directly to the address noted below. The Plan will also provide the forms to the Covered Person upon request.

Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408

1-800-522-0071
405-521-2991 (Oklahoma only)

There will be no charge to the Covered Person for the IRO review. The IRO will notify the Covered Person and/or their authorized representative of its decision, which will be binding on the Plan and on the Covered Person, except to the extent the Covered Person has additional remedies available.

For questions about the Covered Person's rights or for additional assistance, the Covered Person may contact the Oklahoma Consumer Assistance Program at:

Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105

http://www.ok.gov/oid/Consumer/index.html
Telephone: 1-800-522-0071 or 405-521-2828

Definitions

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

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. In this Policy We refer to Our Plan as "Blue Cross and Blue Shield of Oklahoma" and We refer to the Institution of higher education in which a Student is enrolled and active as the "Institution." In this Policy, "We", "Us", and "Our" mean Blue Cross and Blue Shield of Oklahoma.

ALLOWABLE CHARGE

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

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

APPLIANCE

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

BENEFIT PERIOD

The period of time during which a Covered Person receives Covered Services for which the Plan will provide Benefits. The Benefit Period is the period of time starting with the Policy Effective Date through the Termination Date as shown on the face page of the Policy. The Benefit Period is as agreed to by the Policyholder and the Plan.

BENEFIT PERIOD MAXIMUM

The maximum dollar amount the Plan will pay for Covered Services for each Covered Person during a Benefit Period, according to the terms of this Policy and the coverage outlined on the ***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 Covered Person's Deductible and/or Coinsurance amounts, if any.

BENEFITS

The payment, reimbursement and indemnification of any kind which Covered Persons will receive from Us under this Policy.

COINSURANCE

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

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 PERSON

Any eligible Student or an eligible Dependent who applies for coverage, and for whom the required premium is paid to us.

COVERED SERVICE

A service or supply specified in this Policy and given by a Dentist for which Benefits will be provided.

DEDUCTIBLE

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

DENTIST

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

DEPENDENT

A Covered Person other than the Student as shown in the ***Eligibility*** section.

EFFECTIVE DATE OF COVERAGE

The date when a Covered Person's coverage begins under this Policy.

ELIGIBLE PERSON

A person entitled to apply as a Student under the Policy, as specified in the ***Eligibility*** section.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

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

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

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

IDENTIFICATION CARD

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

INSTITUTION

An Institution of higher education as defined in the Higher Education Act of 1965.

INTERCOLLEGIATE SPORT

A sport: a.) which is not an Interscholastic Activity (as defined in this Policy); and (b.) which is administered by such Institution's department of Intercollegiate athletics; and (c.) for which Benefits for injuries are not provided for nor payable under this Policy while Students are playing, participating, and/or traveling to or from an Intercollegiate Sport, contest or competition, including practice or conditioning for such activity.

INTERSCHOLASTIC ACTIVITIES

Playing, participating and/or traveling to or from an Interscholastic, Intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

A specific procedure or supply provided to a Covered Person that is reasonably required, in the judgment of the Plan, for the treatment or management of the Covered Person's specific dental symptom, injury, or condition and is the most efficient and economical procedure that can safely be provided to them. 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.

OUT-OF-NETWORK ALLOWANCE

The amount determined by the Plan as the maximum Provider charge eligible for Benefits. The Covered Person 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 with the Plan to be a Participating Dentist.

PARTICIPATING DENTIST

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

- A Dentist who has entered into a Participating Provider Agreement with the Plan;
- A Dentist who has contracted directly with any division or subsidiary of Health Care Service

- Corporation (HCSC);
- A Dentist who is a member of any other network with which Health Care Service Corporation or any of its subsidiaries has contracted.

PHYSICIAN

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

PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)

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

PLAN

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

POLICY

This Policy issued by the Plan to the Institution, the Institution's Application for Student Blanket Health Insurance, the Covered Person's application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

POLICY EFFECTIVE DATE

The date this Policy begins for the Policyholder, as shown on the face page of the Policy.

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 Student'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 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.

STUDENT

An individual Student or continued person who meets the eligibility requirements for this dental coverage, as specified in the ***Eligibility*** section.

BlueCross BlueShield of Oklahoma

Health care coverage is important for everyone.

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. 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. 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, IL 60601

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

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

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

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.