

Your Dental Care Benefit Program

City of Chicago
652374

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

A message from

City of Chicago

This booklet describes the Dental Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your dental care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your dental care benefits. If you want more information or have any questions about your dental care benefits, please contact the Employee Benefits Department.

Sincerely,
City of Chicago

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator 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 “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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 plan. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE 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. 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.

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BENEFIT HIGHLIGHTS

Your dental care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

DENTAL BENEFITS

Benefit Waiting Period	None
In-Network Deductible	\$100 per benefit period
Out-of-Network Deductible	\$200 per benefit period
Diagnostic and Preventive Care Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	80% of the Maximum Allowance
Miscellaneous Dental Services Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	80% of the Maximum Allowance
Restorative Dental Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
General Dental Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Endodontic Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Periodontic Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Oral Surgery Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance

Crowns, Inlays/Onlays Services
Benefit Payment Level

- Participating Provider 60% of the Maximum Allowance
- Non-Participating Provider 50% of the Maximum Allowance

Prosthetic Services
Benefit Payment Level

- Participating Provider 60% of the Maximum Allowance
- Non-Participating Provider 50% of the Maximum Allowance

Benefit Period
Maximum

\$1,200

DEFINITIONS SECTION

Throughout this benefit booklet, 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 benefit booklet, 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.

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.

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 the Claim Administrator 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 (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

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 the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. 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 the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health

insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

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 or Physician 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 the Dental Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

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

A “Participating Dentist” means a Dentist who has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a Participating Provider Option Dental program to provide services to you at the time you receive services.

A “Non-Participating Dentist” means a Dentist who does not have a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator 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 of the same or opposite sex 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 not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the **ELIGIBILITY SECTION** of this benefit booklet.

EMPLOYER.....means the company with which you are employed.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Dental Care Plan.

HOSPITAL.....means a facility which is 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, and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as Eligible for participation under Title XVIII, Health Insurance for the aged and Disabled.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Dental Care Plan for yourself but not your spouse and/or dependents.

MAXIMUM ALLOWANCE.....means the amount determined by the Claim Administrator, 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 Dentists, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

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

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

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

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

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 operating within the scope of his or 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 or her license.

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.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized

instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

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.

ELIGIBILITY SECTION

This benefit booklet contains information about the dental care benefit program for the persons who:

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description and comply with the other terms and conditions of this benefit booklet, including but limited to payment of premiums, you are entitled to the benefits of this program.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren), a child(ren) for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 will be covered. All of the provisions of this benefit booklet that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. The coverage for children will end on the birthday.

Your enrolled Domestic Partner and his or her enrolled children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 30 days of the date of birth so that your membership records can be adjusted.

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 disabling 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.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

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

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
 - a. The other coverage was in effect when you were first eligible to enroll for this coverage;
 - b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
 - c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

- a. Legal separation, divorce, dissolution from a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
- b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
- c. Reaching a lifetime limit on all benefits in another group health plan;
- d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
- e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 30 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 30 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 30 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Dental Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Dental Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

DENTAL BENEFIT SECTION

Your employer has chosen the Claim Administrator'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 you will receive a directory of Participating Dentists. While there may be changes in the directory from time to time, selection of Participating Dentists by the Claim Administrator 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 to your Employer 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 benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet 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 the Claim Administrator 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.

COVERED SERVICES

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

Diagnostic and Preventive Dental Services

Your benefits for Diagnostic and Preventive Dental Services are designed to help you keep dental disease from starting or to detect it in its early stages. Your Diagnostic and Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine

bitewing X-rays are limited to two sets per benefit period. Any additional full mouth X-rays are subject to Medical Necessity.

- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to persons under age 14, without frequency limitations.
- Sealants—Limited to a lifetime maximum of 1 on the 1st and 2nd molars up to age 16.

Miscellaneous Dental Services

- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment.
- Labs and Tests—Pulp vitality tests.

Restorative Dental Services

- Amalgams (Fillings)
- Pin Retention
- Composites
- Simple Extractions, except as specifically excluded under “Special Limitations” of this Benefit Section.

General Dental Services

- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Stainless Steel Crowns.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Endodontic Services

- Root canal therapy
- Pulp cap
- Apicoectomy
- Apexification
- Retrograde filling
- Root amputation/hemisection
- Therapeutic pulpotomy
- Pulpal debridement.

Periodontic Services

- Periodontal scaling and root planing.
- Full mouth debridement.
- Gingivectomy/gingivoplasty. Your benefits are limited to one full mouth treatment per 24 months.
- Gingival flap procedure
- Osseous Surgery. Your benefits are limited to one full mouth treatment per 24 months.
- Osseous grafts.
- Soft tissue grafts.
- Periodontal maintenance procedures—Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.

