BlueCross BlueShield of Illinois

300 East Randolph
Chicago, IL 60601
Or call us at the phone number on the back of your identification card.

# BLUECARE DENTAL℠ 1A

## OUTLINE OF COVERAGE

**Read your Policy carefully** — This outline of coverage provides only a very brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Illinois (the Plan). It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

This BlueCare Dental coverage is designed to provide you with economic incentives for using designated dental care providers. **Although you can go to the Dentist of your choice, your Benefits under the Policy will be greater when you use the services of designated Dentists.**

**The Coinsurance amounts and Benefit Period Maximum amounts listed below represent the Dental Plan's responsibility.**

**The Deductibles and Out-of-Pocket Maximums listed below represent your responsibility.**

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

## For Subscribers Age 19 and Over

| COVERED SERVICES | Participating Provider | Non-Participating Provider* |
|---|---|---|
| **Diagnostic Evaluations** (Deductible waived)<br>**Preventive Services** (Deductible waived)<br>**Diagnostic Radiographs** (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| **Miscellaneous Preventive Services**<br>**Basic Restorative Services**<br>**Non-Surgical Extractions**<br>**Non-Surgical Periodontal Services**<br>**Adjunctive General Services**<br>**Endodontic Services**<br>**Oral Surgery Services**<br>**Surgical Periodontal Services**** | 80% of Maximum Allowance | 50% of Maximum Allowance |
| **Major Restorative Services****<br>**Prosthodontic Services****<br>**Miscellaneous Restorative and Prosthodontic Services**** | 50% of Maximum Allowance | 30% of Maximum Allowance |
| **Orthodontic Services** | Not Covered | |

| | Participating Dentist | Non-Participating Dentist |
|---|---|---|
| **Deductible** (PPO/Non-PPO accumulate together)<br>Individual | $50 | $50 |
| Family | $150 | $150 |
| **Benefit Period Maximum**<br>(PPO/Non-PPO accumulate together) | $1,500 | |

| | |
|---|---|
| **Out-of-Pocket Maximum per Benefit Period** | None |

*All Benefits are based upon the Maximum Allowance, which is the amount determined by Blue Cross and Blue Shield of Illinois as the maximum amount for payment of Benefits. A Participating Dentist cannot balance bill for charges in excess of the Maximum Allowance. Benefits for services provided by a Non-Participating Dentist will be based upon the same Maximum Allowance, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

** 12-month waiting period may apply.

## For Subscribers Under Age 19

| COVERED SERVICES | Participating Provider | Non-Participating Provider* |
|---|---|---|
| **Diagnostic Evaluations** (Deductible waived)<br>**Preventive Services** (Deductible waived)<br>**Diagnostic Radiographs** (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| **Miscellaneous Preventive Services**<br>**Basic Restorative Services**<br>**Non-Surgical Extractions**<br>**Non-Surgical Periodontal Services**<br>**Adjunctive General Services**<br>**Endodontic Services**<br>**Oral Surgery Services**<br>**Surgical Periodontal Services** | 80% of Maximum Allowance | 50% of Maximum Allowance |
| **Major Restorative Services**<br>**Prosthodontic Services**<br>**Miscellaneous Restorative and Prosthodontic Services** | 50% of Maximum Allowance | 30% of Maximum Allowance |
| **Orthodontic Services** | | |
| **Pediatric Orthodontic Services:**<br>Coverage limited to an orthodontic condition meeting Medically Necessary criteria established by the Plan (e.g., severe, dysfunctional malocclusion) | 50% of Maximum Allowance | 30% of Maximum Allowance |
| **Optional Orthodontic Services:**<br>Coverage for orthodontic conditions not meeting Medically Necessary criteria established by the Plan | Not Covered | |

| | Participating Dentist | Non-Participating Dentist |
|---|---|---|
| **Deductible** (PPO/Non-PPO accumulate together) | | |
| Individual | $50 | $50 |
| Family | $150 | $150 |
| **Benefit Period Maximum -** Excluding any Orthodontic Services (PPO/Non-PPO accumulate together) | Unlimited | |
| **Out-of-Pocket Maximum per Benefit Period** | | |
| 1 Child | $350 | No Limit |
| 2+ Children | $700 | No Limit |

* All Benefits are based upon the Allowable Amount, which is the amount determined by Blue Cross and Blue Shield of Illinois as the maximum amounts eligible for payment of Benefits. A Participating Dentist cannot balance bill for charges in excess of the Maximum Allowance. Benefits for services provided by a Non-Participating Dentist will be based upon the same Maximum Allowance, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses, if applicable.

## ELIGIBILITY

An individual may apply for coverage under the Policy if he/she is an Illinois resident and is not currently enrolled under any other dental coverage underwritten by Blue Cross and Blue Shield of Illinois or any subsidiary or affiliate of Health Care Service Corporation. Coverage is available for the Member and his/her covered spouse or Domestic Partner (if any) under age 65 on his/her Coverage Date. Coverage for a dependent child (if applicable) may continue until their 21st birthday.

## YOUR PARTICIPATING PROVIDER NETWORK

Your BlueCare Dental plan contains special provisions (Benefit reductions) which apply whenever you use Dentists who are not members of the Participating Provider Network. If you use a Non-Participating Dentist, you will be responsible for the following:

- Charges for any services which are not covered under your Policy.
- Any Deductible or Coinsurance amounts which are applicable to your coverage (*including the higher Deductible and/or Coinsurance amounts which apply to Non-Participating Provider services*).
- The difference, if any, between your Dentist's "billed charges" and the Plan's Maximum Allowance Charge for the Covered Services.

The Benefits provided by the Plan and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating Dentist or Non-Participating Dentist.

Participating Dentists will accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you are responsible for the difference between the Plan's Benefit and the Dentist's charge to you, in addition to any Coinsurance and/or Deductible amounts applicable to your services.

Non-Participating Dentists are Dentists who have not signed an agreement to accept the Maximum Allowance as the Benefit in full. Therefore, you are responsible for the difference between the Plan's Non-Participating Benefit and the Dentist's billed charge to you, in addition to any Deductible and/or Coinsurance amounts applicable to your services.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Dentist or the Plan.

## RENEWAL

The Policy is renewable at the option of the Plan by acceptance of premiums. The membership premiums shall be the amount determined by the Plan and filed with the Illinois Department of Insurance. The Plan has the right to change the premiums or Benefits provided by the Policy. You will be given reasonable notice of such changes. You should attach these notices to your Policy, as they will amend a part of the Policy.

When you renew your Blue Cross and Blue Shield coverage or reenroll by selecting a new product (as defined by applicable law), you will need to be current on your premium payments. Any past due premium payments for coverage we provided must be paid no later than your Coverage Date for the new year, in addition to initial premium charges. New coverage will not be effective until all such payments are made.

## NOTICE

The Policy may not fully cover all of your dental costs.

## EXCLUSIONS

No Benefits will be provided under the Policy for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Amounts which are in excess of the Maximum Allowance.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as included in the Medically Necessary Orthodontic Dental Services subsection of the Dental Benefit Section of the Policy.
- Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders or to increase vertical dimension.
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
- Services and supplies for any illness or injury suffered after the Eligible Person's Coverage Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Claims for a service submitted by a dentist, which is for the same service performed on the same date for the same member by another dentist.
- Services or supplies received for behavior management or consultation purposes.
- Any services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental agencies provide benefits (some state or federal laws may affect how we apply this exclusion).
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or Benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or Benefits are received, except however, this exclusion shall not be applicable to medical assistance Benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, Benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Charges for nutritional, tobacco or oral hygiene counseling.
- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a Claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other

specialized techniques.

- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Coverage Date under the Policy; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Coverage Date.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis, diagnostic casts or occlusal adjustments.
- Gold foil restorations.
- Cone beam imaging and cone beam MRI procedures.
- Sealants for teeth other than permanent molars.
- Orthodontic care for dependent children age 19 and over.
- Localized delivery of antimicrobial agents or chemotherapeutic agents.
- Bone grafts in conjunction with extractions, apicoectomy or any non- covered service or non-covered implants.
- Anatomical crown exposures.
- The replacement of a lost, missing or stolen appliances and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
- Restoration occlusion on incisal edges due to bruxism or harmful habits.
- Treatment to replace teeth which were missing prior to the Coverage Date.
- Congenitally missing teeth.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
- Comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.
- Tests and oral pathology procedures, or for re-evaluations.
- Radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
- Restorations placed within 12 months of the initial placement by the same Dentist.
- Local anesthesia or other drugs or medicaments and/or their application.
- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.
- Endodontic therapy if you discontinue endodontic treatment.
- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
- Replacement or repair of an orthodontic appliance.

# BLUECARE DENTAL℠1A
# SCHEDULE OF BENEFITS
# For Subscribers Age 19 and Over

Your dental care Covered Services are highlighted below. To fully understand all of the terms, conditions, limitations and exclusions which apply to your benefits, please read the entire Policy.

The Coinsurance amounts and Benefit Period Maximum amounts listed below represent the Dental Plan's responsibility.

The Deductibles and Out-of-Pocket Maximums listed below represent your responsibility.

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

| Covered Services | Participating Provider | Non-Participating Provider* |
|---|---|---|
| Diagnostic Evaluations (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| Preventive Services (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| Diagnostic Radiographs (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| Miscellaneous Preventive Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Basic Restorative Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Non-Surgical Extractions | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Non-Surgical Periodontal Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Adjunctive Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Endodontic Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Oral Surgery Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Surgical Periodontal Services** | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Major Restorative Services** | 50% of Maximum Allowance | 30% of Maximum Allowance |
| Prosthodontic Services** | 50% of Maximum Allowance | 30% of Maximum Allowance |
| Miscellaneous Restorative and Prosthodontic Services** | 50% of Maximum Allowance | 30% of Maximum Allowance |
| **Orthodontic Services** | Not Covered | |

| | Participating Provider | Non-Participating Provider* |
|---|---|---|
| **Deductible** (per Benefit Period) (PPO/Non-PPO accumulate together) | | |
| Individual | $50 | $50 |
| Family | $150 | $150 |
| **Benefit Period Maximum** (PPO/Non-PPO accumulate together) | $1,500 | |
| **Out-of-Pocket Maximum** | None | |

*All Benefits are based upon the Maximum Allowance, which is the amount determined by Blue Cross and Blue Shield of Illinois as the maximum amounts eligible for payment of Benefits. A Participating Dentist cannot balance bill for charges in

excess of the Maximum Allowance. Benefits for services provided by a Non-Participating Dentist will be based upon the same Maximum Allowance, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses, if applicable.

**12 month waiting period may apply.

# BLUECARE DENTAL℠1A
# SCHEDULE OF BENEFITS
# For Subscribers Under Age 19

Your dental care Covered Services are highlighted below. To fully understand all of the terms, conditions, limitations and exclusions which apply to your Benefits, please read the entire Policy.

The Coinsurance amounts and Benefit Period Maximum amounts listed below represent the Dental Plan's responsibility.

The Deductibles and Out-of-Pocket Maximums listed below represent your responsibility.

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

| Covered Services | Participating Provider | Non-Participating Provider* |
|---|---|---|
| Diagnostic Evaluations (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| Preventive Services (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| Diagnostic Radiographs (Deductible waived) | 100% of Maximum Allowance | 70% of Maximum Allowance |
| Miscellaneous Preventive Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Basic Restorative Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Non-Surgical Extractions | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Non-Surgical Periodontal Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Adjunctive Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Endodontic Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Oral Surgery Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Surgical Periodontal Services | 80% of Maximum Allowance | 50% of Maximum Allowance |
| Major Restorative Services | 50% of Maximum Allowance | 30% of Maximum Allowance |
| Prosthodontic Services | 50% of Maximum Allowance | 30% of Maximum Allowance |
| Miscellaneous Restorative and Prosthodontic Services | 50% of Maximum Allowance | 30% of Maximum Allowance |
| **Orthodontic Services** | | |
| **Pediatric Orthodontic Services**[1]**:** Coverage limited to an orthodontic condition meeting Medically Necessary criteria established by the Plan (e.g., severe, dysfunctional malocclusion) | 50% of Maximum Allowance | 30% of Maximum Allowance |
| **Optional Orthodontic Services:** Coverage for orthodontic conditions not meeting Medically Necessary criteria established by the Plan | Not Covered | |

| | Participating Provider | Non-Participating Provider* |
|---|---|---|
| **Deductible** (per Benefit Period) | | |

| | | |
|---|---|---|
| (PPO/Non-PPO accumulate together) | | |
| Individual | $50 | $50 |
| Family Deductible | $150 | $150 |
| **Benefit Period Maximum**<br>(Excluding any Orthodontic Services)<br>(PPO/Non-PPO accumulate together) | Unlimited | |
| **Out-of-Pocket Maximum**<br>(per Benefit Period) | | |
| 1 child | $350 | No Limit |
| 2+ children | $700 | No Limit |
| *All Benefits are based upon the Maximum Allowance, which is the amount determined by Blue Cross and Blue Shield of Illinois as the maximum amount eligible for payment of Benefits. A Participating Dentist cannot balance bill for charges in excess of the Maximum Allowance. Benefits for services provided by a Non-Participating Dentist will be based upon the same Maximum Allowance, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses, if applicable. | | |

[1]Orthodontic Coverage limited to children meeting or exceeding a score of 42 from the modified Salzmann Index or meeting criteria for medical necessity.

# Your Dental Care Benefit Program

**BlueCross BlueShield of Illinois**

**300 E. Randolph Street**
**Chicago, IL 60601**
**Or call us at the phone number on the back of your identification card.**

A message from

## BLUE CROSS AND BLUE SHIELD

This dental plan may be purchased through the Exchange (also known as the Health Insurance Marketplace) or outside the Exchange. If this dental plan is purchased outside of the Exchange, all references to the Exchange are not applicable.

Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois will provide the dental care benefit program described in this Policy. In this Policy we refer to our company as "Blue Cross and Blue Shield". Please read this entire Policy very carefully. We hope that most of the questions you have about your coverage will be answered.

THIS POLICY REPLACES ANY PREVIOUS POLICY YOU MAY HAVE BEEN ISSUED BY BLUE CROSS AND BLUE SHIELD. THIS POLICY IS CURRENTLY CERTIFIED BY THE HEALTH INSURANCE MARKETPLACE AS AN EXCHANGE-CERTIFIED DENTAL PLAN.

If you have any questions once you have read this Policy, please contact your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield! We are very happy to have you as a member and pledge you our best service.

Sincerely,

Blue Cross and Blue Shield of Illinois,
A Division of Health Care Service Corporation,

Kurtis Kossen
President Retail Markets

# NOTICE

**Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for Blue Cross and Blue Shield to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.**

**Please refer to the provision entitled "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.**

**Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.**

## WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy'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 policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Illinois Insurance Code. Participating 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.

# TABLE OF CONTENTS

## DEFINITIONS SECTION

Throughout this Policy, many words are used which have a specific meaning when applied to your dental care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Policy, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your Benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADVANCE PREMIUM TAX CREDIT.....means the advance payment of a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, 2013, as provided for under applicable law where the advanced payment is used to offset all or a portion of the premium for coverage obtained by that individual through the Exchange.

