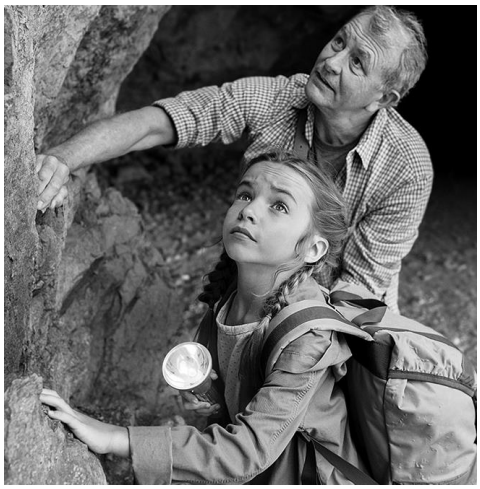
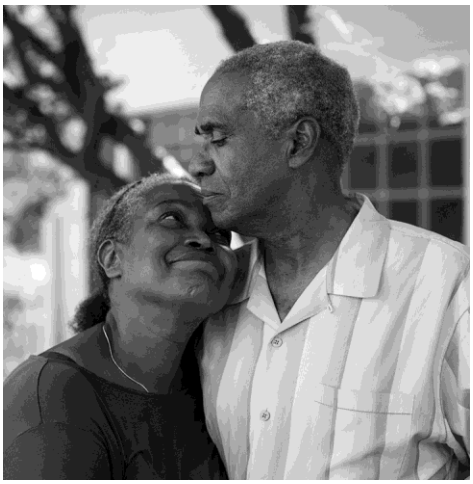
Administered by:

BlueCross BlueShield of Illinois



# Your Dental Care Benefits Program

Dental Benefits
Current Dental Terminology© American Dental Association

The Art Institute of Chicago
Group # 263850



*July 1, 2024*

# DENTAL BENEFIT BOOKLET

This Benefit Booklet contains a description of the group dental benefits available to you. The Claims Administrator for the Plan is Blue Cross and Blue Shield of Illinois (BCBSIL). BCBSIL, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

The Dental Schedule of Coverage enclosed with this Benefit Booklet indicates benefit percentages, Deductibles, maximums, and other benefit and payment issues that apply to the Plan.

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-CONTRACTING PROVIDERS ARE USED.** You should be aware that when you elect to utilize the services of a Non-Contracting Provider for a covered service in non-emergency situations, benefit payments to such Non-Contracting Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your Plan's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Plan. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Contracting Providers may bill members for any amount up to the billed charge after the Plan has paid its portion of the bill. Contracting Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and Deductible Amounts. You may obtain further information about the participating status of professional Providers and information on out-of-pocket expenses by calling the toll-free telephone number on your Identification Card.

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# Dental Schedule of Coverage

BlueCross BlueShield of Illinois

**Plan Effective Date:** July 1, 2024

The Deductibles below are subject to change as permitted by applicable law.

BlueCare Dental℠

| *Covered Services* | *Contracting Dentist* | *Non-Contracting Dentist* |
|---|---|---|
| **Diagnostic Evaluations**<br>(Deductible waived) | 100% | 100% |
| **Preventive Services**<br>*(Deductible waived)* | 100% | 100% |
| **Diagnostic Radiographs**<br>*(Deductible waived)* | 100% | 100% |
| **Miscellaneous Preventive Services**<br>*(Deductible waived)* | 100% | 100% |
| **Basic Restorative Services** | 80% | 60% |
| **Non-Surgical Extractions** | 80% | 60% |
| **Non-Surgical Periodontal Services** | 80% | 60% |
| **Adjunctive Services** | 80% | 60% |
| **Endodontic Services** | 80% | 60% |
| **Oral Surgery Services** | 80% | 60% |
| **Surgical Periodontal Services** | 80% | 60% |
| **Major Restorative Services** | 50% | 40% |
| **Prosthodontic Services** | 50% | 40% |
| **Miscellaneous Restorative and Prosthodontic Services** | 50% | 40% |
| **Implants** | 50% | 40% |
| **Orthodontia**<br>*(Deductible waived)* | 50% | 50% |
| All Participants | | |
| Maximum Lifetime Benefits per individual for Orthodontia | $1,500 | $1,500 |
| **Deductible** | $50 individual / $150 family | $100 individual / $300 family |
| **Annual Maximum** | $1,500 | $1,500 |

Benefits for covered services received from a Contracting Dentist are based on the Allowable Amount, and such Dentist cannot balance bill for charges in excess of this Allowable Amount.

Benefits for covered services received from a Non-Contracting Dentist will be based upon an Allowable Amount determined by the Claim Administrator, where non-contracting Allowable Amount will be not less than the amount the Claim Administrator would have paid, for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist, and it is possible that such Dentist will balance bill for amounts above this.

# INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your dental care expenses for Dentally Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affects your dental care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee.

Benefits available under the Plan are explained in the **COVERED DENTAL SERVICES** section. The benefits available to you are indicated on the Dental Schedule of Coverage in this Benefit Booklet.

**You are covered only for those benefit categories of services selected by your Employer and shown on your Dental Schedule of Coverage.**

The benefit percentage to be applied to each category of service is shown on your Dental Schedule of Coverage.

## Important Contact Information

| Resource | Contact Information | Accessible Hours |
|---|---|---|
| **Dental Customer Service Helpline** | **1-800-367-6401** | **Monday – Friday 8:00 a.m. – 6:00 p.m. (hours are subject to change)** |
| | | |
| **Website** | **www.bcbsil.com** | **24 hours a day 7 days a week** |

## Dental Customer Service Helpline

*Dental Customer Service Representatives can:*

- Give you information about Contracting Dentists;
- Distribute claim forms;
- Answer your questions on claims;
- Assist you in identifying a Contracting Dentist (but will not recommend specific Dentists);
- Provide information on the features of the Plan.

