AcademicBlue℠

School of the Art Institute of Chicago Student Dental Insurance Plan 2024-2025

Underwritten by:
Blue Cross and Blue Shield of Illinois

Please review to fully understand your coverage.

Account Number: 254596

BlueCross BlueShield of Illinois
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company
300 East Randolph Street
Chicago, IL 60601
Or call us at the phone number on the back of your identification card

POLICYHOLDER:	School of the Art Institute of Chicago
POLICY NUMBER:	254596 (“this Policy”)
EFFECTIVE DATE:	August 19, 2024
POLICY TERM:	August 19, 2024 through August 18, 225
PREMIUM DUE DATE:	On or before August 19, 2024 (“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:

Stephen Harris
Plan President, Blue Cross and Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601

STUDENT DENTAL INSURANCE
PLEASE READ THIS POLICY CAREFULLY

Notice

Please note that Blue Cross and Blue Shield of Illinois has contracts with many Dentists or other health care Providers who provide for the Insurer to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services Covered Persons 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.

Covered Persons should be aware that when they 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 Covered Persons' Benefit payment will be determined according to your Policy's fee schedule, Maximum Allowance, or other method as defined by the Policy.

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

Non-Participating Providers may bill Covered Persons 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 the Covered Persons other than Copayment, Coinsurance and Deductible amounts. Covered Persons 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 their identification card.

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BlueCross BlueShield of Illinois
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Schedule of Benefits

For Covered Persons Age 19 and Over

Your dental care Covered Services are highlighted below. To fully understand all of the terms, conditions, limitations, and exclusions which apply to your Benefits, please read the entire Policy.

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

BlueCare Dental 1B

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	
Family Deductible	$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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Schedule of Benefits

For Covered Persons Under Age 19

Your dental care Covered Services are highlighted below. To fully understand all of the terms, conditions, limitations, and exclusions which apply to your Benefits, please read the entire Policy.

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

BlueCare Dental 1B

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	
Family Deductible	$225	
Benefit Period Maximum	None	
Out of Pocket Maximum per Benefit Period 1 Child 2+ Children	 $400 $800	

*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.

Definitions

Throughout this Policy, many words are used which have a specific meaning when applied to your Students' dental care coverage. These terms will always begin with a capital letter. 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 Covered Persons' Benefits. If a term within a definition begins with a capital letter, it means that the term is also defined in these definitions. 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 a Student is enrolled and active as the "Institution" or "Policyholder."

BENEFIT means the payment, reimbursement, and indemnification of any kind which Covered Persons 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.

A ***Covered Person's Benefit Period*** means the period of time the Covered Person is covered under this Plan beginning with the Effective Date of this Policy through the Termination Date as shown on the face page of the Policy.

BENEFIT WAITING PERIOD means the number of months that Covered Persons must be continuously covered under this Benefit program before they are eligible to receive Benefits for certain dental Covered Services.

CIVIL UNION means a legal relationship between two persons of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

CLAIM means notification in a form acceptable to the Insurer that a service has been rendered or furnished to a Covered Person. This notification must include full details of the service received, including a Covered Person's 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 the Insurer may request in connection with services rendered to a Covered Person.

CLAIM CHARGE means the amount which appears on a Claim as the Provider's charge for service rendered to a Covered Person, 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 a Covered Person, 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 Covered Persons 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.

COVERAGE DATE means the date on which your coverage under this Policy begins.

COVERED PERSON means the Insured and the Insured's Dependents 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 Covered Persons must incur in Covered Services before Benefits are provided.

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

A ***"Participating Dentist"*** means a Dentist who has a written agreement with Blue Cross and Blue Shield of Illinois, or the entity chosen by the Insurer, to administer a Participating Provider Option Dental program, to provide services to Covered Persons at the time they 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 the Insurer, to administer a Participating Provider Option Dental program, to provide services to Covered Persons at the time they receive services.

DEPENDENT means:

- An Insured's lawful spouse or Domestic Partner;
- An Insured's partner in a Civil Union (unless indicated otherwise, the term "spouse" includes a partner in a Civil Union); or
- An Insured's Child(ren).

