Your Health Care Benefits Program

For Employees of

Sheet Metal Workers' Local 270 Welfare Fund

Dental

Effective February 1, 2018

Administered by:

BlueCross BlueShield of Oklahoma

70261.0115

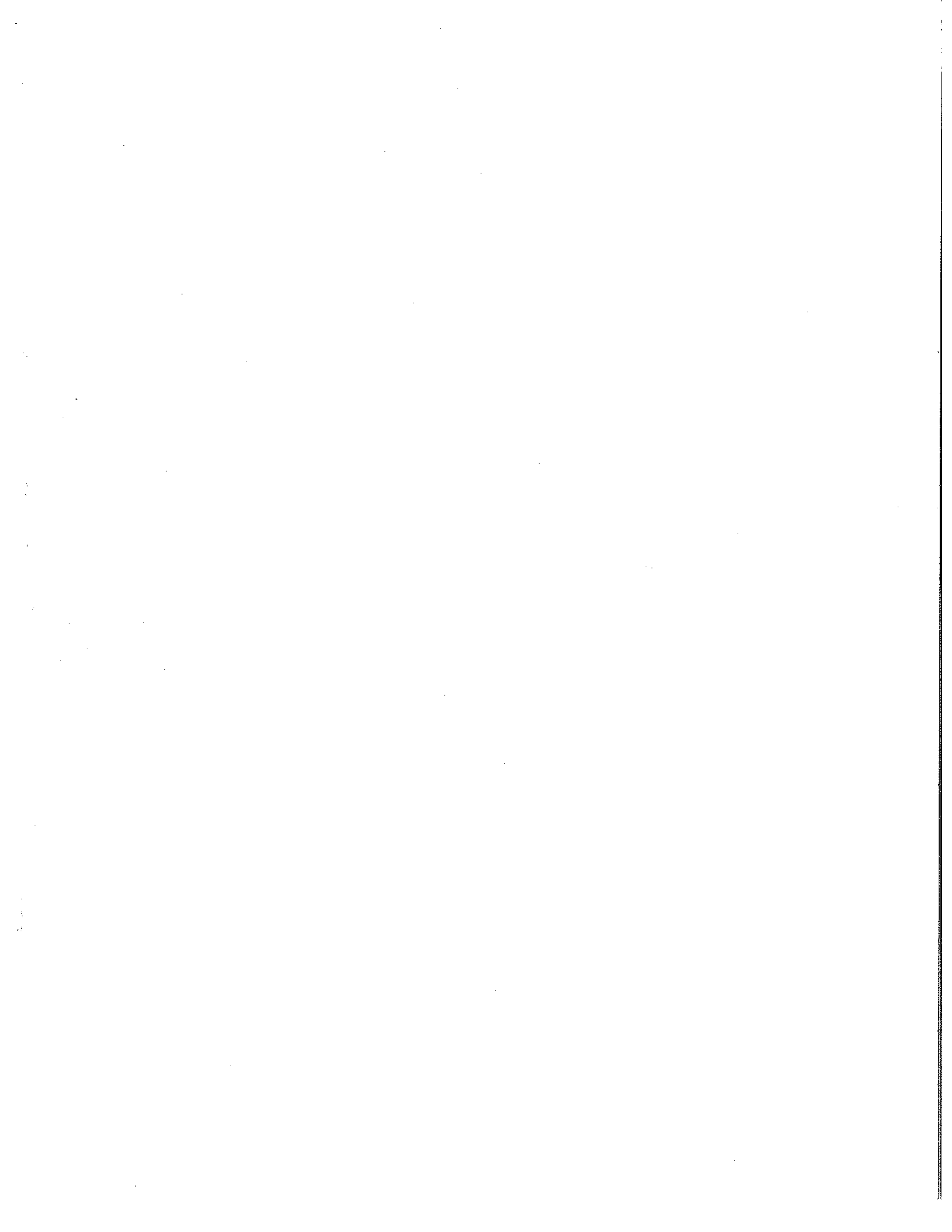

Table of Contents

Plan Summary *1*

Important Information *2*
- Your Participating Dentist Network 2
- How Your Dental Network Works 2
- Cost Sharing Features of Your Coverage 2
- Allowable Charge 2
- Deductible Requirements 3
- Benefit Period Maximum 3
- Coinsurance Requirements 3
- Pre–Determination of Dental Benefits Requirements 3
- Special Notices 4
- Identification Card 4
- Questions 4

