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℠ 1C

OUTLINE OF COVERAGE

Read your Contract carefully — This outline of coverage provides only a very brief description of the important features of your Contract. This is not the Contract, and only the actual Contract provisions will control. The Contract 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 CONTRACT CAREFULLY!**

The BlueCare Dental Contract is of a limited nature and, as such, is not required to meet the minimum standards for accident and sickness insurance prescribed by law.

You have the right to return the Contract for any reason within 10 days of its delivery to you and have any paid dues refunded to you. If you return the Contract, the Plan will have no liability for any Benefits for dental care or services you received.

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	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
Diagnostic Evaluations (Deductible waived) **Preventive Services** (Deductible waived) **Diagnostic Radiographs** (Deductible waived) **Miscellaneous Preventive Services**	80% of Allowable Charge	50% of Allowable Charge
Basic Restorative Services** **Non-Surgical Extractions**** **Non-Surgical Periodontal Services**** **Adjunctive General Services** **Endodontic Services**** **Oral Surgery Services**** **Surgical Periodontal Services***** **Major Restorative Services***** **Prosthodontic Services***** **Miscellaneous Restorative and Prosthodontic Services*****	50% of Allowable Charge	30% of Allowable Charge

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	Out-of-Network Dentist*
Orthodontic Services	Not Covered	
Deductible		
Individual	$75	
Family	$225	
Benefit Period Maximum	$1,000	
Out-of-Pocket Maximum per Benefit Period	None	

* For Out-of-Network Dentist services, the Allowable Charge is the Dentist's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.

** 6-month waiting period applies.

*** 12-month waiting period applies.

For Subscribers Under Age 19

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	Out-of-Network Dentist*
Diagnostic Evaluations (Deductible waived) **Preventive Services** (Periodic Oral Evaluation and Topical Fluoride Application covered at 100%, Deductible waived) **Diagnostic Radiographs** (Deductible waived) **Miscellaneous Preventive Services**	80% of Allowable Charge	50% of Allowable Charge
Basic Restorative Services **Non-Surgical Extractions** **Non-Surgical Periodontal Services** **Adjunctive General Services** **Endodontic Services** **Oral Surgery Services** **Surgical Periodontal Services** **Major Restorative Services** **Prosthodontic Services** **Miscellaneous Restorative and Prosthodontic Services**	50% of Allowable Charge	30% of Allowable Charge

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
Orthodontic Services (Deductible waived) Pediatric Orthodontic Services: Coverage limited to Subscribers under age 19 with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	50% of Allowable Charge (Unlimited Lifetime Maximum)	30% of Allowable Charge (Unlimited Lifetime Maximum)
Deductible		
Individual	$75	
Family	$225	
Benefit Period Maximum	Unlimited	
Out-of-Pocket Maximum per Benefit Period		
1 Child	$375	$375
2+ Children	$750	$750

* For Out-of-Network Dentist services, the Allowable Charge is the Dentist's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.

ELIGIBILITY

An individual may apply for coverage under the Contract if he or 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). Coverage for a Dependent child (if applicable) may continue until his or her 26th birthday.

YOUR PARTICIPATING DENTIST NETWORK

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

- Charges for any services which are not covered under your Contract.
- Any Deductible or Coinsurance amounts which are applicable to your coverage (*including the higher Deductible and/or Coinsurance amounts which apply to Out-of-Network Dentist services*).
- The difference, if any, between your Dentist's "billed charges" and the Plan's Allowable 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 Out-of-Network Dentist.

Participating Dentists will accept the Allowable Charge as payment in full, less any Deductible and/or Coinsurance. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Allowable Charge. 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.

Out-of-Network Dentists are Dentists who have not signed an agreement to accept the Allowable Charge as the Benefit in full. Therefore, you are responsible for the difference between the Plan's Out-of-Network 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 Allowable Charge for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Dentist or the Plan.

RENEWAL

The Contract 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 Contract. You will be given reasonable notice of such changes. You should attach these notices to your Contract, as they will amend a part of the Contract.

NOTICE

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

EXCLUSIONS

No Benefits will be provided under this Contract 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 Allowable Charge, as determined by the Plan.
- 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 pediatric orthodontic Benefit as shown in ***Medically Necessary Orthodontic Services***.
- Dental services or Appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Contract or if resulting from accidental injury. Dental services or Appliances to increase vertical dimension, unless specifically mentioned in this Contract.
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
- Services and supplies for any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.

- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Claims for duplicate services performed on the same date for the same Subscriber.
- Services or supplies received for behavior management or consultation purposes.
- Any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.

  You agree to:

  - pursue your rights under the workers' compensation laws;
  - take no action prejudicing the rights and interests of the Plan; and
  - cooperate and furnish information and assistance the Plan requires to help enforce its rights.

  If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:

  - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
  - repay the Plan any money recovered from the employer or insurance carrier.
- Any services or supplies to the extent payment has been made under Medicare or to the extent governmental units provide benefits or would have provided benefits if you had applied for and claimed those benefits (some state or federal laws may affect how we apply this exclusion).
- Charges for nutritional or oral hygiene counseling.
- For tobacco counseling for Subscribers age 19 and over.
- Charges for local, state, or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state, or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional Appliances.
- Charges for telephone consultations, email, or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or no prescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers.
- Charges for personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than professionally accepted, necessary and appropriate treatment except this exclusion will not apply to the Benefits provided for the Covered Services subject to the Alternate Benefit provision.
- 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 Effective Date under this Contract; 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 Effective

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.
- 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.
- Any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
- Restorations placed within 12 months of the initial placement by the same Dentist.
- Separate Benefits will not be provided for local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application for adults.
- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal.
- Endodontic therapy if you discontinue endodontic treatment.
- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; reduction of dislocation, or excision of the temporomandibular joints.
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
- Bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- The replacement of lost, missing, or stolen Appliances and those for replacement of Appliances that have been damaged due to abuse, misuse, or neglect. Benefits will not be provided for dentures, crowns, inlays, onlays, bridgework, or other Appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
- To restore occlusion on incisal edges due to bruxism or harmful habits.
- Treatment to replace teeth which were missing prior to the Effective Date.
- Congenitally missing teeth.

- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
- Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.