

HealthChoice Dental Insurance Handbook



OSEEGIB

Oklahoma State and Education
Employees Group Insurance Board

Any updates made to this handbook after printing can be found on the OSEEGIB website at www.sib.ok.gov or www.healthchoicework.com.

HEALTHCHOICE DENTAL PLAN

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OnLine Information Available Through Our Website at www.sib.ok.gov or www.healthchoiceok.com

ClaimLink – access to claim status and eligibility information

You have access to your current plan information via the web. Using the *ClaimLink* option from the HealthChoice home page, you can view your eligibility, benefits, deductible, and claim status. Registration is quick and easy. If you have any questions, please contact the dental claims administrator. See the Plan Identification Information and Notice Section on page three.

Network Provider Directory

You can easily access the HealthChoice Network Provider Directory through the HealthChoice website. By clicking on the *Provider Listings* link on the home page, you are routed to the Provider Directories page. By clicking on the *HealthChoice Network Medical or Dental Providers* link, you can search for a HealthChoice Network Provider.

Frequently Asked Questions

The *Frequently Asked Questions* link on our website provides an interactive application that allows you easy access to general Plan information. You have the ability to search for information by category, topic, or by listing a key word or phrase.

A searchable text version of this handbook is available on the OSEEGIB website at www.sib.ok.gov or www.healthchoiceok.com. This guide is also available in CD format at the Oklahoma Library for the Blind and Physically Handicapped (OLBPH). Contact the OLBPH at 1-405-521-3514, toll-free 1-800-523-0288, and TDD 1-405-521-4672.

Plan Identification Information and Notice

Revised January, 2010

Plan Name:	HealthChoice Dental Plan
Plan Administrator:	Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) 3545 NW 58th Street, Suite 110 Oklahoma City, OK 73112 1-405-717-8701 or toll-free 1-800-543-6044
Member Services:	HealthChoice Member Services and Provider Directory 1-405-717-8780 or toll-free 1-800-752-9475 TDD: 1-405-949-2281 or toll-free 1-866-447-0436 FAX: 1-405-717-8942 Website: www.sib.ok.gov or www.healthchoicework.com
Dental Claims Administrator:	HP Administrative Services, LLC Correspondence, Claim Filing, and Claim Review Address: PO Box 24870 Oklahoma City, OK 73124-0870 1-405-416-1800 or toll-free 1-800-782-5218 TDD: 1-405-416-1525 or toll-free 1-800-941-2160

NOTICE: The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) provides dental benefits to eligible state, education, and local government employees, former employees, survivors, and their dependents in accordance with the provisions of Oklahoma Statutes, Title 74, Sections 1301, et seq. The information provided in this handbook is a SUMMARY of the benefits, conditions, limitations, and exclusions of the HealthChoice Dental Plan. It should not be considered an all-inclusive listing.

OSEEGIB Plan benefits are subject to conditions, limitations, and exclusions. These conditions, limitations, and exclusions are described and located in Oklahoma Statutes, OSEEGIB Rules, and Administrative Procedures adopted by the Plan Administrator. You may obtain a copy of the official OSEEGIB Rules from the Office of the Oklahoma Secretary of State. A copy of the Administrative Procedures may be obtained from OSEEGIB.

PLEASE READ THIS HANDBOOK CAREFULLY

A dispute concerning information contained within any OSEEGIB handbook or any other written materials, including any letters, bulletins, notices, or other written document, or oral communication, regardless of the source, shall be resolved by a strict application of OSEEGIB Rules or benefit administration procedures and guidelines as adopted by the Plan. Erroneous, incorrect, misleading, or obsolete language contained within any handbook, other written document, or oral communication, regardless of the source, is of no effect under any circumstance.

This dental handbook replaces and supersedes any dental handbook previously issued to you. This dental handbook will, in turn, be superseded by any subsequent dental handbook OSEEGIB issues to you.

How the HealthChoice Dental Plan Works



This handbook provides a quick guide to the dental plan benefits. Please read this handbook carefully for explanations of the eligibility rules and what the Plan pays, limits, and excludes.

The benefits of the HealthChoice Dental Plan are based on cost-sharing features that include deductibles and coinsurance. Plan benefits and your out-of-pocket costs will differ depending on the provider you choose.

HealthChoice Provider Network

As a HealthChoice member, you have the option to be treated by any dental provider and the option to change dental providers at any time. You are encouraged to use Network providers whenever possible because you will receive a higher level of benefits.

The HealthChoice Provider Network helps you manage your overall dental care needs through a statewide and multi-state network. Network Providers have agreed to accept set dollar amounts, known as Allowed Charges, for the services and equipment they provide.

HealthChoice Network Providers have agreed not to bill you for amounts greater than the Plan's Allowed Charges.

Non-Network providers do not contract with HealthChoice, and are not limited by HealthChoice Allowed Charges. You should be aware that when non-Network services are used, you will be responsible for any amounts in excess of the Allowed Charges.

To locate a Network Provider in your area, access the HealthChoice Telephone Provider Directory by calling 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

The HealthChoice Provider Directory can also be accessed online at www.sib.ok.gov or www.healthchoiceok.com

Outline of Dental Plan Benefits

Network Providers

When using a Network Provider, the Plan provides the following benefits:

- Preventive services covered at 100% of the Allowed Charge
- Basic restorative services covered at 85% of the Allowed Charge
- Major restorative services covered at 60% of the Allowed Charge
- A \$25 per person calendar year deductible for Basic and Major restorative services, or a combined \$75 family calendar year deductible
- Orthodontia services for members under age 19, or members age 19 or over with TMD, are covered at 50% of the Allowed Charge. Orthodontia benefits may be subject to the 12-month orthodontia waiting period. See the Exclusions and Limitations section.

Network Providers will file your claims for you.

The maximum calendar year benefit per person for Preventive, Basic, and Major services combined is \$2,000.

You are responsible for all non-covered services and for amounts above the calendar year maximum.