BENEFITS.....means the payment, reimbursement and indemnification of any kind which you will receive from Blue Cross and Blue Shield under this Policy.

BENEFIT PERIOD.....means the period of time during which you receive Covered Services for which the Plan will provide Benefits. The Benefit Period is a period of one year which begins on January 1st of each year. When you first enroll under this dental coverage, your first Benefit Period begins on your Effective date and ends on December 31st of the same year.

BENEFIT WAITING PERIOD.....means the number of months that you must be continuously covered under this benefit program before you are eligible to receive Benefits for certain dental Covered Services.

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

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.

CLAIM.....means notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with services rendered to you.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the Benefits described in this Policy. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under this Policy begins.

COVERED SERVICE.....means a service or supply specified in this Policy for which Benefits will be provided.

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before Benefits are provided.

DENTIST.....means a duly licensed dentist, operating within the scope of his/her license.

A "Participating Dentist" means a Dentist who has a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield to administer a Participating Provider Option Dental program to provide services to you at the time you receive the services.

A "Non-Participating Dentist" means a Dentist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or the entity chosen by Blue Cross and Blue Shield to administer a Participating Provider Option Dental program to provide services to participants in the Participating Provider Option program.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

ELIGIBLE PERSON.....means a person who meets the eligibility requirements for this dental coverage, as described in the COVERAGE AND PREMIUM INFORMATION section of this Policy.

EXCHANGE ("Health Insurance Marketplace").....means a governmental agency or non-profit entity that meets the applicable Health Insurance Exchange standards, and other related standards established under the Affordable Care Act ("ACA"), and makes Qualified Health Plans (QHPs) and Qualified Dental Plans available to Qualified Individuals and Qualified Employers. Unless otherwise identified, the term Exchange refers to State Exchanges, regional Exchanges, subsidiary Exchanges and a Federally-facilitated Exchange on which Blue Cross and Blue Shield of Illinois offers this Exchange-Certified Dental Plan.

EXCHANGE-CERTIFIED DENTAL PLAN.....means a dental care benefit plan that has in effect a certification that it meets the applicable standards issued or recognized by each Exchange through which such plan is offered. Also known as Qualified Dental Plan.

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.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under this Policy.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

INDIVIDUAL COVERAGE.....means coverage under this Policy for yourself but not your spouse, Domestic Partner, if applicable, and/or dependents.

MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield, which Participating

Dentists have agreed to accept as payment in full for a particular dental Covered Service. All benefit payments for Covered Services rendered by Participating Dentists, and Non-Participating Providers will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by Blue Cross and Blue Shield.

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

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

NON-PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

OPTIONAL ORTHONDONTIC SERVICES.....means coverage for orthodontic conditions not meeting Medically Necessary criteria.

PEDIATRIC ORTHONDONTIC SERVICES.....means coverage limited to children under age 19 with an orthodontic condition meeting Medically Necessary criteria (e.g., severe, dysfunctional malocclusion).

PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

PARTICIPATING PROVIDER OPTION.....means a program of dental care Benefits designed to provide you with economic incentives for using designated Providers of dental care services.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches and operating within the scope of his/her license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of his/her license.

PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

POLICY.....means this booklet, including your application for coverage, whether purchased through the Exchange, if applicable, or directly from Blue Cross and Blue Shield.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you and operating within the scope of such license.

A "Plan Provider" means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Provider" means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

QUALIFIED HEALTH PLAN (QHP).....means a health care benefit program that has in effect a certification that it meets the applicable standards issued or recognized by each Exchange through which such program is offered.

QUALIFIED INDIVIDUAL.....means an individual who has been determined eligible to enroll through the Plan and/or Exchange in a Qualified Health Plan (QHP) or a Qualified Dental Plan in the individual market.

RENEWAL DATE.....means January 1st of each year when your dental coverage under this Policy renews for another Benefit Period.

RESCISSION.....has the meaning set forth in the RESCISSION provision in this Policy.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by Blue Cross and Blue Shield.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

# COVERAGE AND PREMIUM INFORMATION

This Policy contains information about the dental care benefit program for you and your eligible dependents if you:

- Meet the definition of a Qualified Individual as determined by the Exchange (also known as the Health Insurance Marketplace), if applicable, and the definition of an Eligible Person as specified in the Policy;
- In the event that you purchased coverage through the Exchange, have applied for this coverage and received an eligibility determination from the Exchange;
- In the event you purchased coverage outside of the Exchange, have applied for this dental coverage through Blue Cross and Blue Shield;
- Have received a Blue Cross and Blue Shield identification card;
- Live within the service area of Blue Cross and Blue Shield. (Contact customer service at the number on the back of your identification card for the information regarding service area); and,
- Reside, live or work in the geographic network service area served by Blue Cross and Blue Shield for this Policy of coverage. You may call customer service at the number shown on the back of your identification card to determine if you are in the network service area or log on to the website at www.bcbsil.com.

**POLICY YEAR**

Policy Year means the 12-month period beginning on January 1 of each year.

**RESCISSIONS**

Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect, other than cancellation or discontinuance of coverage for reasons related to non-payment of premium. Any intentional fraudulent misstatements or omissions, or intentional misrepresentation of a material fact on your application, or any act or practice that constitutes fraud may result in the cancellation of your coverage (and/or your dependent(s) coverage) retroactive to the effective date, subject to prior notification. You have the right to appeal this cancellation and an independent third party may review the decision. In the event of such cancellation, Blue Cross and Blue Shield may deduct from the premium refund any amounts made in Claim Payments during this period and you may be liable for any Claim Payment amount greater than the total amount of premiums paid during the period for which cancellation is effected.

In the event your age has been misstated, all amounts payable under this Policy shall be based on the premium paid that would have been due if purchased using the correct age.

At any time when Blue Cross and Blue Shield is entitled to rescind coverage already in force, Blue Cross and Blue Shield may at its option make an offer to reform the Policy already in force or is otherwise permitted to make retroactive changes to this Policy and/or a change in the rating category/level. In the event of reformation, the Policy will be issued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

**YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD**

You will receive a Blue Cross and Blue Shield identification card. This card will tell you your Blue Cross and Blue Shield identification number and will be very important to you in obtaining your Benefits.

**YOUR SCHEDULE PAGE**

A Schedule Page has been inserted into and is part of this Policy. The Schedule Page contains specific information about your coverage including, but not limited to:

- Whether you have Individual Coverage or Family Coverage;
- The amount of your Deductible(s) and/or Copayment(s);
- The Covered Benefit payment levels.

**INDIVIDUAL COVERAGE**

If you have Individual Coverage, only your own health care expenses are covered, not the dental care expenses of

other members of your family.

**FAMILY COVERAGE**

If you have Family Coverage, your dental care expenses and those of your enrolled spouse and your (or your spouse's) enrolled children who are under age 26 will be covered unless a higher age is specified elsewhere. All provisions of this Policy that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. A Domestic Partner and his/her children who are

under age 26 are also eligible dependents. Coverage for children will end on the last day of the calendar month in which their 26th birthday falls.

Hereafter, "child" or "children" means a natural child, a stepchild, a child of your Domestic Partner, an adopted child (including a child under 18 involved in a suit for adoption,) a foster child, a child for whom you are the legal guardian or a child for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any continuation of these factors. Coverage for children will end on the last day of the period for which the premium has been paid, after the child's 26th birthday.

Under Family Coverage, any newborn children will be covered from the moment of birth, as long as you notify Blue Cross and Blue Shield within 60 days of the birth.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

For purposes of this section, dependent on other care providers means requiring a Community Integrated Living arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities), the Department of Public Health, or the Department of Public Aid.

