PO Box 655924 Dallas, TX 75265-5924

BLUE DENTAL PLUS[SM] STANDARD

OUTLINE OF COVERAGE

Read your Contract carefully — This outline of coverage provides only a very brief description of the important features of your Contract. This is not the Contract, and only the actual Contract provisions will control. The Contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Oklahoma (the Plan). It is, therefore, important that you **READ YOUR CONTRACT CAREFULLY!**

The BlueCare Dental Contract is of a limited nature and, as such, is not required to meet the minimum standards for accident and sickness insurance prescribed by law.

You have the right to return the Contract for any reason within 10 days of its delivery to you and have any paid dues refunded to you. If you return the Contract, the Plan will have no liability for any Benefits for dental care or services you received.

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

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Provider	**Non-Participating Provider***
Diagnostic Evaluations	80% of Maximum Allowance	80% of Maximum Allowance
Preventive Services	80% of Maximum Allowance	80% of Maximum Allowance
Diagnostic Radiographs	80% of Maximum Allowance	80% of Maximum Allowance
Miscellaneous Preventive Services	50% of Maximum Allowance	50% of Maximum Allowance
Basic Restorative Services	50% of Maximum Allowance	50% of Maximum Allowance
Non-Surgical Extractions	50% of Maximum Allowance	50% of Maximum Allowance
Non-Surgical Periodontal Services	50% of Maximum Allowance	50% of Maximum Allowance
Adjunctive Services	50% of Maximum Allowance	50% of Maximum Allowance
Endodontic Services	50% of Maximum Allowance	50% of Maximum Allowance
Oral Surgery Services	50% of Maximum Allowance	50% of Maximum Allowance
Surgical Periodontal Services* ** (12 Month Waiting Period)	50% of Maximum Allowance	50% of Maximum Allowance

Major Restorative Services* ** (12 Month Waiting Period)	50% of Maximum Allowance	50% of Maximum Allowance
Prosthodontic Services* ** (12 Month Waiting Period)	50% of Maximum Allowance	50% of Maximum Allowance
Miscellaneous Restorative and Prosthodontic Services* ** (12 Month Waiting Period)	50% of Maximum Allowance	50% of Maximum Allowance
Deductible (per Benefit Period) (PPO/Non-PPO accumulate together)		
Individual	$75	$100
Benefit Period Maximum (PPO/Non-PPO accumulate together)	$1,000	

* 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 Member 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.

Hearing Care per Benefit Period	Plan Pays	You Pay
Annual Routine Examination	100%	$0
Hardware Discounts	Generally 30%	Remaining Balance

ELIGIBILITY

An individual may apply for coverage under the Contract if he or she is an Oklahoma Resident and is not currently enrolled under any other dental coverage underwritten by Blue Cross and Blue Shield of Oklahoma or any subsidiary or affiliate.

YOUR PARTICIPATING DENTIST NETWORK

Your BlueCare Dental plan contains special provisions (Benefit reductions) which apply whenever you use Dentists who are not members of the Participating Dentist Network. If you use an Out-of-Network Dentist, you will be responsible for the following:

- Charges for any services which are not covered under your Contract.
- Any Deductible or Coinsurance amounts which are applicable to your coverage (*including the higher Deductible and/or Coinsurance amounts which apply to Out-of-Network Dentist services*).
- The difference, if any, between your Dentist's "billed charges" and the Plan's Allowable Charge for the Covered Services.

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

Participating Dentists will accept the Allowable Charge as payment in full, less any Deductible and/or Coinsurance. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Allowable Charge. Therefore, you are responsible for the difference between the Plan's Benefit and the Dentist's charge to you, in addition to any Coinsurance and/or Deductible amounts applicable to your services.

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

Should you wish to know the Allowable Charge for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Dentist or the Plan.

RENEWAL

The Contract is renewable at the option of the Plan by acceptance of premiums. The membership premiums shall be the amount determined by the Plan and filed with the Oklahoma Insurance Department. The Plan has the right to change the premiums or Benefits provided by the Contract. You will be given reasonable notice of such changes. You should attach these notices to your Contract, as they will amend a part of the Contract.

Premium Discount

You may be eligible for a discount if you are enrolled in a BCBSOK Medicare Supplement policy. The discount is 5%.

NOTICE

The Contract may not fully cover all of your dental costs.

EXCLUSIONS

No Benefits will be provided under the Contract for:

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

- Services and supplies for any illness or injury suffered after the Member's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Services or supplies received for behavior management or consultation purposes.
- Any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
- You agree to:
    - pursue your rights under the workers' compensation laws;
    - take no action prejudicing the rights and interests of the Plan; and
    - cooperate and furnish information and assistance the Plan requires to help enforce its rights.
- If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - repay the Plan any money recovered from the employer or insurance carrier.
- 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 restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than professionally accepted, necessary and appropriate treatment except this exclusion will not apply to the Benefits provided for the Covered Services subject to the Alternate Benefit provision in the Contract.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Effective Date under the Contract; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Effective Date.

- 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.
- Restorative procedures for the purpose of altering vertical dimension of occlusion or treatment of attrition, abfractions, abrasion and erosion.
- Gold foil restorations.
- 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.
- Tests and oral pathology procedures, or for re-evaluations.
- Any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
- Nutritional, tobacco or oral hygiene counseling.
- Restorations placed within 12 months of the initial placement by the same Dentist.
- 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.
- For local anesthesia, other drugs or medicaments and/or their application.
- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
- Endodontic therapy if you discontinue endodontic treatment.
- 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, except if coverage is provided by a Medicare, Medicare Advantage or Medicaid benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
- To restore occlusion on incisal edges due to bruxism or harmful habits.
- The following Prosthodontic Services:
    - Treatment to replace teeth which were missing prior to the Effective Date.
    - Congenitally missing teeth.
    - Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
- The Plan may, without waiving these "Exclusions", elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the "Exclusions" listed above. If it is later determined that the care and services are excluded from the Member's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Contract (see "Plan's Right of Recoupment" in the ***General Provisions*** section). The Member must provide the Plan with all documents it needs to enforce its rights under this provision.