AcademicBlue℠

Rosalind Franklin University Student Health Dental Plan 2026-2027

Underwritten by: Blue Cross and Blue Shield of Illinois

Please review to understand your coverage.

9204528.0226

AcademicBlue℠

A Division of Health Care Service Corporation, A Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

300 E. Randolph Street Chicago, IL 60601

1-800-538-8833

BlueCare Dental℠ 1B

Schedule of Benefits

For Covered Persons Age 19 and Over

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

Covered Services	Participating Provider	Non-Participating Provider*
Diagnostic Evaluations (Deductible waived) Preventive Services (Deductible waived) Diagnostic Radiographs (Deductible waived) Miscellaneous Preventive Services	90% of Maximum Allowance	70% of Maximum Allowance
Basic Restorative Services Non-Surgical Extractions Non-Surgical Periodontal Services Adjunctive Services	70% of Maximum Allowance	50% of Maximum Allowance
Endodontic Services Oral Surgery Services Surgical Periodontal Services** Major Restorative Services** Prosthodontic Services** Miscellaneous Restorative and Prosthodontic Services**	50% of Maximum Allowance	30% of Maximum Allowance
Orthodontic Services	Not Covered	
Deductible (Per Benefit Period) **(PPO/Non-PPO accumulate together)**		
Individual Deductible	$75	$75
Family Deductible	$225	$225
Benefit Period Maximum **(PPO/Non-PPO accumulate together)**	$1,000	
Out of Pocket Maximum	None	

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

**12 Month Waiting Period applies for these services only.

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BlueCare Dental℠ 1B

Schedule of Benefits

For Covered Persons Under Age 19

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

Covered Services	Participating Provider	Non-Participating Provider*
Diagnostic Evaluations (Deductible waived) Preventive Services (Deductible waived) Diagnostic Radiographs (Deductible waived) Miscellaneous Preventive Services	80% of Maximum Allowance	60% of Maximum Allowance
Basic Restorative Services Non-Surgical Extractions Non-Surgical Periodontal Services Adjunctive Services Endodontic Services Oral Surgery Services Surgical Periodontal Services Major Restorative Services Prosthodontic Services Miscellaneous Restorative and Prosthodontic Services	50% of Maximum Allowance	30% of Maximum Allowance
Orthodontic Services (Deductible waived)[1] Medically Necessary Pediatric Orthodontic Services	50% of Maximum Allowance	30% of Maximum Allowance
Optional Orthodontic Services	Not Covered	
Deductible (Per Benefit Period) **(PPO/Non-PPO accumulate together)**		
Individual Deductible	$75	$75
Family Deductible	$225	$225
Benefit Period Maximum	None	
Out of Pocket Maximum per Benefit Period 1 Child 2+ Children	 $450 $900	

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

[1]Orthodontic Coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index or meeting criteria for Medically Necessary.

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POLICYHOLDER:	Rosalind Franklin University
POLICY NUMBER:	125284 ("this Policy")
EFFECTIVE DATE:	June 1, 2026
POLICY TERM:	June 1, 2026 through May 31, 2027
PREMIUM DUE DATE:	On or before the Policy Effective Date

This Policy describes the terms and conditions of coverage as issued to the Policyholder named above. This Policy is issued in the state of Illinois and is governed by its laws. This Policy becomes effective at 12:01 A.M. on the Policy Effective Date at the Policyholder's address.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein referred to as "Blue Cross and Blue Shield", "Blue Cross and Blue Shield of Illinois", "Company", "Insurer", "BCBSIL", "We", and "Us") and the Policyholder have agreed to all of the terms of this Policy as stated herein.

The Policyholder has confirmed to the Insurer that it is an Institution of higher education as defined in the Higher Education Act of 1965 (the "Institution"). This Policy does not make dental insurance available other than in connection with enrollment as a Student (or a Dependent of a Student) in the Policyholder's Institution. Policyholder will provide prospective and current Covered Persons with access to this Policy. If Covered Persons have any questions once they have read this Policy, they can call us at the toll-free telephone number on the back of their identification card. It is important that Covered Persons understand the protection this coverage gives them.

Signed for Blue Cross and Blue Shield of Illinois by:

Brian Snell
Plan President, Blue Cross and Blue Shield of Illinois

STUDENT DENTAL INSURANCE
PLEASE READ THIS POLICY CAREFULLY

AcademicBlue is offered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

NOTICE

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

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

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

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

You should be aware that when you elect to utilize the services of a **non-participating provider** for a **covered service** in non-emergency situations, **benefit** payments to such **non-participating provider** are not based upon the amount billed. The basis of your **benefit** payment will be determined according to your **policy's** fee schedule, **maximum allowance**, or other method as defined by this **policy**.

YOU CAN EXPECT TO PAY MORE THAN THE COPAYMENT AND COINSURANCE AMOUNT DEFINED IN THIS POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.

Non-participating providers may bill you for any amount up to the billed charge after the plan has paid its portion of the bill as provided in the Illinois Insurance Code. **Participating providers** have agreed to accept discounted payments for services with no additional billing to you other than **copayment**, **coinsurance** and **deductible** amounts. You may obtain further information about the participating status of **providers** and information on out-of-pocket expenses by calling the toll-free telephone number on the back of your identification card.

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GLOSSARY

Throughout this **policy**, many words are used which have a specific meaning when applied to your **student** dental care coverage. These terms will always be bolded. When you come across these terms while reading this **policy**, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your **benefits**. If a term within a definition is bolded, it means that the term is also defined in this GLOSSARY. All definitions have been arranged in ALPHABETICAL ORDER. In this **policy** we refer to our **company** as the "insurer" and we refer to the institution of higher education in which you are enrolled and active as the "**institution**" or "policyholder".

Benefit means the payment, reimbursement, and indemnification of any kind which you will receive from us under this **policy**.

Benefit Period means the period of time shown as the "Policy Term" on the face page of this **policy**. This **policy** term is as agreed to by the policyholder and the insurer.

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 us 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 **dentist**, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the **claim charge**, and any other information which we may request in connection with services rendered to you.

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

Claim Payment means the **benefit** payment calculated by the insurer, after submission of a **claim**, in accordance with the **benefits** described in this **policy**. All **claim payments** will be calculated on the basis of the **maximum allowance** for **covered services** rendered to you, regardless of any separate financial arrangement between the insurer and a particular **provider**. (See provisions of this policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

Coinsurance means a percentage of an eligible expense that you are required to pay towards a covered service.

