Your Dental Care Benefit Program

BLUECARE® DENTAL HMO
PLAN NUMBER 630



BlueCross BlueShield of Illinois

GROUP CERTIFICATE RIDER REGARDING DEPENDENT LIMITING AGE

For Dental Plans

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

This Rider is attached to and becomes a part of your Certificate. The Certificate and any Riders thereto are amended as stated below.

DEPENDENT COVERAGE

Benefits will be provided under this Certificate for your and/or your spouse's enrolled child(ren) under the age of 26.

"Child(ren)" used hereafter, means a natural child(ren), a stepchild(ren), a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child(ren) of your child(ren),child(ren) for whom you are the legal guardian 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. If the covered child(ren) is eligible military personnel, the limiting age is 30 years of age as described under the **FAMILY COVERAGE** provision in the ELIGIBILITY section of this Certificate.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Certificate to which this Rider is attached will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Sincerely,



Stephen Harris
President

A message from BLUE CROSS AND BLUE SHIELD

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. We are pleased to provide you with the dental program described in this BlueCare Dental Certificate. We hope that most of your questions about your dental coverage will be answered after you have read this Certificate.

You and your eligible dependents (if you have Family Coverage) are entitled to the benefits described in this Certificate as long as you receive them from the Dental Center you have selected. Your coverage will begin on your "Coverage Date" and continue through the period authorized by your Group (provided your Group pays all premiums and you remain an eligible participant in your Group).

Throughout this Certificate we will refer to the company that you work for as your "Group" and we refer to our company as "Blue Cross and Blue Shield."

Every effort has been made to explain your dental benefits as simply and as thoroughly as possible. However, should you have questions after reading this Certificate, contact Blue Cross Blue Shield of Illinois. It is important to all of us that you understand your benefits.

Welcome to the security and peace of mind of knowing that you have Blue Cross and Blue Shield!

Sincerely,



Stephen Harris
President

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and blue Shield of Illinois)

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DEFINITIONS

The terms listed below are used throughout this Certificate and have a specific meaning when applied to your dental coverage.

These terms will always begin with a capital letter.

Accidental Injury means damage inflicted to the hard and soft tissues of the oral cavity resulting from forces external to the mouth.

Certificate means this benefit booklet. This Certificate describes the BlueCare dental coverage applicable to you (and your eligible dependents if you have Family Coverage).

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.

COBRA means the sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), including any amendments to this Act, which regulate the conditions and manner in which an employer can offer continuation of group health and dental insurance to insureds and dependents whose coverage would otherwise terminate under the terms of this Certificate.

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

Coverage Date means the date on which your coverage under this Certificate begins.

Covered Service means an American Dental Association (ADA) approved dental procedure or treatment plan specified in this Certificate for which benefits will be provided. Such service or treatment plan must be delivered by: 1) a licensed dentist acting within the scope of his license; 2) a licensed physician performing dental services within the scope of his license; or 3) a licensed dental hygienist acting under the supervision and direction of a licensed dentist.

Course of Treatment means any number of orthodontic dental procedures performed by a dentist in a planned series following a dental examination that determines the need for these procedures.

- **Full Course of Treatment** means a complete and comprehensive banding of teeth in order to guide the teeth into their correct relationship (to correct a malocclusion). Treatment usually will involve both the upper and lower arches of the mouth. The length of treatment is about 24 months and should be followed by passive retention treatment.
- **Partial Course of Treatment** means any treatment which is less than a Full Course of Treatment. Treatment may not exceed 24 months. Treatment in progress means a person who is presently banded becomes

covered under this Certificate. Benefits for these situations should be clarified by contacting Blue Cross Blue Shield of Illinois at 1-800-323-7201.

Emergency Dental Care means the provision of dental care for a sudden, acute dental condition that would lead a prudent layperson, who possesses an average knowledge of dentistry, to reasonably expect the absence of immediate care to result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

Family Coverage means coverage under this Certificate for the employee of the Group and the employee's eligible dependents. All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union, unless specifically noted otherwise.

Group means the employer of the Insured.

Individual Coverage means that only the employee of the Group is covered under this Certificate. His or her dependents are not covered.

Insured means the person who is the employee of the Group who has applied for dental coverage under this Certificate.

Medically Necessary means that a specific service provided to you or your dependents (if you have Family Coverage) is essential for the treatment or management of a symptom or condition. The service must be provided in the most efficient and economic manner. In addition, Medically Necessary means:

1. A generally accepted standard of practice for the particular situation being addressed.
2. One for which there is reasonable expectation that your condition will be significantly improved or aided by the service in terms of function and, or, relief of pain and similarly there is reasonable expectation that there will be significant deterioration in your condition, if the service is not performed.

COVERAGE INFORMATION

Eligibility

Blue Cross and Blue Shield has an agreement with your Group to provide dental benefits to you (and to your dependents if you have Family Coverage).

The term "**Group"** refers to a sole proprietor, partnership, corporation or other organization. The term **"Insured"** refers to the employee engaged in the normal activities of the Group who is employed on an active, full-time basis (as defined by the Group). The employment is reasonably expected to be permanent at the time the employee is hired and this Certificate goes into effect. New employees of the Group will become eligible for coverage on the first day of the month following the date notification of coverage is provided to Blue Cross and Blue Shield or on a date that is otherwise determined by the Group. Employees of the Group whose applications have been accepted by Blue Cross and Blue Shield shall receive dental coverage as provided in this Certificate.

Individual Coverage

If you have Individual Coverage, this means that only your dental expenses are covered under this Certificate. No other members of your family will be covered.

Family Coverage

If you have Family Coverage, this means that your dental expenses and the expenses of your eligible family members will be covered, according to the terms of your group contract.

Family Coverage is subject to the following rules:

- Your application for Family Coverage must include all of your eligible dependents on the date such application is made.
- Dependent coverage for a child born to you while you are covered under Family Coverage will be effective from the date of birth.
- If you acquire a dependent (other than through the birth of a child) while you are enrolled for Family Coverage, your Family Coverage for that dependent will go into effect upon receipt of your written notification to Blue Cross and Blue Shield and upon the completion of Blue Cross and Blue Shield's membership change.