Non-Network Providers

When using a non-Network Provider, the Plan provides the following benefits:

- Preventive services covered at 100% of the Allowed Charge
- Basic restorative services covered at 70% of the Allowed Charge
- Major restorative services covered at 50% of the Allowed Charge
- A \$25 per person calendar year deductible for Preventive, Basic, and Major services, or a combined \$75 family calendar year deductible
- Orthodontia services for members under age 19, or members age 19 or over with TMD, are covered at 50% of the Allowed Charge. Orthodontia benefits may be subject to the 12-month orthodontia waiting period. See the Exclusions and Limitations section.

You must file your claims with the dental claims administrator. See the Claims Procedures section.

The maximum calendar year benefit per person for Preventive, Basic, and Major services combined is \$2,000.

You are responsible for all non-covered services, for amounts above the Allowed Charge, and for amounts above the calendar year maximum.

SUMMARY SCHEDULE OF COVERED BENEFITS



Covered Services	Network		Non-Network	
	Calendar Year Deductible	Plan Pays (of Allowed Charges)	Calendar Year Deductible	Plan Pays (of Allowed Charges)
Preventive	None	100%	\$25**	100%
Basic Restorative Services	\$25*	85%	\$25**	70%
Major Restorative Services	\$25*	60%	\$25**	50%
Orthodontia	None	50%	None	50%

***Network Services:** There is a \$25 per person deductible per calendar year for Basic and Major services combined. The calendar year family deductible for Basic and Major services combined is \$75.

****Non-Network Services:** There is a \$25 per person per calendar year deductible for Preventive, Basic, and Major services combined. The calendar year family deductible for Preventive, Basic, and Major services combined is \$75.

Network and non-Network deductibles accumulate separately.

There is no deductible or lifetime maximum for Network and non-Network orthodontia services; however, a 12-month waiting period may apply. See the Exclusions and Limitations section.

You are responsible for non-Network amounts that exceed the Allowed Charges and for all non-covered services.

Maximum Benefits

The following maximum benefit applies per person and does not include deductibles:

- \$2,000 per calendar year per person for Preventive, Basic, and Major services combined.

You are responsible for all charges above the \$2,000 calendar year benefit maximum for Preventive, Basic, and Major services. Once you have exhausted your \$2,000 calendar year benefit, your provider is not limited to the Allowed Charge set by HealthChoice.

Preventive

Covered services include:

- Teeth cleaning, bitewing x-rays, routine oral examinations, two covered per calendar year
- Topical fluoride treatment for dependent children through age 12, two covered per calendar year
- Full mouth x-rays, one covered per 36 months
- Supplemental bitewing x-rays, two covered per calendar year
- Space maintainers to replace prematurely lost teeth for covered dependent children under age 19
- Emergency palliative treatment
- Sealants on permanent teeth for covered dependents through age 16; reapplication is not covered

Basic Restorative

Covered services include:

- Extractions, including wisdom teeth
- Oral surgery, including general anesthesia
- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or fractured teeth
- Certain treatments of periodontal disease
- Endodontic treatment, root canal therapy, and injection of antibiotic medications
- Repair or recementing of bridges, crowns, inlays, onlays, or dentures
- Relining or rebasing of dentures once every three years, except during the first six months after the initial installation or replacement of the denture

Major Restorative

Covered services include:

- Initial placement of full or partial removable dentures, fixed bridge work, replacement of existing partial, or an addition of teeth to a partial removable denture or bridgework as covered by the Plan. The existing denture or bridgework must have been installed at least five years prior to its replacement and cannot be repairable, or the existing denture must be an immediate temporary denture that cannot be made permanent. Replacement with a permanent denture must take place within 12 months of the initial installation of the temporary denture.
- Dental implant systems approved by the Food and Drug Administration (FDA).
- Inlays, onlays, gold fillings, or crown restorations to restore

diseased or fractured teeth, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored to proper function with amalgam, silicate, acrylic, synthetic porcelain, or composite restoration.

Orthodontia

Covered services include:

- Orthodontic expenses for members under age 19
- Orthodontic services for treatment of temporomandibular joint dysfunction for members age 19 and older
- Molar uprighting

Note: There is no deductible or lifetime maximum for Network and non-Network orthodontia services; however, a 12-month waiting period may apply. See the Exclusions and Limitations section.

Please contact the dental claims administrator if you have questions about what orthodontia treatment(s) can be started during the waiting period without jeopardizing your entire benefit.

The waiting period may not apply if you or your dependent(s) had group dental coverage in force up to the effective date of the HealthChoice coverage. Proof of other group dental coverage must be submitted at the time of enrollment.

EXCLUSIONS AND LIMITATIONS

Exclusions

There is no coverage for the items listed below. **This list is not all-inclusive:**

1. Dental care and supplies that are furnished in a facility operated under the direction of, or at the expense of, the U.S. Government, or its agency, or by a provider employed by such a facility.
2. Dental care and supplies for which there is no charge made, or no payment would be required, if the insured individual did not have coverage.
3. Dental care and supplies provided by a dentist.
4. Dental care and supplies that result from taking part in committing, or attempting to commit, an assault or felony.
5. Dental care and supplies due to sickness or injury covered by Workers' Compensation, occupational disease law, or similar laws.
6. Dental care and supplies to the extent that they are payable under other provisions of the policy.
7. Dental care and supplies as a result of an Act of War, declared or undeclared, insurrection, or release of nuclear energy.
8. Charges incurred after the covered individual's benefit ends.
9. Supplies and prescription drugs for care or treatment, other than those used in a dentist's office, or instructions in dental hygiene. Prescription drugs prescribed by your dentist may be covered by your health plan.
10. Expenses relating to an intentionally self-inflicted injury.
11. Hospital confinement and ancillary services, including anesthesia, for dental surgery when the confinement is

necessary due to illness or other health conditions. These charges should be filed with your health plan.

12. Replacement of lost dentures.
13. Separately billed infection control fees.
14. Charges for missed or canceled appointments.
15. Gel-Kam and other take home fluorides.
16. Oral care and supplies which are used to change vertical dimension or closure except as provided under Orthodontia benefits.
17. Adult orthodontics without a diagnosis of temporomandibular joint dysfunction.
18. Cosmetic procedures.
19. Charges made by a duly qualified dentist or oral surgeon for treatment of fractures and dislocations of the jaw, or for cutting procedures and treatment. These charges should be filed with your health plan.
20. Medical expenses for the treatment of temporomandibular joint dysfunction.
21. Medical services treating an oral condition.
22. Services supplied by a provider who is a relative by blood, or by marriage of the patient, or one who normally lives within the patient's home.
23. Separately billed local or block anesthesia used in conjunction with restorative and/or surgical procedures.