## BCBSIL Website

Visit the BCBSIL website at www.bcbsil.com for information about BCBSIL, access to forms referenced in this Benefit Booklet, and much more.

# WHO GETS BENEFITS

## Eligibility

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when the person becomes an eligible Employee or a Dependent under the Plan. The Eligibility Date is:

- The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
- For a new Dependent of an Employee already having coverage under the Plan, the date the Employee acquired the Dependent (date of marriage, Civil Union, birth, Court Order, placement of a foster child, adoption, or suit for adoption).

Any person eligible under this Plan and covered by the Employer's previous dental care Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee.

***Dependent Eligibility***

If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse or Civil Union partner or your Domestic Partner (Note: Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available for your group.);
2. A child under the limiting age shown in the definition of Dependent;
3. A child of any age who is medically certified as *Disabled* and dependent on you;
4. Any other child included as an eligible Dependent under the Plan. A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet.

An Employee must be covered first in order to cover their eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date.

## Applying For Coverage

You may apply for coverage for yourself and your eligible Dependents by submitting an *Enrollment Application/Change form* to your Employer or the Claim Administrator.

No eligibility rules or variations in premium will be imposed based on your health status, dental condition, claims experience, receipt of health care, dental history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated, reasonable dental management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

# WHO GETS BENEFITS

## Effective Dates of Coverage

The Effective Date is the date the coverage for a Participant actually begins.

It is important that your application for coverage under the Plan is received timely by the Claim Administrator. If you apply for coverage and pay any required premium for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claim Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date, provided your application is received timely by the Claim Administrator.

In no event will your Dependent's coverage become effective prior to your Effective Date.

***Late Applications***
If you apply for coverage for yourself or for yourself and any Dependents and your application is not received within 31 days from your Eligibility Date, you will not be eligible to apply for coverage until the next Open Enrollment Period unless qualified for a Special Enrollment Period.

***Special Enrollment Periods***
Special enrollment periods have been designated during which you may apply for or request a change in coverage for yourself and/or your eligible Dependents. You must apply for coverage within 31 days from the date of a triggering event in order to qualify for the changes described in this ***Special Enrollment Period*** subsection, including the following:

1. **Birth, Adoption, or Party to a Suit for Adoption, Placement of a Foster Child or Court-Ordered Dependent Coverage**
   The Effective Date of coverage will be the date of birth, adoption, or party to a suit for adoption or date of placement of a foster child. The Effective Date of coverage for Court-Ordered Dependent coverage will be determined by the Claim Administrator in accordance with the provisions of the Court Order.
2. **Marriage**
   The Effective Date of coverage will be no later than the first day of the month following your marriage date or becoming a party to a Civil Union or establishment of a domestic partnership, provided your Employer covers Domestic Partners.

The Claim Administrator **must** receive notification from you on an *Enrollment Application/Change Form* during the 31-day period after the event. If you wait until after this 31-day period, the coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

## Enrollment Application/Change Form

Use this form to:

- Notify the Plan and Claim Administrator of a change to your name;
- Add Dependents (other than a newborn child where notification only is required);
- Drop Dependents;
- Cancel all or a portion of your coverage;
- Notify the Claim Administrator of all changes in address for yourself and your Dependents.

You may obtain this form from your Employer, by calling the BCBSIL Dental Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSIL website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

## Changes in Your Family

You should promptly notify the Claim Administrator, as appropriate, in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, Civil Union or establishment of a domestic partnership, if applicable to your Plan, or placement of a foster child, adoption, or a child being involved in a suit for which an adoption of a child is sought, or your Employer receives a Court Order to provide health or dental coverage for a Participant's child or your spouse or Civil Union partner, you must submit an *Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in this **WHO GETS BENEFITS** section.

- When you divorce or terminate a Civil Union or terminate a domestic partnership, your child reaches the Dependent child age limit or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions.

**Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available**. If your Dependent's coverage is terminated, premium refunds will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claim Administrator, refunds will be requested.

Please refer to the **Continuation of Group Coverage - Federal** subsection in this Benefit Booklet for additional information.

## Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claim Administrator will pay for Eligible Dental Expenses you incur under the Plan. The portion of the charges by your Dentist that exceeds the Allowable Amount of the Claim Administrator will be your responsibility to pay to your Dentist, except when you have used a Contracting Dentist. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan and any applicable Deductibles and Coinsurance Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by BCBSIL.

## Course of Treatment

Your Dentist may decide on a planned series of dental procedures which a dental exam shows you need. In cases where there is more than one professionally acceptable covered procedure or Course of Treatment, benefits will be covered for the least costly covered procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the person is responsible for expenses that exceed the amount covered for the least costly service.

## Current Dental Terminology (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled "*Current Dental Terminology and Procedure Codes (CDT)*" is used when classifying dental services.

The Allowable Amount for an Eligible Dental Expense will be based on the most inclusive procedure codes.

## Freedom of Choice

| *Each time you need dental care, you can choose to:* | |
|---|---|
| ***See a Contracting Dentist*** | ***See a Non-Contracting Dentist*** |
| • Your out-of-pocket cost will generally be the least amount because Contracting Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses;<br>• You are not required to file claim forms;<br>• You are not balance billed for costs exceeding the Claim Administrator's Allowable Amount for Contracting Dentists. | • Your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with the Claim Administrator to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses;<br>• You are required to file claim forms;<br>• You may be balanced billed by Non-Contracting Dentists for costs exceeding the Claim Administrator's Allowable Amount. |

In each event as described above, you will be responsible for the following:

- Any applicable Deductibles;
- Coinsurance Amounts;
- Services that are limited or not covered under the Plan.

If your Dentist is not a Contracting Dentist, you may be responsible for filing your claim, as described in the **CLAIM FILING AND APPEALS PROCEDURES** portion of this Benefit Booklet. You may also be responsible for payment in full at the time services are rendered.