If you are the Insured, **"Dependent"** means:

1. Your legal spouse.
2. Your children or the children of your legal spouse who are under the limiting age specified in the Schedule of Dental Services.
3. Children who are in your custody in accordance with an interim court order prior to finalization of adoption or placement of adoption vesting temporary care of the children. Such children must be under the limiting age specified in the Schedule of Dental Services of this Certificate.

4. Your legally adopted children who are under the limiting age specified in the Schedule of Dental Services.
5. Your children who are under the limiting age specified in the Schedule of Dental Services and who are legally dependent upon you for support and maintenance while full-time students at an accredited institution of higher education.

   In addition, enrolled unmarried children will be covered up to the age of 30 if they:

   - Live within Blue Cross and Blue Shield's service area; and
   - Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
   - Have received a release or discharge other than a dishonorable discharge.
6. Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age, will be covered regardless of age, as long as they were covered prior to reaching the limiting age specified in the Schedule of Dental Services of this Certificate.
7. Your dependent who is a party to a Civil Union and his or her children.

Payment of Premiums

Your Group will pay your premiums. The premiums are paid monthly in advance and any arrangement requiring you to reimburse your Group for a portion of the premium is entirely between you and your Group. Blue Cross and Blue Shield looks solely to the Group for payment of premiums.

Your Group will be allowed a grace period of 31 days for the late payment of premiums. During this period, this Certificate will remain in effect. If the Group fails to pay any premium, this Certificate will automatically terminate at the end of the grace period. Blue Cross and Blue Shield will not be obligated to give you or your Group notice if this Certificate is automatically terminated. However, if Blue Cross and Blue Shield accepts payment from the Group after the expiration of the grace period, your coverage will be reinstated as of that acceptance date.

If this Certificate is terminated for any reason, the Group will be liable for all premiums then due, including charges for any period this Certificate was in effect during a grace period.

Termination of Coverage

Your coverage under this Certificate (and the coverage of your dependents if you have Family Coverage) will end if:

1. you are no longer a covered employee with your Group; or
2. your Group fails to pay premiums; or

3. your Group terminates its BlueCare Dental Agreement with Blue Cross and Blue Shield.

Your dependent's coverage will automatically end if:

1. this Certificate is terminated; or
2. he or she ceases to be a dependent according to the definition of Dependent stated in the Family Coverage provision of this Certificate, or
3. he or she reaches the limiting age specified in the Schedule of Dental Services of this Certificate.

ABOUT YOUR DENTAL BENEFITS

Types of Dental Services

The following is a summary of the types of dental services your BlueCare Certificate covers:

- **Diagnostic and Preventive Care Services**

  Diagnostic services means the procedures necessary to aid the dentist in evaluating your existing dental condition and to determine what type of dental care is required. Preventive care services means those procedures necessary to prevent oral disease. Diagnostic and Preventive Care services include:

  a. Dental examinations.

  b. X-rays — full mouth x-rays, panoramic x-rays, bitewing x-rays and other routine x-rays.

  c. Prophylaxis — cleaning and polishing of teeth.

  d. Topical fluoride applications for dependent children.

- **Oral Surgery Services**

  Oral Surgery means the procedures for surgical extractions and other dental surgery under local anesthetics which do not require that you be hospitalized.

- **Restorative Services**

  Restorative services means procedures necessary to restore your teeth to a healthy condition, including amalgam and resin based composite restorations.

- **Periodontal Services**

  Periodontics involves procedures necessary for the treatment of disease of the gums and bones supporting the teeth.

- **Endodontic Services**

  Endodontics involves procedures necessary for the treatment of disease of the pulp chamber and pulp canals. Endodontics procedures include:

  a. Root canal therapy.

  b. Pulpotomy.

  c. Pulp capping.

- **Crowns, Inlays/Onlays**

  Procedures necessary when teeth cannot be restored with other filling material.

- **Prosthodontics**

  Prosthodontics involves procedures necessary for providing artificial replacements for missing natural teeth. Procedures include the following:

  a. Construction, placement, and insertion of bridges; partial and complete dentures.

  b. Repair of bridges and relining and rebasing of partial and complete dentures.

- **Pediatric Dentistry**

  a. Dependents under age 6, who cannot be treated at a participating general dentist, can be referred to a participating Pediatric Dentist. Benefits for eligible services will be provided until age 6.

  b. Dependents age 6 and over, who cannot be treated at a participating general dentist, must have appropriate documentation in order to be referred to a participating Pediatric Dentist.

- **General Services**

  a. Prefabricated stainless steel crown.

  b. Deep sedation/general anesthesia.

  c. Occlusal adjustment.

- **Miscellaneous Services**

  a. Palliative treatment – non-invasive treatment for relief of pain.

  b. Space maintainers.

  c. Sealant application.

  d. Pulp vitality tests.

Your Selected Dental Center

When you enroll for BlueCare Dental HMO coverage under this Certificate, you will be required to select a Dental Center. If you enrolled in Family Coverage, your dependents may select a different Dental Center. You must obtain dental Covered Services, including written referrals to specialists (with the exception of emergency care), from your selected Dental Center. Reimbursement for emergency treatment may differ depending upon if you receive treatment from your Dental Center or from another dentist or Dental Center. For information regarding Emergency Treatment, refer to the Emergency Treatment section of this Certificate.

You will receive a *BlueCare Wallet Card* containing the toll-free customer service telephone number. Your Dental Center will receive a monthly list of all persons who are eligible for BlueCare dental coverage.

Changing Your Dental Center

You may transfer from one Dental Center to another at any time. Changes submitted to BlueCare Dental by the 20th of the current month will be effective the 1st of the following month. Transfers may be requested in writing or by calling customer service at 1-800-323-7201.

Appointment for Services

To receive dental treatment, telephone your selected Dental Center and give the Dental Center your name and member ID so that your enrollment can be verified.

Dental services will be provided by appointment only. Appointments will be made according to the following order of priority:

a. Emergency treatment for the relief of pain;

b. X-rays, teeth cleaning, and examinations;

c. Regular appointments to complete non-emergency dental treatment.

Every reasonable effort will be made to schedule your non-emergency appointments (routine preventive services as determined by your dentist) within 30 days of your request.