Limitations

Orthodontia Waiting Period

If group dental coverage was not in effect immediately prior to your being covered under this Plan, there will be a 12-month waiting period before orthodontia benefits will be available, and no benefits will be paid for any orthodontia treatment during that time period. You must be covered under the HealthChoice Dental Plan for 12 months, and the banding must occur after the 12-month waiting period. Please contact the dental claims administrator if you have questions about what orthodontia treatment(s) can be started during the waiting period without jeopardizing your entire benefit.

This limitation may not apply if you or your dependent(s) have had continuous group dental coverage. The orthodontia limitation may be waived if all of the following conditions are met:

- There has been no break in coverage
- You can provide proof of loss of other group dental coverage
- The request for coverage is submitted within 30 days of loss of other coverage

Example 1:

A dependent is enrolled in HealthChoice dental effective 10-1-09, and is subject to the orthodontic waiting period. The dependent receives an appliance made on 1-5-10 that costs \$500. Banding for braces of \$6,000 is done 9-1-10. Under this scenario, no orthodontia benefits are paid for the appliance or the braces.

Example 2:

Next scenario is identical to Example 1, except that the banding occurs 12-15-10. In this case, no benefits are available for the appliance, but benefits are available for the braces.

Example 3:

Coverage is effective 2-1-09, and banding for braces occurs 12-16-09. No benefits are payable for braces. An appliance that costs \$500 is made 6-1-10, and is eligible for benefits.

Dental Accidents

Dental accidents are covered under the HealthChoice Health Plan which pays for medically necessary treatment for the repair of injury to sound natural teeth or gums. You must be a participant in the HealthChoice Health Plan and treatment must be performed within 12 months following the accident. If you are enrolled in another health plan, contact that plan for information on how dental accidents are covered.

Procedures Requiring Certification

To be covered, certain procedures require certification by HealthChoice. Providers must submit requests for these procedures to the dental claims administrator and receive certification prior to services being performed.

CLAIM PROCEDURES



Payment of Plan Benefits

Dental claims must be submitted on an ADA 2006 form, items such as cash register receipts, pull-apart forms, and accounts receivable billing statements are not acceptable and will be returned to the sender.

Network

HealthChoice Network Providers are required by contract to submit claims for you using the appropriate form. Payment is automatically made to your provider.

Non-Network

Non-Network providers are not required to submit claims on your behalf and may not use the appropriate form. If this is the case, ask if they will submit the claim on your behalf using the appropriate form or if they will provide a completed form to you so that you can file the claim yourself.

Claims should be filed as soon as services are received or completed. Send your claim to the dental claims administrator. See the Plan Identification Information and Notice section on page three.

Non-Network claims are usually paid to you; however, you may choose to assign benefits directly to your provider.

When a valid assignment of benefits to your provider is submitted with the claim, payment will be made to your provider. When there is no valid assignment of benefits, payment will be made to you and you will be responsible for paying your provider.

Claims Requiring Additional Information

Effective February 1, 2010, if additional information is needed from you or your provider to process your claim, your Explanation of Benefits will identify the specific information needed. In some instances, a letter will also be sent further explaining what information is required to complete processing. Be aware that your claim will be pended until the needed information is received. If the information is not received within 60 days, your claim will be denied; however, your claim will automatically be processed without resubmitting the claim once the information is received.

Claims Filing Deadline

Claims must be received no later than the last day of the calendar year following the year the claim was incurred. For example, if the date of service was July 1, 2009, the claim will be accepted through December 31, 2010. After December 31, 2010, the claim would not be eligible for payment under the timely filing rule.

Claims for Services Outside the United States

If you receive services outside the United States, the claim procedures listed below must be followed:

- You must make arrangements to pay for the services or supplies
- You must submit a claim
- All claims must be translated into English and converted to U.S. dollar amounts using the exchange rates applicable for the date(s) of service; you must file the original claim along with the translation
- The Plan does not pay any costs for translating claims or dental records

- Allowed Charges will be paid at the non-Network rate of coinsurance; you will be responsible for amounts above the Allowed Charges

Coordination of Benefits (COB)

If you or your enrolled dependent(s) incur charges covered by another group dental plan, the benefits of each plan will be coordinated so the total benefits received are not greater than the charges billed, or greater than your liability.

Verification of Other Insurance Coverage (VOIC)

When a VOIC form is needed in relation to the processing of a claim, the dental claims administrator will request one from you. **Failure to provide a VOIC form when requested will cause your claim to be delayed or denied for non-compliance.**

Pre-Estimate

If a dental treatment is expected to cost more than \$200 for Preventive, Basic, or Major covered services, a pre-estimate of benefits is recommended. A pre-estimate is filed like a claim and provides you with an overview of the costs of your treatment and the amount of benefits the Plan will pay. The pre-estimate should be submitted before treatment begins and include any required supporting documentation.

Your dentist or specialist must bill for the exact services pre-estimated, unless you make a request for additional services.

Disputed Claims Procedure

If your claim is denied in whole or in part for any reason, you have the right to have your claim reviewed. Requests for review of your denied claim along with any additional information you

wish to provide must be submitted in writing to the dental claims administrator at the claims review address or call the dental claims administrator. See the Plan Identification Information and Notice section on page three.

If your claim remains denied after a claims review, you may appeal that decision to the Grievance Panel by contacting:

The Legal Grievance Department
3545 NW 58th Street, Ste 110
Oklahoma City, OK 73112

or call 1-405-717-8701 or toll-free 1-800-543-6044. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

The Grievance Panel is an independent review group established by statute [74 O.S. Section 1306(6)].

All requests for hearings must be filed within one year from the date you are notified of a denial of a claim, benefit, or coverage.

You may submit a request for a Grievance Panel hearing and represent yourself in these proceedings. If you are unable to submit a request for a Grievance Panel hearing yourself, only attorneys licensed to practice in Oklahoma are permitted to submit your hearing request for you, or to represent you through the hearing process [75 O. S. Section 310(5)].

