BlueCross BlueShield of Oklahoma

Dental Benefit Program Description

Custom Insured & ASO Accounts

for 1/1/2023 effective dates

Account Name: City of Lawton

Group Name (if different)**:** N/A

Account Number: YNS005

Group & Section Numbers: 266590 – 0001, 0002, 0003, 0004, 1001, 1002, 1003, 1004, 2001, 2002, 2003, 2004

Effective Date: 07/01/2023

ERISA Plan Year (same as benefit plan year)**:** N/A

Benefit Agreement: 0032, 0033, 0034

☒ Local Account ☐ National Account

☐ New Business ☒ Existing Business

☐ Add new group section

☐ Benefit changes

ERISA Plan Administration Information – Include in certificate booklet: ☐ Yes ☒ No

Funding: ☒ Fully Insured ☐ ASO

Account Executive:	Chris Engelman	**Cost center #**		**Phone Number:**	405-316-7011
Underwriter:	Sara Palin	**Cost center #**		**Phone Number:**	972-766-5347
Full Service Unit:	Tulsa			**Phone Number:**	

NMAS Implementation: ☐ Yes ☐ No ☒ N/A

Date Form Completed: 04/10/2023 **Form completed by:** Chris Engelman

Benefit Program Description Composition

This Benefit Program Description (BPD) consists of the following components:

Check each section that has been completed and attached.

☒ Dental PPO 151+ Custom Benefits	☒ Eligibility Provisions
☒ Miscellaneous Benefits/Provisions	☒ Exclusions & Limitations
☐ Data Entry Fields (processing team use only)	☐ Approval Signatures

For Insured Accounts: In addition to the benefits stated in this document, benefits for covered individuals who reside outside of Oklahoma will conform to all extraterritorial requirements of those states according to the group's funding arrangement.

NOTE: Non-standard benefits/provisions that require Department of Insurance (DOI) approval will become effective on the DOI approval date.

Dental PPO 151+ Custom Benefits

BlueCare Dental PPO & Plan Options

Separate Dental Booklet Requested: ☒ Yes ☐ No

Benefit Period: ☐ Calendar Year ☒ Contract Year; if Contract Year, to 07/01 – 06/30

Benefit Period Maximum: $**750** ($500-$5,000 in $100 increments; not applicable to Orthodontics, if any)

☐ **BlueMax Advantage** (graduated maximum) – optional

Graduated Annual Maximum Increment: Start Date: N/A
Number of Increments: N/A

In-Network Amount: N/A

Out-of-Network Amount: N/A

Transfer In: ☐ Yes
☐ No

Note: BlueMax Advantage benefit maximum increment is applied after first dental benefit year.

	PPO	Non-PPO
Non-PPO Payment Level:	n/a	☐ Schedule of Maximum Allowances ☒ Usual & Customary: **95th** Percentile (70th-95th percentile in increments of 5)
Individual Deductible:	$0 per benefit period ($0-$200 in $50 increments)	$0 per benefit period ($0-$200 in $50 increments)
Family Deductible:	☐ $**0** aggregate (standard) ☒ **N/A** times (2 or 3) individual deductibles	

Dental Service Categories			
	Deductible Applies	**PPO**	**Non-PPO**
Diagnostic Services periodic oral evaluations, problem focused evaluations, and comprehensive oral evaluations	☐ Yes ☒ No (standard)	100% (50% - 100% in 5% increments)	100% (50% - 90% in 5% increments)
Preventive Services Includes prophylaxis (cleanings) and topical fluoride applications.	☐ Yes ☒ No (standard)	100% (50% - 100% in 5% increments)	100% (50% - 90% in 5% increments)
Diagnostic Radiographs Includes full-mouth and panoramic films, bitewing films, and periapical films.	☐ Yes ☒ No (standard)	100% (50% - 100% in 5% increments)	100% (50% - 90% in 5% increments)
Miscellaneous Preventive Services Includes space maintainers and sealants.	☐ Yes ☒ No (standard varies by plan)	100% (50% - 100% in 5% increments)	100% (50% - 90% in 5% increments)
Basic Restorative Dental Services Includes amalgams and resin-based composite restorations.	☒ Yes (standard) ☐ No	80% (50% - 100% in 5% increments)	80% (50% - 90% in 5% increments)
Non-Surgical Extractions Includes removal of retained coronal remnants and removal of erupted tooth or exposed root.	☒ Yes ☐ No (standard)	80% (50% - 100% in 5% increments)	80% (50% - 90% in 5% increments)
Non-Surgical Periodontal Services Includes scaling and root planing, full mouth debridement and periodontal maintenance procedures.	☒ Yes ☐ No (standard)	80% (50% - 100% in 5% increments)	80% (50% - 90% in 5% increments)