"Child(ren)" used hereafter in this Policy, means a natural Child(ren), a stepchild(ren), foster Child(ren), adopted Child(ren), a Child(ren) of an Insured's Domestic Partner (provided an Insured's Institution covers Domestic Partners), a Child(ren) who is in an Insured's custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a Child(ren) of an Insured's Child(ren), grandchild(ren), Child(ren) for whom a Student is 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; and
- 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 the Insured and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the Child's condition and dependence must be submitted to the Insurer within 31 days after the date the Child ceases to qualify as a Child for the reasons listed above. During the next two years, the Insurer may, from time to time, require proof of the continuation of such condition and dependence. After that, the Insurer may require proof no more than once a year.

DOMESTIC PARTNER means a person with whom an Insured has entered into a Domestic Partnership.

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

- An Insured and an Insured's Domestic Partner have lived together for at least 6 months;
- Neither an Insured nor an Insured's Domestic Partner is married to anyone else or has another Domestic Partner;
- An Insured's Domestic Partner is at least 18 years of age and mentally competent to consent to contract;
- An Insured's Domestic Partner resides with the Insured and intends to do so indefinitely;
- An Insured and an Insured's Domestic Partner have an exclusive mutual commitment similar to marriage; and
- An Insured and an Insured's 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 Insureds and their 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 an Insured but not an Insured's Dependents.

INSTITUTION means the Policyholder shown on the face page of this Policy, which has confirmed to the Insurer 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 the Policy.

INTERCOLLEGIATE SPORT means a sport: (a.) which is not an Interscholastic Activity (as defined in this Policy); and (b.) which is administered by such Institution's department of intercollegiate athletics; and (c.) for which Benefits for injuries are not provided for nor payable under this Policy while Insureds 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 sports, 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 the Insurer, 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 the Insurer.

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 Covered Persons with economic incentives for using designated Providers of dental care services.

PEDIATRIC ORTHONDONTIC 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 his or her license.

POLICY means this Policy issued by the Insurer to the Institution, any addenda, the Institution's Application for Dental Insurance, the Covered Person's 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 Covered Persons 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 Covered Persons at the time services are rendered to them.

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 Covered Persons at the time services are rendered to them, 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 the Insurer.

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 the CLASS(ES) OF ELIGIBLE PERSONS shown below who has received a Blue Cross and Blue Shield identification card is eligible for Benefits under this Policy when premiums are paid, and all other coverage requirements have been met. This includes anyone who is eligible on the Policy Effective Date and may become eligible after the Policy Effective Date while the Policy is in force. Students must meet the Institution's requirements for maintaining their status as an active and enrolled Student. Students must meet the Institution's requirements for maintaining their status as an eligible Student. Some courses may not fulfill the eligibility requirements of your Institution, please contact your Institution for detailed information. The Insurer maintains the right to investigate Student status and attendance records to verify that eligibility requirements have been met. If the Insurer discovers the eligibility requirements have not been met, its only obligation is to refund any premium paid for that person.

A person may be insured under only one Class of Eligible Persons shown below, even though the person may be eligible under more than one Class.

CLASSES OF ELIGIBLE PERSONS

Class 1: All enrolled Students, and their Dependents, are eligible for coverage under this Student Policy.

NOTE: Multiple classes may be added depending on the Institution.

Dependents of all Students are eligible for coverage under this Policy. A Student's Dependent is eligible on the date:

- The Student is eligible if the Student has Dependents on that date; or
- The date the person becomes a Dependent of the Student, 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 expression. 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

The Policy begins on the Policy Effective Date at 12:01 AM, Standard Time at the address of the Policyholder. Insurance for a Student who enrolls during the program's enrollment period, as established by the Policyholder, is effective on the latest of the following dates:

- The Policy Effective Date;
- The date the Insurer receives the completed enrollment form;
- The date after the required premium is paid; or
- The date the Student enters the Eligible Class.

Coverage for a Student's eligible Dependent who enrolls: (1) During the enrollment period established by the Policyholder; (2) Within 31 days after the Student acquires 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 Covered Person’s Benefit Period;
- The date the Student enters the Eligible Class;
- The date the Insurer receives the completed enrollment form; or
- The date after the required premium is paid.

After the time periods described above, the Student or Dependent 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.