All claim reviews and final decisions of the Grievance Panel are made as quickly as possible. After completing the claim review and grievance procedures, an appeal may be pursued in an Oklahoma District Court.

Subrogation

Subrogation applies when you are sick or injured as a result of the negligent act or omission of another person or party. Subrogation means the HealthChoice Plans have a right to recover any benefit

payments made to you, or your dependent(s), by a third party's insurer, because of an injury or illness caused by the third party. Third party means another person or organization.

If you or your covered dependents receive HealthChoice benefits and have a right to recover damages from a third party, this Plan has the right to recover any benefits paid on your behalf. All payments from a third party, whether by lawsuit, settlement, or otherwise, must be used to repay HealthChoice.

You must promptly notify HealthChoice if you make a claim against a third party regarding any illness or injury for which HealthChoice benefits have been or will be paid. You, or your dependent, must provide information requested by HealthChoice. HealthChoice benefits may be withheld until information is received.

After any requested information is received from you, HealthChoice will process your covered claims, regardless of whether any third party may eventually be found liable for the expenses arising from the injury.

For more information about subrogation, contact OSEEGIB. Do not contact the dental claims administrator regarding subrogation as this will only delay a response.

GENERAL PROVISIONS



Provider-Patient Relationship

You may choose any provider or practitioner who is licensed or certified under the laws of the state in which they practice, and who is **recognized by the Plan**. Each provider offering dental care service is an independent contractor. The provider retains the provider-patient relationship with you and is solely responsible to you for dental advice and treatment or any subsequent liability resulting from the advice or treatment.

Although a provider may recommend or prescribe a service or supply, this does not necessarily establish coverage by the Plan.

For information on what types of providers are recognized by the Plan, contact HealthChoice Provider Relations at 1-405-717-8790 or toll-free 1-800-543-6044. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436. You may also check the Frequently Asked Questions on the HealthChoice website at www.sib.ok.gov or www.healthchoicework.com.

Inaccurate or Erroneous Information

Coverage obtained by means of inaccurate or erroneous information will be canceled retroactive to the effective date, and premiums for coverage refunded. The refunded premiums will be reduced by any claims paid by HealthChoice during that time.

Confirmation Statements

When you enroll or make changes to your coverage, you will be mailed a Confirmation Statement (CS). The CS will list the

coverage in which you are enrolled, the effective date of the coverage, and the premium amounts for the coverage.

Corrections to Benefit Elections

You should review your CS to ensure that the coverage listed is correct. Any corrections must be submitted within 60 days of the election. For current employees, corrections must be submitted to your Insurance/Benefits Coordinator. For former employees, you must submit corrections to OSEEGIB. Corrections reported after 60 days will be effective the first of the month following notification.

Right of Recovery

OSEEGIB shall retain the right to recover any payments made by the Plan in excess of the maximum allowable expenses, as set forth in the Plan. OSEEGIB shall have the right to recover such payments, to the extent of excess, from one or more of the following:

- Any person(s) to, or for, or with respect to whom such payments were made
- Any other insurers
- Service plans or any other organizations

ELIGIBILITY AND EFFECTIVE DATES



You are eligible to participate in the HealthChoice Dental Plan if you are:

- A current **Education** employee eligible to participate in the Oklahoma Teachers' Retirement System and working a minimum of four hours per day or 20 hours per week.
- A current **State of Oklahoma** or **Local Government** employee regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee.

New Employee(s)

Coverage for new employees becomes effective the first day of the month following your employment date or the date you become eligible with a participating employer. If you wish to make changes to the coverage you initially elected, you have a 30-day window following the date you became eligible to make benefit changes. These changes are effective the first day of the month following the date the change is made.

Note: Orthodontia benefits may be subject to a 12-month waiting period. See the Exclusions and Limitations section.

Dependent Coverage

You must be enrolled in a group health plan in order to enroll yourself and your dependents in the dental plan. If dependent coverage is selected, all of your eligible dependents must be covered unless they are covered under another group dental plan, or are eligible for Indian or military dental benefits.

If you are enrolled and have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your dependent(s) provided that you request enrollment within 30 days following the marriage, birth, adoption, or placement for adoption. All other enrollments must be made during the annual Option Period and some limitations may apply. See the Exclusions and Limitations section.

Eligible Dependents

Eligible dependents include:

- Your legal spouse. See the following section on common-law marriages.
- Your unmarried children up to age 25 provided you are primarily responsible for their support.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed before the age of 25. A *Disabled Dependent Assessment Form* must be submitted at least 30 days prior to the dependent's 25th birthday. The *Disabled Dependent Assessment Form* must be approved by OSEEGIB before coverage begins.
- Your stepchildren, provided you are primarily responsible for their support, or regardless of residence if your spouse has been court ordered to provide coverage and your spouse is also covered.
- Other dependent children – in the absence of a federal income tax return listing the child(ren) as dependent(s), you will be required to provide and have approved a Declaration of Dependency form.

Common-law marriages are recognized by the Plan. A new employee can add a common-law spouse at the same time the employee enrolls. A current employee can request coverage on a common-law spouse during the annual Option Period, or in the event the common-law spouse loses other group coverage. To

enroll a common-law spouse, the employee and spouse must sign and submit an Enrollment/Change Form.

Eligible dependents can be excluded from coverage if they have other group dental coverage or are eligible for Indian or military dental benefits.

You may elect to exclude your spouse from coverage. Your spouse must sign the Spouse Exclusion section of your Enrollment/Change Form.

A dependent who is no longer eligible may apply for continuation of coverage under COBRA for a maximum of 36 months. See the Continuing Coverage After Termination of Employment section for more information.

Note: If your spouse is also a primary member of a HealthChoice plan through his/her employer, dependent children may be covered under either parent's dental plan, provided the parent is also enrolled in the dental plan. Dependent children cannot be covered under both parents' plan.