Company means Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (also referred to herein as "BCBSIL").

Copayment means a specified dollar amount that you are required to pay towards a **covered service**.

Course Of Treatment means any number of dental procedures or treatments performed by a **dentist** in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

Covered Person means you and/or your **dependents** (if **dependent** coverage is offered) who meet the eligibility requirements for this dental coverage, are properly enrolled, and for whom the required premium is paid.

Covered Service means a service or supply specified in this **policy** for which **benefits** will be provided.

Deductible means the amount of expense that you must incur in **covered services** before **benefits** are provided.

Dentist means a duly licensed **dentist**, operating within the scope of their license.

- A **Participating Dentist** means a **dentist** who has a written agreement with Blue Cross and Blue Shield of Illinois, or the entity chosen by us, to administer a **Participating Provider Option** dental program, to provide services to you at the time you receive the services.
- A **Non-Participating Dentist** means a **dentist** who does not have a written agreement with Blue Cross and Blue Shield of Illinois, or the entity chosen by us, to administer a **Participating Provider Option** dental program, to provide services to you at the time you receive the services.

Dependent means:

- Your lawful spouse or **domestic partner** (provided your **institution** covers **domestic partners**)
- Your partner in a **civil union** (unless indicated otherwise, the term "spouse" includes a partner in a **civil union**)
- Your child(ren)

"Child(ren)" used hereafter in this policy means a natural child(ren), stepchild(ren), foster child(ren), adopted child(ren), child(ren) of your **domestic partner** (provided your **institution** covers **domestic partners**), child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, child(ren) of your child(ren), grandchild(ren), and child(ren) for whom you are the legal guardian when any of the above child(ren) are under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the service area of Blue Cross and Blue Shield's network for this **policy**
- Have served as an active or reserve member of any branch of the Armed Forces of the United States and we have received a release or discharge other than a dishonorable discharge

Coverage will continue for a child who is 26 or more years old, chiefly supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a child for the reasons listed above. During the next two years, we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.

Domestic Partner means a person with whom you have entered into a **domestic partnership**.

Domestic Partnership means long-term committed relationship of indefinite duration with a person which meets the following criteria:

- You and your **domestic partner** have lived together for at least 6 months
- Neither you or your **domestic partner** is married to anyone else or has another **domestic partner**
- Your **domestic partner** is at least 18 years of age and mentally competent to consent to a contract
- Your **domestic partner** resides with you and intends to do so indefinitely
- You and your **domestic partner** have an exclusive mutual commitment similar to marriage
- You and your **domestic partner** are jointly responsible for each other's common welfare and share financial obligations

Effective Date means 12:01 a.m. on the date on which a policyholder's coverage under this **policy** begins as shown on the face page of this **policy**.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated
- Are appropriate for the **hospital** or facility other **provider** in which they were performed
- The **physician** or professional other **provider** has had the appropriate training and experience to provide the treatment or procedure

The medical staff of Blue Cross and Blue Shield shall determine whether treatment, procedure, facility, equipment, drug, device, or supply is **experimental/investigational**, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a **physician** or professional **provider** may have prescribed treatment, and the services or supplies have been provided as the treatment of last resort, BCBSIL still may determine such services or supplies to be **experimental/investigational** within this definition. Treatment provided as part of a clinical trial, or a research study is **experimental/investigational**.

Family Coverage means coverage for you and your eligible **dependents** under this **policy**.

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

Individual Coverage means coverage under this **policy** for you but not your **dependents**.

Institution means the policyholder shown on the face page of this **policy**, which has confirmed to us that it is an institution of higher education as defined in the Higher Education Act of 1965.

Insured means a person in a class of eligible persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An insured is not a **dependent** covered under this **policy**.

Intercollegiate Sport means a sport: (1) which is not an interscholastic activity as defined in this **policy**; (2) which is administered by such **institution's** department of **intercollegiate athletics**; and (3) for which **benefits** for injuries are not provided for nor payable under this **policy** while you are playing, participating, and/or traveling to or from an **intercollegiate sport**, contest, or competition, including practice or conditioning for such activity.

Interscholastic Activities means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sport, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

Intoxification means that which is defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

Maximum Allowance means the amount determined by us, which **participating providers** have agreed to accept as payment in full for a particular dental **covered service**. All **benefit** payments for **covered services** rendered by **participating providers** and **non-participating providers** will be based on the schedule of **maximum allowances**. These amounts may be amended from time to time by us.

Medically Necessary or Medical Necessity generally means that a specific service or procedure to the Covered Person is required for the treatment or management of a dental symptom or condition and that the service or procedure performed is the most efficient and economical service or procedure which can safely be provided to the Covered Person. The fact that a Provider may prescribe, order, recommend, or approve does not by itself make such service or procedure Medically Necessary.

Non-Participating Dentist - SEE DEFINITION OF DENTIST

Participating Dentist - SEE DEFINITION OF DENTIST

Participating Provider Option means a program of dental care benefits designed to provide you with economic incentives for using designated **providers** of dental care services.

Pediatric Orthodontic Services means coverage limited to children under age 19 with an orthodontic condition meeting **medical necessity** criterion (e.g., severe, dysfunctional malocclusion).

Physician means a **physician** duly licensed to practice medicine in all of its branches and operating within the scope of their license.

Policy means this **policy** issued by us to the **institution**, any addenda, the **institution's** application for dental insurance, your application(s) for coverage, if any, along with any exhibits, appendices, addenda and/or other required information.

Provider means any health care facility (for example, a **hospital** or skilled nursing facility) or person (for example, a **physician** or **dentist**) or entity duly licensed to render **covered services** to you and operating within the scope of such license.

A **Participating Provider** means a **dentist** or other health care **provider** who has a written agreement

with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A **Non-Participating Provider** means a **dentist** or other health care **provider** who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you, unless otherwise specified in the definition of a particular **provider**.

Rescission has the meaning set forth in the RESCISSIONS provision of this **policy**.

Student means an individual **student** who meets the eligibility requirements for this dental coverage, as described in the eligibility requirements of this **policy**.

Surgery means the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by us.

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 jawbone and skull and the complex of muscles, nerves and other tissues relating to that joint.