To find a Contracting Dentist, you may look up a dental Provider in the Dental Directory, log on to the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com and search for a Dentist using Provider Finder, or call the Dental Customer Service Helpline number located in this Benefit Booklet or on your Identification Card.

## How Benefits are Calculated

Your benefits are based on a percentage of the Dentist's Allowable Amount. To determine your benefits, subtract the Deductible (if applicable and not previously satisfied) from your Eligible Dental Expenses, then, multiply the difference by the Coinsurance Amount percentage applicable to the benefit category of services shown on your Dental Schedule of Coverage. The resulting total is the amount of benefits available.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, except when you have used a Contracting Dentist, any Deductible, and your Coinsurance Amount will be your responsibility to pay to your Dentist.

When using a Non-Contracting Dentist, your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with the Claim Administrator to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses. You may be balanced billed by Non-Contracting Dentists for costs exceeding the Claim Administrator's Allowable Amount.

## Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's dental care Plan with the Claim Administrator. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number***. This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Illinois as your Claim Administrator.
- ***Your group number***. This is the number assigned to identify your Employer's dental care Plan with the Claim Administrator.
- ***Important telephone numbers***.

*Always remember to carry your Identification Card with you and present it to your Dentist when receiving dental care services or supplies. Do not let anyone who is not named in your coverage use your Identification Card to receive benefits.*

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claim Administrator will provide a new Identification Card.

## Predetermination of Benefits

If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of $300, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with and predetermined by the Claim Administrator prior to the commencement of treatment.

The Claim Administrator may request copies of existing radiographic images, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. The Claim Administrator will review the reports and materials, taking into consideration alternative Courses of Treatment. The Claim Administrator will notify you and the Dentist of the benefits to be provided under the Plan. Predetermination gives you and your Dentist the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

# CLAIM FILING AND APPEALS PROCEDURES

## Filing of Claims Required

In order to obtain your dental benefits under this Benefit Booklet, it is necessary for a claim to be filed with the Claim Administrator.

To file a claim, obtain an Attending Dentist's Statement from your Employer before going to the Dentist. The Attending Dentist's Statement is used for pre-estimation of benefits. It is your responsibility to ensure that the necessary claim information has been provided to the Claim Administrator.

You must complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

Blue Cross and Blue Shield of Illinois
P. O. Box 23059
Belleville, Illinois 62223-0059

Claims must be filed with the Claim Administrator within 365 days from the date your covered service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing claims, ask your Employer or call the Claim Administrator.

## Dental Claim Procedures

The Claim Administrator will process all claims according to the benefit program within 30 days of receipt of all information required to process a claim. In the event that the Claim Administrator does not process a claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a claim within 30 days of the claim's receipt has not been received. (For information regarding assigning benefits, see **Assignment and Payment of Benefits** subsection of this Benefit Booklet.)

If the claim is denied you will receive a notice from the Claim Administrator with:

1. The reasons for denial;
2. A reference to the dental care plan provisions on which the denial is based;
3. A description of additional information which may be necessary to perfect the claim, and
4. An explanation of how you may have the claim reviewed by the Claim Administrator if you do not agree with the denial.

## REVIEW OF CLAIM DETERMINATIONS

## Claim Appeal Procedures

If your claim has been denied you may request an appeal the Claim Administrator will review its decision in accordance with the following procedure.

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

Blue Cross and Blue Shield of Illinois
P. O. Box 23059
Belleville, Illinois 62223-0059

You may also designate a representative to act for you in the review appeal 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. To obtain an authorized representative form, you or your authorized representative may call the Claim Administrator at the number on the back of your Identification Card.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for appeal.

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 or at any time during the claim appeal process. The Claim Administrator will give you a written decision within 60 days after it receives your request for appeal.

If you have any questions about the claims procedures or the review procedure, write or call BCBSIL Headquarters. BCBSIL offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601-5099

Filing an appeal does not prevent you from filing a complaint with the Illinois Department of Insurance (IDOI) or keep IDOI from investigating a complaint. IDOI can be contacted at the following address:

Illinois Department of Insurance
Consumer Division
320 Washington Street
Springfield, IL 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

If you have a claim for benefits which is denied or ignored, you may have the right to file suit in a state or federal court.

## Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the limited authority to process claims per the terms and conditions of the Plan and to determine benefits in accordance with the Plan's provisions.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

## Actions Against BCBSIL

No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of 60 days after Proof of Loss has been filed in accordance with the requirement of the Plan and no such action will be brought at all unless brought within three years from the expiration of the time within which Proof of Loss is required by the Plan.

# ELIGIBLE DENTAL EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

## Eligible Dental Expenses

The Plan provides coverage for services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each category of service is shown on the Dental Schedule of Coverage.

For benefits available for Eligible Dental Expenses, please refer to the Dental Schedule of Coverage in this Benefit Booklet. Your benefits are calculated on a Plan Year basis unless otherwise stated. At the end of a Plan Year, a new Plan Year starts for each Participant.

## Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Dental Schedule of Coverage. The Deductibles are explained as follows:

**Plan Year Deductible**: The individual Deductible amount shown under "Deductible" on your Dental Schedule of Coverage must be satisfied by each Participant under your coverage each Plan Year. This Deductible, unless otherwise indicated, will be applied to all categories of services, before benefits are available under the Plan.

The following are exceptions to the Deductibles described above.

If you have several covered Dependents, all charges used to apply toward a "per individual" amount will be applied toward the "per family" amount shown on your Dental Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Plan Year. No Participant will contribute more than the individual Deductible amount to the family Deductible amount.

## Maximum Dental Benefits

***Annual Maximum Benefit***
The total amount of benefits available to any one Participant for all combined categories of services for a Calendar Year shall not exceed the "Annual Maximum Benefit" amount shown on your Dental Schedule of Coverage.