Blue Cross and Blue Shield may inquire 60 days prior to the dependent reaching the limiting age, or at any reasonable time thereafter, whether the dependent is in fact a disabled and dependent person. If you do not provide proof within the 60 days, coverage will be automatically terminated on the last day of the month for which premium has been paid.

Any children who are under your legal guardianship, in your custody under an interim court order prior to finalization of adoption or placed with you as a foster child will be covered.

This coverage does not include Benefits for grandchildren (unless such children are under your legal guardianship).

**CHILD-ONLY COVERAGE**

Eligible children that have not attained age 19 may enroll as the sole enrollee under this Dental Plan. In such event, this Dental Plan is considered Child-Only coverage and the following restrictions apply:

- The parent or legal guardian is not covered and is not eligible for Benefits under this Dental Plan.
- If a child covered under this Plan acquires a new enrolled eligible child of his/her own, the new enrolled eligible child may be enrolled in his/her own Plan coverage if application for coverage is made within 60 days of the child's birth.
- If a child is under the age of 18, the child's parent, legal guardian, or other responsible party must submit the application for Child-Only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Exchange, if applicable, and Blue Cross and Blue Shield. For any child under 18 covered under this Dental Plan, any obligations set forth in this Dental Plan, and exhibits, appendices, addenda and/or other required information will be the obligation of the parent, legal guardian, or other responsible party applying for coverage for the child's behalf. Application for a Child-Only coverage will not be accepted for an adult child that has attained age 19 as of the beginning of the Plan Year. Adult children (at least 18 years of age but has not attained the age of 19 years) who are applying as the sole Eligible Person under this Dental Plan must apply for their own individual Plan and must sign or authorize the application(s).

## APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your eligible dependents (see below) by submitting the application(s) for individual medical insurance form, along with any exhibits, appendices, addenda and/or other required information ("Application(s)") to the Exchange, if applicable, and to Blue Cross and Blue Shield. The Application(s) for coverage may or may not be accepted.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, Claims experience, receipt of healthcare, medical history, genetic information, evidence of instability, disability, or any other health status related factor. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variation in the administration, processes or Benefits of this policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

You may enroll in or change coverage for yourself and/or your eligible dependents during one of the following enrollment periods. Your and/or your eligible dependents' effective date will be determined by the Exchange, if applicable, and by Blue Cross and Blue Shield depending upon the date your application is received, payment of the initial premiums no later than the day before the effective date of coverage (unless any Advance Premium Tax Credit, if applicable, is greater than the initial premium), and other determining factors.

## ANNUAL OPEN ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

You may apply for or change coverage for yourself and/or your eligible dependents during the annual open enrollment period designated by the Exchange.

When you enroll during the annual open enrollment period your and/or your eligible dependents' effective date will be the following January 1, unless otherwise designated by the Exchange, if applicable, and Blue Cross and Blue Shield.

Coverage under this Policy is contingent upon timely receipt by Blue Cross and Blue Shield of necessary information and initial premium. When you renew your Blue Cross and Blue Shield coverage or reenroll by selecting a new product (as defined by applicable law), you will need to be current on your premium payments. Any past due premium payments for coverage we provided must be paid no later than your Coverage Date for the new year, in addition to initial premium charges. New coverage will not be effective until all such payments are made.

This provision "Annual Open Enrollment Periods/Effective Date of Coverage" is subject to change by the Exchange, if applicable, Blue Cross and Blue Shield, and/or applicable law, as appropriate.

## SPECIAL ENROLLMENT PERIODS/EFFECTIVE DATES OF COVERAGE

Special enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your eligible dependents. You must apply for coverage within 60 days from the date of a special enrollment event in order to qualify for the changes described in this provision Special Enrollment Periods/Effective Dates of Coverage.

Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be no later than the 1st day of the following month, or if you apply between the 16th day and the end of the month, you and your eligible dependents' effective date will be no later than the 1st day of the second following month.

You must provide acceptable proof of a qualifying event with your application. Special enrollment qualifying events are discussed in detail below. Blue Cross and Blue Shield will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with your application will delay or prevent the processing of your application and enrollment in coverage. Please call the customer service number on the back of your identification card or visit Blue Cross and Blue Shield's website at *www.bcbsil.com* for examples of acceptable proof for the following qualifying events.

**Special Enrollment Events:**

1. You experience a loss of Minimum Essential Coverage. New coverage for you and/or your eligible dependents will be effective no later than the first day of the month following the loss;

   A loss of Minimum Essential Coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage, or situations allowing for a rescission, as

determined by the Exchange, if applicable.

For purposes of this Special Enrollment Periods/Effective Dates of Coverage provision, "Minimum Essential Coverage" means health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group, or government health insurance coverage. For additional information on whether particular coverage is recognized as "Minimum Essential Coverage," please call the customer service number on the back of your identification card or visit *www.cms.gov*.

You gain a dependent or become a dependent through marriage, establishment of a Domestic Partnership, or becoming a party to a Civil Union. New coverage for you and/or your eligible dependents will be effective no later than the first day of the following month.

You gain a dependent through birth, adoption, or placement for adoption or court-ordered dependent coverage. New coverage for you and/or your eligible dependents will be effective on the date of the birth, adoption, or placement for adoption. However, advance payments of any Advance Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement as a foster child or for adoption occurs on the first day of the month. The effective date for court-ordered eligible child coverage will be determined by Blue Cross and Blue Shield in accordance with the provision of the court order.

2. You gain a dependent or become a dependent through marriage, establishment of a Domestic Partnership, or becoming a party to a Civil Union. New coverage for you and/or your eligible dependents will be effective on the first day of the following month.
3. You gain a dependent through birth, adoption, or placement for adoption or court-ordered dependent coverage. New coverage for you and/or your eligible dependents will be effective on the date of the birth, adoption, or placement for adoption. However, advance payments of any Advance Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption, or placement of a foster child or for adoption occurs on the first day of the month. The effective date for court-ordered eligible child coverage will be determined by Blue Cross and Blue Shield in accordance with the provisions of the court order.
4. You were not previously a citizen(s), national(s), or lawfully present and gain such status.
5. Your enrollment or non-enrollment in an Exchange-Certified Dental Plan is unintentional, inadvertent, or erroneous as evaluated and determined by the Exchange, if applicable, and/or Blue Cross and Blue Shield.
6. You adequately demonstrate to the Exchange that the Exchange-Certified Dental Plan in which you are enrolled substantially violated a material provision of its contract in relation to you.
7. You are determined newly eligible or newly ineligible for an Advance Premium Tax Credit or have a change in eligibility for cost-sharing reductions, regardless of whether or not you are already enrolled in an Exchange-Certified Dental Plan.

   For purposes of this Special Open Enrollment Periods/Effective Dates of Coverage provision, "Premium Tax Credit" means a refundable premium tax credit you may receive for taxable years ending after December 31, 2013, to the extent provided for under applicable law, where the credit is meant to offset all or a portion of the premium tax paid by you for coverage obtained through an Exchange during the preceding calendar year.
8. You gain access to new Exchange-Certified Dental Plans as a result of a permanent move.
9. You are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act. You may enroll yourself and/or your eligible dependents' in an Exchange-Certified Dental Plan or change from one Exchange-Certified Dental Plan to another one time per month.
10. You demonstrate to the Exchange, in accordance with the guidelines issued by Health and Human Services (HHS), that you meet other exceptional circumstances as the Exchange may provide.

This provision "Special Enrollment/Effective Date of Coverage" is subject to change by the Exchange, if applicable, Blue Cross and Blue Shield, and/or applicable law.