ELIGIBILITY FOR INSURANCE

Each person in one of the classes of eligible persons shown below is eligible to be insured under this **policy**. This includes anyone who is eligible on the **policy effective date** and may become eligible after the **policy effective date** while this **policy** is in force. You must meet the **institution's** requirements for maintaining their status as an eligible **student**. Please contact your institution for further information. You must maintain your eligibility in order to maintain or continue coverage under this **policy**. **Students** enrolled for the summer sessions will not experience a loss in coverage as long as they were covered immediately preceding summer sessions. We maintain the right to investigate **student** status and attendance records to verify that eligibility requirements have been met.

Classes Of Eligible Persons

Class 1: All enrolled students and their dependents (including domestic partners) are eligible for coverage under this policy.

NOTE: Multiple classes may be added depending on the **institution**.

Dependents, as defined by this **policy**, are eligible for coverage under this **policy**.

A person may not be insured as a **dependent** and a **student** at the same time.

Your **dependent** is eligible on the date:

- You are eligible if you have **dependents** on that date
- The date the person becomes your **dependent**, if later

No eligibility rules or variations in premium will be imposed based on a student's health status, medical condition, claims experience, receipt of health care, medical or dental history, genetic information, evidence of insurability, disability, life expectancy, quality of life, or any other health status factor. A student will not be discriminated against for coverage under this policy on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits. Variations in the administration, processes or benefits of this policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

EFFECTIVE DATE OF INSURANCE

This **policy** begins on the **policy effective date** at 12:01 AM, Standard Time at the address of the policyholder.

Coverage when you enroll during the program's enrollment period, as established by the **institution**, is effective on the latest of the following dates:

- The **policy effective date**
- The date we receive the completed enrollment form
- The date after the required premium is paid
- The date you enter the eligible class

Coverage for your eligible **dependent** who enrolls: (1) during the enrollment period established by the policyholder; (2) within 31 days after you acquire a new **dependent**; or (3) within 31 days after a **dependent** terminates coverage under another dental care plan, is effective on the latest of the following dates:

- The first day of the **benefit period**
- The date you enter the eligible class
- The date we receive the completed enrollment form
- The date after the required premium is paid

After the time periods described above, you and/or your **dependent** (if applicable) must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another dental care plan.

We will pay **benefits** for your newborn child until that child is 31 days old. Coverage may be continued beyond the 31 days if you notify us of the child's birth and pays the required premium, if any.

Adopted children, as defined by this **policy**, will be covered on the same basis as a newborn child from the date the Child is placed for adoption with you or the date you become a party to a suit for the adoption of the child. Coverage will cease on the date the Child is removed from placement and the Insured's legal obligation terminates.

Annual Open Enrollment Periods

We, or the entity designed by us to administer enrollment periods, along with the **institution** will designate annual open enrollment periods during which **students** may apply for or change coverage for themselves and/or their eligible **dependents** (if applicable). This section “Annual Open Enrollment Periods" is subject to change by us and/or applicable law, as appropriate.

Qualifying Event

You and your eligible **dependents** (if applicable) who have a change in status, and lose coverage under another health care plan, are eligible to enroll for coverage under this **policy**. Within 31 days of the qualifying event, you or your **dependent** must complete supporting documentation. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, including **domestic partner** (if applicable), whether by death, divorce, or annulment, gain of a **dependent** whether by birth, adoption,

suit for adoption, court-ordered **dependent** coverage, or loss of **dependent** status because of age. The premium will be prorated based on what it would have been at the beginning of the semester or quarter, whichever applies. However, the **effective date** will be the later of the date you or your **dependent** enroll for coverage under this **policy** and pay the required premium, or the day after the prior coverage ends. Please contact your **institution** for further information.

IMPORTANT INFORMATION

Your Blue Cross And Blue Shield Identification Card

You will receive a Blue Cross and Blue Shield identification card. This card will tell you your Blue Cross and Blue Shield identification number and will be very important to you in obtaining your **benefits**. Always remember to carry the identification card with you. Do not let anyone who is not named in your coverage use your identification card to receive **benefits**.

Schedule Of Benefits

A Schedule of Benefits will be inserted into and is part of this **policy** for you. The Schedule of Benefits contains specific information about your coverage including, but not limited to:

- Whether you have individual coverage or family coverage
- The amount of your **deductible(s)**, **coinsurance** and/or **copayment(s)**
- The covered **benefit** payment levels
- Your **benefit period**

Individual Coverage

If you have individual coverage, only your own dental care expenses are covered, not the dental care expenses of other members of your family.

Family Coverage

If you have family coverage, your **covered services** and those of your enrolled **dependents** will be covered. All provisions of this **policy** that pertain to a spouse also apply to a party of a **civil union** and **domestic partner** unless specifically noted otherwise. Coverage for children will end on the last day of the period for which premium has been accepted after which the limiting age birthday falls, or other loss of eligibility.

Coverage will continue for a child who is 26 or more years old, chiefly supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a **dependent** for the reasons listed in the definition of "**dependent**". During the next two years, we may require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.

TERMINATION OF INSURANCE

Your coverage will end on the earliest of the date:

- This **policy** terminates
- You are no longer eligible
- The period ends for which premium is paid

A **dependent's** coverage will end on the earliest of the date:

- They are no longer a **dependent**
- Your coverage ends
- The period ends for which premium is paid
- This **policy** terminates

We may terminate this **policy** by giving 31 days written (authorized electronic or telephonic) notice to the policyholder. Either we or the policyholder may terminate this **policy** on any premium due date by giving 31 days advance written (authorized electronic or telephonic) notice to the other. This **policy** may be terminated at any time by mutual written or authorized electronic/telephonic consent of the policyholder and us.

This **policy** terminates automatically on the earlier of:

- The termination date shown in this **policy**
- The premium due date if premiums are not paid when due, except as provided in the **policy** grace period provision

Termination takes effect at 12:00 AM, prevailing time at the address of the policyholder on the date of termination.