The Insurer will pay Benefits for a newborn Child of a Covered Person until that Child is 31 days old. Coverage may be continued beyond the 31 days if the Covered Person notifies the Insurer 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 the Insured or the date the Insured becomes 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

The Insurer, or the entity designed by the Insurer 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.

This section ***Annual Open Enrollment Periods*** is subject to change by the Insurer, and/or applicable law, as appropriate.

QUALIFYING EVENT

Eligible Students and eligible Dependents who have a change in status, and lose coverage under another Health Care Plan, are eligible to enroll for coverage under this Policy. Within 30 days of the qualifying event, the Student or Dependent must complete supporting documentation. Go to *www.bcbsil.com*, click on “Shop for Student Health Plans” and select your university for more information. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, including Domestic Partner, whether by death, divorce, or annulment, gain of a Dependent whether by birth, adoption, or suit for adoption or court-ordered Dependent coverage, or loss of Dependent status because of age. The premium will the same as 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 the Student or Dependent enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. Please contact your Institution for further information.

Important Information

COVERED PERSONS' BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD

Covered Persons will receive a Blue Cross and Blue Shield identification card. This card will tell Covered Persons their Blue Cross and Blue Shield identification number and will be very important to them in obtaining their 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 each Insured. The Schedule of Benefits contains specific information about an Insured's coverage including, but not limited to:

- Whether the Insured has Individual Coverage or Family Coverage;
- The amount of the Insured's Deductible(s), Coinsurance and/or Copayment(s);
- The Covered Benefit payment levels; and
- The Covered Person's Benefit Period.

INDIVIDUAL COVERAGE

If Students have Individual Coverage, only their own dental care expenses are covered, not the dental care expenses of other members of their family.

FAMILY COVERAGE

If an Insured has Family Coverage, an Insured's Covered Services and those of the Insured's 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 the Insured and incapable of self- sustaining employment by reason of mental or physical handicap. Proof of the Child's condition and dependence must be submitted to the Insurer 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, the Insurer may, from time to time, require proof of the continuation of such condition and dependence. After that, the Insurer may require proof no more than once a year.

Termination of Insurance

An Insured's coverage will end on the earliest of the date:

- The Policy terminates;
- The Insured is no longer eligible; or
- The period ends for which premium is paid.

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

- He or she is no longer a Dependent;
- The Insured's coverage ends;
- The period ends for which premium is paid; or
- The Policy terminates.

The Insurer may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either the Insurer 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 the Insurer.

This Policy terminates automatically on the earlier of:

- The end of the Policy Term shown in this Policy; or
- The Premium due date if Premiums are not paid when due, except as provided in the ***Policy Grace Period*** section.

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 by the Policyholder to the Insured will be made only in the event:

- Of a Covered Person's death; or
- The Covered Person enters full-time active duty in any Armed Forces and the Insurer receives proof of such active-duty service.

Premiums and Reinstatement Provisions

The premiums charged to the Policyholder 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

The Insurer may change the premium rates from time to time 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 the 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, the Insurer reserves the right to change rates at any time if any of the following events take place:

- The terms of the Policy change;
- A division, subsidiary, affiliated organization, or eligible class is added or deleted from the Policy; or
- 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 the 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 the Policy Effective Date. After that, premiums will be due monthly unless the Insurer agrees with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the ***Policy Grace Period*** section.

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 the Policy will continue in force provided that the Policyholder has not, prior to the premium due date, given adequate timely written notice to the Insurer that the Policy is to be terminated as of the last day of the grace period.

In addition, if the Covered Person is in default of the Covered Person's obligation to make any premium payment as provided hereunder or if any other default hereunder has occurred and is continuing, then any indebtedness from the Insurer to the Policyholder (including any and all contractual obligations of the Insurer 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, the Policy will be terminated, at the Insurer's option, on the last day of the grace period and the Policyholder will be liable to the Insurer for the payment of all premiums then due, including those for the grace period.