Eligibility, Enrollment, Changes & Termination *6*
- Who Is an Eligible Person 6
- Who Is an Eligible Dependent 6
- How to Enroll 6
- How to Add Dependents 6
- Special Enrollment Period 7
- Open Enrollment Period 7
- Deleting a Dependent 7
- COBRA Continuation Coverage 7
- When Coverage Under The Plan Ends 9
- Extension of Your Dental Benefits in Case of Termination 9

Schedule of Benefits for Dental Care Services *10*

Dental Care Services *11*
- Diagnostic and Preventive Dental Services 11
- Basic Services 11
- Major Services 12

Dental Exclusions *13*
- Dental Procedures Which are Not Medically Necessary 13
- Care By More Than One Dentist 13
- Alternate Benefit Program 13
- Dental Care Exclusions 13

General Provisions *16*
- Benefits to Which You Are Entitled 16
- Prior Approval 16
- Notice and Properly Filed Claim 16
- Limitation of Actions 16
- Payment of Benefits 16
- Determination of Benefits and Utilization Review 17
- Covered Person/Provider Relationship 17
- Plan's Right of Recoupment 17
- Limitations on Plan's Right of Recoupment/Recovery 18

Claims Filing Procedures *19*
- Participating Providers 19
- Provider Claims 19
- Employee–Filed Claims 19
- Benefit Determinations for Properly Filed Claims 20
- Dental Claim Review Procedures 20
- Direct Claims Line 21

Definitions* *22

Plan Summary

Sheet Metal Workers Union Local 270 Welfare Fund (called the ***Employer***) has established and maintains a self-insured Plan of Dental Care Benefits for its eligible Employees and other persons as designated in its personnel policy.

The Plan is operated under an Administrative Services Agreement between the Employer and Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (called the ***Claims Administrator***).

Under this Agreement, the Claims Administrator provides Benefits on behalf of the Employer in accordance with the terms of the Plan and performs certain other services on behalf of the Employer. The Employer reserves the right to amend or cancel any or all provisions of the Plan at any time as it relates to any Covered Person.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This dental benefit booklet is issued according to the terms of the Plan. It is not a summary plan description. It is only a summary of Benefits, and all statements in this benefit booklet are subject to the terms of the Plan documents on file in your Human Resources Department.

This dental benefit booklet replaces any and all summaries, certificates or dental benefit booklets previously issued for the Employees under the Plan. It describes the Plan in effect as of February 1, 2018, for all Covered Persons (called "you" or "your").

Important Information

PLEASE READ THIS SECTION CAREFULLY! It explains the role Participating Dentists play in your dental care coverage. It also explains important cost containment features in your dental care program. Together, these features allow you to receive quality dental care in cost-effective settings, while helping you experience lower out-of-pocket expenses.

YOUR PARTICIPATING DENTIST NETWORK

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

- A Participating Dentist will file your claims for you.
- Payment for Covered Services you receive will be sent directly to the Participating Dentist.
- For Covered Services, you only have to pay your shared payment amount. **If your Participating Dentist charges more than the Plan's allowance for Covered Services, you aren't responsible for the difference.**

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

To locate a Participating Dentist, please call one of the Customer Service Representatives at 1-888-381-9727. You may also look up in-state (Oklahoma) and out-of-state Dentists on the "Provider Directory" section of the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com.

HOW YOUR DENTAL NETWORK WORKS

This dental program is designed to give 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, the program offers considerable financial advantages to Covered Persons whenever they use a Participating Dentist.