Refund of Premium

A refund of premium will be made only in the event:

- Of your death
- You enter full-time active duty in any Armed Forces, and we receive proof of such active-duty service

Continuation of Coverage

A **covered person** who has been insured under this **policy** may continue to be insured under this **policy** when coverage terminates subject to the following:

- Continuation of coverage is available to **insureds** and their covered **dependents** (when applicable) when the **student** leaves school, dies, or when the covered **dependent** no longer qualifies as an eligible **dependent**.
- The **covered person** requesting coverage must have been insured under this **policy** for at least 4 months.
- Requests for continuation of coverage, with the applicable premium, must be submitted within 30 days of:
    - The date the existing coverage would otherwise terminate
    - The date the **covered person** is notified of the right to continue the coverage
- Coverage and **benefits** will be the same as those that were applicable prior to continuation.
- Premium rates for continuation of coverage may be higher than **student** rates.

- The maximum period for which coverage may be continued is 6 months.
- Continuation of coverage is not available to persons who are eligible for coverage under another dental care plan, including Medicare.

PREMIUMS AND REINSTATEMENT PROVISIONS

The premiums for this **policy** will be based on the rates currently in force, the plan and amount of insurance in effect and other factors permitted by applicable law.

Changes In Premium Rates

We may change the premium rates with at least sixty (60) days advanced written (or authorized electronic or telephonic notice) to the policyholder. No change in rates will be made until twelve (12) consecutive months after this **policy effective date** except as otherwise provided in this policy. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

- The terms of this **policy** change
- A division, subsidiary, affiliated organization, or eligible class is added or deleted from this policy
- There is a change in the factors bearing on the risk assumed, including but not limited to the taxes, fees or other governmental amounts relating to this **policy**

If an increase or decrease in rates takes place on a date that is not a premium due date, a pro rata adjustment will apply from the date of the change to the next premium due date.

Payment of Premium

The first premium is due on this **policy effective date**. After that, premiums will be due monthly unless we agree with the policyholder on some other method of premium payment.

If any premium is not paid when due, this **policy** will be canceled as of the premium due date, except as provided in the **policy** grace period provision.

Policy Grace Period

A grace period of thirty-one (31) days will be allowed for payment of any premium after the first payment. During such grace period this **policy** will continue in force provided that the policyholder has not, prior to the premium due date, given adequate timely written notice to us that the **policy** is to be terminated as of the last day of the grace period.

In addition, if you are in default of your obligation to make any premium payment as provided hereunder or if any other default hereunder has occurred and is continuing, then any indebtedness from us to the policyholder (including any and all contractual obligations of us to the policyholder) may be offset and/or recouped and applied toward the payment of the policyholder's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the policyholder.

If the policyholder does not pay the premium during the grace period, this **policy** will be terminated, at our option, on the last day of the grace period and the policyholder will be liable to us for the payment of all premiums then due, including those for the grace period.

Rescission

Any act, practice, or omission that constitutes fraud, or any intentional misrepresentation made by or on behalf of anyone seeking coverage under this **policy**, may result in the cancellation of your coverage (and/or your **dependent(s)** coverage) retroactive to the **effective date** (a "**rescission**"). A **rescission** does not include other types of coverage cancellations, such as a cancellation of coverage due to a

failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates. Any intentional fraudulent misstatements or omissions, or intentional misrepresentation of a material fact on your application, or any act or practice that constitutes fraud may result in a **rescission** of your coverage (and/or your **dependent(s)** coverage) retroactive to the **effective date**, subject to prior notification. You have the right to appeal this rescission and an independent third party may review the decision. In the event of a **rescission**, we may deduct from the premium refund any amounts made in **claim payments** during this period and you may be liable for any **claim payment** amount greater than the total amount of premiums paid during the period for which **rescission** is affected.

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

Reinstatement

If this **policy** terminates due to default in premium payment(s), the subsequent acceptance of such defaulted premium by us or any duly authorized agents shall fully reinstate this **policy**. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of this **policy** shall not be deemed a waiver of either the requirement of timely premium payment or the right of termination for default in premium payment in the event of any future failure to make timely premium payments.

Currency

All premiums for, and **claims** payable, pursuant to this **policy** are payable only in the currency of the United States of America.

HOW YOUR DENTAL COVERAGE WORKS

This Dental Plan

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

As a participant in the **Participating Provider Option** program a directory of **participating providers** is available to you. You can visit the Blue Cross and Blue Shield of Illinois website at www.bcbsil.com for a list of **participating providers** or they can request a copy of the directory and one will be sent to you upon request by calling the toll-free telephone number on the back of your identification card. While there may be changes in the directory, our selection of **participating providers** 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 you annually or as required, to allow you to make selections within the network. However, you are urged to check with your **provider** before undergoing treatment to make certain of their participation status. Although you can go to the **provider** of your choice, **benefits** under the **Participating Provider Option** will be greater when you use the services of a **participating provider**.

The **benefits** of this section are subject to all of the terms and conditions of this **policy**. Certain **benefits** may also be subject to a **benefit waiting period**. Please refer to the GLOSSARY and EXCLUSIONS & LIMITATIONS sections of this **policy** for additional information regarding any limitations and/or special conditions pertaining to your **benefits**.

For **benefits** to be available, dental services must be **medically necessary** and rendered and billed for by a **dentist**, a dental auxiliary, or **physician**, unless otherwise specified. No payment will be made by us until after receipt of an attending **dentist's** statement. In addition, **benefits** will be provided only if services are rendered on or after your **effective date**.

Benefit Payment For Dental Covered Services

Benefit Period

Your **benefit period** means the period of time you are covered under this plan beginning with the **effective date** of this **policy** through the termination date as shown on the face page of this **policy**.

Deductible Requirements

Your **deductible** amounts are shown on the SCHEDULE OF BENEFITS. The **deductible** is the amount that you must pay for **covered services** received during your **benefit period** before this **policy** begins paying its share for **covered services**. The amount applied to the **deductible** for a **covered service** cannot exceed the **maximum allowance** amount for the **covered service**.

Copayment and Coinsurance Requirements

Your **coinsurance** is the percentage of the **maximum allowance** that you are required to pay for **covered services** after the **deductible**, if applicable, has been met.

For each **covered service**, and after you have met the **deductible**, if applicable, this **policy** covers a certain percentage (specified on the SCHEDULE OF BENEFITS) of the **maximum allowance** for the **covered service** or covers the amount above your **copayments**, if applicable. When a **covered service**

is received from a **participating provider**, you pay only the **deductible**, **copayment**, and/or **coinsurance** amount applicable to that service. When a **covered service** is received from a **non-participating provider**, you are also responsible for the amount charged by the **non-participating provider** that exceeds the **maximum allowance** for the **covered service**.