RESCISSIONS

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 the Covered Person's coverage (and/or the Covered Person's Dependent(s) coverage) retroactive to the Coverage 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 a Student's application, or any act or practice that constitutes fraud may result in a Rescission of a Student's coverage (and/or a Student's Dependent(s) coverage) retroactive to the Coverage Date, subject to prior notification. Students have the right to appeal this Rescission and an independent third party may review the decision. In the event of a Rescission, the Insurer may deduct from the premium refund any amounts made in Claim Payments during this period and Students 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 the Insurer is entitled to rescind coverage already in force, the Insurer may at its option make an offer to reform the 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 the Insurer or any duly authorized agents shall fully reinstate the Policy. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of the 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 the 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 Students' dental Benefits. The Participating Provider Option is a program of dental care Benefits designed to provide Covered Persons 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 Covered Persons. Covered Persons 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 them upon request by contacting the number on the back of their identification card. While there may be changes in the directory from time to time, selection of Participating Providers by the Insurer 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 Covered Persons to make selection within the network. However, Covered Persons are urged to check with their Provider before undergoing treatment to make certain of his/her participation status. Although Covered Persons can go to the Provider of their choice, Benefits under the Participating Provider Option will be greater when they 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 ***Definitions***, ***Eligibility***, and ***Exclusions*** sections of this Policy for additional information regarding any limitations and/or special conditions pertaining to your Students' 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 the Insurer until after receipt of an attending Dentist's statement. In addition, Benefits will be provided only if services are rendered on or after a Covered Person's Effective Date.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

A ***Covered Person's Benefit Period*** means the period of time the Covered Person is covered under this Plan beginning with the Effective Date of this Policy through the Termination Date as shown on the Face page of the Policy.

Deductible Requirements

An Insured's Deductible amounts are shown on the Schedule of Benefits. The Deductible is the amount that a n Insured must pay for Covered Services received during a Covered Person's 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

A Covered Person's Coinsurance is the percentage of the Maximum Allowance that a Covered Person is required to pay for Covered Services after the Deductible, if applicable, has been met.

For each Covered Service, and after a Covered Person has met the Deductible, if applicable, this Policy covers a certain percentage (specified on the Schedule of Benefits) of the Maximum Allowance for this Covered Service or covers the amount above the Covered Person's Copayments, if applicable. When a Covered Service is received from a Participating Provider, a Covered Person pays only the Deductible, Copayment, and/or Coinsurance amount applicable to that service. When a Covered Service is received from a Non-Participating Provider, a Covered Person is 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 the Insurer and the expenses that are a Covered Person's responsibility for a Covered Person's Covered Services will depend on whether a Covered Person receives services from a Participating or Non- Participating Provider. A Covered Person's Copayment and Coinsurance amounts are shown on the Schedule of Benefits.

Participating Dentists are Dentists who have signed an agreement with the Insurer, or the entity chosen by the Insurer 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 Covered Persons for Covered Service amounts in excess of the Maximum Allowance. Therefore, Covered Persons will be responsible only for the difference between the Insurer Benefit payment and the Maximum Allowance for the particular Covered Service--that is, a Covered Person's Copayment, Coinsurance and Deductible.

Non-Participating Dentists are Dentists who have not signed an agreement with the Insurer, or the entity chosen by the Insurer to administer a Participating Provider Option Dental program, to accept the Maximum Allowance as payment in full. Therefore, Covered Persons are responsible to these Dentists for the difference between the Insurer Benefit payment and such Dentist's charge to them.

Should Covered Persons wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, they may contact their Dentist or the Insurer.

Benefit Maximum

The maximum amount available for Covered Persons in dental Benefits each Covered Person's 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 a Covered Person's responsibility.

Out-of-Pocket Expense Maximum

The maximum amount of expenses Covered Persons are required to pay for Covered Services each Covered Person's 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. Covered Persons will not be eligible for Benefits for these Covered Services for the number of months specified in the Schedule of Benefits.

A Covered Person's Benefit Waiting Period will begin on a Covered Person's 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 Covered Persons should change Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if they had stayed with the same Dentist until their 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 a Covered Person's dental condition, the Benefit will be based on the least costly Covered Service or Course of Treatment. If the Covered Person requests or accepts the more costly Covered Service, the Covered Person is responsible for expenses that exceed the amount covered for the least costly Covered Service.

