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

3. Dependent Child if Parents Separated or Divorced

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

   a. First, the program of the parent with custody of the Child;

   b. Then, the program of the spouse of the parent with custody of the Child; and

   c. Finally, the program of the parent not having custody of the Child.

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

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adult as a Dependent

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

6. Active or Inactive Employee

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

7. Continuation Coverage

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

   a. First, the Benefits of a Benefit Program covering the person as an employee, member or subscriber (or as that person's Dependent);

   b. Second, the Benefits under the continuation coverage.

8. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The Benefits of this Benefit Program will be reduced when:

1. The Benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and

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

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Insurer need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Benefit Program must give the Insurer any facts it needs to pay the Claim.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

1. The person(s) it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

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

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain a Covered Person's dental Benefits under this Policy, it is necessary for a Claim to be filed with the Insurer.

To file a Claim, Covered Persons must obtain an Attending Dentist's Statement from the Insurer, or the Insurer's designee, before going to their Dentist. The Attending Dentist's Statement is also used for pre- estimation of Benefits. It is a Covered Person's responsibility to insure that the necessary Claim information has been provided to the Insurer.

Covered Persons must complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, Covered Persons must ask their 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 Insurer within 365 days from the date a Covered Person's Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should Covered Persons have any questions about filing Claims, they may ask the Insurer or the Insurer's designee.

DENTAL CLAIM PROCEDURES

The Insurer will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that the Insurer does not process a Claim within this 30-day period, the Covered Person 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 Insurer will notify the Covered Person 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 Policy.)

If the Claim is denied, Covered Persons will receive a notice from the Insurer with: (1) the reasons for denial; (2) a reference to the dental care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the Claim, and (4) an explanation of how they may have the Claim reviewed by the Insurer if they do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If a Covered Person's Claim has been denied, Covered Persons may request an appeal. The Insurer will review its decision in accordance with the following procedure.

Within 180 days after Covered Persons receive notice of a denial or partial denial, they should write to the Insurer. The Insurer will need to know the reasons why Covered Persons do not agree with the denial or partial denial. Covered Persons should send their requests to:

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

Covered Persons may also designate a representative to act for them in the appeal procedure. A Covered Person's designation of a representative must be in writing as it is necessary to protect against disclosure of information about a Covered Person except to a Covered Person's authorized representative. To obtain an Authorized Representative form, a Covered Person or a Covered Person's authorized representative may call the Insurer at the number on the back of a Covered Person's ID card.

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

A Covered Person and a Covered Person's authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after a Covered Person receives notice of a denial or partial denial or at any time during the Claim appeal process. The Insurer will give Covered Persons a written decision within 60 days after it receives their request for appeal.

If Covered Persons have any questions about the Claims procedures or the appeal procedure, they may write or call Blue Cross and Blue Shield Headquarters. Blue Cross and Blue Shield offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday. Customer service hours and operations are subject to change without notice.

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

If Covered Persons have a Claim for Benefits which is denied or ignored, they may have the right to file suit in a state or federal court.

Filing an appeal does not prevent Covered Persons from filing a complaint with the Illinois Department of Insurance or keep Illinois Department of Insurance from investigating a complaint. Illinois Department of Insurance can be contacted at the following addresses:

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

Illinois Department of Insurance
Consumer Division
122 South Michigan Avenue, 19th Floor
Chicago, IL 60603
312-814-2420 Toll-free phone
312-814-5416 Fax number

GENERAL PROVISIONS

1. THE INSURER'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Insurer hereby informs you that it has contracts with certain Providers ("Participating 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 Insurer is a party, including all persons covered under this Policy. Under certain circumstances described in its contracts with Participating Providers, the Insurer may:

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

In the case of Dentists, the calculation of any maximum amounts of Benefits payable by the Insurer under this Policy and the calculation of all required Deductible and Coinsurance amounts payable by Covered Persons under this Policy shall be based on the lesser of the Maximum Allowance or Dentist's Claim Charge for Covered Services rendered to them. Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Policyholder nor Covered Persons are entitled to receive any portion of any such payments, discounts and/or other allowances.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Policy, the Insurer has the right to make any benefit payment either directly to the Dentist of the Covered Services or to the Covered Person, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment. For example, the Insurer may pay Benefits to Covered Persons if they receive Covered Services from a Non-Participating Dentist. The Insurer is specifically authorized by Covered Persons to determine to whom any benefit payment should be made.

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

c. Except for the Assignment of Benefit Payment described above, this Policy and a Covered Person's Claim for Benefits under this Policy is expressly non-assignable and non-transferable to any person or entity, including any Dentist, at any time before or after Covered Services are rendered to a Covered Person, and coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if Covered Persons 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. COVERED PERSONS' DENTIST RELATIONSHIPS

a. The choice of a Dentist is solely a Covered Person's choice and the Insurer will not interfere with a Covered Person's relationship with any Dentist.

b. The Insurer does not itself undertake to furnish health or dental care services, but solely to make payments to Dentists for the Covered Services received by Covered Persons. The Insurer is not in any event liable for any act or omission of any Dentist or the agent or employee of such Dentist, including, but not limited to, the failure or refusal to render services to Covered Persons. Professional services which can only be legally performed by a Dentist are not provided by the Insurer. Any contractual relationship between a Dentist, a dental auxiliary, or Physician and a Plan Hospital or other Participating Provider shall not be construed to mean that the Insurer is providing professional service.

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

d. Each Dentist provides Covered Services only to Covered Persons.

4. NOTICES

Any information or notice which the Policyholder or Covered Persons furnish to the Insurer under this Policy must be in writing and sent to the Insurer at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Policy for a specific situation). Any information or notice which the Insurer furnishes to the Policyholder or Covered Persons must be in writing and sent to the Policyholder or Covered Persons at their respective addresses as they appear on the Insurer's records. Blue Cross and Blue Shield 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 this Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to the Insurer in accordance with the requirements of this Policy. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Insurer in accordance with the requirements of this Policy.

6. INFORMATION AND RECORDS

Covered Persons agree that it is their responsibility to ensure that any Dentist, other Blue Cross and/or Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for Benefits are made under this Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any Benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Insurer or its agent, and agree that any such Dentist, person or other entity may furnish to the Insurer 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 Insurer may furnish similar information and records (or copies of records) to Dentists, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing or administering insurance-type Benefits requesting the same. It is also a Covered Person's responsibility to furnish the Insurer information regarding a Covered Person's or a Covered Person's Dependents becoming eligible for Medicare,

termination of Medicare eligibility or any change in Medicare eligibility status in order that the Insurer be able to make Claim Payments in accordance with MSP laws.

7. VALUE BASED DESIGN PROGRAMS

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

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, the Insurer will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact the Insurer for additional information regarding any value based programs offered by the Insurer.

Covered Persons may contact the Policyholder for additional information regarding any value base programs offered by the Policyholder.

8. TIME LIMIT ON CERTAIN DEFENSES

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

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

9. CONFORMITY WITH STATE STATUTES

This Policy provides, at a minimum, coverage as required by Illinois law. Laws in some other states require that certain Benefits or provisions be provided to Covered Persons if a Covered Person is a resident of their state when the policy that insures a Covered Person is not issued in a Covered Person’s state. In the event any provision of this Policy, on its Effective Date, conflicts with the laws of the state in which a Covered Person permanently resides, a Covered Person will be provided the greater of the benefit under this Policy or that required under the laws of the state in which a Covered Person permanently resides.

10. ENTIRE CONTRACT

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