Late Enrollee(s)

If you previously declined enrollment in the dental plan because you had other group dental insurance coverage or Indian or military dental benefits, you may enroll:

- Within 30 days following the date your other group coverage ends
- During the annual Option Period

Changes to Coverage After Initial Enrollment

Certain qualifying events may allow a midyear benefit change; however, an Enrollment/Change Form must be completed within

30 days of the qualifying event. Examples of midyear qualifying events include:

- A change in your legal marital status, such as marriage, divorce, or death of your spouse
- A change in the number of your dependents, such as the birth of a child
- A change in employment status that affects your eligibility or that of your spouse or dependent
- An event that causes your dependent to meet, or fail to meet, eligibility requirements
- Commencement or termination of adoption procedures
- Any judgments, decrees, or orders (employer may allow changes only to health and dental)
- Changes in the coverage of your spouse or dependent under another employer's plan
- Eligibility for leave under the Family Medical Leave Act

Current Employees

You may make changes to coverage within 30 days of a qualifying event or during the annual Option Period.

All changes to coverage must be in compliance with the rules of your employer's Section 125 Plan, or if no 125 Plan is offered, in compliance with allowed midyear coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations. Current employees must contact their Insurance/Benefits Coordinator for an Enrollment/Change Form to make changes in coverage.

Former Employees

You may make eligible changes **only** within 30 days of a qualifying event. Dependents or new benefit plans other than vision cannot be added during the annual Option Period.

Former employees and surviving dependents must submit a written request for changes in coverage to:

**Oklahoma State and Education
Employees Group Insurance Board
3545 NW 58th, Ste 110
Oklahoma City, OK 73112**

Verbal requests for changes in coverage will not be accepted.

Note: Oklahoma law prohibits dropping your spouse/dependents in anticipation of a divorce or legal separation. If you are in the process of separation or divorce, it is important that you contact your legal counsel for advice before making any changes to your benefits coverage.

Options for Members Called to Active Military Service

Under the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA), coverage can be continued for up to 24 months. USERRA provides certain rights and protections for all employees called to serve our nation. All branches of the military including the Army, Navy, Marines, Air Force, Coast Guard, all Military Reserve units, and all National Guard units come under USERRA.

In addition to dental care provided by the military, you have the following four choices regarding your current coverage:

- Keep all coverage. Your current employer is responsible for collecting and forwarding all premiums to OSEEGIB.
- Discontinue member coverage but keep dependent coverage. This is the COBRA option and dependents will be billed directly at 102% of premiums, the COBRA rate, for health, dental, and/or vision coverage. Under COBRA rules, life insurance cannot be continued.

- Discontinue all coverage except life insurance. You will be billed directly.
- Discontinue all member and dependent coverage.

Regardless of whether you receive written or verbal military orders, the OSEEGIB staff and/or your Insurance/Benefits Coordinator will assist you in making any benefit arrangements.

There is no penalty for renewing coverage upon discharge from active duty if coverage is elected within 30 days of your return to the same employment.

If you are a member of a Military Reserve unit or the National Guard and anticipate being called to active service, notify your Insurance/Benefits Coordinator at work.

Coverage for Other Eligible Dependents

You may also obtain coverage for certain other dependents if they are legally adopted, you have legal guardianship, or the dependents meet other specific requirements. You must:

- Request coverage within the time frame specified in each of the following categories
- Provide the necessary documentation
- Meet all eligibility requirements
- Pay all premiums
- Cover all eligible dependents

Legal Adoption

An adopted dependent is eligible for coverage the first day of the month you obtain physical custody. You must submit an Enrollment/Change Form to HealthChoice, including a copy of your adoption papers. In the absence of adoption papers or other court records, someone involved in the adoption process, such as your attorney or a representative of the adoption agency, must

provide proof of the date you actually received custody of the child(ren) pending the final adoption hearing.

You must request coverage within 30 days of the date of the initial placement for adoption, otherwise:

- Current employees cannot add coverage until the next annual Option Period
- Former employees are not allowed to add coverage at any later date

Legal Guardianship

Guardianship follows the same guidelines as an adoption; however, you have the option to begin coverage the first day of the month you obtain physical custody of the child(ren) or the first day of the month following the date the child(ren) was placed in your custody.

Other Forms of Custody

In the absence of a court order indicating adoption, guardianship, or divorce, you may request coverage for other eligible dependents by submitting an Enrollment/Change Form with a copy of the portion of your most recent income tax return that lists the child(ren) as dependent(s) for income tax deduction purposes.

Coverage for other eligible dependents begins on the first day of the month following the date you obtained physical custody and never applies retroactively.

In the absence of a federal income tax return listing the child(ren) as dependent(s), you will be required to provide a ***Declaration of Dependency Form*** as specified by the Plan. Coverage, when approved, begins on the first day of the month following approval and never applies retroactively.

You must request coverage within 30 days of the date of initial placement, otherwise:

- Current employees cannot add coverage until the next annual Option Period
- Former employees are not allowed to add coverage at any future date

Note: The Plan has the right to verify the dependent status of the child(ren), to request copies of that portion of your most recent income tax return that lists the child(ren) as dependent(s), and to discontinue coverage for any dependents that are found ineligible for coverage.

Loss of Other Group Dental Insurance

You may have elected not to enroll in the HealthChoice Dental Plan because you were covered under another group dental plan. If you later lose coverage under your other group dental plan, you may enroll in the HealthChoice Dental Plan provided the election is made within 30 days following the loss of other group dental coverage. If your previous coverage is in effect the day before your HealthChoice coverage becomes effective, no plan limitations will apply. If your previous coverage is not in effect the day before your HealthChoice coverage becomes effective or the coverage was individual coverage, benefit limitations may apply. In order to avoid plan limitations, you may elect to have your HealthChoice coverage begin on the first day of the month in which your other group coverage was lost. This option is subject to payment of the full premium for that month; otherwise, coverage shall become effective under this Plan on the first day of the month following your election.

Participating former employees may add eligible dependents within 30 days of loss of other group dental insurance under which the dependents were covered.

Loss of another type of group coverage, such as health coverage, does not grant the right to enroll in the dental plan. Loss of group dental coverage does not grant the right to enroll in other types of HealthChoice plans, such as health or life.

Premium Payment

Each month, you must pay the full premium for the coverage you have selected. Failure to pay premiums on a timely basis will result in your coverage terminating at the end of the month for which the last premium was received.

Leave Without Pay

If you are on approved leave without pay through your employer, you may continue coverage for up to 24 months from the first day you begin leave without pay status. You must make timely premium payments in full each month to your Insurance/Benefits Coordinator.