If a Covered Person and a Covered Person's Dentist, a dental auxiliary, or Physician decides 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 a Covered Person's Dentist recommends a Course of Treatment that will cost more than $300, a Covered Person's 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 a Covered Person beginning the Course of Treatment. The Insurer will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify the Covered Person and the Covered Person's 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 the Policyholder's Students to refer to their Schedule of Benefits to find out what a Covered Person's Deductible, Benefit Period Maximums, Copayment, Coinsurance and Out-of-Pocket Maximums will be for a Covered Service. If they do not have a Schedule of Benefits, please call a Customer Service Representative at the toll-free telephone number on the back of their identification card.

Your Students' Dental Benefits include coverage for the following Covered Services as long as these services are rendered to Covered Persons 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; and
- 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 Plan Year.

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; and
- 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; and
- 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; and
- 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; and
- 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 limited to once per lifetime;
- Scaling in the presence of generalized moderate to severe gingival inflammation is limited to once every 36 months; and
- 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; and
- 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; and
- 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; and
- 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; and
- 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; and
- 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 includes:

- 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 the plan found in the ***Exclusions and Limitations*** section of this Policy;
- 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; and
- 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 is considered part of the restorative procedure;
- Adjustments - Benefits will be limited to three times per appliance every 12 months; and

- 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 members 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; and
- 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 covered 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 the Plan (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, the Covered Person is 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 ***Definitions*** section) licensed to perform services covered under this dental Policy and operating within the scope of his or her license.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Dental Procedures Which Are Not Medically Necessary

Please note that in order to provide Covered Persons 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 a Covered Person 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 a Covered Person.

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 a Covered Person changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if a Covered Person had stayed with the same Dentist until a Covered Person's 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 a Covered Person's dental condition, the Benefit will be based upon the least costly Covered Service or Course of Treatment. If the Covered Person requests or accepts the more costly Covered Service, the Covered Person is responsible for expenses that exceed the amount covered for the least costly Covered Service.

If a Covered Person and a Covered Person's Dentist, a dental auxiliary, or Physician decides 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 service.

Non-Compliance with Prescribed Care

Any additional treatment and resulting liability which is caused by the lack of a Covered Person's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Covered Person.

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 a Covered Person's 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 the Insured's 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 Covered Persons are not required to make payment or would have no legal obligation to pay if they 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 Covered Persons 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 Covered Persons make a Claim for such compensation or receive such Benefits. However, this exclusion shall not apply if a Covered Person is a corporate officer of any domestic or foreign corporation and is employed by the corporation and elected to withdraw himself/herself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act;
- Services or supplies that are furnished to Covered Persons 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 the Participant 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 a Covered Person's Effective Date under this Policy; except this exclusion will not apply to:
    1. Any Covered Person who has been continuously covered for 24 months under a group dental care Policy with BCBSIL or a combination of coverage of BCBSIL and the previous group dental care Policy by the School, which included prosthetic Benefits.
    2. A partial or full denture or fixed bridge which includes replacement of a missing tooth which was extracted after a Covered Person's Effective Date.

- 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 a Covered Person discontinues 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; or
- The replacement of a lost or defective crown.

The Plan 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 a Covered Person's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Policy. Covered Persons must provide the Plan with all documents it needs to enforce its rights under this provision.

Coordination of Benefits

Coordination of Benefits (COB) applies to this Benefit Program when a Student or a Student's covered Dependent(s) has 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 ***Definitions*** section 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 a Covered Person's 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; or
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 a Covered Person has 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; and
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; and
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; and
c. Finally, the program of the parent not having custody of the Child.

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

4. Dependent Child if Parents Share Joint Custody

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

5. Young Adult as a Dependent

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

6. Active or Inactive Employee

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

7. Continuation Coverage

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

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

8. Length of Coverage

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

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

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

The Benefits of this Benefit Program will be reduced when:

1. The Benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The Benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether a Claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of this Benefit Program will be reduced so that they and the Benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

If Covered Persons are eligible for Medicare Part B, the Benefits of this Benefit Program may be reduced taking into consideration the amount that would be payable for an Allowable Expense under Medicare Part B whether a Covered Person has enrolled in Part B and/or received payment from Medicare.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

How To File A Claim

FILING DENTAL CLAIMS

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

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

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

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

Claims must be filed with the Insurer within 365 days from the date a Covered Person's Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should Covered Persons have any questions about filing Claims, they may ask the Insurer or the Insurer's designee.