This Annual Maximum Benefit amount includes:

1. All payments made by the Claim Administrator under the benefit provisions of the Plan; and

2. Any benefits provided to a Participant under a dental care Plan held by the Employer with the Claim Administrator immediately prior to the Participant's Effective Date of coverage under this Plan.

***Maximum Lifetime Benefits***
The total amount of benefits available to any one Participant under the Plan shall not exceed the "Maximum Lifetime Benefits" amount as shown on your Dental Schedule of Coverage.

This Maximum Lifetime Benefits amount includes all payments made by the Claim Administrator under the Orthodontic Services provision of the Plan as indicated on your Dental Schedule of Coverage.

## Changes in Benefits

Benefits for Eligible Dental Expenses incurred during a Course of Treatment that begins before the change will be those benefits in effect on the day the Course of Treatment was started.

# COVERED DENTAL SERVICES

The Plan will provide benefits for the following Eligible Dental Expenses, subject to the limitations and exclusions described in this Benefit Booklet, only if the category of service is shown on your Dental Schedule of Coverage. The benefit percentage applicable to each category of service is also shown on your Dental Schedule of Coverage.

**You are covered only for those categories of services shown on the Dental Schedule of Coverage issued with this Benefit Booklet.**

## Diagnostic Evaluations

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

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

Benefits for periodic, extensive, and detailed oral evaluations are limited to a combined maximum of two exam(s) every Plan Year. Comprehensive oral evaluations are limited to one every 36 months when performed by the same Dentist.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations when Eligible Dental Expenses are rendered on the same date as any other oral evaluation by the same Dentist.

## Preventive Services

Preventive services are performed to prevent dental disease. Eligible Dental Expenses include:

- Prophylaxis – Professional cleaning and polishing of the teeth. Benefits are limited to two cleaning(s) every Plan Year.
- Scaling in presence of generalized moderate or severe gingival inflammation. Benefits are limited to two per Plan Year.
- Topical application of fluoride – Benefits for topical application of fluoride are available for Participants under age 19 and are limited to one application(s) every Plan Year.

Combination of prophylaxes, scaling in presence of generalized moderate or severe gingival inflammation and periodontal maintenance treatments are limited to a combination of two every Plan Year.

## Diagnostic Radiographs

Diagnostic radiographic images are taken to diagnose a dental disease and includes their interpretations. Eligible Dental Expenses include:

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films – Benefits are limited to four horizontal images or eight vertical radiographic images once every Plan Year.
- Bitewing films are not separately eligible when taken on the same date as full-mouth films.
- Periapical films, as necessary for diagnosis – Benefits are limited to six every Plan Year.

## Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

- Sealants – Benefits for sealants are limited to one per permanent (first and second) molar 3 per lifetime and are available for Participants under age 14.
- Space Maintainers – Benefits for space maintainers are limited to a lifetime maximum of one appliance per arch for Participants up to age 14.
- Palliative treatment (emergency) of dental pain, when treatment is not performed in conjunction with a definitive treatment or service.

## Basic Restorative Services

Basic restorative services are restorations necessary to repair dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Eligible Dental Expenses include:

- Amalgam restorations.
- Resin-based composite restorations.

## Non-Surgical Extractions

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

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

## Non-Surgical Periodontal Services

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

- Periodontal scaling and root planning.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.
- Periodontal maintenance procedures –Benefits are limited to two every Plan Year following active periodontal treatment.

## Enhanced Benefits

Participants diagnosed and receiving active medical care for the following medical conditions as determined by the Plan such as – pregnancy, diabetes, and cardiovascular disease – may receive one of the following enhanced dental benefits after standard benefits are completed:

- One additional cleaning; or
- Periodontal scaling and root planing (up to 2 quadrants); or
- Periodontal maintenance.

Enhanced benefits apply to the annual benefit maximum.

## Adjunctive Services

Adjunctive general services include:

- Palliative treatment (emergency) of dental pain, when treatment is not performed in conjunction with a definitive treatment or service.
- Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Medically Necessary by the Plan for Participants with documented medical or dental conditions. A person's apprehension does not constitute a Medical Necessity.

## Endodontic Services

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

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

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

## Oral Surgery Services

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

- Surgical tooth extractions.
- Alveoloplasty and vestibuloplasty.
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess. Intraoral soft tissue incision and drainage is covered only when provided as the definitive treatment for an abscess. Routine follow-up care is considered part of the procedure.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Plan.

## Surgical Periodontal Services

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

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planning).
- Clinical crown lengthening once per lifetime per tooth.
- Osseous surgery, including flap entry and closure – In addition, osseous surgery performed in conjunction with crown lengthening on the same date of service and in the same area of the mouth, will receive the benefit of crown lengthening in the absence of periodontal disease.
- Osseous grafts.

- Soft tissue grafts/allografts (including donor site).
- Distal or proximal wedge procedure not in conjunction with osseous surgery.
- Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

## Major Restorative Services

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

- Single crown restorations.
- Inlay/onlay restorations.
- Labial veneer restorations not performed for cosmetic reasons.

Benefits for major restorations are limited to one per tooth every 8 years whether placement was provided under this Plan or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

## Prosthodontic Services

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

- Complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 8 year period, whether placement was provided under this Plan or under any prior dental coverage.
- Denture reline/rebase procedures.
- Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the prosthetic delivery.
- Fixed bridgework – Benefits will be provided for the initial installation of an eligible bridgework, including inlays/onlays and crowns. Benefits will be limited to one every 8 years whether placement was under this Plan or under any prior dental coverage.
- Prosthetics placed over implants will be covered.

## Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

- Prefabricated crowns – Benefits for stainless steel and resin-based crowns are limited to one per tooth every 8 years. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to recementations per Plan Year. Recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect.
- Adjustments – Benefits will be limited to two time(s) per appliance per Plan Year.

- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of a missing or broken tooth or clasp (unless additions are completed on the same date as replacement partials/dentures).