**Coverage resulting from any of the Special Enrollment Events outlined above is contingent upon timely completion of the Application(s) and remittance of the appropriate premiums in accordance with the guidelines as established by the Exchange, if applicable, and by Blue Cross and Blue Shield.**

**WHO IS NOT ELIGIBLE**

The following individuals are not eligible for this coverage:

1. Unless listed as an eligible dependent as provided above under the heading "Family Coverage", no other family member, relative, or person is eligible for coverage under this Policy.
2. Individuals who are eligible to receive Medicare benefits are **not** eligible to enroll in this Plan, unless they fall within a Federal exception.
3. Incarcerated individuals, other than incarcerated individuals pending disposition of charges.
4. Individuals that do not live, reside or work in the network service area.
5. Individuals that do not meet any other Exchange, if applicable, and Blue Cross and Blue Shield eligibility requirements or residency standards.

This section "Who Is Not Eligible" is subject to change by the Exchange, if applicable, Blue Cross and Blue Shield, and/or applicable law.

**NOTIFICATION OF ELIGIBILITY CHANGES**

It is the Eligible Person's responsibility to notify the Exchange, if applicable, and Blue Cross and Blue Shield of any change to an Eligible Person's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible family members. For example, if you move out of Blue Cross and Blue Shield's "network service area". You must reside, live or work in the geographic "network service area" designated by Blue Cross and Blue Shield. You may call customer service at the number shown on your identification card to determine if you reside, live or work in the network service area, or log on to Blue Cross and Blue Shield's website at *www.bcbsil.com.*

**PAYMENT OF PREMIUMS**

The required premiums are determined and established by Blue Cross and Blue Shield based on many such factors, such as the age, place of residence and the number of eligible dependents covered under this Policy.

a. Premiums are due and payable on the due date.

b. The initial premium for Individual Coverage is based on your age at the time your coverage begins and the initial premium for Family Coverage is based on your age, your spouse's age and any eligible dependent children at the time coverage is applied for, as permitted by law.

c. Blue Cross and Blue Shield may establish a new premium for any of the Benefits of this Policy on any of the following dates or occurrences:

   1. whenever the Benefits of this Policy are increased, which may occur whenever required by law or whenever Blue Cross and Blue Shield gives notice of an increase in Benefits;
   2. whenever anyone who is covered under this Policy attains an age which results in a change in the premium amount due for that age category of coverage;
   3. whenever the number of persons under this Policy is changed;
   4. whenever you move your residence from one geographical rating area to another.

d. If the ages upon which the premium is based have been misstated, an amount which will provide Blue Cross and Blue Shield with the correct premium from your Coverage Date shall be due and payable upon billing or receipt from Blue Cross and Blue Shield.

e. In the event you are not receiving an Advance Premium Tax Credit, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force. After a grace period of 31 days, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid, unless coverage is extended as described below.

   In the event you are receiving an Advance Premium Tax Credit, you have a three-month grace period for paying premiums in full. If full premium is not paid for you and your covered family members within one month of the premium due date, Claim Payments for Covered Services received during the second and third month's grace period under this Policy will be pended until full premium payment is made. If full payment of the premium is

not made within the three month grace period, then coverage under this Policy will automatically terminate on the last day of the first month of the three-month grace period.

f. If you pay your premium in full during the 31 day grace period, then you may submit a Claim to Blue Cross and Blue Shield for any expenses that you paid to your Providers and Pharmacies during the grace period. See the HOW TO FILE A CLAIM section of this Policy for additional information.

If you fail to pay premiums to Blue Cross and Blue Shield and/or the Exchange within 31 days of the premium due date, this Policy will automatically terminate. During such grace period this Policy will continue in force, subject to the right of Blue Cross and Blue Shield to terminate this Policy in accordance with the TERMINIATION OF COVERAGE provision of this Policy. If the coverage is terminated for non-payment of premium, any Claims received and paid for during the 31 day grace period will be billed to you.

In the event you are receiving an Advance Premium Tax Credit, you have a three-month grace period for paying the full premiums falling due after the first termination. If full premium is not paid for you and your covered family members within one month of the premium due date, Claim Payments for Covered Services received during the second and third month's grace period under this Policy will be pended until full premium payment is made. If full payment of the premium is not made within the three month grace period, then coverage under this Policy will automatically terminate on the last day of the first month of the three-month grace period.

g. During the grace period, in the event you are receiving an Advanced Premium Tax Credit, Blue Cross and Blue Shield will:

- Pay all appropriate Claims for services rendered during the first month of the grace period and may pend Claims for services rendered in the second and third months of the grace period;
- Notify the Department of Health and Human Services of such non-payment; and,
- Notify Providers of the possibility of denied Claims during the second and third months of

your grace period.

**REINSTATEMENT**

If any premium is not paid within the time granted you for payment, a subsequent acceptance of premium by the Exchange, if applicable, and/or by Blue Cross and Blue Shield or by any agent duly authorized by Blue Cross and Blue Shield or by the Exchange, if applicable, to accept such premium, without requiring an application for reinstatement in connection with the premium payment, shall reinstate the Policy. However, if the Exchange, if applicable, and/or Blue Cross and Blue Shield or such agent requires an application for reinstatement and issues a conditional receipt for the premium given, the Policy will be reinstated upon approval of such application, upon the 45th day following the date of such conditional receipt unless the Exchange, if applicable, and/or Blue Cross and Blue Shield has previously notified you in writing of its disapproval of such application.

The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such illness as may begin more than 10 days after such date. In all other respect you will have the same rights as you had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed and attached hereto in connection with reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

During the term of this Policy, if you are activated for military service and become eligible for a federal government-sponsored program as a result of that activation, you (and your covered dependents if you have Family Coverage) may not be denied reinstatement of this Policy after your discharge unless the discharge is under less than honorable conditions or you are no longer an Illinois resident.

**TERMINATION OF COVERAGE**

Blue Cross and Blue Shield will not terminate coverage for any member based solely on the member's health status or health care needs.

If Blue Cross and Blue Shield terminates this Policy for any reason, Blue Cross and Blue Shield will provide you and the Exchange, if applicable, with a notice of termination of coverage that includes the termination effective date and reason for termination at least 30 days prior to the last day of coverage, except as otherwise provided in this Policy.

You and your eligible family members' coverage will be terminated due to the following events and will end on the dates specified below:

1. You terminate your coverage under this Policy, including as a result of your obtaining other minimum essential coverage, with reasonable, appropriate notice to the Exchange, if applicable, and Blue Cross and Blue Shield. For purposes of this provision, reasonable notice is defined as 14 days from the requested effective date of termination.

   The last day of coverage will be:

   - The termination date specified by you, if you provide reasonable notice;
   - 14 days after the termination is requested by you, if you do not provide reasonable notice; or
   - On a date determined by Blue Cross and Blue Shield, if Blue Cross and Blue Shield is able to effectuate termination in fewer than 14 days and you request an earlier termination effective date.
2. When you are no longer eligible for coverage through the Exchange, if applicable. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange, unless you request an earlier termination effective date.
3. When Blue Cross and Blue Shield does not receive the full amount of the premium payment on time or when there is a bank draft failure of premiums for your and/or your eligible family members' coverage, and

   - In the event you are receiving an Advance Premium Tax Credit, the three-month grace period for individuals receiving an Advance Premium tax credit has been exhausted. The last day of coverage will be the last day of the first month of the three-month grace period. Blue Cross and Blue Shield will pay all appropriate Claims for services rendered to you and/or your eligible dependents during the first month of the grace period and may pend Claims for services rendered to you and/or your eligible dependents in the second and third months of the grace period. Or,
   - In the event you are not receiving an Advance Premium Tax Credit, after the 31-day grace period has been exhausted, the last day of coverage will be the last day of the 31-day grace period and will be billed to you.