Emergency Treatment

The following rules will apply to dental services received for emergency treatment:

If you have an emergency, you can receive emergency care from any provider, not only your Dental Center. You should first attempt to contact your Dental Center or customer service at 1-800-323-7201 and follow the directions you receive.

In the event you cannot reach your Dental Center or customer service, you may seek emergency dental treatment from the nearest dentist or Dental Center. Remember, only services for palliative care (for the relief of pain) will be covered.

Reimbursement for emergency care will be provided as follows:

- ***Benefits for emergency care received from your Dental Center will be provided according to the Schedule of Dental Services in this Certificate (any Copayment indicated in the Schedule of Dental Services applies).***
- ***Benefits for emergency care received from a dentist or dental office other than your selected Dental Center will be provided up to a maximum amount of $50.00. You will need to obtain a paid receipt and itemized statement of services rendered from the dentist or dental office providing your treatment.***

Send Claims to:
BlueCare Dental HMO
701 E. 22nd Street, Suite 300
Lombard, Illinois, 60148

Questions About Your Benefits

Any questions you have about benefits or dental services should be directed to your Dental Center. Additional information can be obtained by writing or calling your Benefits Administrator at your Group.

If you need more detailed information about BlueCare dental coverage, address your concerns to:

BlueCare Dental HMO
701 E. 22nd Street, Suite 300
Lombard, Illinois, 60148

A second opinion regarding dental surgery can be arranged only if you submit a written request to BlueCare Dental at the above address. Benefit questions can also be answered by calling customer service at **1-800-323-7201.**

Department of Insurance Address

In compliance with Section 143(c) of the Illinois Insurance Code, you are hereby given notice of the addresses of the Consumer Divisions of the Department of Insurance. These addresses are:

Illinois Department of Insurance
Consumer Division
100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601
or
Illinois Department of Insurance
Consumer Division
320 West Washington Street
Springfield, Illinois 62767

Grievance Procedures

To resolve grievances concerning dental care and treatment, a customer oriented plan has been established.

First, it is important to work within the traditional dentist-patient relationship. You are encouraged to contact the dental office or provider directly to discuss your questions or concerns. If a satisfactory conclusion can not be reached or you do not wish to discuss your concerns with the provider, BlueCare Dental will serve as an intermediary.

You must submit a written request, providing details of your concerns, to:

BlueCare Dental HMO
701 E. 22nd Street, Suite 300
Lombard, Illinois, 60148
Attn.: Customer Relations

BlueCare Dental will acknowledge receipt of your inquiry within 72 hours of receipt. Within 30 days of receiving your inquiry you will be notified of a resolution. All parties will be notified in writing if additional time is needed for the review.

Extended Benefits at Termination

Benefits will be provided under this Certificate after the termination date of coverage only if the dental procedure began prior to the termination date and is completed within 30 days after the termination date. Orthodontic treatment in progress is an exception and benefits will end upon termination. Any balance owed will be your responsibility.

SCHEDULE OF DENTAL SERVICES FOR PLAN 630

The Covered Services specified in this Schedule of Dental Services are subject to all of the terms, conditions, limitations, and exclusions of this Certificate, and to the annual maximum indicated below.

Covered Services must be received at the Dental Center you have selected for your dental care — except for an emergency or if you have received prior written authorization from Blue Cross and Blue Shield, authorizing you to receive dental services elsewhere.

Annual Maximum

No annual maximum applies to your benefits under the Certificate.

Age Limitations

Dependents are covered to age 19. Dependent full-time students are covered to age 25. Coverage will automatically terminate on the last day of the period for which premium has been accepted.

The student age extension does NOT apply to the orthodontic benefit.

Accidental Injury

There is no coverage for accidental injury. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Failed Appointments

If you fail to give your Dental Center 24-hour notice of cancellation or fail to keep your appointment, you will be responsible for any fee your Dental Center charges for failed appointments.

COVERED SERVICES

ADA CODE	DIAGNOSTIC AND PREVENTIVE CARE SERVICES	COPAYMENT AMOUNT
00120	Periodic Oral Evaluation	No Charge
00140	Limited Oral Evaluation-Problem Focused	$25.00
00150	Comprehensive Oral Evaluation	No Charge
00160	Detailed Extended Oral Evaluation-Problem Focused	No Charge
00170	Re-Evaluation-Limited Problem Focused	No Charge
00180	Comprehensive Periodontal Evaluation	No Charge
00210	Intraoral radiographs-complete series (including bitewings) once every 3 years	No Charge
00220	Intraoral periapical radiograph-first film	No Charge
00230	Intraoral periapical radiograph - each additional film	No Charge
00240	Intraoral occlusal film	No Charge
00270	Bitewing radiograph -1 film	No Charge
00272	Bitewing radiograph - 2 films - once per year	No Charge
00274	Bitewing radiograph - 4 films - once per year	No Charge
00277	Vertical Bitewing radiograph - 7 to 8 films	No Charge
00330	Panoramic film	No Charge
00340	Cephalometric film	No Charge
01110	Prophylaxis (adult) - 2 per year	No Charge
01120	Prophylaxis (child) - 2 per year	No Charge
01201	Topical application of fluoride including prophylaxis (child)	No Charge
01203	Topical application of fluoride excluding prophylaxis (child) once per year to age 19	No Charge

ADA CODE	DIAGNOSTIC AND PREVENTIVE CARE SERVICES	COPAYMENT AMOUNT
01310	Nutritional counseling - control of dental disease	No Charge
01330	Oral hygiene instructions	No Charge

ADA CODE	MISCELLANEOUS SERVICES	COPAYMENT AMOUNT
00460	Pulp vitality tests	No Charge
00470	Diagnostic casts	No Charge
01351	Sealant - per tooth	No Charge
01510	Space Maintainer - fixed-unilateral	No Charge
01515	Space Maintainer - fixed-bilateral	No Charge
01520	Space Maintainer - removable-unilateral	No Charge
01525	Space Maintainer - removable-bilateral	No Charge
01550	Recementation of Space Maintainer	No Charge
09110	Palliative (emergency) treatment -dental pain - minor procedure	$10.00