## Orthodontic Services

Orthodontic procedures and treatment include examination records, tooth guidance repositioning (straightening) and retention of the teeth for Participants covered for orthodontics as shown on your Dental Schedule of Coverage. Covered services include:

- Limited**,** interceptive and comprehensive orthodontic treatment, which all accumulate to the Participant's lifetime maximum.

***Special Provisions Regarding Orthodontic Services*:**

- Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic benefit, as shown on your Dental Schedule of Coverage. Benefits cease when the Participant is no longer covered, whether or not the entire benefit has been paid.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic benefit and subject to the maximum benefit, as shown on your Dental Schedule of Coverage for orthodontic services.
- If orthodontic treatment is terminated for any reason before completion, benefits will cease on the date of termination.
- If the Participant's coverage is terminated prior to the completion of the orthodontic treatment plan, the Participant is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Dentist who placed the appliance and/or who is responsible for the ongoing care of the Participant is not covered.
- Benefits are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the Effective Date, benefits will be reduced based on the benefits paid prior to this coverage beginning.

## Implant Services

Depending on the dental Plan chosen, benefits may be available for covered services incurred for an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth. See your Dental Schedule of Coverage for more information.

# DENTAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to all services described in this dental Plan. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, (as defined in the **DEFINITIONS** section) licensed to perform services covered under this dental Plan.

## Important Information About Your Dental Benefits

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

  **Please note that in order to provide you with dental care benefits at a reasonable cost, this Plan provides benefits only for those Eligible Dental Expenses that are determined by the Plan to be Medically Necessary.**

  No benefits will be provided for procedures which are not Medically Necessary.

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

- ***Care By More Than One Dentist***

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

- ***Alternate Benefits***

  In all cases in which there is more than one covered procedure or Course of Treatment possible to treat a covered dental condition, the benefit will be based upon the least costly covered procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the Participant is responsible for expenses that exceed the amount covered for the least costly service.

  If you and your Dentist decide on:
  - personalized restorations; or
  - personalized complete or partial dentures and overdentures; or
  - to employ specialized techniques for dental services rather than standard procedures,

  the benefits provided will be limited to the benefit for the standard procedures for dental services, as determined by the Plan.

- ***Non-Compliance with Prescribed Care***

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

## Exclusions and Limitations

No benefits will be provided under this Plan 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. 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.
11. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance Amounts are offered.
12. 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.
13. Services or supplies received for behavior management or consultation purposes.
14. 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.
15. 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.
16. Charges for nutritional, tobacco or oral hygiene counseling.
17. Charges for local, state or territorial taxes on dental services or procedures.
18. Charges for the administration of infection control procedures as required by OSHA, local, state or federal mandates.
19. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
20. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or radiographic images.
21. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
22. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
23. 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.

24. Chemical treatments or localized delivery of chemotherapeutic agents.
25. Charges for local anesthesia, nitrous oxide analgesia, therapeutic, parenteral drugs, or other drugs or medicaments and/or their application.
26. Replacement of an extracted or missing third molar and/or congenitally missing teeth.
27. Any services, treatments or supplies included as Eligible Dental Expenses under other hospital, medical and/or surgical coverage.
28. Case presentations or detailed and extensive treatment planning when billed for separately.
29. Charges for occlusion analysis or occlusal adjustments.
30. Endodontic retreatment provided within 12 months of the initial endodontic therapy by the same Dentist.
31. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparations, fitting of preformed dowel and post, or post removal.
32. Endodontic therapy if you discontinue endodontic treatment.
33. Surgical services related to congenital or developmental malformation.
34. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological) or for bony impactions covered by another benefit plan.
35. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
36. Anatomical crown exposure.
37. 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.
38. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
39. Charges for replacement of stolen, lost, or defective dentures, crowns or other appliances.
40. Splinting of teeth including double retainers for removable partial dentures and fixed bridgework.
41. Any procedure, service, or appliance for the purpose of altering or maintenance of vertical dimension of occlusion.
42. 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.
43. 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.
44. Precision or semiprecision attachments.
45. Gold foil restorations.
46. Tests and oral pathology procedures, or for re-evaluations.
47. The replacement of a lost or defective crown.

# DEFINITIONS

*The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.*

**Accidental Injury** means accidental bodily injury resulting, directly and independently of all other causes.

**Allowable Amount** means the maximum amount determined by the Claim Administrator to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Dentists contracting with the Claim Administrator*** – The Allowable Amount is based on the terms of the Dentist's contract and the Claim Administrator's methodology in effect on the date of service.

- ***For Dentists not contracting with the Claim Administrator –*** The Allowable Amount is based on the amount the Claim Administrator would have paid for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and the Claim Administrator:

- ***For services performed in Illinois*** – The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.

- ***For services performed outside of Illinois*** – The Allowable Amount will be established by identifying Dentists with similar experience or skills in order to establish the applicable amount for the procedure, services, or supplies.

- ***For multiple surgical procedures performed in the same operative area –*** The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.

- ***When a less expensive professionally acceptable service, supply, or procedure is available –*** The Allowable Amount will be based upon the least expensive services. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

The Allowable Amount for all Eligible Dental Expenses also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

**Claim Administrator** means Blue Cross and Blue Shield of Illinois (BCBSIL). BCBSIL, as part of its duties as Claim Administrator, may subcontract portions of its responsibilities.

**Civil Union** means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

**Coinsurance Amount** means the dollar amount (expressed as a percentage) of Eligible Dental Expenses incurred by a Participant during a Plan Year that exceeds benefits provided under the Plan.

**Contracting Dentist** means a Dentist who has entered into a written agreement with the Claim Administrator to participate as a DentalBlue dental Provider or a BlueCare dental Provider.

**Course of Treatment** means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

**Court Order** means a direction issued by a court or a judge requiring a Participant to do or not do something. A Court Order may also include an administrative order.