   Blue Cross and Blue Shield applied its termination policy for non-payment of premium uniformly to enrollees in similar circumstances.
4. Your coverage has been rescinded.
5. This Exchange-Certified Dental Plan terminates or is decertified.
6. You change from this Exchange-Certified Dental Plan to another during an annual open enrollment period or special enrollment period. The last day of coverage in this Exchange-Certified Dental Plan is the day before the effective date of coverage in your new Exchange-Certified Dental Plan.

Cancellation of your coverage under this Policy terminates the coverage of all your dependents under this Policy.

Benefits will not be provided for any services or supplies received after the date coverage terminates under this Policy, unless specifically stated otherwise in this Policy. However, termination of your coverage will not affect your benefits for any services or supplies that you received prior to your termination date.

**RIGHT TO EXAMINE THIS POLICY**

You have the right to examine this Policy for a 30-day period after its issuance. If, for any reason you are not satisfied with the dental care Benefits described in this Policy, you may return the Policy and identification card(s) to Blue Cross and Blue Shield and void your coverage. Any premium paid to Blue Cross and Blue Shield will be refunded to you, provided that you have not had a Claim paid under this Policy before the end of the 30-day period.

**NOTICE OF ANNUAL MEETING**

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Members of Blue Cross and Blue Shield. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term "Member" as used above refers only to the person to whom this Policy is issued. It does not include any other family members covered under Family Coverage unless such family member is acting on your behalf.

# HOW YOUR DENTAL COVERAGE WORKS

## THIS DENTAL PLAN

You have chosen Blue Cross and Blue Shield's Participating Provider Option for the administration of your dental Benefits. The Participating Provider Option is a program of dental care Benefits designed to provide you with economic incentives for using designated Providers of dental care services.

As a participant in the Participating Provider Option program a directory of Participating Dentists is available to you. You can visit the Blue Cross and Blue Shield of Illinois website at *www.bcbsil.com* for a list of Participating Dentists or you can request a copy of the directory and one will be sent to you upon request by contacting the number on the back of your identification card. While there may be changes in the directory from time to time, selection of Participating Dentists by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, Benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist.

The Benefits of this section are subject to all of the terms and conditions of this Policy. Certain Benefits may also be subject to a Benefit Waiting Period. Please refer to the DEFINITIONS SECTION, COVERAGE AND PREMIUM INFORMATION and EXCLUSIONS AND LIMITATIONS sections of this Policy for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

For Benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by Blue Cross and Blue Shield until after receipt of an Attending Dentist's Statement. In addition, Benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

## BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

### Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

### Deductible Requirements

Your Deductible amounts are shown on the **Schedule of Benefits**. The Deductible is the amount that you must pay for Covered Services received during a Benefit Period before this Policy begins paying its percentage for Covered Services. The amount applied to the Deductible for a Covered Service cannot exceed the maximum amount for the Covered Service.

### Coinsurance Requirements

Your Coinsurance is the percentage of the Maximum Allowance that you are required to pay for Covered Services after the Deductible, if applicable, has been met.

For each Covered Service, and after you have met the Deductible, if applicable, this Policy covers a certain percentage (specified on the **Schedule of Benefits**) of the Maximum Allowance for the Covered Service. When a Covered Service is received from a Participating Provider, you pay only the Deductible and/or Coinsurance amount applicable to that service. When a Covered Service is received from a Non-Participating Provider that exceeds the Maximum Allowance and/or Usual & Customary Fee charged for the Covered Service.

### Benefit Payment for Dental Services

The Benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Dentist. Your Coinsurance amounts are shown on the **Schedule of Benefits**.

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield or the entity chosen by Blue Cross and Blue Shield to administer a Participating Provider Option Dental program, to accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service—that is, your Coinsurance amounts and Deductible.

Non-Participating Dentists are Dentists who have not signed an agreement with Blue Cross and Blue Shield or the entity chosen by Blue Cross and Blue Shield to administer a Participating Provider Option Dental program, to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Blue Cross and Blue Shield benefit payment and such Dentist's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Dentist or Blue Cross and Blue Shield.

**Benefit Maximum**

The maximum amount available for you in dental Benefits each benefit period is shown on your **Schedule of Benefits**. This is an individual maximum. There is no family maximum.

This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a separate lifetime maximum shown on your **Schedule of Benefits**.

Any expenses incurred beyond the benefit maximum are your responsibility.

**DENTAL BENEFIT WAITING PERIOD**

Certain dental Benefits under this benefit program are subject to a Benefit Waiting Period. You will not be eligible for Benefits for these Covered Services for the number of months specified in the **Schedule of Benefits**.

Your Benefit Waiting Period will begin on your Coverage Date and will continue for the number of months specified in the **Schedule of Benefits**.

**IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS**

**Care By More Than One Dentist**

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

**Alternate Benefit Program**

In all cases in which there is more than one service or Course of Treatment to treat your dental condition, the Benefit will be based on the least costly Covered Service or Course of Treatment.

The alternate Benefit Copayment or Coinsurance will be based on the less costly Covered Service, and you will be responsible for paying the difference between the less costly service and the more costly service elected. .

If you and your Dentist or Physician decide on personalized restorations 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.

**Pre-Estimation of Benefits**

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. Blue Cross and Blue Shield will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated Benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the Benefits available for the proposed services to be rendered.

# DENTAL BENEFIT SECTION

## COVERED SERVICES

The Benefits of this section are subject to all the terms and conditions of your Policy. Benefits are available only for services and supplies that are determined to be "Medically Necessary", unless otherwise specified. All Covered Services listed in this section are subject to the ***Exclusions and Limitations*** section of this Policy, which lists services, supplies, situations or related expenses that are not covered.

**It is important for you to refer to your *Schedule of Benefits* to find out what your Deductible, Benefit Period Maximums, Coinsurance and Out-of-Pocket Maximums will be for a Covered Service. If you do not have a *Schedule of Benefits*, please call a Customer Service Representative at the number shown on your identification card.**

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

## DIAGNOSTIC EVALUATIONS

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

- Periodic oral evaluations for established patients.
- Problem focused oral evaluations, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children under the age of three, including counseling with primary caregiver.
- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your Benefits are limited to one comprehensive and one periodic examinations every benefit period
- .

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

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

## PREVENTIVE SERVICES

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

- Prophylaxis—Professional cleaning, scaling and polishing of the teeth. Benefits will be limited to two cleanings every 12 months..
- Topical Fluoride Application—Benefits for fluoride application is only available to Eligible Persons under age 19 and are limited to two applications every 12 months.

### Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Following active periodontal treatment, benefits are available for a combination of two prophylaxes and two periodontal maintenance treatments (see "Non-Surgical Periodontic Services") every 12 months.

## DIAGNOSTIC RADIOGRAPHS

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

- Full-mouth (intraoral complete series) and panoramic films—Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films—Benefits are limited to four horizontal films or eight vertical films once every 12 months. However, Benefits are not available for bitewing films taken on the same date as full-mouth films or within 6 months of a complete series of radiographic images.

- Periapical films, as necessary for diagnosis—Benefits are limited to six every 12 months.

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

**MISCELLANEOUS PREVENTIVE SERVICES**

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

- Sealants—Benefits for sealants are limited to a lifetime maximum of one per permanent unrestored molar and are available to Eligible Persons under age 19.
- Space Maintainers—Benefits for space maintainers are limited to a lifetime maximum of one appliance per quadrant for posterior primary teeth for Eligible Persons under age 19.

Benefits are not available for nutritional, tobacco or oral hygiene counseling.