ADA CODE	RESTORATIVE SERVICES (includes indirect pulp capping, bases, liners, acid etching procedures and treatment under local anesthetic)	COPAYMENT AMOUNT
02140	Amalgam - one surface, primary or permanent	$10.00
02150	Amalgam - two surfaces, primary or permanent	$14.00
02160	Amalgam - three surfaces, primary or permanent	$16.00
02161	Amalgam - four or more surfaces, primary or permanent	$20.00
02330	Resin - one surface, anterior	$14.00
02331	Resin - two surfaces, anterior	$16.00
02332	Resin - three surfaces, anterior	$19.00

ADA CODE	RESTORATIVE SERVICES (includes indirect pulp capping, bases, liners, acid etching procedures and treatment under local anesthetic)	COPAYMENT AMOUNT
02335	Resin - four or more surfaces or involving incisal angle (anterior)	$23.00
02390	Resin - crown (anterior)	$24.00
02391	Resin - one surface, posterior	$14.00
02392	Resin - two surfaces, posterior	$19.00
02393	Resin - three surfaces, posterior	$24.00
02394	Resin - four or more surfaces, posterior	$26.00
02940	Sedative filling	$17.00
02951	Pin retention–per tooth, in addition to restoration	$11.00
07111	Coronal remnants - deciduous tooth	$13.00
07140	Extraction - erupted tooth or exposed root	$13.00

ADA CODE	GENERAL SERVICES	COPAYMENT AMOUNT
02930	Prefabricated stainless steel crown-primary	$42.00
02931	Prefabricated stainless steel crown-permanent	$60.00
02932	Prefabricated resin crown	$65.00
02933	Prefabricated stainless steel crown with resin window	$75.00
02934	Prefabricated esthetic coated stainless steel crown - primary	$75.00
09210	Local anesthesia - not in conjunction with operative or surgical procedure	No Charge
09211	Regional block anesthesia	No Charge
09212	Trigeminal division block anesthesia	No Charge
09215	Local anesthesia	No Charge
09220	Deep sedation - general anesthesia - first 30 minutes (SEE EXCLUSIONS)	$31.00

ADA CODE	GENERAL SERVICES	COPAYMENT AMOUNT
09221	Deep sedation - general anesthesia - each additional 15 minutes (SEE EXCLUSIONS)	$19.00
09241	Intravenous conscious sedation - analgesia - first 30 minutes (SEE EXCLUSIONS)	$33.00
09242	Intravenous conscious sedation - each additional 15 minutes (SEE EXCLUSIONS)	$12.00
09248	Non-intravenous conscious sedation (SEE EXCLUSIONS)	$6.00
09430	Office visit for observation (regular hours) - no other services performed	$6.00
09440	Office visit (after regular hours)	$10.00
09450	Case presentation - detailed and extensive treatment planning	No Charge
09951	Occlusal adjustment – limited	$13.00
09952	Occlusal adjustment – complete	$47.00

ADA CODE	ENDODONTIC SERVICES (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
03110	Pulp capping - direct (excluding final restoration)	$6.00
03120	Pulp capping - indirect (excluding final restoration)	$6.00
03220	Therapeutic Pulpotomy (excluding final restoration)	$16.00
03221	Pulpal debridement - primary and permanent teeth	$14.00
03230	Pulpal therapy (resorbable fill) anterior primary tooth	$17.00
03240	Pulpal therapy (resorbable fill) posterior primary tooth	$18.00
03310	Root canal - anterior (excluding final restoration)	$70.00

ADA CODE	ENDODONTIC SERVICES (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
03320	Root canal - bicuspid (excluding final restoration)	$85.00
03330	Root canal - molar (excluding final restoration)	$105.00
03332	Incomplete endodontics therapy; inoperable/fractured tooth	$48.00
03346	Retreatment of previous root canal therapy - anterior	$75.00
03347	Retreatment of previous root canal therapy - bicuspid	$90.00
03348	Retreatment of previous root canal therapy - molar	$120.00
03351	Apexification/recalcification - initial visit	$39.00
03352	Apexification/recalcification - interim medication replacement	$17.00
03353	Apexification/recalcification-final visit	$55.00
03410	Apicoectomy/periradicular surgery - anterior	$85.00
03421	Apicoectomy/periradicular surgery - bicuspid (first root)	$85.00
03425	Apicoectomy/periradicular surgery - molar (first root)	$85.00
03426	Apicoectomy/periradicular surgery (each additional root)	$40.00
03430	Retrograde filling - per root	$24.00
03450	Root amputation - per root	$48.00
03920	Hemisection (including root removal) not including root canal therapy	$37.00

ADA CODE	PERIODONTIC SERVICES (includes postoperative evaluations, treatment under local anesthetic and biologic materials to aid in soft and osseous tissue regeneration)	COPAYMENT AMOUNT
04210	Gingivectomy or gingivoplasty - four or more teeth per quadrant	$60.00
04211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	$19.00
04240	Gingival flap procedure including root planing - four or more teeth per quadrant	$70.00
04241	Gingival flap procedure including root planing - one to three teeth per quadrant	$35.00
04249	Clinical crown lengthening - hard tissue	$55.00
04260	Osseous surgery, including flap entry and closure - four or more teeth per quadrant	$115.00
04261	Osseous surgery, including flap entry and closure - one to three teeth per quadrant	$57.00
04270	Pedicle soft tissue graft procedure	$75.00
04271	Free soft tissue graft procedure (including donor site surgery)	$80.00
04273	Subepithelial connective tissue graft procedure	$85.00
04274	Distal or proximal wedge procedure	$24.00
04276	Combined connective tissue and double pedicle graft	$85.00
04341	Periodontal scaling and root planing - four or more teeth per quadrant (4 quadrants per year)	$24.00
04342	Periodontal scaling and root planing-one to three teeth per quadrant (4 quadrants per year)	$12.00
04355	Full mouth debridement - enable periodontal evaluation and diagnosis	$13.00
04910	Periodontal maintenance procedure following active therapy (Limit One)	$14.00

