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) **Preventive Services** (Deductible waived) **Diagnostic Radiographs** (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Miscellaneous Preventive Services **Basic Restorative Services** **Non-Surgical Extractions** **Non-Surgical Periodontal Services** **Adjunctive General Services** **Endodontic Services** **Oral Surgery Services** **Surgical Periodontal Services****	80% of Maximum Allowance	50% of Maximum Allowance
Major Restorative Services** **Prosthodontic Services**** **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) Individual	$50	$50
Family	$150	$150
Benefit Period Maximum (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) **Preventive Services** (Deductible waived) **Diagnostic Radiographs** (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Miscellaneous Preventive Services **Basic Restorative Services** **Non-Surgical Extractions** **Non-Surgical Periodontal Services** **Adjunctive General Services** **Endodontic Services** **Oral Surgery Services** **Surgical Periodontal Services**	80% of Maximum Allowance	50% of Maximum Allowance
Major Restorative Services **Prosthodontic Services** **Miscellaneous Restorative and Prosthodontic Services**	50% of Maximum Allowance	30% of Maximum Allowance
Orthodontic Services		
Pediatric Orthodontic Services: 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 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 19th 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 thePolicy.

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 accidentalinjury.
- 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 dentalpractice.
- 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 fromsomeone other than a Dentist, except for those services received froma 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 thisexclusion).
- 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 orx-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 postremoval.
- 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.