Benefit Payment for Dental Services

The **benefits** provided by us and the expenses that are your responsibility for your **covered services** will depend on whether you receive services from a **participating** or **non-participating provider**. Your **copayment** and **coinsurance** amounts are shown on the SCHEDULE OF BENEFITS.

Participating dentists are **dentists** who have signed an agreement with us, or the entity chosen by us to administer a **Participating Provider Option** dental program, to accept the **maximum allowance** as payment in full. Such participating **dentists** have agreed not to bill you for **covered service** amounts in excess of the **maximum allowance**. Therefore, you will be responsible only for the difference between our **benefit** payment and the **maximum allowance** for the particular **covered service** - that is, your **copayment**, **coinsurance** and **deductible**.

Non-participating dentists are **dentists** who have not signed an agreement with us, or the entity chosen by us to administer a **Participating Provider Option** dental program, to accept the **maximum allowance** as payment in full. Therefore, you are responsible to these **dentists** for the difference between our **benefit** payment and such **dentist's** charge to them.

Should you wish to know the **maximum allowance** for a particular procedure or whether a particular **dentist** is a **participating dentist**, you may contact your **dentist** or us.

Benefit Maximum

The maximum amount available for you in dental **benefits** each **benefit period** is shown on the SCHEDULE OF BENEFITS. This is an individual maximum. There is no family maximum.

Any expenses incurred beyond the **benefit** maximum are your responsibility.

Out-of-Pocket Expense Maximum

The maximum amount of expenses you are required to pay for **covered services** each **benefit period** are shown on your SCHEDULE OF BENEFITS.

Dental Benefit Waiting Period

Certain dental **benefits** under this benefit program are subject to a **benefit waiting period**. You will not be eligible for **benefits** for these **covered services** for the number of months specified in the SCHEDULE OF BENEFITS.

Your **benefit waiting period** will begin on your **effective date** and will continue for the number of months specified in the SCHEDULE OF BENEFITS.

Important Information About Your Dental Benefits

Care by More than One Dentist

If you should change **dentists** in the middle of a particular **course of treatment**, **benefits** will be provided as if you had stayed with the same **dentist** until your treatment was completed. There will be no duplication of **benefits**.

Alternate Benefit Program

In all cases in which there is more than one **covered service** or **course of treatment** to treat your dental condition, the **benefit** will be based on the least costly **covered service** or **course of treatment**. If you request or accept the more costly covered service, you are responsible for expenses that exceed the amount covered for the least costly **covered service**.

If you and your **dentist**, a dental auxiliary, or **physician** decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the **benefits** provided will be limited to the **benefit** for the standard procedures for dental services.

Pre-Estimation of Benefits

If your **dentist** recommends a **course of treatment** that will cost more than $300, your **dentist** should prepare a **claim** form describing the planned treatment, copies of necessary radiographic images, photographs and models and an estimate of the charges prior to you beginning the **course of treatment**. We will review the report and materials, taking into consideration alternative adequate **course of treatment**, and will notify you and your **dentist** of the estimated **benefits** which will be provided under this **benefit** section. This is not a guarantee of payment, but an estimate of the **benefits** available for the proposed services to be rendered.

DENTAL BENEFITS

Covered Services

The **benefits** of this section are subject to all the terms and conditions of your **policy**. **Benefits** are available only for services and supplies that are determined to be **medically necessary**, unless otherwise specified. All **covered services** listed in this section are subject to the EXCLUSIONS AND LIMITATIONS section of this **policy**, which lists services, supplies, situations, or related expenses that are not covered.

It is important for you to refer to your SCHEDULE OF BENEFITS to find out what your **deductible**, **benefit period** maximums, **copayment**, **coinsurance** and out-of-pocket maximums will be for a **covered service**. If you do not have a SCHEDULE OF BENEFITS, please call Customer Service at the toll- free telephone number on the back of your identification card.

Your dental **benefits** include coverage for the following **covered services** as long as these services are rendered to you by a **dentist**, a dental auxiliary, or a **physician**. When the term "**Dentist**" is used in this **policy**, it will mean **dentist**, **physician**, or a dental auxiliary.

Diagnostic Evaluations

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

- Periodic oral evaluations for established patients
- Problem focused oral exam, whether limited, detailed, or extensive
- Comprehensive oral evaluations for new or established patients
- Comprehensive periodontal evaluations for new or established patients
- Oral evaluations of children under three years of age, including counseling with primary caregiver
- Oral examinations - the initial oral examination and periodic routine oral examinations

However, your **benefits** are limited to one comprehensive and one periodic examination every **benefit period**.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations if **covered services** are rendered on the same date as any other oral evaluation and by the same **dentist**. **Benefits** will not be provided for tests and oral pathology procedures, or for re-evaluations.

Preventive Services

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

- Prophylaxis - professional cleaning and polishing of the teeth. **Benefits** will be limited to two cleanings every 12 months.
- Topical application of fluoride - **benefits** for topical application of fluoride is only available to **covered persons** under age 19 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Following active periodontal treatment, the **benefit** of a combination of two prophylaxes and two periodontal maintenance treatments (see "non-surgical periodontal services") every 12 months.

Combination of prophylaxes and periodontal maintenance treatments are limited to a combination of two every 12 months.

Diagnostic Radiographs

Diagnostic radiographic images are taken to diagnose a dental disease and include their interpretations. **Covered services** include:

- Full-mouth (intraoral complete series) and panoramic films - **benefits** are limited to a combined maximum of one every 36 months.
- Bitewing films - **benefits** are limited to four horizontal images or eight vertical radiographic images once every 12 months.
- Bitewing films are not separately eligible when taken on the same date as full-mouth films or within 6 months of a complete series of radiographic images.
- Periapical films, as necessary for diagnosis - **benefits** are limited to six every 12 months.

Miscellaneous Preventive Services

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

- Sealants - **benefits** for sealants are limited to one per permanent (first and second) molar per lifetime and are available to covered persons under age 19.
- Space Maintainers - **benefits** for space maintainers are limited to a lifetime maximum of one appliance per arch for **covered persons** under age 19.