ADA CODE	ORAL SURGERY SERVICES (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
07210	Surgical removal of erupted tooth	$25.00
07220	Surgical removal of tooth - soft tissue impaction	$27.00
07230	Surgical removal of tooth - partial bony impaction	$37.00
07240	Surgical removal of tooth - complete bony impaction	$50.00
07241	Surgical removal of tooth - complete bony impaction (unusual complication)	$55.00
07250	Surgical removal of residual tooth roots (cutting procedure)	$22.00
07280	Surgical access of an unerupted tooth	$55.00
07310	Alveoloplasty - in conjunction with extractions - per quadrant	$24.00
07311	Alveoloplasty - in conjunction with extractions - one to three teeth per quadrant	$12.00
07320	Alveoloplasty - not in conjunction with extractions - per quadrant	$37.00
07321	Alveoloplasty - not in conjunction with extractions - one to three teeth per quadrant	$19.00
07450	Removal of benign odontogenic cyst, tumor or lesion (less than 1.25 cm)	No Charge
07451	Removal of benign odontogenic cyst, tumor or lesion (1.25 cm or larger)	No Charge
07510	Incision and drainage of abscess - intraoral soft tissue	$19.00
07511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$24.00
07960	Frenulectomy or Frenectomy (separate procedures)	$39.00
07963	Frenuloplasty	$49.00

ADA CODE	ORAL SURGERY SERVICES (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
07970	Excision of hyperplastic tissue (per arch)	$60.00
07971	Excision of pericoronal gingiva	$17.00

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02510	Inlay - metallic, one surface	$145.00
02520	Inlay - metallic, two surfaces	$165.00
02530	Inlay - metallic, three or more surfaces	$195.00
02542	Onlay - metallic, two surfaces	$180.00
02543	Onlay - metallic, three surfaces	$215.00
02544	Onlay - metallic, four or more surfaces	$215.00
02610	Inlay - porcelain/ceramic-one surface	$145.00
02620	Inlay - porcelain/ceramic-two surfaces	$165.00
02630	Inlay - porcelain/ceramic-three or more surfaces	$195.00
02642	Onlay porcelain/ceramic-two surfaces	$180.00
02643	Onlay porcelain/ceramic-three surfaces	$215.00
02644	Onlay porcelain/ceramic-four or more surfaces	$215.00
02650	Inlay - resin-one surface	$110.00
02651	Inlay - resin-two surfaces	$130.00
02652	Inlay - resin-three or more surfaces	$135.00
02662	Onlay - resin-two surfaces	$120.00
02663	Onlay - resin-three surfaces	$140.00
02664	Onlay - resin-four or more surfaces	$150.00
02710	Crown - resin	$85.00
02712	Crown - 3/4 resin-based composite (indirect)	$85.00
02720	Crown - resin fused to high noble metal	$205.00