# DEFINITIONS

**Deductible** means the dollar amount of Eligible Dental Expenses that must be incurred by a Participant before benefits under the Plan will be available.

**Dentally Necessary or Dental Necessity** means those services, supplies, or appliances covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. Not primarily for the convenience of the Participant or the Participant's Dentist; and
4. The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

The Claim Administrator shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

**Dentist** means a person, when acting within the scope of their license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

**Dependent** means your spouse or Civil Union partner or Domestic Partner (provided your Employer covers Domestic Partners) or any *child* who has been determined to be eligible for coverage, if applicable, and who is covered under the Plan.

*Child* means a natural child, a stepchild, an eligible foster child, a child of your Civil Union partner, a child of your Domestic Partner, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (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. An unmarried grandchild must be dependent on you for federal income tax purposes at the time of application of coverage for the grandchild is made under the Plan. Enrolled unmarried children will be covered up to age 30 if they: Live within the state of Illinois; and have served as an active or reserve member of any branch of the Armed Forces of the United States; and have received a release or discharge other than a dishonorable discharge. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States, is also considered a Dependent *child* under the Plan.

For purposes of this Plan, the term *Dependent (*inclusive of Civil Union partners and Domestic Partners) will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

**Domestic Partner** means a person with whom you have entered into a domestic partnership in accordance with the Employer's Plan guidelines. *Note:* Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available under your Plan.

**Effective Date** means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

# DEFINITIONS

**Eligible Dental Expenses** means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant has an obligation to pay.

**Employee** means a person who:

1. Regularly provides personal services at the Employee's usual and customary place of employment with the Employer; and
2. Works a specified number of hours per week or month as required by the Employer; and
3. Is recorded as an Employee on the payroll records of the Employer; and
4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* may also include those individuals who are no longer an Employee of the Employer, but who are Participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

**Employer** means the person, firm, or institution named on this Benefit Booklet.

**EOB** means an Explanation of Benefits.

**Experimental/Investigational** means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

*Approval* by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

*Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or Provider in which they were performed; and
- the Dentist has had the appropriate training and experience to provide the treatment or procedure.

The medical/dental staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Dentist may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claim Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

**Identification Card** means the card issued to the Employee by the Claim Administrator indicating pertinent information applicable to the Participant's dental coverage.

# DEFINITIONS

**Medically Necessary or Medical Necessity** generally means that a specific procedure to you is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you.

The fact that a Provider may prescribe, order, recommend or approve a procedure does not by itself make such procedure Medically Necessary.

**Non-Contracting Dentist** means a Dentist who is not a Contracting Dentist as defined herein.

**Open Enrollment Period** means the 31-day period, selected by the Employer, preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

**Participant** means an Employee or Dependent whose coverage has become effective under this Plan.

**Plan** means a program of health benefits established by the Plan sponsor for the benefit of its Participants as part of the self-funded employee welfare benefit plan whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

**Plan Administrator** means the named administrator of the Plan having fiduciary responsibility for its operation, in the alternative it means Employer. BCBSIL is not the Plan Administrator.

**Plan Anniversary Date** means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as the Benefit Booklet is in force.

**Plan Effective Date** means the date on which coverage for the Employer's Plan begins with the Claim Administrator.

**Plan Month** means each succeeding calendar month period, beginning on the Plan Effective Date.

**Plan Year** means the period commencing on the Plan Effective Date/Plan Anniversary and ending on the day before the next Plan Anniversary Date. Please see your Dental Schedule of Coverage or contact your Employer for Plan Year information.

**Proof of Loss** means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

**Provider** means a physician, Dentist or any other person, company, or institution furnishing to a Participant, when acting within their scope of their license, an item of service or supply listed as an Eligible Dental Expenses.

**Waiting Period** means the number of days of continuous employment required by the Employer that must pass before an individual, who is a potential enrollee under the Plan, is eligible to be covered for benefits.

# GENERAL PROVISIONS

## Agent

The Employer is not the agent of the Claim Administrator.

## Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claim Administrator.

## Assignment and Payment of Benefits

Under this Benefit Booklet, the Claim Administrator has the right to make any benefit payment either directly to the Provider of the covered services or to you, unless reasonable evidence of a properly executed and enforceable assignment of benefit payment has been received by the Claim Administrator sufficiently in advance of the Claim Administrator's benefit payment. For example, the Claim Administrator may pay benefits to you if you receive covered services from a Non-Contracting Dentist. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

Once covered services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

Except for the assignment of benefit payment described above, this Benefit Booklet and a Participant's claim for benefits under this Benefit Booklet is expressly non-assignable and non-transferable to any person or entity, including any Provider, at any time before or after covered services are rendered to a Participant, and coverage under this Benefit Booklet is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

## Conformity with State Statutes

Any provision of this Benefit Booklet which, on its Effective Date, is in conflict with the statutes of the state in which the Participant resides on such date is hereby amended to conform to the minimum requirements of such statutes.

## Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any Dentist, insurance carrier, or other entity to furnish the Claim Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

## Entire Contract

This Benefit Booklet, including the application and any amendments and riders constitutes the entire contract of insurance and no change is valid unless approved by an executive officer of the Claim Administrator and unless such approval be endorsed hereon and attached hereto.

## Participant/Dentist Relationship

The choice of a Dentist should be made solely by you or your Dependents. The Claim Administrator does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any Dentist. The Claim Administrator does not have any responsibility for a Dentist's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the Dentist selected and are available only for treatment acceptable to the Dentist.

## Refund Of Benefit Payments

If the Claim Administrator pays benefits for Eligible Dental Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Claim Administrator has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claim Administrator may deduct any refund due to them from any future benefit payment.

## Time Limit on Certain Defenses

After two years from the date of issue of this Benefit Booklet no misstatements, except fraudulent misstatements, made by the applicant in the application for such Benefit Booklet shall be used to void the Benefit Booklet or to deny a claim for illness or injury beginning after the expiration of such two year period.