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

COST SHARING FEATURES OF YOUR COVERAGE

As a participant in the Plan, you have the responsibility for sharing in a portion of your dental care costs. You are responsible for the applicable Copayment, Deductible and Coinsurance provisions of your coverage, as well as any charges for which Benefits are not provided. You may also be responsible for a portion of your dental care contributions, depending upon the terms of the Plan. Check with your Plan Administrator for specific premium amounts applicable to the coverage you have selected for you and your family.

ALLOWABLE CHARGE

To take full advantage of the negotiated pricing arrangements in effect between Blue Cross and Blue Shield of Oklahoma and their network of Participating Dentists, you must use Participating Dentists whenever possible.

Participating Dentists have agreed to hold the line on dental care costs by providing special prices for Covered Persons. A Participating Dentist will accept this negotiated price as payment for Covered Services. This means that, if a Participating Dentist bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference.***

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

If you use an Out-of-Network Dentist, you will be responsible for the following:

- Charges for any services which are not covered under the Plan;
- Any Deductible or Coinsurance amounts that are applicable to your coverage; and
- The difference, if any, between your Dentist's "billed charges" and the "Allowable Charge" determined by the Claims Administrator.

Your coverage includes a higher Coinsurance percentage for services you receive out-of-network (refer to the ***Schedule of Benefits for Covered Dental Services***).

Deductible Requirements

The Deductible amounts for each Covered Person are shown on the ***Schedule of Benefits for Covered Dental Services***. The Deductible is the amount that each Covered Person must pay for Covered Services received during a Benefit Period before this dental Benefit program begins paying its percentage of the Allowable Charge for Covered Services. The amount applied to the Deductible for a Covered Service cannot exceed the Allowable Charge for the Covered Service.

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 the Plan and the coverage outlined in the ***Schedule of Benefits for Covered Dental Services***.

Each Covered Person's Benefit Period Maximum amount is given on the ***Schedule of Benefits for Covered Dental Services***.

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

Coinsurance Requirements

Your Coinsurance amount is the percentage of the Allowable Charges you are required to pay for a Covered Service after the Deductible has been met.

For each Covered Service, and after the Covered Person has met the Deductible (if applicable), this dental Benefit program pays a certain percentage (specified on the *Covered Person's Schedule of Benefits*) of the Allowable Charge for the Covered Service. When a Covered Service is received from a Participating Dentist, the Covered Person pays only the Deductible and the Coinsurance (or in excess of the maximum lifetime orthodontic Benefit). When a Covered Service is received from an Out-of-Network Dentist, the Covered Person is also responsible for the amount charged by the Out-of-Network Dentist that exceeds the Allowable Charge for the Covered Service.

Pre-Determination of Dental Benefits Requirements

If a recommended course of dental treatment is expected to exceed $300, you must request a pre-determination of the dental Benefits payable under this Plan before you or your Dependent undergoes treatment. You must submit an itemized Treatment Plan from your Dentist to the Claims Administrator accompanied by supporting pre-treatment x-rays and any other appropriate diagnostic studies. You will receive a Pre-Determination of Benefit in return.

In determining the Benefits payable, the Claims Administrator will consider alternative procedures that may also provide a professionally satisfactory result. Benefits will be based upon the least expensive service which meets broadly accepted standards of dental care as determined by the Claims Administrator. If you and your Dentist decide on a more expensive procedure, Benefits will still be payable but only up to the lease expensive alternative procedure.

Since this may result in a significant out-of-pocket expense to you, we strongly encourage you to follow the pre-determination requirement for any Treatment Plan which exceeds $300.

If services subject to this requirement are rendered without obtaining a Pre-Determination of Benefits, Benefits will still be determined based on this provision. You will not have the advantage of learning Plan Benefits beforehand and lose the opportunity to discuss any alternative procedure with your Dentist.