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02721	Crown - resin fused to predominantly base metal	$195.00
02722	Crown - resin fused to noble metal	$195.00
02740	Crown - porcelain/ceramic substrate	$210.00
02750	Crown - porcelain fused to high noble metal	$205.00
02751	Crown - porcelain fused to predominantly base metal	$190.00
02752	Crown - porcelain fused to noble metal	$195.00
02780	Crown - 3/4 cast high noble metal	$200.00
02781	Crown - 3/4 cast predominantly base metal	$190.00
02782	Crown - 3/4 cast noble metal	$195.00
02783	Crown - 3/4 porcelain/ceramic	$205.00
02790	Crown - full cast high noble metal	$200.00
02791	Crown - full cast predominantly base metal	$190.00
02792	Crown - full cast noble metal	$190.00
02794	Crown - titanium	$200.00
02799	Provisional crown	No Charge
02910	Recement inlay (See Limitations)	$16.00
02915	Recement - cast or prefabricated post and core (See Limitations)	$16.00
02920	Recement crown (See Limitations)	$16.00
02950	Core build-up, including any pins	$43.00
02952	Cast post and core, in addition to crown	$65.00
02953	Each additional cast post (same tooth)	$40.00
02954	Prefabricated post and core, in addition to crown	$55.00
02957	Each additional prefabricated post (same tooth)	$33.00
02980	Crown repair by report	$40.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
05110	Complete denture - maxillary	$280.00
05120	Complete denture - mandibular	$280.00
05130	Immediate denture - maxillary	$300.00
05140	Immediate denture - mandibular	$300.00
05211	Maxillary partial denture - resin base (clasp/rests)	$255.00
05212	Mandibular partial denture - resin base (clasp/rests)	$255.00
05213	Maxillary partial denture - metal frame with resin base	$295.00
05214	Mandibular partial denture - metal frame with resin base	$295.00
05225	Maxillary partial denture - flexible base (clasp/rests)	$255.00
05226	Mandibular partial denture - flexible base (clasp/rests)	$255.00
05281	Removable unilateral partial denture - one piece metal (with resin base)	$170.00
05410	Adjust complete denture - maxillary	$15.00
05411	Adjust complete denture - mandibular	$15.00
05421	Adjust partial denture - maxillary	$15.00
05422	Adjust partial denture - mandibular	$15.00
05510	Repair broken complete denture base	$36.00
05520	Replace missing/broken teeth – complete denture – per tooth	$27.00
05610	Repair resin denture base	$36.00
05620	Repair cast framework, partial denture	$36.00
05630	Repair or replace broken clasp, partial denture	$45.00
05640	Replace broken teeth – partial denture – per tooth	$27.00
05650	Add tooth to existing partial denture	$36.00
05660	Add clasp to existing partial denture	$44.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
05670	Replace all teeth and acrylic cast metal framework - maxillary	$105.00
05671	Replace all teeth and acrylic cast metal framework - mandibular	$105.00
05710	Rebase complete maxillary denture	$105.00
05711	Rebase complete mandibular denture	$105.00
05720	Rebase partial denture - maxillary	$105.00
05721	Rebase partial denture - mandibular	$105.00
05730	Reline complete denture - maxillary (chairside)	$60.00
05731	Reline complete denture - mandibular (chairside)	$60.00
05740	Reline partial denture - maxillary (chairside)	$60.00
05741	Reline partial denture - mandibular (chairside)	$60.00
05750	Reline complete denture - maxillary (laboratory)	$80.00
05751	Reline complete denture - mandibular (laboratory)	$80.00
05760	Reline partial denture - maxillary (laboratory)	$80.00
05761	Reline partial denture - mandibular (laboratory)	$80.00
05860	Overdenture - complete	$280.00 SEE LIMITATIONS
05861	Overdenture - partial	$295.00 SEE LIMITATIONS
06205	Pontic - indirect resin based composite	$77.00
06210	Pontic - cast high noble metal	$200.00
06211	Pontic - cast predominantly base metal	$190.00
06212	Pontic - cast noble metal	$190.00
06214	Pontic - titanium	$200.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06240	Pontic - porcelain fused to high noble metal	$205.00
06241	Pontic - porcelain fused to predominantly base metal	$190.00
06242	Pontic - porcelain fused to noble metal	$195.00
06245	Pontic - porcelain/ceramic	$195.00
06250	Pontic - resin fused to high noble metal	$190.00
06251	Pontic - resin fused to predominantly base metal	$175.00
06252	Pontic - resin fused to noble metal	$180.00
06253	Provisional Pontic	No Charge
06545	Retainer - cast metal-resin bonded fixed prosthesis	$80.00
06548	Retainer - porcelain/ceramic-resin bonded fixed prosthesis	$90.00
06600	Inlay - porcelain/ceramic-two surfaces	$180.00
06601	Inlay - porcelain/ceramic-three or more surfaces	$180.00
06602	Inlay - cast high noble metal-two surfaces	$165.00
06603	Inlay - cast high noble metal-three or more surfaces	$195.00
06604	Inlay - cast fused to predominantly base metal-two surfaces	$165.00
06605	Inlay - cast fused to predominantly base metal-three or more surfaces	$195.00
06606	Inlay - cast noble metal-two surfaces	$165.00
06607	Inlay - cast noble metal-three or more surfaces	$195.00
06608	Onlay - porcelain/ceramic-two surfaces	$180.00
06609	Onlay - porcelain/ceramic-three or more surfaces	$180.00
06610	Onlay - cast high noble metal-two surfaces	$205.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06611	Onlay - cast high noble metal-three or more surfaces	$205.00
06612	Onlay - cast fused to predominantly base metal-two surfaces	$205.00
06613	Onlay - cast fused to predominantly base metal-three or more surfaces	$205.00
06614	Onlay - cast noble metal-two surfaces	$205.00
06615	Onlay - cast noble metal-three or more surfaces	$205.00
06624	Inlay - titanium	$195.00
06634	Onlay - titanium	$205.00
06710	Crown - indirect resin based composite	$85.00
06720	Crown - resin fused to high noble metal	$210.00
06721	Crown - resin fused to predominantly base metal	$200.00
06722	Crown - resin fused to noble metal	$205.00
06740	Crown - porcelain/ceramic	$225.00
06750	Crown - porcelain fused to high noble metal	$205.00
06751	Crown - porcelain fused to predominantly base metal	$190.00
06752	Crown - porcelain fused to noble metal	$195.00
06780	Crown - 3/4 cast high noble metal	$190.00
06781	Crown - 3/4 cast fused to predominantly base metal	$190.00
06782	Crown - 3/4 cast fused to noble metal	$190.00
06783	Crown - 3/4 porcelain/ceramic	$210.00
06790	Crown - full cast high noble metal	$200.00
06791	Crown - full cast predominantly base metal	$190.00
06792	Crown - full cast noble metal	$190.00
06793	Crown - provisional	No Charge
06794	Crown - titanium	$200.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06930	Recement fixed partial denture (bridge) (See Limitations)	$26.00
06970	Cast post and core/addition to bridge retainer	$70.00
06971	Cast post as part of bridge retainer	$65.00
06972	Prefabricated post and core in addition to bridge retainer	$60.00
06973	Core build up for retainer, including any pins	$46.00
06976	Each additional cast post- same tooth	$30.00
06977	Each additional prefabricated post-same tooth	$29.00
06980	Fixed partial denture repair by report	$48.00
06985	Fixed partial denture - pediatric	$255.00
09942	Repair and/or reline of occlusal guard	$36.00

	ORTHODONTICS	COPAYMENT AMOUNT
Dependent Orthodontics		
	Orthodontic benefits for a dependent child - **Full Course of Treatment**	$1,500.00
Adult Orthodontics		
	Orthodontic benefits for a Covered Person other than a dependent child – **Full Course of Treatment**	$1,500.00

Orthodontic benefits for the treatment to correct malocclusions are limited to one Phase II Course of Treatment and Retention. Benefits include consultation, office records, comprehensive full banding and/or bonding of the dentition, the initial retention appliances and office visits for retention. The benefit period for treatment and retention will not exceed 24 months and will begin with the initial banding and/or bonding of the particular case as reported by the participating dentist. Should your coverage terminate during a course of orthodontic treatment, the balance of payments would be your responsibility.

SPECIAL LIMITATIONS

Your dental benefits under this Certificate will be subject to the special conditions and limitations stated below.

Prosthodontics (Prosthetic appliances such as bridges, partial and full dentures)

A prosthetic appliance will be provided only once in every 4-year period. However, your existing appliance must be unserviceable or not functional (as determined by your dentist). The 4-year period will begin on the date on which the existing appliance was last supplied. The term "existing" means an appliance that was in place on and before the 4-year period begins.

The following appliances will be covered as indicated below:

1. **Fixed versus Removable Appliance.** If there are multiple spaces in the same arch, benefits will be provided for a removable appliance. If one or more missing teeth in the same arch can be replaced using a maximum of 4 units (a combination of retainers and pontics), benefits will be provided for a fixed bridge. If more than 4 units are required, benefits will be provided for a removable appliance.
2. **Recementation.** Recementation of inlays, crowns, bridges and Maryland bridges initially placed by your Dental Center will not be charged to you (within the first 12 (twelve) months). Recementation of pre-existing inlays, crowns, bridges and Maryland bridges not placed by your Dental Center will be provided according to the actual fee-for-service normally charged.
3. **Partial Dentures**. Benefits for a removable appliance will be provided if a satisfactory result can be achieved by a standard cast chrome and/or acrylic partial denture, but if you and your dentist select a more personal appliance or one involving special techniques, benefits under this Certificate will be limited to the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will be your responsibility.
4. **Complete Dentures.** If a satisfactory result can be achieved by using standard procedures and materials, but you and your dentist select a more personal appliance or one which may involve a special technique, benefits under this Certificate will be limited to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of your cost will be your responsibility.
5. **Overdenture.** If an overdenture is the treatment you choose, benefits will be provided to the limits of a standard denture. All other related services or procedures will not be covered.
6. **Temporary Full or Partial Dentures.** If you decide to have a temporary appliance instead of the conventional prosthesis, your copayment will be the same as that applicable to the conventional prosthesis (and you will have used the benefit available for the 4-year period).