**BASIC RESTORATIVE DENTAL SERVICES**

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

- Amalgams restorations—Benefits are limited to one restoration per tooth every 12 months.
- Resin-based composite restorations—Benefits are limited to one restoration per tooth every 12 months.
- Sedative Filings

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

**NON-SURGICAL EXTRACTIONS**

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

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

**NON-SURGICAL PERIODONTAL SERVICES**

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

- Periodontal scaling and root planing—Benefits are limited to one per quadrant every 36 months. Additional scaling in the presence of generalized moderate to severe gingival inflammation is limited to one additional scaling once per quadrant every 36 months.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
- Periodontal maintenance procedures—Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

**ADJUNCTIVE SERVICES**

Adjunctive general services include:

- Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- Deep sedation/general anesthesia and intravenous sedation/non-intravenous conscious sedation—By report only and when determined to be Medically Necessary for documented Eligible Persons with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute medical necessity.
- Nitrous oxide analgesia—Nitrous oxide analgesia will be covered for Eligible Persons under age 19.
- Therapeutic parenteral drugs—Therapeutic parenteral drugs will be covered for Eligible

Persons under age 19. Benefits will not be provided for local anesthesia or other drugs or medicaments and/or their application.

**ENDODONTIC SERVICES**

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

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

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

Benefits will not be provided for the following "Endondontic Services":

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

**ORAL SURGERY SERVICES**

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

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

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

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

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

**SURGICAL PERIODONTAL SERVICES**

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

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planning)—Benefits are limited to one quadrant every 24 months.
- Clinical crown lengthening once per lifetime.
- Osseous surgery, including flap entry and closure—Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.

- Osseous grafts—Benefits are limited to one per site every 36 months. Benefits are not available for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- Soft tissue grafts/allografts (including donor site)—Benefits are limited to one per site every 36 months.
- Distal or proximal wedge procedure.
- Anatomical crown exposures is not covered. .

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

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

**MAJOR RESTORATIVE SERVICES**

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

- Single crown restorations.
- Inlay and onlay restorations.
- Labial veneer restorations.

Benefits will not be provided for the replacement of a lost, missing or stolen appliances and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

Benefits will not be provided for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions

Benefits will not be provided to restore occlusion on incisal edges due to bruxism or harmful habits.

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

**PROSTHODONTIC SERVICES**

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

- Complete (upper and lower dentures) and removable partial dentures (upper and lower 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 60-month period, whether placement was provided under this Policy or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures are limited to one in a 24 month period after the initial 6 month period following initial placement.
- Fixed bridgework (fixed prosthetics)—Benefits will be provided for the initial installation of a

bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months whether placement was under this Policy or under any prior dental coverage. Maxillofacial prosthetics—Benefits will be provided for maxillofacial prosthetics to Eligible Persons under the age of 19. Prosthetics placed over implants will be covered.

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

**Note**: Implant retained crowns, bridges, and dentures are subject to the Alternate Benefit Program in the HOW YOUR DENTAL COVERAGE WORKS section of the Policy.

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Coverage Date.
- Congenitally missing teeth.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

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

**MEDICALLY NECESSARY ORTHODONTIC DENTAL SERVICES**

Benefits for Medically Necessary orthodontic services are limited to members who meet the Policy criteria related to a medical condition such as but not limited to:

- Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services
- Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services
- Skeletal anomaly involving maxillary and/or mandibular structures

Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth. Your Covered Services for orthodontics as shown on your *Schedule of Benefits*. Covered Services include:

- Diagnostic orthodontic records and radiographs **limited to a lifetime maximum of once per person**.
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention, **limited to a lifetime maximum of one appliance per person**.

**Special Provisions Regarding Orthodontic Services:**

- Pediatric Orthodontic Services are limited to children under age 19 with an orthodontic condition meeting Medically Necessary criteria established by the Plan (e.g., severe, dysfunctional malocclusion) or meeting or exceeding a score of 42 from the Modified Salzmann Index.
- Orthodontic services are paid over the Course of Treatment, up to the Benefit Period maximum for orthodontic services. Benefits cease when you are no longer covered, whether or not the entire Benefit has been paid out.
- 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 Benefit Period maximum for orthodontic services.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- If your coverage is terminated prior to the completion of the orthodontic treatment plan, you are responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is

responsible for your ongoing care is not covered.

- Benefits are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the Coverage Date, Benefits will be reduced based on the Benefits paid prior to this coverage beginning.

## EXCLUSIONS AND LIMITATIONS

These general *Exclusions and Limitations* apply to all services described in this dental Policy. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the DEFINITIONS SECTION) licensed to perform services covered under this dental Policy.

**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 Policy provides Benefits only for those Covered Services for eligible dental treatment that are determined to be Medically Necessary.**

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

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not by itself make such a procedure 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 service or Course of Treatment to treat your dental condition, the Benefit will be based on the less costly Covered Service or Course of Treatment.

The alternate benefit Copayment or Coinsurance will be based on the less costly Covered Service and you will be responsible to pay the difference between the less costly service and more costly service elected.

If you and your Dentist or Physician decide on personalized restorations 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.

— **Non-Compliance with Prescribed Care**

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

**EXCLUSIONS—WHAT IS NOT COVERED**

No Benefits will be provided under this Policy for:

1. Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
2. Amounts which are in excess of the Maximum Allowance.
3. Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as included in the MEDICALLY NECESSARY ORTHODONTIC DENTAL SERVICES subsection of the DENTAL BENEFIT SECTION.
4. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders or to increase vertical dimension.
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, except for persons under the age of 19.
6. Services and supplies for any illness or injury suffered after the Eligible Person's Coverage Date as a result of war or any war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
7. Services or supplies that do not meet accepted standards of dental practice.

8. Experimental, Investigational and/or unproven services and supplies and all related services and supplies.
9. Hospital and ancillary charges.
10. Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of injuries.
11. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
12. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
13. Services rendered by a Dentist related to you by blood or marriage.
14. 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.
15. Claims for a service which is for the same service performed on the same date for the same member.
16. Services or supplies received for behavior management or consultation purposes.
17. Any services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental agencies provide benefits (some state or federal laws may affect how we apply this exclusion).
18. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or Benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or Benefits are received (except in the case of Medicare), except however, this exclusion shall not be applicable to medical assistance Benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, Benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
19. Charges for nutritional, tobacco or oral hygiene counseling.
20. Charges for local, state or territorial taxes on dental services or procedures.
21. Charges for the administration of infection control procedures as required by local, state or federal mandates.
22. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
23. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a Claim form or forwarding requested records or x-rays.
24. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
25. Charges for athletic mouth guards, isolation of a tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
26. Charges for partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Coverage Date under this Policy; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Coverage Date.
27. Any services, treatments or supplies included as Covered Services 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, diagnostic casts, or occlusal adjustments.
30. Gold foil restorations.
31. Cone beam imaging and cone beam MRI procedures.
32. Sealants for teeth other than permanent molars.
33. Orthodontic care for dependent children age 19 and over.
34. Localized delivery of antimicrobial agents or chemotherapeutic agents.

35. Bone grafts in conjunction with extractions, apicoectomy or any non- covered service or non-covered implants.
36. Anatomical crown exposures.
37. The replacement of lost, missing or stolen appliances and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
38. Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
39. Restoration occlusion on incisal edges due to bruxism or harmful habits.
40. Treatment to replace teeth which were missing prior to the Coverage Date.
41. Congenitally missing teeth.
42. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
43. Comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.
44. Tests and oral pathology procedures, or for re-evaluations.
45. Radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
46. Restorations placed within 12 months of the initial placement by the same Dentist.
47. Local anesthesia or other drugs or medicaments and/or their application.
48. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
49. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.
50. Endodontic therapy if you discontinue endodontic treatment.
51. Surgical services related to a congenital malformation.
52. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
53. Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
54. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
55. Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
56. Replacement or repair of an orthodontic appliance.

