BlueCross BlueShield
of Oklahoma

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

PEDIATRIC DENTAL SERVICES ADDENDUM
For Subscribers Under Age 19

The Certificate of Benefits (Certificate) to which this Addendum is attached and becomes a part is hereby amended as stated below.

This *Pediatric Dental Services Addendum* provides information about coverage for the pediatric dental services outlined below, which are specifically excluded under your ***Comprehensive Health Care Services*** Benefits. Services that are covered under your ***Comprehensive Health Care Services*** Benefits are not covered under this *Pediatric Dental Services Addendum*. All provisions in your Certificate for ***Comprehensive Health Care Services*** Benefits apply to this *Pediatric Dental Services Addendum* unless specifically indicated otherwise below.

This dental care coverage allows Subscribers to select the Provider of their choice, in or out of the Dental Care Provider Network. The Plan has designed these Benefits to deliver quality care, matched with your ***Comprehensive Health Care Services*** Benefits, at the most affordable cost, through network services. You also have the flexibility to visit an Out-of-Network Provider, with a reduction in Benefits.

For a list of Dental Care Network Providers, please contact a Customer Service Representative at the number shown on the back of your Identification Card, or visit the Plan's Web site at www.bcbsok.com.

DEFINITIONS

The following definitions are added to the ***Definitions*** section of your Certificate:

- **Allowable Charge –** The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under the Certificate and this Addendum. The Plan will use the following criteria to establish the Allowable Charge for Covered Dental Services:
  - **Participating Dentist** – the amount the Dentist has agreed to accept as full payment for Covered Services.
  - **Out-of-Network Dentists** – the Dentist's usual charge for Covered Services, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.
- **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.
- **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).

- **Medically Necessary (or Medical Necessity) –** A specific procedure or supply provided to you is reasonably required in the judgment of the Plan, for the treatment or management of your specific dental symptom, injury, or condition and that the procedure performed is the most efficient and economical procedure that can safely be provided to you. The fact that a Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by the Plan. These consultants review the claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

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

ELIGIBILITY

Children who are covered under the Blue Cross and Blue Shield of Oklahoma Certificate for ***Comprehensive Health Care Services*** Benefits, up to age 19, are eligible for coverage under this *Pediatric Dental Services Addendum.* NOTE: Once coverage is lost under the Certificate, all Benefits cease under this *Pediatric Dental Services Addendum,* except as set forth under *"Extension of Your Dental Benefits in Case of Termination"*.

SCHEDULE OF BENEFITS
FOR
PEDIATRIC DENTAL SERVICES

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

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

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	Your Benefits for Pediatric Dental Services are subject to the Benefit Period Deductible for *"Network Provider Services"* set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
BENEFIT PERIOD MAXIMUM	Unlimited
OUT–OF–POCKET LIMIT	Your Benefits for Pediatric Dental Services are subject to the Out-of-Pocket Limit for *"Network Provider Services"* set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by this Addendum through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible amounts have been satisfied.

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
Diagnostic Evaluations	70% of Allowable Charge	50% of Allowable Charge
Preventive Services (Topical Fluoride Application covered at 100%, Deductible waived)	70% of Allowable Charge	50% of Allowable Charge
Diagnostic Radiographs	70% of Allowable Charge	50% of Allowable Charge
Miscellaneous Preventive Services	70% of Allowable Charge	50% of Allowable Charge
Basic Restorative Services	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Extractions	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Periodontal Services	70% of Allowable Charge	50% of Allowable Charge
Adjunctive General Services	70% of Allowable Charge	50% of Allowable Charge e
Endodontic Services	70% of Allowable Charge	50% of Allowable Charge
Oral Surgery Services	70% of Allowable Charge	50% of Allowable Charge
Surgical Periodontal Services	70% of Allowable Charge	50% of Allowable Charge
Major Restorative Services	70% of Allowable Charge	50% of Allowable Charge
Prosthodontic Services	70% of Allowable Charge	50% of Allowable Charge
Miscellaneous Restorative and Prosthodontic Services	70% of Allowable Charge	50% of Allowable Charge
Orthodontic Services Pediatric Orthodontic Services: Coverage limited to Subscribers with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	70% of Allowable Charge (Unlimited Lifetime Maximum)	50% of Allowable Charge (Unlimited Lifetime Maximum)

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

Pediatric Dental Services

The Benefits of this section are subject to all the terms and conditions of the Certificate. 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"* (listed below) and the ***Exclusions*** section of the Certificate, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your *Schedule of Benefits* above to find out what your Deductible, Coinsurance and Benefit Period Maximum will be for a Covered Service.

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

COVERED DENTAL SERVICES:

DIAGNOSTIC EVALUATIONS

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

- Periodic oral evaluations for established patients.
- Problem-focused oral evaluations, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children, including counseling with primary caregiver.

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

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.

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

PREVENTIVE SERVICES

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

- Prophylaxis – Professional cleaning, scaling and polishing of the teeth. Benefits are limited to two cleanings every 12 months. Additional Benefits will not be provided for prophylaxis based on degree of difficulty.
- Topical Fluoride Application – Benefits for Fluoride Application are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Combination of prophylaxes and periodontal maintenance treatments (see "*Non-Surgical Periodontal Services*") are limited to two every 12 months.

DIAGNOSTIC RADIOGRAPHS

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

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films – Benefits are limited to two sets every 12 months. However, Benefits are not available for bitewing films taken on the same date as full-mouth films.
- Periapical films, as Medically Necessary for diagnosis.

Benefits 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 Subscribers under age 19 and are limited to permanent molars only.
- Space Maintainers.
- Smoking and tobacco use cessation counseling.

Benefits are not available for nutritional or oral hygiene counseling.