Oral Surgery Services

- Surgical tooth extraction
- Alveoloplasty
- Vestibuloplasty
- Other necessary dental surgical procedures.

Crowns, Inlays/Onlays Services

- Prefabricated post and cores
- Cast post and cores
- Crowns, inlays/onlays repairs
- Recementation of crowns, inlays/onlays

Prosthodontic Services

- Bridges
- Dentures
- Adjustments to Bridges and Dentures—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Bridge and Denture repairs
- Addition of tooth or clasp
- Reline/Rebase.

Prosthodontic Services

- Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable. Missing tooth exclusion applies for dentures and bridges. Initial placement of a full or partial denture or bridge replacing teeth extracted prior to effective date of the policy.

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.

In-Network Deductible

Each benefit period, you (and each member of your family) must satisfy a \$100 in -network deductible for services rendered by a participating (contracted) dentist. This deductible applies to:

- Diagnostic and Preventive Care
- Miscellaneous Dental Services
- Restorative Dental Services
- General Dental Services
- Endodontic Services
- Periodontic Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services

In other words, after you incur eligible charges of more than \$100 for the Covered Services listed above in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

An additional \$10 copay for preventive services applies once per benefit period from a Participating Provider.

Out-of-Network Deductible

Each benefit period, you (and each member of you family) must satisfy a \$200 out-of-network deductible for services rendered by a non-participating (non-contracted) dentist. This deductible applies to:

- Restorative Dental Services

- General Dental Services
- Endodontic Services
- Periodontic Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services

In other words, after you incur eligible charges of more than \$200 for the Covered Services listed above in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

Benefit Payment for Dental 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 or Non-Participating Dentist.

Participating Dentists are Dentists who have signed an agreement with the Claim Administrator 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 Claim Administrator 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 the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Claim Administrator benefit payment and such Dentist's charge to you. Custom Maximum Allowable charge will be scheduled for the Non-Participating reimbursement level.

Participating Dentists

Diagnostic and Preventive Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance after you have met your deductible.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance after you have met your deductible.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Non-Participating Dentists

Diagnostic and Preventive Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be

provided at 50% of the Maximum Allowance after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Emergency Care

Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at 60% of the Maximum Allowance when rendered by a Participating Dentist, after you have met your in-network deductible. Benefits for palliative care will be provided at 50% of the Maximum Allowance, when rendered by a Non-Participating Dentist, after you have met your out-of-network deductible.

Benefit Maximum

The maximum amount of dental benefits available for you (and each covered member of your family) each benefit period is \$1,200. This is an individual maximum. There is no family maximum. The benefit period maximum does not apply to preventive services for participants under the age of 19.

Any expenses incurred beyond the benefit maximum are your responsibility.

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 Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

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, as reasonably determined by the Claim Administrator.

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. The Claim Administrator 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.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Oral Surgery for the following procedures:
 - surgical services related to a congenital malformation;
 - surgical removal of complete bony impacted teeth;
 - 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 bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
3. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
4. Hospital and ancillary charges.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Plan should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Plan.

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Dental procedures which are not Medically Necessary.**

PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THE PLAN PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT THE CLAIM ADMINISTRATOR DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Claim Administrator, 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 of itself make such a procedure or supply Medically Necessary.

- Services or supplies that are not specifically mentioned in this benefit booklet.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- 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.
- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.

- Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program.
- 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.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Dental Care Plan.
- Implants - Including the crown over the implant.
- Hospitalization for any dental procedure;
- Home visits;
- Hospital bedside visits;
- Hospital-administered anesthesia;
- Experimental procedures
- Implantation;
- Pharmacological regimens;
- Prescription or over-the-counter medications;
- Convenience and personal item;
- The setting of fractures or dislocation;
- Treatment of malignancies, cysts or neoplasms;
- Service which, in the opinion of the attending dentist, are not necessary for the patient's dental health;
- Missed appointment fees;
- Orthodontic work in progress;
- Any items covered under the Medical Plan;
- Services covered by Workers' Compensation or employer's liability laws;
- Services provided to the member , without cost, by any municipality, county or other political subdivision, other than Medicaid services;
- Dental services with respect congenital malformation or primarily for cosmetic or aesthetic purposes, except where such services are within the scope of benefits;