If your coverage terminates for failure to pay premiums on a timely basis, you may re-enroll as a new employee upon returning to work.

If you take leave under the Family Medical Leave Act (FMLA), please make premium payment arrangements with your employer before taking leave.

CONTINUING COVERAGE AFTER TERMINATION OF EMPLOYMENT



If you leave employment, you and/or your covered dependent(s) may be able to keep coverage under the Plan through one of the following options:

- Vesting or retirement rights through one of the public employee retirement systems established by the State of Oklahoma
- Years of service with state, education, or local government employers; also see Years of Service below
- Receiving benefits through the HealthChoice Disability Plan administered by OSEEGIB
- Survivors' Rights for your covered dependent(s) in the event of your death
- COBRA (Consolidated Omnibus Budget Reconciliation Act)

Each month, premiums must be paid in full for coverage selected. Failure to pay premiums on a timely basis will result in termination of coverage at the end of the month for which the last premium was received.

Years of Service

You may keep coverage after leaving employment if you make an election within 30 days following your termination date, and you meet one of the following conditions:

- You are eligible to participate in the Oklahoma Public Employees Retirement System (OPERS) and have eight or more years of service with a participating employer, but do not have a vesting right
- You are eligible to participate in the Oklahoma Teachers' Retirement System (TRS) and have ten or more

- years of service with a participating employer
- You are an employee of an education employer that participates in the Plan but does not participate in the Oklahoma Teachers' Retirement System (TRS), and have ten or more years of service
- You are an employee of a local government employer that participates in the Plan but does not participate in the Oklahoma Public Employees Retirement System (OPERS), and have eight or more years of service

Education Employees

If you were a career tech employee or a common school employee who terminated active employment on or after May 1, 1993, you may continue coverage through the Plan as long as the school system from which you retired or vested continues to participate in the Plan. If your school system terminates coverage under the Plan, you must follow your school system to its new insurance carrier. If you retired prior to May 1, 1993, you have the option to continue coverage with OSEEGIB or follow your employer to its new insurance carrier.

If you were an employee of an education entity other than a common school (e.g., higher education, charter school, etc.), you may continue coverage through the Plan as long as the education entity from which you retired or vested continues to participate in the Plan. There is no grandfathered date for this type of employer, so if your employer terminates coverage with the Plan, you must follow your former employer to its new insurance carrier regardless of the date you terminated active employment.

Local Government Employees

If you were a local government employee who terminated employment on or after January 1, 2002, you may continue coverage through the Plan as long as the local government employer from which you retired or vested continues to participate

in the Plan. If your local government employer terminates coverage with the Plan, you must follow your former employer to its new insurance carrier. If you retired prior to January 1, 2002, you have the option to continue coverage with OSEEGIB or follow your employer to its new insurance carrier.

Note: You cannot reinstate coverage that you discontinue or allow to lapse unless you return to work as an employee of a participating employer and maintain that coverage for three years. Some reinstatement exceptions may apply if you are a state employee who terminated employment as a result of a Reduction in Force (RIF).

New Employer Retirees

All retirees with former employers that join the Plan after the grandfathered dates specified on this and the previous page must follow their former employer to its new insurance carrier.

Following Your Employer to a New Plan

When you terminate employment, your benefits are tied to your most recent employer. If your most recent employer discontinues participation with OSEEGIB, some or all of the employer's retirees and their dependents (depending on the type of employer) must follow the employer to its new insurance carrier. This is true regardless of the amount of time you were employed with any participating employer.

If you retire and then return to work for another employer and enroll in benefits through your new employer, your benefits will be tied to your new employer.

Continuation through the Disability Program

You may keep dental coverage in effect as an employee if you are receiving benefits through the HealthChoice Disability

Plan. You may continue coverage as long as you are covered under the HealthChoice Disability Plan and pay premiums in a timely manner. You must maintain continuous coverage. If you discontinue coverage, or allow coverage to lapse, it cannot be reinstated unless you return to work as an employee of a participating employer.

Survivors' Rights

Your surviving spouse and dependent(s) have 60 days following your death to notify OSEEGIB that they wish to continue coverage. Coverage will be effective the first day of the month following your death.

Your surviving spouse is eligible to continue insurance coverage as long as premiums are paid.

Surviving dependent children are eligible for coverage until:

- Age 25
- The child marries

Disabled dependent children will be eligible to continue survivors' coverage as long as they continue to meet the HealthChoice definition of a disabled dependent.

Note: COBRA continuation of coverage is available for dependent children who lose eligibility.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

If you or your dependent(s) coverage is terminated for any of the reasons listed below, each covered member has the right to elect temporary continuation of coverage through COBRA.

You are eligible for limited continuation of coverage (up to 18 months) if you lose coverage due to:

- A reduction in your hours of employment
- Termination of your employment for reasons other than gross misconduct

Your covered **spouse** is eligible for limited continuation of coverage if his/her coverage is lost due to:

- Your death (see Survivors' Rights)
- Termination of your employment for reasons other than gross misconduct
- A reduction in your hours of employment resulting in loss of coverage
- A divorce or legal separation*

Your covered **dependent child(ren)** is eligible for limited continuation of coverage if his/her coverage is lost due to:

- Your death (see Survivors' Rights)
- Termination of your employment for reasons other than gross misconduct
- A reduction in your hours of employment resulting in loss of coverage
- A divorce or legal separation of the parents*
- Your dependent no longer meets the requirements for dependent status

*Oklahoma law prohibits dropping your spouse/dependents in anticipation of a divorce or legal separation. If you are in the process of a legal separation or divorce, it is important you contact your legal counsel for advice before making changes to your benefits coverage.

If you are a participating **current employee**, it is your responsibility to notify your employer within 30 days of a divorce,

legal separation, or your child's loss of dependent status under this Plan.