A Pre-Determination of Benefits does not guarantee payment. Benefits payable will be based upon those for which you or your Dependent qualified at that the time services are completed.

Special Notices

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

Because of changes in some federal or state laws, changes in your dental care program, or the special needs of the Plan, provisions called "special notices" may be added to this Plan Summary.

Be sure to check for a "special notice". It changes provisions or Benefits in the Plan and this Plan Summary.

Identification Card

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

This Card shows the Employee's personal identification number which applies to you and each of your Covered Dependents. Duplicate cards can be obtained for each member of your family.

Carry your card at all times. If you lose your card, you can still use your coverage. You can replace your card faster, however, if you know your identification number.

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

Questions

Whenever you call the Claims Administrator for assistance, please have your Identification Card with you.

You usually will be able to answer your dental care Benefit questions by referring to this benefit booklet. If you need more help, please call at Customer Service Representative at 1-888-381-9727.

Or you can write:

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

When you call or write, be sure to give your identification number which is on your Identification Card. If the question involves a claim, be sure to give:

- the date of service;
- name of the Provider;
- the kind of service you received; and
- the charges involved.

Eligibility, Enrollment, Changes & Termination

This section tells:

- How and when you become eligible for coverage under the Plan;
- Who is considered an Eligible Dependent;
- How and when your coverage becomes effective;
- How to change types of coverage; and
- How and when your coverage stops under the Plan.

WHO IS AN ELIGIBLE PERSON

Unless otherwise specified in the Group Contract, you are an Eligible Person if you are employed on a full-time or part-time basis.

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

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse.
- your Dependent child. Wherever used in this Plan, "Dependent child" means your natural child, a stepchild, an adopted child or child Placed for Adoption (including a child for whom you or your spouse is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors. A child not listed above who is legally and financially dependent upon the Member or spouse is also considered a Dependent child under the Certificate, provided proof of dependency is provided with the child's application.

  A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

HOW TO ENROLL

To be covered under the Plan, you must complete the enrollment process outlined by your Human Resources Department.

HOW TO ADD DEPENDENTS

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

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

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

Special Enrollment Period

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

Open Enrollment Period

If you do not apply for coverage for yourself or for your Eligible Dependent(s) when first eligible to do so, or during a Special Enrollment Period, then you may submit an application to the Plan during the next Open Enrollment Period. An Open Enrollment Period will be held each year during the 31-day period immediately before the Plan Anniversary (renewal date). Your application for coverage must be received by the Plan Administrator within this time.

Deleting a Dependent

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

COBRA Continuation Coverage

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

- **Eligibility for Continuation Coverage**

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

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

  — your divorce or legal separation; or

  — your Dependent child ceasing to be an Eligible Dependent under the Plan; or

  — the birth, adoption or Placement for Adoption of a child while you are covered under COBRA Continuation Coverage.

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

- **Election of Continuation Coverage**

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

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

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

- **COBRA Continuation Coverage Period**

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

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

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

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

    ○ the ineligibility of a Dependent child;

  provided the premiums are paid for the coverage as required.

- **Disability Extension**

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

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

- **Multiple Qualifying Events**

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

- **Special TAA/ATAA Election Period**

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

assistance, as determined by the Department of Labor or state labor agency. The Employee is not eligible for the special election period if the TAA/ATAA eligibility determination is made more than six months after termination of employment.

When Coverage Under The Plan Ends

When a Covered Person is no longer an Eligible Person or Eligible Dependent, coverage will end as follows:

- When a Covered Person ceases to be an Eligible Person because of termination of employment, coverage will end on the date in which the termination occurs.
- When a Covered Person ceases to be an Eligible Dependent, coverage stops on the date in which eligibility ceases.
- A Covered Person's COBRA Continuation Coverage, when applicable, will end on the earliest to occur of the following dates:
  - — the end of the month following expiration of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period, whichever is applicable;
  - — the end of the month following 30 days after the date of the Social Security Administration's final determination that the Covered Person is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);
  - — the date on which the Employer stops providing ***any*** Group Dental Plan to ***any*** Employee;
  - — the date on which coverage stops because of a Covered Person's failure to pay any premiums required for the COBRA Continuation Coverage;
  - — the end of the month following the date on which the Covered Person first becomes (after the date of the election) covered under any other Group Dental Plan which does not contain any exclusion or limitation with respect to a Preexisting Condition applicable to the Covered Person (or the date the Covered Person has satisfied the Preexisting Condition Exclusion period under that plan); or
  - — the end of the month following the date on which the Covered Person enters full-time military, naval, or air services; or
  - — the end of the month following the date on which the Covered Person becomes (after the date of the election) entitled to benefits under Medicare.
- When a Covered Person is no longer an Eligible Person or Eligible Dependent due to an event not described above, coverage will stop on the date in which eligibility ceases.

If you fail to make a required contribution for your coverage under this Plan, your coverage will stop at the end of the coverage period for which your contribution has been made.

Termination of the Plan automatically ends all of your coverage at the same time and date.

Extension of Your Dental Benefits in Case of Termination

After the date you stop being a Covered Person, the Plan will not pay for any procedures or services, including orthodontic procedures or services, which you receive after your coverage ends.

Schedule of Benefits for Dental Care Services

This section shows how much we pay for Covered Services described in the ***Covered Dental Services*** section that follows subject to the conditions and limitations of the Plan.

DENTAL CARE EXPENSES

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	• $50 per Benefit Period per Covered Person Deductible does not apply to **Diagnostic and Preventive Services**
MAXIMUM	• $1,000 per Benefit Period per Covered Person

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

BENEFIT PERCENTAGE AMOUNT — The following chart shows the amount of Allowable Charges covered by the Plan through payments and/or contractual arrangements with Dentists. These percentages apply only after your Deductible and/or Coinsurance has been satisfied.

COVERED SERVICES (Subject to the Covered Dental Services section which follows)	**AMOUNT:**
DIAGNOSTIC AND PREVENTIVE SERVICES	100% of the Allowable Charge for Covered Services
BASIC SERVICES	80% of the Allowable Charge for Covered Services
MAJOR SERVICES	50% of the Allowable Charge for Covered Services

Dental Care Services

This section describes the services and supplies covered by this dental Plan. Benefits are payable only for services and supplies that are considered "Medically Necessary."

Diagnostic and Preventive Dental Services

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

- Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than twice per Benefit Period;
- Periapical x-rays, as required, and bitewing x-rays limited to twice per Benefit Period;
- Full mouth x-rays, but not more than once in any period of 60 consecutive months;
- Topical application of fluoride for Dependent children under age 19, but not more than twice per Benefit Period;
- Sealants for Dependent children under age 14, but not more than once in any period of 60 consecutive months, limited to permanent first and second molars; and
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent children under ag 19. No payment will be made for duplicate space maintainers.

Basic Services

- All Medically Necessary x-rays;
- Amalgam, silicate, acrylic, synthetic porcelain and composite filing restorations to restore diseased or accidentally broken teeth. Gold foil restoration are not eligible;
- Simple extractions;
- Oral Surgery;
- Root Canal therapy;
- General anesthesia;
- I.V. Sedation;
- Stainless steel crowns, primary teeth only;
- Recementation of crowns, inlays/onlays;
- Repairs to full and partial dentures;
- Bone repair;
- Surgical gum examination;

- Deep scaling of the gums; and
- Cutting and repair of the gum.

Major Services

- Crowns, inlays/onlays repairs (not part of a bridge);
- Bridge and Denture repairs;
- Reline/Rebase;
- Fixed bridge; and
  - — Veneers or similar properties of crowns and bridges placed on or replacing the 10 upper and 10 lower anterior teeth.

Dental Exclusions

Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in ***"Definitions"***) licensed to perform services covered under this dental Benefit program.