- Any services, treatment or supplies which are not reasonably necessary for the care and treatment of a person;
- Orthodontic treatment including, but not limited to, removable and fixed appliances, pre-orthodontic treatment and orthodontic retention;
- Separate laboratory charges when not included and billed by dentist;
- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group;
- Dental services rendered or supplies furnished after the termination date of the person's Dental PPO Plan coverage;
- Dental services for which coverage is available to the person, in whole or in part, under a medical plan;
- Sealants (except for back molars);
- Mouth rehabilitation where the obligation of the dental plan administrator will be to cover only those benefits appropriate to those procedures necessary to eliminate oral disease and replace missing teeth; the balance of the treatment including cost to increase vertical dimension or restore the occlusion will remain the responsibility of the patient;
- Initial placement of a full or partial denture or bridge replacing teeth extracted prior to the effective date of the policy;
- Bruxism appliances, mouth guards, occlusal guards or bite plates;
- Anything not listed as a covered service.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have dental care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled under this Health Care. In other words, the total payment from all of your coverages together will never be less than what would have been paid under this Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to

notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

In order to prevent duplicate payment of benefits for a Claim, the Claim Administrator uses the following process to determine benefits when it is the secondary payor.

- determines what the payment for service would be following the payment provisions of this coverage; and
- deducts from this resulting amount the amount paid by the primary payor. The difference is the amount that will be paid under this coverage.
- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to Domestic Partners and their children. This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to your dependent who is a party to a Civil Union and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of “Domestic Partnership” in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the party to a Civil Union of an Eligible Person or as the dependent child of a party to a Civil Union. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is party to a Civil Union or their child and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union Partnership with the Eligible Person terminates. Your Civil Union Partnership will terminate if your partnership no longer meets the criteria described in the definition of “Civil Union” in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

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

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

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

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

Claims must be filed with the Claim Administrator within two years from the date your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

DENTAL CLAIMS PROCEDURES

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

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal, and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

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

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

You may also designate a representative to act for you in the review 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.

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

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. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator 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, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (“Administrator 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 the Claim Administrator is a party, including all persons covered under the Dental Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

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

In the case of Dentists, the calculation of any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Maximum Allowance or Provider’s Claim Charge for Covered Services rendered to you. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator’s behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (“Servicing Plan Providers”) in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan’s applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Dental Care Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Cov-

ered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Dental Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person's claim for benefits under this Dental Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Dental Care Plan 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 the Claim Administrator will not interfere with your relationship with any Provider.
- b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator 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 the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

- c. The use of an adjective such as Participating, Administrator or approved 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 Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator 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 and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Dental Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Dental Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. 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 the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure 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 the Dental Care Plan, (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 the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator 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, the Claim Administrator 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.

7. PHYSICAL EXAMINATION AND AUTOPSY

The Claim Administrator, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

8. OVERPAYMENT

If your group's benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your group's plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

- a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or
- b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program; or
- c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or
- d. Any future benefit payment, or other payment, made to any person or entity; or
- e. Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's or policy's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy's Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Public employees and surviving spouses or surviving parties to a Civil Union of such employees who are eligible for continued group health coverage under Sections 367 (g), (h) and (i) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The public employee, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such employee, spouse or party to a Civil Union has Family Coverage, he/she may continue to have Family Coverage.
2. Group coverage can be continued until the public employee, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Sections 367 (g), (h) and (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or surviving party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of his/her loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the public employee, surviving spouse or surviving party to a Civil Union.
4. If the public employee, surviving spouse or surviving party to a Civil Union should choose to convert his or her group coverage to a "direct-payment" conversion policy, as described above under Conversion Privilege, such employee, spouse or party to a Civil Union will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Firemen and surviving spouses or surviving parties to a Civil Union of such firemen who are eligible for continued group health coverage under Section 367 (f) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The fireman, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such fireman, spouse or party to a Civil Union has Family Coverage, he/she may continue to have Family Coverage.
2. Group coverage can be continued until the fireman, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Section 367 (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of his/her loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the fireman, surviving spouse or surviving party to a Civil Union.
4. If the fireman, surviving spouse or surviving party to a Civil Union should choose to convert his or her group coverage to a "direct-payment" conversion policy, as described above under Conversion Privilege, such fireman, spouse or party to a Civil Union will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued group health insurance under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such group health insurance under the following conditions:

1. You and your eligible dependents must have been insured under this Certificate on the day immediately preceding the date of eligibility for continued group health insurance.
2. Your Group shall pay the entire premium of the group health insurance coverage for you, your spouse, your party to a Civil Union and each dependent child until the child reaches the limiting age under this Certificate.
3. If you subsequently die, your Group shall continue to pay the entire health insurance premium for your surviving spouse or your surviving party to a Civil Union until he or she remarries or enters another Civil Union and for your dependent children under the conditions established in 2. above.
4. Health insurance benefits under this Certificate shall be reduced by health insurance benefits payable from any other source.

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ASO-1

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www.bcbsil.com

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