7. **Prosthetic Appliances.** Crowns, bridges, partial and complete dentures placed over an implant are covered at the standard benefit level and copayment listed.

Crowns, Inlays/Onlays (Silver or tooth colored fillings, inlays, porcelain, metal, or porcelain to metal crowns)

1. Inlays, porcelain, metals, or porcelain to metal crowns. If a tooth can be restored with amalgam or composite resins, these materials will be used to restore the tooth. The judgment will be up to the dentist providing the service.
2. Restorations for abrasion, erosion and attrition will be covered only when a clinical recommendation has been made by your dentist.
3. Crowns, bridges, partial and complete dentures placed over an implant are covered at the standard benefit level and copayment listed.

Mouth Rehabilitation

If you and your dentist agree to select a course of mouth rehabilitation, your benefits under this Certificate will be limited to covering only those procedures necessary to eliminate oral disease and replace missing teeth. The balance of the cost of your treatment, including costs to increase vertical dimension or restore the occlusion, will be your responsibility.

Referrals to Specialists

Benefits, excluding emergency care, will be provided for services received from a specialist only when the referral has been made by your primary dentist and when proper authorization has been obtained prior to treatment or referral.

EXCLUSIONS

The following treatments, procedures or costs are not covered under this Certificate.

General Exclusions

1. Services not specifically mentioned in this Certificate.
2. Procedures which were begun but not completed prior to coverage under this Certificate.
3. Dental treatment for cosmetic purposes.
4. Dental service performed in a hospital, including any related hospital fee, unless you have received written authorization.
5. Procedures deemed experimental by prevailing dental standards.
6. Treatment of congenital malformation, including but not limited to cleft palate, anodontia, mandibular prognathism and enamel hypoplasia in the absence of dental carries.
7. Treatment which, in the professional judgment of the attending dentist, will not produce a satisfactory result.
8. Major restorative work caused by orthodontic treatment.
9. The placement of bone graft or synthetic substances in the treatment of periodontal disorders.
10. Dental implants, transplants or augmentation and any diagnostic or definitive treatment related to implants, transplants or augmentations.
11. Tissue conditioning procedures.
12. Second opinions.
13. Accidental injury, except as provided under palliative emergency treatment.
14. The cost of services received from physicians, dentists, oral surgeons or dental offices outside of your selected Dental Center, unless you have received written authorization from your Dental Center (or as indicated under the Emergency Treatment provisions of this Certificate).
15. Treatment for any condition to the extent to which benefits are recovered or found to be recoverable, whether by adjudication or settlement under any Workers Compensation, Occupational Disease or other law, even though you or your dependents fail to claim the right to such benefits.
16. Diagnostic procedures related to non-covered services.
17. Splinting procedures.
18. Treatment for any disease, condition, or injuries received as a result of war, declared or undeclared, or if caused by atomic explosion, whether or not the result of war.

19. Treatment obtained from, or which payment is made by, any federal, state, county, municipal, or other governmental agency, including any foreign government.
20. Temporomandibular joint (TMJ) disorders or dysfunctions and related services.
21. General anesthesia and IV sedation without documented medical necessity. Allergy to local anesthesia must be documented by a licensed physician following testing procedures. If you decide to have general anesthesia or IV sedation without obtaining medical documentation and this requires a referral to a dental office not affiliated with the Network, or a referral to a dental office affiliated with the Network but not responsible for providing the covered services specified in the Schedule of Dental Services, benefits will not be provided for these services.
22. Orthodontic Treatment.

COORDINATION OF BENEFITS

If you should receive payment under another group policy, certificate or agreement providing the same kind of dental benefits that this Certificate provides, Blue Cross and Blue Shield or your Dental Center shall have the right to recover such payments from you, to the extent such recovery is consistent with the priority of benefit applications indicated in this section.

When the total value of benefits or services you are entitled to under this Certificate and under any other group contract exceeds your actual expense (including the premiums), Blue Cross and Blue Shield or your Dental Center reserves the right to reduce the total benefits and services provided under this Certificate so that the benefits will not exceed the total expense for the covered services received.

If any other group contract contains provisions establishing similar rules as those stated below, then the benefits under this Certificate and the other group contract will be determined by applying the following rules:

1. The benefits of the group contract which covers the person with the claim as an Insured rather than as a dependent will be determined before the benefits of the group contract which covers that person as a dependent.
2. The benefits of the group contract which covers a dependent as the *Relative* (that is, a person who is entitled to benefits under this Certificate because of a connection or relationship to the Insured) of a person whose date of birth (but not year of birth) occurs earlier in a calendar year will be determined before the benefits under any other group contract which covers that dependent as a Relative of a person whose date of birth (but not year of birth) occurs later in the calendar year. If the dependent's Relatives have the same date of birth (but not year of birth), the benefits under the group contract covering the dependent as a Relative of the person whose group policy has been in effect for the longer period of time will be determined first – except that if the claim is for a dependent child, the following rules will apply:
    (i) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the group contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the group contract which covers the child as a dependent of the parent without custody.

    (ii) when the parents are divorced and the parent with custody of the child has remarried, the benefits of the group contract which covers the child as a dependent of the parent with custody will be determined before the benefits of the group contract which covers that child as a dependent of the stepparent and the benefits of the group contract which covers the child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Despite the provisions stated above, if there is a court decree which establishes financial responsibility for the dental care expenses of the child, the benefits of the group contract which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of the group contract which covers the child as a dependent child.