## Reimbursement

When the Claim Administrator pays benefits under the Plan and it is determined that a negligent third party is liable for the same expenses, the Claim Administrator has the right to receive first reimbursement from the monies payable from the negligent third party equal to the amount the Claim Administrator has paid for such expenses. The Participant hereby agrees to reimburse the Claim Administrator from any monies recovered from a negligent third party as a result of a judgment against, settlement with, or otherwise paid by the third party. The Participant agrees to take action against the third party, furnish all information, and provide assistance to the Claim Administrator regarding the action taken, and execute and deliver all documents and information necessary for the Claim Administrator to enforce our rights of reimbursement.

The Claim Administrator's process to recover by subrogation or reimbursement will be conducted in accordance with Illinois law.

## Coordination of Benefits

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered Dependent has health/dental care coverage under more than one Benefit Program.

The order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Benefit Program are determined before or after those of another Benefit Program. The benefits of this Benefit Program:

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in ***When this Benefit Program is a Secondary Program*** section.

In addition to the **DEFINITIONS** section of this Benefit Booklet, the following definitions apply to this section:

**Allowable Expense** means covered service, when the covered service is covered at least in part by one or more Benefit Program covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under this definition unless your stay in a private hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Benefit Program.

When a Benefit Program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

**Benefit Program** means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (1) or (2) above is a separate Benefit Program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Benefit Program.

**Claim Determination Period** means a Plan Year. However, it does not include any part of a year during which a person has no coverage under this Benefit Program, or any part of a year before the date this COB provision or a similar provision takes effect.

**Primary Program or Secondary Program** means the order of payment responsibility as determined by the order of benefit determination rules.

When this Benefit Program is the Primary Program, its benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its benefits are determined after those of the other Benefit Program and may be reduced because of the other program's benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs, and may be a Secondary Program as to a different program or programs.

***Order of Benefit Determination***

When there is a basis for a claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program that has its benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of benefit payments using the first of the following rules that applies:

1. Non-Dependent or Dependent

   The benefits of the Benefit Program that covers the person as an Employee, member or Subscriber (that is, other than a Dependent) are determined before those of the Benefit Program that covers the person as Dependent; except that, if the person is also a Medicare beneficiary, Medicare is:

   a. Secondary to the Benefit Program covering the person as a Dependent; and
   b. Primary to the Benefit Program covering the person as other than a Dependent, for example a retired Employee.

2. Dependent Child if Parents not Separated or Divorced

   Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a Dependent of different persons, (i.e., "parent"):

   a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a Calendar Year are determined before those of the program of the parent whose birthday falls later in that year; but
   b. If both parents have the same birthday, the benefits of the Benefit Program that covered the parents longer are determined before those of the Benefit Program that covered the other parent for a shorter period of time.

   However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

   If two or more Benefit Programs cover a person as a Dependent child of divorced or separate parents, benefits for the child are determined in this order:

   a. First, the program of the parent with custody of the child;
   b. Then, the program of the spouse of the parent with custody of the child; and
   c. Finally, the program of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health/dental care expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This does not apply with respect to any Claim Determination Period or Benefit Program year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify the Claim Administrator and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

   If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health/dental care expenses of the child, the Benefit Programs covering the child shall follow the order of benefit determination rules outlined in 2 above.

5. Young Adult as a Dependent

   For a Dependent child who has coverage under either or both parents' plans and also has their own coverage as a Dependent under a spouse's plan, rule 8, "Length of Coverage" applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule of rule 2 to the Dependent child's parent or parents and the Dependent's spouse.

6. Active or Inactive Employee

   The benefits of a Benefit Program that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Benefit Program that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule shall not apply.

7. Continuation of Coverage

   If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of benefit determination:

   a. First, the benefits of a Benefit Program covering the person as an Employee, member or Subscriber (or as that person's Dependent);
   b. Second, the benefits under the continuation coverage.

8. Length of Coverage

   If none of the rules in this section determines the order of benefits, the benefits of the Benefit Program that covered an Employee, member or Subscriber longer are determined before those of the Benefit Program that covered that person for the shorter term.

***When this Benefit Program is a Secondary Program***
In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the benefits of this Benefit Program may be reduced.

The benefits of this Benefit Program will be reduced when:

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

If you are eligible for Medicare Part B, the benefits of this Benefit Program may be reduced taking into consideration the amount that would be payable for an Allowable Expense under Medicare Part B whether or not you have enrolled in Part B and/or received payment from Medicare.

When the benefits of this Benefit Program are reduced as described, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Program.

***Right to Receive and Release Needed Information***
Certain facts are needed to apply these COB rules. The Claim Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Claim Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give the Claim Administrator any facts it needs to pay the claim.

***Facility of Payment***
A payment made under another Benefit Program may include an amount that should have been paid under this Benefit Program. If it does, the Claim Administrator may pay that amount to the organization that made the payment under the other Benefit Program. That amount will then be treated as though it were a benefit paid under this Benefit Program. The Claim Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

***Right of Recovery***
If the amount of payments made by the Claim Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

## Termination of Coverage

The Claim Administrator is not required to give you prior notice of termination of coverage. The Claim Administrator will not always know of the events causing termination until after the events have occurred.

***Termination of Individual Coverage***
Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Claim Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claim Administrator may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on you will not terminate upon reaching the limiting age shown in the definition of Dependent if the child continues to be both:

1. *Disabled*; and
2. Dependent upon you for support and maintenance as defined by the Internal Revenue Code of the United States.