Dental Procedures Which are Not Medically Necessary

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

No Benefits will be provided for procedures which are not, in the reasonable judgment of the Claims Administrator, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Claims Administrator, for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you. The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

Care By More Than One Dentist

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

Alternate Benefit Program

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

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

Dental Care Exclusions

In addition to the exclusions outlined in the ***Exclusions*** section of this benefit booklet, no Benefits will be provided under this ***Covered Dental Services*** section for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Dental services which are not Medically Necessary as defined by the Claims Administrator.
- Dental services which no charge is made.
- Dental services completed after you or your Dependent are no longer covered under this dental Plan.

- Dental services which is also covered by your Health Care Plan.
- Dental services which is performed more frequently than the Plan allows.
- Dental services which are performed for cosmetic purposes, including but not limited to, bleaching teeth and grafts to improve esthetics.
- Services or supplies for gold foil restorations, oral hygiene, plaque control programs, and dental implants.
- Services or supplies for local anesthesia when billed separately.
- Services or supplies for replacement of lost or stolen appliances.
- Services or supplies for orthodontia.
- Services or supplies which the Plan determines are Experimental/Investigational in nature.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services received from a member of your immediate family.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Services or supplies received for behavior management or consultation purposes.
- For the following oral surgery procedures:

  — surgical services related to a congenital malformation;

  — surgical removal of partial, complete and complicated bony impacted teeth;

  — excision of tumors or cysts of the jaws, 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 bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
- Charges for nutritional, tobacco, and oral hygiene counseling.
- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state, or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions or preparations.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.

- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- 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 dental Plan; 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.
- For any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer–employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
  - You agree to:
    - pursue your rights under the workers' compensation laws;
    - take no action prejudicing the rights and interests of the Plan; and
    - cooperate and furnish information and assistance the Plan requires to help enforce its rights.
  - If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - repay the Plan any money recovered from your employer or insurance carrier.
- Any services or supplies to the extent payment has been made under Medicare or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).

General Provisions

This section tells:

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

Benefits to Which You Are Entitled

The Plan provides only the Benefits specified in this benefit booklet.

Only Covered Persons are entitled to Benefits from the Plan and they may not transfer their rights to Benefits to anyone else.

Benefits for Covered Services specified in this benefit booklet will be covered only for those Providers specified in this booklet.

Prior Approval

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

Notice and Properly Filed Claim

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

Your Properly Filed Claim must be furnished to the Claims Administrator within 12 months from the date of service for which claim is made.

Failure to provide a Properly Filed Claim to the Claims Administrator within the time specified above will not reduce any Benefit if you show that the claim was given as soon as reasonably possible.

Limitation of Actions

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

Payment of Benefits

You authorize the Claims Administrator to make payments directly to Providers giving Covered Services for which the Plan provides Benefits under this benefit booklet. The Claims Administrator also reserve the right to make payments directly to you.

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

Once a Dentist gives a Covered Service, the Claims Administrator will not honor a request not to pay the claims submitted.

Benefits under this benefit booklet will be based upon the Allowable Charge (as the Claims Administrator determines) for Covered Services. A Participating Dentist will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services. However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

Determination of Benefits and Utilization Review

The Claims Administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Plan and to determine its Benefits.

The Claims Administrator's medical staff may conduct a medical review of your claims to determine that the care and services received are Medically Necessary. **The fact that a Dentist, Physician or other Provider prescribes, orders, recommends or approves a service or supply does not, of itself, make it Medically Necessary or a Covered Service, even if it is not specifically listed as an exclusion under this benefit booklet.**

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

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

Failure of the Covered Person to comply with the Claims Administrator'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 Provider is solely yours.