If you are a **former employee**, you must notify OSEEGIB in writing within 30 days of a divorce, legal separation, or your child's loss of dependent status under this Plan. You or your eligible dependents must elect continuation of coverage within 60 days after the later of the following events occurs:

- The date the qualifying event would cause you or your dependents to lose coverage
- The date your employer notifies you or your dependents of continuation of coverage rights

If the qualifying event is related to termination of employment or reduced hours, the coverage may be continued for a maximum period of 18 months. If the qualifying event is for any other eligible reason, the coverage may be continued for a maximum period of 36 months. However, continuation of coverage will terminate immediately for you and/or all covered dependents under the following circumstances:

- The Plan ceases to provide coverage
- The required premiums are not paid in a timely manner
- You and/or your dependents become covered under another group dental plan

If you have additional questions regarding COBRA, contact your Insurance/Benefits Coordinator or OSEEGIB.

If you elect to continue coverage under COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify OSEEGIB of a disability or second qualifying event in order to extend the coverage continuation period. Failure to provide timely notice of a disability or second qualifying event may affect your right to extend the coverage continuation period.

TERMINATION/REINSTATEMENT OF COVERAGE



Termination

Your coverage, as well as any dependent coverage, ends on the last day of the month one or more of the following events takes place:

- You terminate employment with a participating employer and choose not to continue coverage through vesting, non-vest, retirement, disability, or COBRA
- You do not pay the required premiums
- The Plan is terminated
- Your death occurs

In addition, a dependent's coverage will end on the last day of the month he/she ceases to be an eligible dependent. Upon review by OSEEGIB, if you or your dependent is found to be ineligible, coverage will be terminated effective on the first day of the month of discovery. OSEEGIB reserves the right to recover any claims paid on behalf of an ineligible member.

Reinstatement

If you are currently employed by a participating employer and discontinue coverage on yourself or your dependents, you cannot apply for reinstatement of coverage for at least 12 months. To reinstate the discontinued coverage, you must enroll within 30 days of:

- The expiration of the 12 month period; if coverage is not reinstated within 30 days of the end of the waiting period, you cannot enroll in coverage until the next annual Option Period
- The loss of other group dental coverage or other qualifying event

To reinstate coverage, proof of the loss of other group dental coverage or other qualifying event must be submitted. If coverage is not continuous between the two plans, the 12-month orthodontia waiting period will apply. See the Exclusions and Limitations section.

Loss of Coverage While Under Treatment

If you or your covered dependent(s) lose dental coverage while undergoing treatment, the Plan still continues to provide benefits for two months following termination of coverage. The Plan will pay the Allowed Charges in the following situations according to Plan benefits:

- For dentures, denture impressions must be taken before coverage ends.
- For bridgework, crowns, and gold restoration, the tooth must be prepared before coverage ends and the bridgework, crown, or gold restoration must be installed within the extended benefit period.
- For endodontics, including root canal, the tooth has to be opened before coverage ends, all covered services must be provided, and the Allowed Charge must be incurred within the extended benefit period.

State Government Reduction In Force and Severance Benefits Act

If you are a former state employee who:

- Had a vested or retirement benefit based on the provisions of any of the state public retirement systems,
- Was separated from state service as a result of a reduction in force anytime after July 1, 1997, and
- Was offered severance benefits pursuant to the State Government Reduction in Force and Severance Benefits Act, you may reinstate dental insurance coverage at any

time within two years following the date of the reduction in force from the state. Reinstated coverage must be maintained for three years to allow you to carry it into retirement.

For further information, contact HealthChoice Member Services. See the Plan Identification Information and Notice section on page three.

Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

OSEEGIB is a State of Oklahoma governmental agency that is created and governed by Oklahoma law for the purpose of administering health, life, disability, and dental benefits to state, local government, and education employees, and other groups designated by statute, including each of the preceding group's respective retirees. Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act (HIPAA) govern privacy matters between OSEEGIB and its participants concerning the privacy of identifiable health information. Information contained in an OSEEGIB member's file is confidential by law and we at OSEEGIB are committed to protecting this information.

This notice describes and gives you examples of the permitted ways your health information may be used and disclosed.

OSEEGIB uses and discloses your protected health information for your treatment, payment for services, and OSEEGIB business operations in the administration of health plans. The health claims you submit, or health claims submitted by providers for your treatment, contain protected health information and are processed for payment and data collection by claims administrators according to Oklahoma law and contractual terms of confidentiality with OSEEGIB. Your health information is used and disclosed by OSEEGIB employees and other entities under contract with OSEEGIB, according to the "minimum necessary" standard. OSEEGIB or its claims administrators may use and disclose health information to determine medical necessity for certification of hospital and medical benefits, case management, approval for

supplemental life insurance, grievance matters, premium rate setting, required disease management programs, law enforcement, public health threats, workers' compensation/disability, national security, and as required by law. OSEEGIB will ask for your written permission before it uses or discloses your health information for purposes that are not described in this Notice.

You have the right to: a) inspect and copy your health information, (generally EOBs) with the exception of psychotherapy notes and/or information that requires a court order; b) amend and restrict the health information that OSEEGIB discloses about you; however, OSEEGIB is not required to agree to a requested restriction; c) request your communications remain confidential with OSEEGIB; d) receive a copy of this Notice; e) file a complaint if you believe OSEEGIB has improperly used or disclosed your information; f) request a listing of disclosures except for treatment, payment, business operations, and per your Authorization after April 14, 2003; and, g) receive a paper copy of this Notice upon request if you have received this Notice electronically.

OSEEGIB reserves the right to change the terms of this Privacy Notice and will provide all interested persons a revised notice either by U.S. Postal Service delivered to the individual's mailing address on file with OSEEGIB or electronic communication by posting the revised Privacy Notice on the OSEEGIB website at www.sib.ok.gov and www.healthchoiceok.com

If you believe your privacy rights have been violated, call or send a written complaint to the OSEEGIB HIPAA Information Officer at 3545 NW 58th, Suite 110, Oklahoma City, Oklahoma, 73112, 1-405-717-8701, toll-free 1-800-543-6044, TDD 1-405-949-2281, toll-free TDD 1-866-447-0436; the Secretary of the U. S. Department of Health and Human Services (HHS) at the Office of Civil Rights, 1301 Young Street, Suite 1169, Dallas, TX 75202, 1-214-767-4056, or submit an electronic complaint according to directions located on the HHS Office of Civil Rights website. Complaints to HHS must be filed within 180 days after the date on which you became aware, or should have been aware, of the violation. No retaliation is allowed against the individual filing a complaint.

Revised Notice 8/5/05

PLAN DEFINITIONS



Allowed Charges: The set dollar amount allowed under the Plans for a covered service or supply.