*Disabled* means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Employer to the Claim Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claim Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

***Termination of the Group***
The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

## Continuation of Group Coverage - Federal

The following "events" may provide you or your Dependents an option to continue group coverage:

1. Your death, divorce, retirement, or eligibility for Medicare;
2. The termination of your status as an Employee (except for reason of gross misconduct) or retirement;
3. If you are covered as a retired Employee, the filing of a Title XI bankruptcy proceeding by the group; or
4. Your child's marriage or reaching the "Dependent child age limit".

**If such an event occurs, you or your Dependents should immediately contact your Employer to determine your rights.**

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within a prescribed time period. You or your Dependents may be required to pay your own premium rates. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Dental Schedule of Coverage). Hence, changes in the group premium rates or benefits will change the premium rates or benefits for any continued coverage.

The continued coverage automatically terminates after a period of time (never to exceed three years) but will be terminated earlier upon the occurrence of certain circumstances. These circumstances include, but are not limited to, nonpayment of premium, entitlement to or coverage under Medicare and coverage under any other group health coverage which does not contain a limitation with respect to a preexisting condition of the Participant (even if such coverage is less valuable than your current health plan). Your Employer will give you more detailed information upon your request.

## Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other Plan Participants and to the government as required by ERISA and its regulations.

2. The Claim Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Plan. Upon written request by the Plan Administrator, the Claim Administrator will send any information which the Claim Administrator has that will aid the Plan Administrator in making its annual reports.

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Plan. Claim filing and claim review procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

4. BCBSIL, as the Claim Administrator, is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Plan.

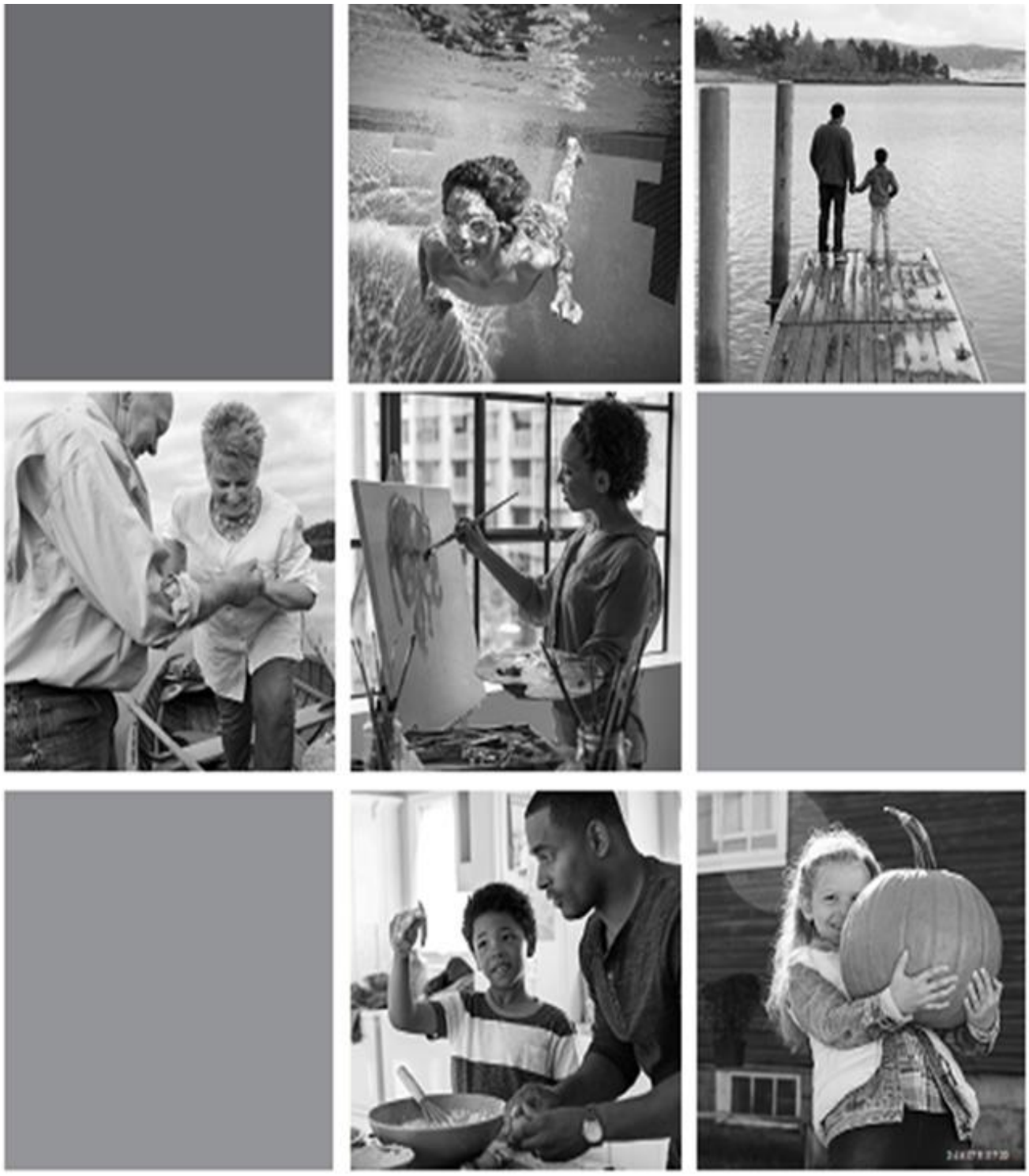
5. This Benefit Booklet is not a summary plan description.

6. The Plan Administrator has given the Claim Administrator the limited authority to process claims per the terms and conditions of the Plan and to determine benefits in accordance with the Plan's provisions. The Plan Administrator has full and complete authority to make decisions regarding the Plan's provisions and determining questions of eligibility and benefit design. Any decisions regarding eligibility and benefit design made by the Plan Administrator shall be final and conclusive.

   Plan Administrator delegated to Claim Administrator limited authority to administer claims in accordance with the terms of the Plan's provisions and to make initial claim determinations and benefit determinations for appealed claims.

# AMENDMENTS

# NOTICES



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