DENTAL CLAIM PROCEDURES

The Insurer will usually process all Claims according to the terms of the Benefit program within 30 days of receipt of all information required to process a Claim. In the event that the Insurer does not process a Claim within this 30-day period, the Covered Person or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Insurer will notify the Covered Person or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning Benefits, see "Payment of Claims and Assignment of Benefits" provisions in the ***General Provisions*** section of this Policy.)

If the Claim is denied, Covered Persons will receive a notice from the Insurer with:

1. The reasons for denial;
2. A reference to the dental care plan provisions on which the denial is based;
3. A description of additional information which may be necessary to perfect the Claim; and
4. An explanation of how they may have the Claim reviewed by the Insurer if they do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

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

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

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

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

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

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

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

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

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

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

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street 4th Floor
Springfield, IL 62767
Toll-free: (877) 527-9431
Fax: (217) 558-2083
Email: DOI.externalreview@illinois.gov
Web address: https://mc.insurance.illinois.gov/messagecenter.nsf

General Provisions

THE INSURER'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Insurer hereby informs you that it has contracts with certain Providers ("Participating Providers") in its service area to provide and pay for dental care services to all persons entitled to dental care Benefits under dental policies and contracts to which the Insurer is a party, including all persons covered under this Policy. Under certain circumstances described in its contracts with Participating Providers, the Insurer may:

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

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

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1. Under this Policy, the Insurer has the right to make any Benefit payment either directly to the Dentist of the Covered Services or to the Covered Person, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Plan sufficiently in advance of the Plan's Benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment. For example, the Insurer may pay Benefits to Covered Persons if they receive Covered Services from a Non-Participating Dentist. The Insurer is specifically authorized by Covered Persons to determine to whom any Benefit payment should be made.
2. Once Covered Services are rendered by a Dentist, Covered Persons have no right to request the Insurer not to pay the Claim submitted by such Dentist and no such request will be given effect. In addition, the Insurer will have no liability to Covered Persons or any other person because of its rejection of such request.
3. Except for the Assignment of Benefit Payment described above, this Policy and a Covered Person's Claim for Benefits under this Policy is expressly non-assignable and non-transferable to any person or entity, including any Dentist, at any time before or after Covered Services are rendered to a Covered Person, and coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if Covered Persons attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a Claim for Benefits or coverage shall be null and void.

COVERED PERSONS' DENTIST RELATIONSHIPS

1. The choice of a Dentist is solely a Covered Person's choice, and the Insurer will not interfere with a Covered Person's relationship with any Dentist.
2. The Insurer does not itself undertake to furnish health or dental care services, but solely to make payments to Dentists for the Covered Services received by Covered Persons. The Insurer is not in any event liable for any act or omission of any Dentist or the agent or employee of such Dentist, including, but not limited to, the failure or refusal to render services to Covered Persons. Professional services which can only be legally performed by a Dentist are not provided by the Insurer. Any contractual relationship between a Dentist, a dental auxiliary, or Physician and a Plan Hospital or other Participating Provider shall not be construed to mean that the Insurer is providing professional service.
3. 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.

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

NOTICES

Any information or notice which the Policyholder or Covered Persons furnish to the Insurer under this Policy must be in writing and sent to the Insurer at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Policy for a specific situation). Any information or notice which the Insurer furnishes to the Policyholder or Covered Persons must be in writing and sent to the Policyholder or Covered Persons at their respective addresses as they appear on the Insurer's records. Blue Cross and Blue Shield may also provide such notices electronically, to the extent permitted by applicable law.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to the Insurer in accordance with the requirements of this Policy. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Insurer in accordance with the requirements of this Policy.

INFORMATION AND RECORDS

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

VALUE BASED DESIGN PROGRAMS

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

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

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

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

TIME LIMIT ON CERTAIN DEFENSES

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

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

CONFORMITY WITH STATE STATUTES

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

ENTIRE CONTRACT

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

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

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication 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, contact us to file a grievance.

Office of Civil Rights Coordinator (voicemail)
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697

Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

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

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká ánánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.