Basic Restorative Services

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

- Amalgam restorations - **benefits** are limited to one restorative service per tooth every 12 months.
- Resin-based composite restorations - **benefits** are limited to one restorative service per tooth every 12 months.
- Sedative fillings

Non-Surgical Extractions

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

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

Non-Surgical Periodontal Services

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

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

Adjunctive Services

Adjunctive general services include:

- Palliative treatment (emergency) of dental pain when treatment is not performed in conjunction with a definitive treatment or service
- Deep sedation/general anesthesia and intravenous sedation/non-intravenous conscious sedation - by report only and when determined to be **medically necessary** for **covered persons** with documented medical or dental conditions. A person's apprehension does not constitute **medical necessity**.

Endodontic Services

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

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

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

Oral Surgery Services

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

- Surgical tooth extractions
- Alveoloplasty and vestibuloplasty
- Excision of benign odontogenic tumor/cysts
- Excision of bone tissue
- Incision and drainage of an intraoral abscess. Intraoral soft tissue incision and drainage is covered only when provided as the definitive treatment for an abscess. Routine follow-up care is considered part of the procedure.
- Other **medically necessary** surgical and repair procedures not specifically excluded in this **policy**

Surgical Periodontal Services

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

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) - **benefits** are limited to no more than one surgical periodontal procedure (periodontal **surgery**, osseous **surgery**, gingivectomy or gingivoplasty) per quadrant every 24 months.
- Clinical crown lengthening
- Osseous **surgery**, including flap entry and closure - **benefits** are limited to one per quadrant every 24 months. In addition, osseous **surgery** performed in a limited area and in conjunction with crown lengthening on the same date of service and in the same area of the mouth, will receive the **benefit** of crown lengthening in the absence of periodontal disease.
- Osseous grafts - **benefits** are limited to one per site every 36 months. Bone grafts are excluded in conjunction with extractions, apicoectomy or any non-covered service or non-eligible implants.

- Soft tissue grafts/allografts (including donor site) - **benefits** are limited to one per quadrant every 36 months.
- Distal or proximal wedge procedure, limited to one per quadrant every 36 months, not in conjunction with osseous **surgery**
- Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

Major Restorative Services

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

- Single crown restorations
- Inlay/onlay restorations
- Labial veneer restorations not performed for cosmetic reasons

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

Prosthodontic Services

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

- Complete and removable partial dentures - **benefits** will be provided for the initial installation of removable complete, immediate, or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. **Benefits** for replacements are limited to once in any 60-month period, whether placement was provided under this **policy** or under any prior dental coverage.
- Implant retained crowns, bridges, and dentures are subject to the alternate **benefit** provision of this **policy** found in the EXCLUSIONS AND LIMITATIONS section.
- Dentures reline/rebase procedures - **benefits** will be limited to one in a 24-month period after the initial 6-month period following initial placement.
- Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the prosthetic delivery.
- Fixed bridgework - **benefits** will be provided for the initial installation of an eligible bridgework, including inlays/onlays and crowns. **Benefits** will be limited to once every 60 months whether placement was under this **policy** or under any prior dental coverage.
- Maxillofacial prosthetics - **benefits** will be provided for maxillofacial prosthetics to **covered persons** under the age of 19.
- Prosthetics placed over implants will be covered.

Miscellaneous Restorative And Prosthodontic Services

Other restorative and prosthodontics services include:

- Prefabricated crowns - **benefits** for stainless steel and resin-based crowns are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core - **benefits** will be limited to two recementations every 12 months. Recementation provided within six months of an initial placement by the same **dentist** is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services

- Pulp cap - direct and indirect are considered part of the restorative procedure
- Adjustments - **benefits** will be limited to three times per appliance every 12 months.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of a missing or broken tooth or clasp (unless additions are completed on the same date as replacement partials/dentures) - **benefits** are limited to a lifetime maximum of once per tooth or clasp.

Medically Necessary Orthodontic Dental Services

Medically necessary orthodontic services are limited to **covered persons** who meet the plans criteria related to a medical condition such as:

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

Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment does not meet the definition of **medical necessity**.

Medically necessary orthodontic procedures and treatment include examination, records, tooth guidance repositioning (straightening) and retention of the teeth for **covered persons** eligible for orthodontics as shown on your SCHEDULE OF BENEFITS.

Special Provisions Regarding Orthodontic Services

- Pediatric orthodontic services are limited to children under age 19 with an orthodontic condition meeting **medical necessity** criterion established by us (e.g., severe, dysfunctional malocclusion) or meeting or exceeding a score of 42 from the Modified Salzmann Index.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- If orthodontic treatment is terminated for any reason before completion, **benefits** will cease on the date of termination.
- If a **covered person's** coverage is terminated prior to the completion of the orthodontic treatment plan, you are responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same **dentist** who placed the appliance and/or who is responsible for a covered person's ongoing care is not covered.
- **Benefits** are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the **effective date**, **benefits** will be reduced based on the **benefits** paid prior to this coverage beginning.

Implant Services

Depending on the dental plan chosen, **benefits** may be available for **covered services** incurred for an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth. See the SCHEDULE OF BENEFITS for more information.

EXCLUSIONS AND LIMITATIONS

These general exclusions and limitations apply to all services described in this dental **policy**. Dental coverage is limited to services provided by a **dentist**, a dental auxiliary, or other **provider** (as defined in the GLOSSARY) licensed to perform services covered under this dental **policy** and operating within the scope of their license.

Important Information About Your Dental Benefits

Dental Procedures Which Are Not Medically Necessary

Please note that in order to provide you with dental care **benefits** at a reasonable cost, this **policy** provides **benefits** only for those **covered services** for eligible dental treatment that are determined to be **medically necessary**.

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

The fact that a **physician** or **dentist**, or a dental auxiliary, may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply **medically necessary**.

Care by More than One Dentist

If you change **dentists** in the middle of a particular **course of treatment**, **benefits** will be provided as if you had stayed with the same **dentist** until your treatment was completed. There will be no duplication of **benefits**.

Alternate Benefits

In all cases in which there is more than one **covered service** or **course of treatment** possible to treat your dental condition, the **benefit** will be based upon the least costly **covered service** or **course of treatment**. If you request or accepts the more costly **covered service**, you are responsible for expenses that exceed the amount covered for the least costly **covered service**.

If you and your **dentist**, a dental auxiliary, or **physician** decide on personalized restorations, personalized complete or partial dentures and overdentures, 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 service.