Adjunctive Services Includes palliative treatment (emergency) and deep sedation/ general anesthesia.	☒ Yes ☐ No (standard)	80% (50% - 100% in 5% increments)	80% (50% - 90% in 5% increments)
	Deductible Applies	**PPO**	**Non-PPO**
Endodontic Services Includes root canals therapy, apexification/recalcification, and therapeutic pulpotomy and pulpal debridement.	☒ Yes ☐ No (standard)	0% (50% - 100% in 5% increments)	0% (50% - 90% in 5% increments)
Oral Surgery Services Includes alveoloplasty, surgical extractions and vestibuloplasty, excision of benign odontogenic tumor/cyst, excision of bone tissue and incision, and drainage of an intraoral abscess. (Bony impactions typically covered under medical plan)	☒ Yes (standard) ☐ No	0% (50% - 100% in 5% increments)	0% (50% - 90% in 5% increments)
Surgical Periodontal Services Includes gingivectomy or gingivoplasty and gingival flap procedures, clinical crown lengthening, osseous surgery, osseous grafts, soft tissue grafts/ allografts and distal or proximal wedge procedure.	☒ Yes (standard) ☐ No	0% (50% - 100% in 5% increments)	0% (50% - 90% in 5% increments)
Major Restorative Services Includes single crown restorations, inlay/onlay restorations, labial veneer restorations, and crowns placed over implants.	☐ Yes ☒ No (standard)	N/A% (50% - 100% in 5% increments)	N/A% (50% - 90% in 5% increments)
Prosthodontic Services Includes complete and removable partial dentures, denture reline/rebase procedures, fixed bridgework, and prosthetics placed over implants. **Implants:** ☐ Yes ☒ No	☐ Yes (standard) ☒ No	N/A% (50% - 100% in 5% increments)	N/A% (50% - 90% in 5% increments)
Miscellaneous Restorative and Prosthodontic Services Includes prefabricated crowns, recementations, post and core, pin retention, and crown/bridge repairs and adjustments.	☐ Yes ☒ No (standard)	N/A% (50% - 100% in 5% increments)	N/A% (50% - 90% in 5% increments)
Orthodontic Benefits: ☐ Yes (complete fields to the right) ☒ No	☐ Yes ☒ No (standard)	N/A% (50% - 100% in 5% increments)	N/A% (50% - 90% in 5% increments)
	Lifetime Maximum: $**N/A** ($0 or $500-$3,000 in $100 increments)		
	Employee Eligible: ☐ Yes ☒ No **Spouse Eligible:** ☐ Yes ☒ No **Dependent child Eligible:** ☐ Yes; if Yes, age limit: ☐ 19 (standard) ☐ 26 ☒ No		