Coinsurance: The percentage of Allowed Charges that will be paid by you and by HealthChoice once your deductible is satisfied.

Cosmetic Procedure: A procedure that primarily serves to improve appearance.

Deductible: The initial amount of out-of-pocket expense you pay on Allowed Charges before a benefit is paid by the Plan.

Eligible Dependent(s):

- Your legal spouse (including common-law).
- Your unmarried children up to age 25 provided you are primarily responsible for their support.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed before the age of 25. A *Disabled Dependent Assessment Form* must be submitted at least 30 days prior to the dependent's 25th birthday. The *Disabled Dependent Assessment Form* must be approved by OSEEGIB before coverage begins.
- Your stepchildren, provided you are primarily responsible for their support, or regardless of residence if your spouse has been court ordered to provide coverage and your spouse is also being covered.
- Other dependent children – in the absence of a federal income tax return listing the child(ren) as dependent(s), you will be required to provide and have approved a Declaration of Dependency form.

Eligible Employee: An employee of a participating employer who receives compensation for services rendered and is listed on that

employer's payroll. This includes persons elected by popular vote (i.e. board members for education, and elected officials of state and local government, state employees, rural water district board members, county election board secretaries, and any employee otherwise eligible who is on approved leave without pay, not to exceed 24 months).

- Education employees must be eligible to participate in the Oklahoma Teachers' Retirement System and work a minimum of four hours per day or 20 hours per week.
- Local government employees, including rural water districts, must be employed in a position requiring a minimum of 1,000 hours work per year.

Eligible Participating Former Employee: An employee who is participating in any of the Plans authorized by or through the State and Education Employees Group Insurance Act who retired or vested their rights with a state funded retirement plan, or has the required years of service with a participating employer.

Late Enrollee: Any eligible employee and/or eligible dependent(s) who waived coverage or failed to enroll within 30 days of the initial enrollment offering, or any participating member or dependent who voluntarily terminates coverage and re-enrolls.

Network Provider: A provider who has entered into a contract with OSEEGIB to accept the Plan's Allowed Charges for services and/or supplies provided to Plan participants.

Non-covered Service: Any service, procedure, or supply excluded from coverage and not paid for by the Plan.

Option Period: The annual time period established by OSEEGIB in which changes may be made to coverage.

OSEEGIB: The Oklahoma State and Education Employees Group Insurance Board.

Out-of-Pocket Maximum: The amounts for which you are responsible based on the use of Network or non-Network services, including deductible and coinsurance. **You will still be responsible for all amounts above the Allowed Charges when using non-Network providers.**

Orthodontia Limitation: A waiting period for orthodontia benefits for the first 12 months of coverage. See the Exclusions and Limitations section.

Participating Employer: Any municipality, county, or education employer, or other state agency whose employees or members are eligible to participate in any plan authorized by or through the State and Education Employees Group Insurance Act.

Plan: The HealthChoice dental insurance plan offered through OSEEGIB and described in this handbook.

COMMON DENTAL TERMS



Note: The following definitions are included for your convenience as a general guide to specialized dental terms. The following descriptions should not be interpreted as the official definitions of the American Dental Association or of this Plan.

Amalgam: A mixture of two or more metals in combination with mercury that is generally used as a restorative material.

Anesthesia: The loss of sensation or feeling with or without the loss of consciousness.

Anterior: Front; the first six teeth in the upper and lower jaw.

Bitewing: X-ray film, generally diagnostic, used to detect the presence of dental decay.

Bridge: A fixed appliance replacing missing or extracted natural teeth that is supported and held by attachments to restored (abutment) teeth and that is usually not removable.

Cast: Reproduction of the form of all or part of the dental arch (teeth and tissues) made from plaster or stone.

Coronal: Pertaining to the crown of a tooth.

Crown: The portion of the human tooth covered by enamel; a dental prosthesis restoring the function and aesthetics of part or all of the coronal portion of a natural tooth. Crowns are usually composed of gold, porcelain, and/or acrylic resin.

Denture: An artificial substitute for missing natural teeth. A denture may be complete (full) or partial.

Endodontics: A specialty area of dentistry that deals with the diagnosis and treatment of diseases of the pulp chamber and canals of the teeth.

Extraction: The separation and surgical removal of a tooth from its natural position.

Fluoride Treatment: A topical application of a fluoride solution to the teeth to protect against decay.

Impacted Tooth: An unerupted, or partially erupted, tooth that is positioned against another tooth, bone, or soft tissue, thereby preventing complete eruption (emergence through the gum).

Implant: An insert into bone to support a crown or crowns; a partial or complete denture.

Inlay: A filling made outside the mouth, inserted in the tooth as one piece and secured with cement.

Intraoral: Inside the mouth.

Onlay: A restoration that replaces a cusp or cusps of the tooth.

Oral Hygiene Instruction: Instruction on the proper care of teeth and gum tissue.

Orthodontics: Treatment such as braces to correct the position or alignment of teeth.

Palliative: Intended to relieve pain but will not cure the condition.

Panorex: An x-ray film that shows the curve of both dental arches and all corresponding teeth; a full mouth x-ray.

Partial Denture: An artificial device, either fixed or removable, that replaces one or more, but less than all the natural teeth and associated structures supported by the teeth.

Periodontics: Treatment for diseases of the mouth and gum tissue.

Pontic: A false tooth used within a dental bridge.

Prophylaxis: A procedure removing plaque, calcium, and stains from tooth surfaces by scaling and polishing techniques; cleaning.

Prosthetics: Replacement of teeth with an appliance such as dentures or bridges.

Rebase: The process of refitting a denture by replacing the denture base material.

Sealant: Protective covering applied to the occlusal (biting or grinding) surfaces of permanent bicuspid and molars to prevent decay.

Space Maintainer: A fixed or removable appliance designed to preserve the space created by the premature loss of a tooth.

Temporomandibular Joint: The connecting hinge mechanism between the mandible (lower jaw) and the base of the skull (temporal bone).

Veneer: A layer of tooth-colored material, usually porcelain or acrylic resin, that is attached to the surface of a crown or pontic by direct fusion, cementation, or mechanical retention.

HealthChoice

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