Non-Compliance with Prescribed Care

Any additional treatment and resulting liability which is caused by the lack of your cooperation with the **dentist** or from non-compliance with prescribed dental care will be your responsibility.

No Benefits will be provided under this Policy for:

- Services or supplies not specifically listed as a **covered service**, or when they are related to a non-covered service
- Amounts which are in excess of the **maximum allowance**

- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth, lack of enamel and grafts to improve aesthetics, except as included in the pediatric orthodontic **benefit**
- Dental services, radiographic images, or appliances for the diagnosis and/or treatment of dysfunction and related disorders or to increase vertical dimension
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury, except for persons under the age of 19
- Services and supplies for any illness or injury suffered after your effective date as a result of war or any act of war, declared or undeclared, or while on active or reserve duty in the armed forces of any country or international authority
- Services or supplies that do not meet accepted standards of dental practice
- Services or supplies which are **experimental/investigational** in nature or not fully approved by a Council of the American Dental Association
- **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 except as otherwise stated in the SCHEDULE OF BENEFITS
- 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
- Services or supplies received for behavior management or consultation purposes
- 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 is employed by the corporation and elected 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 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
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by you for dental expenses which is written as a part of, or in conjunction with, any automobile casualty insurance policy
- Charges for nutritional, tobacco or oral hygiene counseling

- Charges for local, state, or territorial taxes on dental services or procedures
- Charges for the administration of infection control procedures as required by local, state, or federal mandates
- Charges for telephone consultations, email, or other electronic consultations, missed appointments, completion of a **claim** form or forwarding requested records or radiographic images
- Charges for athletic mouth guards, isolation of a tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers
- Charges for partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your **effective date** under this **policy**
- Replacement of an extracted or missing third molar and/or congenitally missing teeth
- 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 or occlusal adjustments
- Charges for prescription or nonprescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques
- Services and supplies to the extent **benefits** are duplicated because the spouse, parent, and/or child are covered separately under this **policy**
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary, or provisional appliances
- Radiographic images taken in conjunction with **temporomandibular Joint (TMJ) dysfunction and related disorders**
- Chemical treatments or localized delivery of chemotherapeutic agents
- Charges for local anesthesia, nitrous oxide analgesia, therapeutic, parenteral drugs, or other drugs or medicaments and/or their application
- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same **dentist**
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of performed dowel and post, or post removal
- Endodontic therapy if you discontinue endodontic treatment
- Surgical services related to congenital or developmental 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
- Anatomical crown exposure
- 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
- Charges for replacement of stolen, lost, or defective dentures, crowns, or other appliances
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework
- Any procedure, service, or appliance for the purpose of altering or maintenance of vertical

dimension of occlusion

- Appliances or restoration of teeth due to lost vertical dimension of occlusion, erosion, attrition, abrasion, or abfraction. **Benefits** are not provided for the appliances or restorations to restore occlusion or incisal edges due to bruxism or harmful habits
- Any procedure, service, or appliance provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall be considered cosmetic
- Precision or semi-precision attachments
- Gold foil restorations
- Tests and oral pathology procedures, or for re-evaluations
- The replacement of a lost or defective crown

We may, without waiving these exclusions, elect to provide **benefits** for care and services while awaiting the decision of whether the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount it has allowed for **benefits** under this **policy**. You must provide us with all documents it needs to enforce our rights under this provision.

COORDINATION OF BENEFITS

Coordination of benefits (COB) applies to this benefit program when you and/or your covered dependents (if dependent coverage is offered) have health/dental care coverage under more than one benefit program.

The order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this benefit program are determined before or after those of another benefit program. The benefits of this benefit program:

1. Shall not be reduced when, under the order of benefit determination rules, this benefit program determines its benefits before another benefit program; but
2. May be reduced when, under the order of benefits determination rules, another benefit program determines its benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

In addition to the GLOSSARY of this policy, the following definitions apply to this section:

Allowable Expense means a covered service when the covered service is covered at least in part by one or more benefit program covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless your stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the benefit program.

When a benefit program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

Benefit Program means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (1) or (2) above is a separate benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate benefit program.

Claim Determination Period means the policyholder's benefit period. However, it does not include any part of the benefit period during which you have no coverage under this benefit program, or any part of the policyholder's benefit period before the date this COB provision or a similar provision takes effect.

Primary Program or Secondary Program means the order of payment responsibility as determined by the order of benefit determination rules.

When this benefit program is the primary program, its benefits are determined before those of the other benefit program and without considering the other program's benefits.

When this benefit program is a secondary program, its benefits are determined after those of the other benefit program and may be reduced because of the other program's benefits.

When there are more than two benefit programs covering the person, this benefit program may be a primary program as to one or more other programs and may be a secondary program as to a different program or programs.

Order of Benefit Determination

When there is a basis for a claim under this benefit program and another benefit program, this benefit program is a secondary program that has its benefits determined after those of the other program, unless:

1. The other benefit program has rules coordinating its benefits with those of this benefit program
2. Both those rules and this benefit program's rules, described below, require that this benefit program's benefits be determined before those of the other benefit program.

This benefit program determines its order of benefit payments using the first of the following rules that applies:

1. Non-dependent or dependent

The benefits of the benefit program that covers the person as an employee, member, or subscriber (that is, other than a dependent) are determined before those of the benefit program that covers the person as dependent, except that, if the person is also a Medicare beneficiary, Medicare is:

a. Secondary to the benefit program covering the person as a dependent
b. Primary to the benefit program covering the person as other than a dependent, for example a retired employee

2. Dependent child if parents not separated or divorced

Except as stated in rule (3) below, when this benefit program and another benefit program cover the same child as a dependent of different persons, (i.e., "parent"):

a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but
b. If both parents have the same birthday, the benefits of the benefit program that covered the parent longer are determined before those of the benefit program that covered the other parent for a shorter period of time.

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

3. Dependent child if parents separated or divorced

If two or more benefit programs cover a person as a dependent child of divorced or separate parents, benefits for the child are determined in this order:

a. First, the program of the parent with custody of the child
b. Then, the program of the spouse of the parent with custody of the child
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 of 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
c. Third, length of 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
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 a claim is made; exceeds those allowable expenses in a claim determination period. In that case, the benefits of this benefit program will be reduced so that they and the benefits payable under the other benefit programs do not total more than those allowable expenses.