Other Options	
Missing Tooth Exclusion:	☒ **Yes** (standard) An exclusion applies to expenses involving the replacement of teeth that were missing prior to the effective date of coverage, except when a participant has had continuous coverage for the following number of months under a group dental care contract with BCBSOK, a previous group dental contract or a combination of the two. Plans must include major services (prosthetic benefits). ☒ 24 months (standard) ☐ 99 months (exclusion permanently applies) **Does exclusion apply to initial enrollees?** ☐ *Yes* (Same rules as above apply) ☒ *No* (Initial enrollees receive immediate coverage standard) ☐ **No Exclusion** All teeth covered beginning on first day of coverage •
Prior Deductible Credit:	☐ Yes ☒ No (available only with calendar year benefit period)
Carry-over Credit:	☐ Yes ☒ No (available only with calendar year benefit period)
Claim filing time limit:	☒ Within 365 days of the date of service (standard) ☐ End of the year following the year of service ☐ Two years from the date of service ☐ Other (explain in Additional Provisions section below)
Deductibles cross-apply in-network and out-of-network	☒ Yes (standard) ☐ No

Preventive Services (Selected services will not apply to the annual maximum.)

☒ Diagnostic Services
☒ Preventive Services
☒ Diagnostic Radiographs
☒ Miscellaneous Preventive Services

Benefit Waiting Period

☐ Yes (The following information is required as per Group request.)

IF A BENEFIT WAITING PERIOD APPLIES; WAITING PERIOD IS WAIVED FOR EXISTING GROUP DENTAL PLANS AND/OR TRANSFERS GROUPS.

Effective Date: N/A

Member must be continuously covered under this policy for N/A months before being eligible for the following Covered Services:

- ☐ Oral Surgery
- ☐ Endodontics
- ☐ Non-Surgical Periodontal Services
- ☐ Surgical Periodontal Services
- ☐ Major Restorative Services
- ☐ Prosthodontic Services
- ☐ Miscellaneous Restorative and Prosthodontic Services
- ☐ Orthodontic Services

☒ No

Enhanced Dental Benefit - ☒ Yes (standard) ☐ No

Enhanced Benefit allows groups to provide additional dental benefits to members with specific medical conditions. The group must also have their medical coverage through BCBS.

Select Covered Conditions:

X Cardiovascular disease, Diabetes or Pregnancy (standard grouping)

☐ Pre-Diabetes (requires standard grouping)

Additional benefit for one of the following:

- Scaling & Root Planing
- Periodontal Maintenance
- Cleaning

Apply toward annual maximum - ☒Applies (standard) ☐ Does not apply

Additional Enhanced Benefit provisions require Division of Insurance and/or CBSR approval.
Any customization should be noted in the Additional Provisions section.

Additional Provisions Pertaining to Dental PPO 151+ Custom Benefits

Eligibility Provisions

Eligible Dependents

Includes the employee's spouse and the employee's and/or employee's spouse's unmarried children. Children are covered until they reach the limiting age selected below. Newborn children are covered from birth if no additional premium is required. Children in custody prior to finalization of adoption or who are under legal guardianship are covered. Children who are dependent for support because of a handicapped condition are covered regardless of age if they were continuously covered prior to reaching the limiting age.

Domestic Partners Eligible

☒ Yes
☐ No

Domestic Partners cannot be limited to the same gender.

Dependent Child Limiting Age (Standard and ASO Options)

Dependent age: 26 years
Student age: 26 years
Student coverage ends: ☐ On the limiting age birthday
☒ At the end of the month following the limiting age birthday
☐ At the end of year

Student certification: ☐ Annually
☐ Semi-annually

Late enrollment accepted: ☒ Yes; if Yes, late enrollment accepted: ☐ During open enrollment only
☒ At any time (standard)
☐ During open enrollment and/or at any time

☐ No

Additional Provisions Pertaining to Eligibility:

Eff 02/01/2021 - The Account is changing the Eligibility End Date from the End of the Month to the Date of Termination from Employment.