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

The Claims Administrator does not furnish Covered Services but only pays for Covered Services you receive from Providers. They are not liable for any act or omission of any Dentist. They have no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

Plan's Right of Recoupment

You agree to reimburse the Plan for Benefits it has paid and for which you were not eligible under the terms of the Plan. This payment is due and payable immediately when you are notified by the Claims Administrator. Also, we have the sole right to determine that any overpayments, wrong payments, or any excess payments made for you under this Plan are an indebtedness which we may recover by deducting it from any future Benefits under the Plan, or under any other coverage provided by the Plan. Our acceptance of your premiums or payment of Benefits under this Plan does not waive our rights to enforce these provisions in the future.

To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, each 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 or 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.

You must hold in trust for the Plan any money (up to the amount of Benefits we have paid) you recover, as described above. You must give us information and assistance and sign necessary documents to help us enforce our rights.

Limitations on Plan's Right of Recoupment/Recovery

The Plan will not seek recovery of any excess or erroneous payment made under this Plan more than 24 months after the payment is made, unless;

- 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.

Claims Filing Procedures

The Plan begins to pay only after the Deductible amount you incur toward eligible expenses shows on the Claims Administrator's records. When your Dental or other Provider of dental care care services submits bills for you, your Copayment and/or Deductible will be recorded automatically and then the Plan will begin its share of the payment. If you file your own claims, you must submit copies of all your bills, even those you must pay to meet your Copayment and/or Deductible. Then the Claims Administrator's records will show that you have Incurred the Deductible amount, and your dental care coverage will begin to help pay the balance of your eligible expenses.

Participating Providers

Participating Providers have agreed to submit claims directly to the Claims Administrator for you. When you receive Covered Services from a network Provider, simply show your Identification Card, and claims submission will be handled for you. If you must use an Out-of-Network Provider, you should follow the guidelines below in submitting your claims.

Provider Claims

Many Providers will submit claims directly to the Claims Administrator for services rendered to you, even if they are not a Participating Provider. If your Provider will file your claims for you, follow these steps:

- Before visiting your Provider, obtain a claim form by contacting the nearest Claims Administrator's office.
- A separate claim form must be filed for each Covered Person, i.e., if you have Family Coverage, a separate claim form must be filed for each member of your family, including yourself.
- Complete the EMPLOYEE's STATEMENT, then sign the claim form.
- Give the claim form to your Provider at the time of your visit.

The Provider can then mail the form to the Claims Administrator.

Employee-Filed Claims

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Claims Administrator's office.

Be sure to fill out the claim form completely, sign it, and attach the Dental Provider's itemized statement.

Send the completed dental forms to:

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

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

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

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

- Full name of patient;
- Dental service(s) performed;
- Date of service(s);
- Who rendered service(s);
- Charge for service(s);

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

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

Remember, the Claims Administrator must receive your claims for Covered Services within 12 months from the date of the service for which claim is made.

Benefit Determinations for Properly Filed Claims

Once the Claims Administrator receives a Properly Filed Claim from you or your Provider, a Benefit determination will be made within 30 days. This period may be extended one time for up to 15 additional days, if the Claims Administrator determines that additional time is necessary due to matters beyond their control.

If the Claims Administrator determines that additional time is necessary, you will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make the determination.

Upon receipt of your claim, if the Claims Administrator determines that additional information is necessary in order for it to be a Properly Filed Claim, they will provide written notice to you, prior to the expiration of the initial 30-day period, of the specific information needed. You will have 45 days from receipt of the notice to provide the additional information. The Claims Administrator will notify you of its Benefit determination within 15 days following receipt of the additional information.

The procedure for appealing an adverse Benefit determination is set forth in the section entitled, "***Claim Review Procedure.***"

Dental Claim Review Procedures

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

Within 180 days from the date you received notice of a denial or partial denial, write to the Group Administrator. The Group Administrator will need to know the reasons why you do not agree with the denial or partial denial.

Send your dental request to:

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

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

While the Group Administrator 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 Group Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the claims procedures or the review procedure, you may call a Customer Service Representative at 1-888-381-9727 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Or, for dental questions, you can write:

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

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

Direct Claims Line

The Claims Administrator has a direct line for claims and membership inquiries. You may call 1-888-381-9727 (for dental claims) between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Definitions

This section defines terms that have special meanings in the Plan. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in this section or where used in the text or it is a title.