BASIC RESTORATIVE SERVICES

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

- Amalgam restorations.
- Resin-based composite restorations.

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

NON-SURGICAL EXTRACTIONS

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

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

NON-SURGICAL PERIODONTAL SERVICES

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

- Periodontal scaling and root planing.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once every 12 months.
- Periodontal maintenance procedures – Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services include:

- Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Medically Necessary for documented Subscribers with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.
- Nitrous oxide analgesia.

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

ENDODONTIC SERVICES

Endodontics is the treatment of dental disease of the tooth pulp and includes:

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.
- Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Pulpal debridement is considered part of endodontic therapy when performed by the same Provider and not associated with a definitive emergency visit.

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

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

ORAL SURGERY SERVICES

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

- Surgical tooth extractions.
- Alveoloplasty and vestibuloplasty.
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Addendum.

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

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

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.

SURGICAL PERIODONTAL SERVICES

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

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one per quadrant every 24 months.
- Clinical crown lengthening.
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.
- Osseous grafts – Benefits are limited to one per site every 24 months.
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 24 months.
- Distal or proximal wedge procedure.
- Anatomical crown exposures – Benefits are limited to one per quadrant every 24 months.

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

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

MAJOR RESTORATIVE SERVICES

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

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

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

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

PROSTHODONTIC SERVICES

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

- Complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are available, whether placement was provided under this Certificate or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures – Benefits will be limited to one procedure every 36 months.
- Fixed bridgework – Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits are available, whether placement was under this Certificate or under any prior dental coverage.

Prosthetics placed over implants will be covered.

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

Benefits will not be provided for the following Prosthodontic Services:

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

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services include:

- Prefabricated crowns – Benefits are provided for stainless steel and resin-based crowns. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to two recementations every 12 months. However, any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect.
- Adjustments – Benefits will be limited to three times per appliance every 12 months.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (unless additions are completed on the same date as replacement partials/dentures).

ORTHODONTIC SERVICES

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

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

Special Provisions Regarding Orthodontic Services:

- Orthodontic services are paid over the Course of Treatment. Benefits cease when the Subscriber is no longer covered.

- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- If the Subscriber's coverage is terminated prior to the completion of the orthodontic treatment plan, the Subscriber is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Subscriber is not covered.
- Benefits are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the Effective Date, Benefits will be reduced based on other benefits paid prior to this coverage beginning.

EXCLUSIONS AND LIMITATIONS

These general "*Exclusions and Limitations"* apply to all services described in this ***Pediatric Dental Services*** section. 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 Addendum.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

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

  Please note that in order to provide you with dental care Benefits at a reasonable cost, this Addendum provides Benefits only for those Covered Services for eligible dental treatment that are determined by the Plan to be Medically Necessary.

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

  The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

- **Care By More Than One Dentist**

  If you change Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

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

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

- **Non-Compliance with Prescribed Care**

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

EXCLUSIONS — WHAT IS NOT COVERED

No Benefits will be provided under this Addendum for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Charge, as determined by the Plan.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Addendum or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Addendum.
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
- Services and supplies for any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Services or supplies received for behavior management or consultation purposes.
- Any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
  - You agree to:
    - pursue your rights under the workers' compensation laws;
    - take no action prejudicing the rights and interests of the Plan; and
    - cooperate and furnish information and assistance the Plan requires to help enforce its rights.

  - If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - repay the Plan any money recovered from the employer or insurance carrier.
- Any services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- Charges for nutritional or oral hygiene counseling.
- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Effective Date under this Addendum; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Effective Date.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis or occlusal adjustments.

The Plan may, without waiving these "*Exclusions 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 Subscriber's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Addendum. The Subscriber must provide the Plan with all documents it needs to enforce its rights under this provision.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If coverage under your Certificate or under this ***Pediatric Dental Services Addendum*** should terminate, Benefits will continue for any dental Covered Services described in this ***Pediatric Dental Services Addendum,*** as long as the Covered Service began prior to the date your coverage terminated and is completed within 30 days of your termination date. No Benefits will be provided for periodontal treatment after the termination of your Certificate or this Addendum.

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLAN

If your Dentist recommends a Course of Treatment, your Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Plan will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated Benefits which will be provided under this Certificate. 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 Certificate requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, you are responsible for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by the Plan.

HOW TO FILE A CLAIM

The following provisions are added to the ***Claims Filing Procedures*** section of your Certificate.

- **Filing Dental Claims**

  In order to obtain your dental Benefits under this Addendum, it is necessary for a claim to be filed with the plan. Usually all you have to do is show your Blue Cross and Blue Shield of Oklahoma Identification Card to your Dentist. They will file you claim for you. Remember, however, it is your responsibility to insure that the necessary claim information has been provided to the Plan.

  If you use an Out-of-Network Dentist and have to file a claim yourself, you should complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

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

  Claims must be filed with the Plan within 180 days following the end of the Benefit Period for which the claim is made. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing claims, call a Customer Service Representative at 1-888-454-5590 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

- **Dental Claim Review Procedures**

  If your claim has been denied in whole or in part, you may have your claim reviewed. The Plan will review its decision in accordance with the following procedure.

  Within 180 days after you receive notice of a denial or partial denial, write to the Plan. The Plan will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

  You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing, as it is necessary to protect against disclosure of information about you except to your authorized representative.

  While the Plan will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Plan will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the claim procedures or the review procedure, you may call a Customer Service Representative at 1-888-454-5590 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Or, you can write to:

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

If you have a claim for Benefits which is denied, in whole or in part, you may file suit in a state or federal court.

Except as amended by this *Pediatric Dental Services Addendum*, all other terms, conditions, limitations and exclusions of the Certificate, to which this Addendum is attached, will remain in full force and effect.

Blue Cross and Blue Shield of Oklahoma