Miscellaneous Benefits / Provisions		
	Custom Insured	**ASO**
Coordination of Benefits (COB):	Birthday rule applies (standard)	☐ Birthday rule applies (standard) ☐ Gender rule applies
Non-duplication of Benefits:	☐ Yes (all benefits combined, not to exceed benefits of this program) ☒ No (standard – all benefits combined, not to exceed total charges)	☐ Yes (all benefits combined, not to exceed benefits of this program) ☐ No (standard – all benefits combined, not to exceed total charges)

Exclusions & Limitations

No benefits will be provided under this Contract for:

1. Services or supplies not specifically listed as an Eligible Dental Expense, or when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Amount, as determined by the Plan.
3. 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.
4. Dental services, radiographic images, or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Benefit Booklet or if resulting from an Accidental Injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Benefit Booklet.
5. 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.
6. Services and supplies for any illness or injury suffered after the Participant's Effective Date:
   - as a result of war or any act of war, declared or undeclared; or
   - while on active or reserve duty in the armed forces of any country or international authority.
7. Services or supplies that are not Dentally Necessary or do not meet accepted standards of dental practice.
8. Services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the American Dental Association.
9. Hospital and ancillary charges.
10. Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants, unless your Dental Schedule of Coverage shows that the dental Plan chosen provides coverage for implant services.
11. 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.
12. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance Amounts are offered.
13. 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.
14. Services or supplies received for behavior management or consultation purposes.
15. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
16. Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
17. Charges for nutritional, tobacco or oral hygiene counseling.

18. Charges for local, state or territorial taxes on dental services or procedures.
19. Charges for the administration of infection control procedures as required by OSHA, local, state or federal mandates.
20. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
21. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or radiographic images.
22. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
23. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
24. 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.
25. Chemical treatments or localized delivery of chemotherapeutic agents.
26. Charges for local anesthesia, nitrous oxide analgesia, therapeutic, parenteral drugs, or other drugs or medicaments and/or their application.
27. 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 Contract; except this exclusion will not apply to:
    - Any Participant who has been continuously covered for 24 months under a group dental care contract with BCBSOK or a combination of coverage of BCBSOK and the previous group dental care contract by the Employer, which included prosthetic benefits.
    - A partial or full denture or fixed bridge which includes replacement of a missing tooth which was extracted after your Effective Date.
28. Replacement of an extracted or missing third molar and/or congenitally missing teeth.
29. Any services, treatments or supplies included as Eligible Dental Expenses under other hospital, medical and/or surgical coverage.
30. Case presentations or detailed and extensive treatment planning when billed for separately.
31. Charges for occlusion analysis or occlusal adjustments.
32. Endodontic retreatment provided within 12 months of the initial endodontic therapy by the same Dentist.
33. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparations, fitting of preformed dowel and post, or post removal.
34. Endodontic therapy if you discontinue endodontic treatment.
35. Surgical services related to congenital or developmental malformation.
36. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological) or for bony impactions covered by another benefit plan.
37. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
38. Anatomical crown exposure.
39. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prosthesis); 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.
40. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
41. Charges for replacement of stolen, lost, or defective dentures, crowns or other appliances.
42. Splinting of teeth including double retainers for removable partial dentures and fixed bridgework.
43. Any procedure, service, or appliance for the purpose of altering or maintenance of vertical dimension of occlusion.
44. Appliances or restoration of teeth due to lost vertical dimension of occlusion, erosion, attrition, abrasion, or abfraction. Benefits are not provided for the appliances or restorations to restore occlusion or incisal edges due to bruxism or harmful habits.
45. Any procedure, service, or appliance provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall be considered cosmetic.
46. Precision or semiprecision attachments.
47. Gold foil restorations.
48. Tests and oral pathology procedures, or for re-evaluations.

49. The replacement of a lost or defective crown.
Additional Provisions Pertaining to Exclusions & Limitations:

Data Entry Fields		
ID Type:	Special Program Indicator:	Department Type:
ID Mail Code:	Type of Business:	Scope of Benefit:
Claim System:	Policy Type:	
Plan Code:	Contract Codes:	Network Code:

Approval Signatures		
For the Group Account		
Name:		
Title:		Date:
For Blue Cross and Blue Shield of Oklahoma (Account Executive)		
Name:	**Christopher Y. Engelman**	
Title:	**National Accounts Sr. Strategic Account manager**	Date: **04-10-2023**