Allowable Charge

The charge that the Claims Administrator will use as the basis for Benefit determination for Covered Services you receive under the Contract. The Claims Administrator will use the following criteria to establish the Allowable Charge:

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

Appliance

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

Benefit Period 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 Dental Plan 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.

Calendar Year

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

Claims Administrator

Blue Cross and Blue Shield of Oklahoma (called BCBSOK, a Division of Health care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association).

COBRA

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

Course of Treatment

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

Covered Employee

A person covered by the Plan.

Covered Person

The Employee and each of his or hers Dependents covered under this Plan.

Deductible

A specified amount of Covered Services that you must incur before the Plan will start to pay its share of the remaining Covered Services.

Dental Hygienist

A person who is licensed to practice dental prophylaxis and is acting under the direction of a Dentist and within the scope of that illness.

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).

Employer

Sheet Metal Workers' Local 270 Welfare Fund

ERISA

"ERISA" shall mean Public Law No. 93-406, The Employee Retirement Income Security Act of 1974, as amended from time to time.

Family Coverage

Coverage under the Plan for the Employee and one or more of the Employee's Dependents.

Functioning Natural Tooth

A natural tooth which meets another natural tooth or artificial tooth replacement in the opposite dental arch which permits chewing.

Group Dental Plan

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

Identification Card

The card issued to the Employee by the Claims Administrator, bearing the Employee's name, identification number, and Group number.

Incurred

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

Initial Enrollment Period

The 31-day period immediately following the date an Employee or Dependent first becomes eligible to Enroll for coverage under the Plan.

Medically Necessary (or Medical Necessity)

Health care services that the Plan determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness injury or disease.

Natural Tooth

A tooth or portion of a tooth that was oranically formed during the natural development of the body. Organic portions of a tooth include the crown enamel and dentin, the root cementurn and dentin, and the enclosed pulp (nerve).

Open Enrollment Period

A period designated by the Plan Sponsor, prior to the Plan's anniversary date, during which an individual who previously declined coverage may Enroll for coverage under the Plan.

Orthognathic Surgery

Services or supplies received for correction of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily respositioning of entire jaws.

Orthotic Appliance

An external device intended to correct any defect in form or function of the human body.

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

Participating Dentist

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

- A Dentist who has entered into a Participating Provider Agreement with Blue Cross and Blue Shield of Oklahoma;
- A Dentist who has contracted directly with any division of subsidiary of Health Care Services 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.

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

Sheet Metal Workers' Local 270 Welfare Fund

Plan Administrator

The person or entity designated by the Employer who has the discretion and authority to control and manage the operation of the Plan.

Predetermination Estimate

A Predetermination 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 Covered Person's coverage, and may include an allowance for alternate Benefits. Final determination of Benefits is made upon submission of a claim to the Plan for actual payment.

Properly Filed Claim

A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the Plan to determine its liability for Covered Services. This includes: a completed claim form; the Provider's itemized statement of services rendered and related charges; and medical records, when requested by the Claims Administrator.

Provider

A Hospital, Physician, Dentist or other practitioner or Provider of services or supplies licensed to render Covered Services and performing within the scope of such license.

Qualifying Event

Any one of the following events which, but for the COBRA Continuation Coverage provisions of the Plan, would result in the loss of a Covered Person's coverage:

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

Special Enrollment Period

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

Temporomandibular Joint Dysfunction/Syndrome (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Treatment Plan

The Dentist's statement of recommended treatment on forms satisfactory to us which lists the proposed dental procedures and itemizes the charges for each procedure.

Waiting Period

The period that must pass before an Eligible Person or Dependent is eligible to Enroll under the terms of a Group Health Plan. If an Eligible Person or Dependent Enrolls as a Late Enrollee or during a Special Enrollment Period, any period before such late or special enrollment is not a Waiting Period.