3. When the rules stated above do not establish an order of benefit determination, the benefits of the group contract which has been in effect for the longer period of time will decide, provided that:

   (i) the benefits of the group contract covering the person with the claim as a laid-off or retired employee or as the dependent of a laid-off or retired employee will be determined after the benefits of the group contract covering such person as an employee who is not laid off or retired; and

   (ii) if any group contract does not have a provision regarding laid-off or retired employees and the group contract determines its benefits after this contract, then the provisions of (i) above will not apply.

If the other group contract does not contain provisions establishing the same rules as set forth in this section, then the benefits under the other group contract will be determined before the benefits under this Certificate.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Law)

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the former spouse of or former party to a Civil Union with the Insured who has died or from whom you have been divorced or from whom your Civil Union has been dissolved. The provisions described in Article B will apply if you are the dependent child of the Insured who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided in Article A.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: **Continuation of Coverage if you are the former spouse of the Insured or spouse of a retired Insured**

If the coverage of the spouse of the Insured should terminate because of the death of the Insured, a divorce from the Insured, dissolution of a Civil Union from the Insured, or the retirement of an Insured, the former spouse or retired Insured's spouse if at least 55 years of age will be entitled to continue the coverage provided under this Certificate for himself/herself and his/her eligible dependents (if Family coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Insured or spouse of a retired Insured only if you provide the employer of the Insured with written notice of the dissolution of marriage, or Civil Union, the death or retirement of the Insured within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Insured will give written notice to Blue Cross and Blue Shield of the dissolution of your marriage to or Civil Union with the Insured, the death of the Insured or the retirement of the Insured as well as notice of your address. Such notice will include the Group Number and the Insured's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Insured, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:
    a. a form for election to continue coverage under this Certificate.
    b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

c. instructions for returning the election form by certified mail, return receipt requested, within 30 days after the date of mailing receipt of such instruction by Blue Cross and Blue Shield.

3. In the event you fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Insured under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Insured. Your right to continuation of coverage will then be forfeited.

4. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Insureds under this Certificate.

5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Insured, with Individual or Family Coverage, as the case may be, plus

   b. an amount, if any, that the employer would contribute toward the charge if you were the Insured under this Certificate.

   Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

   If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Insured; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Insured's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Insured, except in the event this entire Certificate is modified or terminated.

c. the date on which you remarry or enter another Civil Union.

d. the date on which you become an insured employee under any other group health plan.

e. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate, except due to the retirement of the Insured, under this Certificate if you were still married to or in a Civil Union with the Insured; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Insured's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Insured, except in the event this entire Certificate is modified or terminated.

   c. the date on which you remarry or enter another Civil Union.

   d. the date on which you become an insured employee under any other group health plan.

   e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

9. If you exercise the right to continuation of coverage under this Certificate you shall not be required to pay charges greater than those applicable to any other Insured covered under this Certificate, except as specifically stated in these provisions.

10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE B: **Continuation of Coverage if you are the dependent child of the Insured**

If the coverage of a dependent child should terminate because of the death of the Insured and the dependent child is not eligible to continue coverage under ARTICLE A or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Insured only if you, or a responsible adult acting on your behalf as the dependent

child, provide the employer of the Insured with written notice of the death of the Insured within 30 days of the date the coverage terminates.

2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Insured with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.
3. Within 15 days of receipt of such notice, the employer of the Insured will give written notice to Blue Cross and Blue Shield of the death of the Insured or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Insured's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Insured, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:
    a. a form for election to continue coverage under this Certificate.
    b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
    c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Insured under this Certificate as a result of the death of the Insured or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.
5. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Insureds under this Certificate.
6. The monthly charge will be computed as follows:
    a. an amount, if any, that would be charged to you if you were an Insured, plus
    b. an amount, if any, that the employer would contribute toward the charge if you were the Insured under this Certificate.

    Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
    a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
    b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Insured.
    c. the date on which you become an insured employee, after the date of election, under any other group health plan.
    d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Insured covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a ''direct pay'' basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

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

Continuation of Coverage

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or to a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Certificate.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS section of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Plan Administrator should you have any questions about COBRA.

Introduction

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

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

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

What Is COBRA Continuation Coverage

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

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

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

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

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

Disability Extension Of 18-Month Period Of Continuation Coverage

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

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

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

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

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

Plan Contact Information

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

GENERAL PROVISIONS

1. This Certificate, including any endorsement attached to it, is the entire agreement between you and Blue Cross and Blue Shield. Your dental benefits will be provided in accordance with the terms and conditions described in this Certificate. No statement you make in your application shall void this Certificate or be used in any legal proceedings unless your application, or an exact copy of it, is attached to this Certificate.
2. No agent of Blue Cross and Blue Shield has authority to change this Certificate or to waive any of its provisions. No change shall be valid unless it has been approved by an officer of Blue Cross and Blue Shield and such approval is endorsed and attached to this Certificate.
3. The Dental Center you select will be solely responsible for all dental advice and services performed or prescribed. Neither Blue Cross and Blue Shield, its agents, nor any employer shall be liable for injuries, damages or expenses resulting from negligence, malfeasance, nonfeasance or malpractice on the part of any officer or employee or agent of Blue Cross and Blue Shield. Neither shall Blue Cross and Blue Shield be responsible for such acts on the part of any person, organization or entity rendering services to you or your family members under this Certificate. You agree and acknowledge that Blue Cross and Blue Shield does not practice dentistry or medicine. Dentists are not employees or agents of Blue Cross and Blue Shield. The relationship between Blue Cross and Blue Shield and the dentists is that of purchaser and seller of dental services.
4. The dental services described in this Certificate are personal to you and your family and are not assignable.
5. All Copayments and additional fees or charges specified in this Certificate are due to the Dental Center. Neither Blue Cross and Blue Shield nor your Group will have any liability for the collection of such fees or charges.
6. All dental services rendered to you must be performed at the Dental Center you have selected. You may select a personal dentist from those on staff at the Dental Center you have chosen. You have the right to transfer to another Dental Center at any time. Changes submitted by the 20th of the month will become effective the 1st of the following month.
7. Payments will not be made to you for any dental services described in this Certificate unless such payment is for emergency treatment or reimbursement for payments you made to a dentist or specialist after receiving written authorization from Blue Cross and Blue Shield.



BlueCross BlueShield of Illinois

GB-17 HCSC
Plan ID: DHMO0630
www.bcbsil.com

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