If you are eligible for Medicare Part B, the benefits of this benefit program may be reduced taking into consideration the amount that would be payable for an allowable expense under Medicare Part B whether you have enrolled in Part B and/or received payment from Medicare.

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

Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. 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 we made is more than we should have paid under this COB provision, we may recover the excess from one or more of:

- The person(s) it has paid or for whom it has paid
- Insurance companies
- Other organizations

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

HOW TO FILE A CLAIM

Filing Dental Claims

In order to obtain your dental **benefits** under this **policy**, it is necessary for a **claim** to be filed with us.

To file a **claim**, you must obtain an attending **dentist's** statement from us, or our designee, before going to your **dentist**. The attending **dentist's** statement is also used for pre-estimation of **benefits**. It is your responsibility to ensure that the necessary **claim** information has been provided to us.

You must complete and sign your information of the attending **dentist's** statement. As soon as treatment has ended, you must 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 660247
Dallas, Texas 75266-0247

Claims must be filed with us within 365 days from the date your 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**, you may ask us or our designee.

Dental Claim Procedures

We 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 we do not process a **claim** within this 30-day period, you or your 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. We will notify you or your 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, you will receive a notice from us with:

- The reasons for denial
- A reference to the dental care plan provisions on which the denial is based
- A description of additional information which may be necessary to perfect the **claim**
- An explanation of how they may have the **claim** reviewed by us if they do not agree with the denial

Dental Claim Review Procedures

If your Claim has been denied, you may request an appeal. We will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, you should write to us. We will need to know the reasons why you do not agree with the denial or partial denial. You should send your request to:

Blue Cross and Blue Shield of Illinois
P.O. Box 660247
Dallas, Texas 75266-0247

You may also designate a representative to act for you in the appeal procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of your information except to your authorized representative. To obtain an authorized representative form, you or your authorized representative may call us at the toll-free telephone number on the back of your identification card.

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

You and your authorized representative may ask to see relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of a denial or partial denial or at any time during the **claim** appeal process. We will give you a written decision within 60 days after we receive your request for appeal.

If you have any questions about the **claims** procedures or the appeal procedure, you 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 you have a **claim** for **benefits** which is denied or ignored, you may have the right to file suit in a state or federal court.

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

Illinois Department of Insurance
Office of Consumer Health Insurance
115 S. LaSalle Street, 13th Floor Chicago, IL 60603
Toll-free: (877) 527-9431
Fax: (217) 558-2083
Email: DOI.Complaints@illinois.gov
Web address: https://mc.insurance.illinois.gov/messagecenter.nsf

GENERAL PROVISIONS

Our Separate Financial Arrangements With Providers

We hereby inform you that we have contracts with certain **providers** ("**participating providers**") in our 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 we are a party, including all persons covered under this **policy**. Under certain circumstances described in its contracts with **participating providers**, we may:

- Receive substantial payments from **participating providers** with respect to services rendered to you for which we were obligated to pay the **participating provider**
- Pay **participating providers** substantially less than their **claim charges** for services, by discount or otherwise
- Receive from **participating providers** other substantial allowances under our contracts with them

In the case of **dentists**, the calculation of any maximum amounts of **benefits** payable by us under this **policy** and the calculation of all required **deductible** and **coinsurance** amounts payable by you under this **policy** shall be based on the lesser of the **maximum allowance** or **dentist's claim charge** for **covered services** rendered to you. Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of this **policy**. Neither the policyholder nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

Payment of Claims And Assignment of Benefits

- Under this **policy**, we have the right to make any **benefit** payment either directly to your dentist or to you, unless reasonable evidence of a properly executed and enforceable assignment of **benefit** payment has been received by us sufficiently in advance of our **benefit** payment. We reserve the right to require submission of a copy of the assignment of **benefit** payment. For example, we may pay **benefits** to you if you receive **covered services** from a **non-participating dentist**. We are specifically authorized by you to determine to whom any **benefit** payment should be made.

- Once **covered services** are rendered by a **dentist,** you have no right to request us not to pay the **claim** submitted by such **dentist** and no such request will be given effect. In addition, we will have no liability to you or any other person because of its rejection of such request.

- Except for the assignment of **benefit** payment described above, this **policy** and your **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 you, and coverage under this **policy** is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a **claim** for **benefits** or coverage shall be null and void.

Covered Persons' Dentist Relationships

- The choice of a **dentist** is solely your choice, and we will not interfere with your relationship with any **dentist**.
- We do not ourselves undertake to furnish health or dental care services, but solely to make payments to **dentists** for the **covered services** received by you. We are 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 you. Professional services which can only be

legally performed by a **dentist** are not provided by us. Any contractual relationship between a **dentist**, dental auxiliary, **physician**, plan **hospital**, or other **participating provider** shall not be construed to mean that we are providing professional service.

- 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**.
- Each **dentist** provides **covered services** only to you.

Notices

Any information or notice which you or the policyholder furnish to us under this **policy** must be in writing and sent to us at our 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 we furnish to you or the policyholder must be in writing and sent to you or the policyholder at your respective addresses as they appear on our records. Blue Cross and Blue Shield may also provide such notices electronically, to the extent permitted by applicable law.

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 us 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 us in accordance with the requirements of this **policy**.

Information And Records

You agree that it is your 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 us or our agent, and agree that any such **dentist**, person or other entity may furnish to us or our 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, we 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 your responsibility to furnish us information regarding you or your **dependents** becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that we may be able to make **claim** payments in accordance with MSP laws.

Value Based Design Programs

We and the policyholder have 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**, costs, or a combination of these incentives or

disincentives for participation in any such program offered or administered by us, or an entity chosen by us, 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, we 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 us for additional information regarding any value-based programs offered by us.

You may contact the policyholder for additional information regarding any value base programs they may offer.

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 this **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**.

Conformity With State Statutes

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

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 our executive officer and unless such approval be endorsed hereon and attached hereto.

Notice Of Annual Meeting

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

The term “member” as used above refers only to the policyholder to whom this **policy** is issued. It does not include any other family members covered under **family coverage** unless such family member is acting on your behalf.

Blue Cross and Blue Shield pays indemnification or advances expenses to a director, officer, employee, or agent consistent with Blue Cross and Blue Shield's bylaws then in force and as otherwise required by applicable law.

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

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

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.