The Plan may, without waiving these exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from your coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Policy. You must provide the Plan with all documents it needs to enforce its rights under this provision.

# COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent has health care and/or dental coverage by 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."

In addition to the DEFINITIONS SECTION of this Policy, the following definitions apply to this section:

ALLOWABLE EXPENSE.....means a 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:

(i) 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.

(ii) 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 (i) or (ii) 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 program.

CLAIM DETERMINATION PERIOD.....means a calendar 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 program which 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 the 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 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 Blue Cross and Blue Shield 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 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 his/her own coverage as a dependent under a spouse's plan, rule 8, "Length of Coverage" applies. In the event the dependent's child coverage under the spouse's plan began on the same date as the dependent's child 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's child 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 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.

If the other Benefit Program does not contain the order of benefits determination described within this rule, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

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. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Benefit Program must give Blue Cross and Blue Shield 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, Blue Cross and Blue Shield 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. Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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.

# HOW TO FILE A CLAIM

## FILING DENTAL CLAIMS

In order to obtain your dental Benefits under this Policy, it is necessary for a Claim to be filed with Blue Cross and Blue Shield.

To file a Claim, usually all you will have to do it show your identification card to your Dentist. They will file your Claim for you. Remember, however, it is your responsibility to ensure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

In certain situations, you will have to file your own Claim. These Claim forms are available from Blue Cross and Blue Shield. 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 Blue Cross and Blue Shield 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 call Blue Cross and Blue Shield.

## DENTAL CLAIM PROCEDURES

Blue Cross and Blue Shield will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield 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. Blue Cross and Blue Shield 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 "Payment of Claims and Assignment of Benefits" provision in the GENERAL PROVISIONS section of this Policy.)

If the Claim is denied, you will receive a notice from Blue Cross and Blue Shield 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 Blue Cross and Blue Shield if you do not agree with the denial.

## DENTAL CLAIM REVIEW PROCEDURES

If your Claim has been denied, you may request an appeal of your Claim. Blue Cross and Blue Shield 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 Blue Cross and Blue Shield. Blue Cross and Blue Shield 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 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 Blue Cross and Blue Shield at the number on the back of your, identification card.

While Blue Cross and Blue Shield will honor telephone requests for information, such inquiries will not constitute a request for an 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. Blue Cross and Blue Shield 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 appeal procedure, write or call Blue Cross and Blue Shield Headquarters. Blue Cross and Blue Shield offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

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 or keep Illinois Department of Insurance from investigating a complaint. Illinois Department of Insurance can be contacted at the following addresses:

Illinois Department of
Insurance Consumer
Division
320 West Washington
Street Springfield, Illinois
62767
Toll Free: 866-445-5364
TDD: 866-323-5321
Phone: 217-782-4515
Fax: 217-782-5020

122 S. Michigan Avenue,
19th Floor
Chicago, IL 60603
Phone: 312-814-2420
Fax: 312-814-5416

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.

# GENERAL PROVISIONS

**1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS**

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for dental care services to all persons entitled to dental care Benefits under dental policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Policy. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider, or
- pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Dentists, the calculation of any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Policy and the calculation of all required Deductible and Coinsurance amounts payable by you under this Policy shall be based on the lesser of the Maximum Allowance or Provider's Claim Charge for Covered Services rendered to you. Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. You are not entitled to receive any portion of any such payments, discounts and/or other allowances.

**2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS**

a. Under this Policy, Blue Cross and Blue Shield 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 Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment. If such Assignment of Benefit Payment is not received. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made, subject to such Assignment of Benefit Payment.

b. Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.

c. Except for the Assignment of Benefit Payment described above, this Policy and a covered person's claim for benefits under this Policy is expressly non-assignable and non-transferable to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a covered person, and coverage under this Policy 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 other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

**3. YOUR PROVIDER RELATIONSHIPS**

a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.

b. Blue Cross and Blue Shield does not itself undertake to furnish health or dental care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield. Any contractual relationship between a Dentist, Physician and a Plan Hospital or other Plan Provider shall not be construed

to mean that Blue Cross and Blue Shield is providing professional service.

c. The use of an adjective such as Plan or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

d. Each Provider provides Covered Services only to you.

**4. AGENCY RELATIONSHIPS**

If this Policy is purchased through the Exchange, in no event shall Blue Cross and Blue Shield be considered the agent of the Exchange or be responsible for the Exchange. All information you provide to the Exchange and received by Blue Cross and Blue Shield from the Exchange will be relied upon as accurate and complete. You must promptly notify the Exchange and Blue Cross and Blue Shield of any changes to such information.

**5. NOTICES**

Any information or notice which you furnish to Blue Cross and Blue Shield under this Policy must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Policy for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in

pears on Blue Cross and Blue Shield's records in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

**6. LIMITATIONS OF ACTIONS**

No legal action may be brought to recover under this Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Policy.

**7. INFORMATION AND RECORDS**

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agree that any such Provider, person or other entity may furnish to Blue Cross and Blue Shield or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

**8. VALUE BASED DESIGN PROGRAMS**

Blue Cross and Blue Shield has the right to offer medical management programs, quality improvement programs and health behavior wellness, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums or in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by Blue Cross and Blue Shield to administer such programs. In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, Blue Cross and Blue Shield will allow a reasonable alternative to any individual for whom

it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Blue Cross and Blue Shield of Illinois makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by Blue Cross and Blue Shield of Illinois' designated outside vendor and acceptance or declination of these services is optional to you. If you wish to accept such identity theft protection services you will need to individually enroll in the program online at *www.bcbsil.com* or telephonically by calling the toll free telephone number on your identification card. Services may automatically end if you are no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice and Blue Cross and Blue Shield of Illinois does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered Benefits under this Policy.

Contact Blue Cross and Blue Shield for additional information regarding any value based programs offered by Blue Cross and Blue Shield.

**9. TIME LIMIT ON CERTAIN DEFENSES**

After 2 years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for illness or injury beginning after the expiration of such 2-year period.

No claim for an illness or injury beginning after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**10. CONFORMITY WITH STATE STATUTES**

This Policy provides, at a minimum, coverage as required by Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision of this Policy, on its effective date, conflicts with the laws of the state in which you permanently reside, you will be provided the greater of the benefit under this Policy or that required under the laws of the state in which you permanently reside.

**11. ENTIRE CONTRACT**

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

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

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| العربية<br>Arabic | إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984. |
| 繁體中文<br>Chinese | 如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。 |
| Français<br>French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984. |
| Deutsch<br>German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an. |
| Ελληνικά<br>Greek | Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરો રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો. |
| हिंदी<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे है उसके, प्रश्न है, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।. |
| Italiano<br>Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984. |
| 한국어<br>Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오. |
| Diné<br>Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984. |
| Polski<br>Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский<br>Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984. |
| Español<br>Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984. |
| Tagalog<br>Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984. |
| اردو<br>Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984. |

**bcbsil.com**

BlueCross BlueShield of Illinois

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

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| Office of Civil Rights Coordinator | Phone: 855-664-7270 (voicemail) |
| 300 E. Randolph St. | TTY/TDD: 855-661-6965 |
| 35th Floor | Fax: 855-661-6960 |
| Chicago, Illinois 60601 | Email: CivilRightsCoordinator@hcsc.net |

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

| | |
|---|---|
| U.S. Dept. of Health & Human Services | Phone: 800-368-1019 |
| 200 Independence Avenue SW | TTY/TDD: 800-537-7697 |
| Room 509F, HHH Building 1019 | Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf |
| Washington, DC 20201 | Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html |

**bcbsil.com**

IL-1557-2019

BlueCross BlueShield of Illinois