Your Dental Care Benefit Program

Oak Lawn Community High School District #229

099287

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

A message from

Oak Lawn Community High School District #229

This booklet is your Certificate of Dental Care Benefits. It describes the dental care benefit program that we have arranged for you. This program is underwritten by Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois.

We are pleased to offer this program to you and your family. We believe it will help relieve you of many financial worries should you have dental care expenses.

Sincerely,

Oak Lawn Community High School District #229

A message from

BLUE CROSS AND BLUE SHIELD

Your Group has entered into an agreement with us (Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois) to provide you with this benefit program. Like most people, you probably have many questions about your coverage. This Certificate contains a great deal of information about the services and supplies for which benefits will be provided under your benefit program. Please read your entire Certificate very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Certificate we refer to our company as "Blue Cross and Blue Shield" and we refer to the company that you work for as the "Group." The DEFINITIONS SECTION will explain the meaning of many of the terms used in this Certificate. All terms used in this Certificate, when defined in the DEFINITIONS SECTION, begin with a capital letter. Whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

If you have any questions once you have read this Certificate, talk to your Group Administrator or call us at your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield! We are very happy to have you as a member and pledge you our best service.

Sincerely,



Stephen Harris

President, Blue Cross Blue Shield of Illinois

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for Blue Cross and Blue Shield to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those 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 booklet for a further explanation of these arrangements.

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

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, (except for Mental Illness or Substance Use Disorder services provided in a Hospital emergency department) benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section §562.3 of the Illinois Insurance Code. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional Providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Your benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire Certificate.

DENTAL BENEFITS	
Benefit Waiting Period	None
Deductible	$100 per benefit period
Family Deductible	$200 per benefit period
Diagnostic and Preventive Dental Services Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	100% of the U&C Fee*
Miscellaneous Dental Services Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	100% of the U&C Fee*
Restorative Dental Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the U&C Fee*
General Dental Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the U&C Fee*
Endodontic Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the U&C Fee*
Periodontic Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the U&C Fee*
Oral Surgery Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the U&C Fee*

Crowns, Inlays/Onlays Services Benefit Payment Level	
— Participating Provider	50% of the Maximum Allowance
— Non-Participating Provider	50% of the U&C Fee*
Prosthodontic Services Benefit Payment Level	
— Participating Provider	50% of the Maximum Allowance
— Non-Participating Provider	50% of the U&C Fee*
Implants Benefit Payment Level	
— Participating Provider	50% of the Maximum Allowance
— Non-Participating Provider	50% of the U&C Fee*
Benefit Period Maximum	$2,000
Orthodontic Dental Services Benefit Payment Level	
— Participating Provider	50% of the Maximum Allowance
— Non-Participating Provider	50% of the U&C Fee*
Orthodontic Dental Services Lifetime Maximum	$1,000

*Usual and Customary Fee

DEFINITIONS SECTION

Throughout this Certificate, many words are used which have a specific meaning when applied to your dental care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Certificate, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

BENEFIT WAITING PERIOD.....means the number of months that you must be continuously covered under this benefit program before you are eligible to receive benefits for certain dental Covered Services.

CERTIFICATE.....means this booklet, including your application for coverage under the Blue Cross and Blue Shield benefit program described in this booklet.

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 Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with Covered Services rendered to you.

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

CLAIM PAYMENT.....means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Certificate regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

COINSURANCE.....means a percentage of an eligible expense 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 Certificate begins.

COVERED SERVICE.....means a service or supply specified in this Certificate for which benefits will be provided.

DENTIST.....means a duly licensed dentist operating within the scope of such 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 Blue Cross and Blue Shield to administer a Participating Provider Option Dental program to provide Covered Services to you at the time you receive the Covered 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 Blue Cross and Blue Shield to administer a Participating Provider Option Dental program to provide Covered Services to participants in the Participating Provider Option program.

ELIGIBLE PERSON.....means an employee of the Group who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this Certificate.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under this Certificate.

GROUP POLICY or POLICY.....means the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Benefit Program Application of the Group and the individual applications of the persons covered under the Policy.

HOSPITAL.....means a duly licensed institution under state law for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses, irrespective of whether the institution provides Surgery on its premises or at another licensed hospital pursuant to a formal written agreement between the two institutions.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional Covered Services for the safe and effective administration of the medication.

INDIVIDUAL COVERAGE.....means coverage under this Certificate for yourself but not your spouse and/or dependents.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, Covered Services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

Approval by a governmental or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device biological product, supply and equipment for medical treatment or procedure but will not be determinative.

MAXIMUM ALLOWANCE.....means the amount determined by Blue Cross and Blue Shield, which Participating Dentists have agreed to accept as payment in full for a particular dental Covered Service. All benefit payments for Covered Services rendered by Participating Dentists will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by Blue Cross and Blue Shield.

MEDICALLY NECESSARY.....means that a specific procedure provided to you is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical service which can safely be provided to you.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

NON-PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

PARTICIPATING PROVIDER OPTION.....means a program of dental care benefits designed to provide you with economic incentives for using designated Providers of dental care services.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of such license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of such license.

PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you and operating within the scope of such license.

A “Plan Provider” means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered to you.

A “Non-Plan Provider” means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

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 Blue Cross and Blue Shield.

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

USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician Dentist who renders the particular Covered Services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians Dentists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if Blue Cross and Blue Shield reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by Blue Cross and Blue Shield but in no event shall the reasonable fee be less than the Usual and Customary Fee.

VALUE-BASED PROGRAM.....means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

ELIGIBILITY SECTION

This Certificate contains information about the dental care benefit program for the persons in your Group who:

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Have applied for this coverage; and
- Have received a Blue Cross and Blue Shield dental identification card.

If you meet this description of an Eligible Person, you are entitled to the benefits of this program.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your eligible spouse, party to a Civil Union and/or dependents (see below) by submitting the application(s) for medical insurance form, along with any exhibits, appendices, addenda and/or other required information ("application(s)") to Blue Cross and Blue Shield.

You can get the application form from your Group Administrator. An application to add a newborn to Family Coverage is not necessary if an additional premium is not required. However, you must notify your Group Administrator within 31 days of the birth of a newborn child for coverage to continue beyond the 31 day period or you will have to wait until your Group's open enrollment period to enroll the child.

The application(s) for coverage may or may not be accepted. Please note, some employers only offer coverage to their employees, not to their employees' spouses, party to a Civil Union or dependents. In those circumstances, the references in this Certificate to an employee's family members are not applicable.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status factor. You will not be discriminated against for coverage under this Certificate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Certificate 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.

You may enroll in or change coverage for yourself and/or your eligible spouse, party to a Civil Union and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse, party to a Civil Union and/or dependents' effective date will be determined by Blue Cross and Blue Shield, depending upon the date your application is received and other determining factors.

Blue Cross and Blue Shield may require acceptable proof (such as copies of legal adoption or legal guardianship papers or court orders) that an individual qualifies as an Eligible Person and/or family member under this Certificate.

Annual Open Enrollment Periods

Your Group will designate an annual open enrollment period during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union and/or dependents.

This "Annual Open Enrollment Period" provision is subject to change by Blue Cross and Blue Shield and/or applicable law or regulatory guidance, as appropriate.

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods

Special enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union and/or dependents. You must apply for or request a change in coverage within 31 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods provision.

You must provide acceptable proof of a qualifying event with your application Special enrollment qualifying events are discussed in detail below. Blue Cross and Blue Shield will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with your application will delay or prevent the processing of your application and enrollment in coverage. Please call the customer service number on the back of your identification card or visit the Blue Cross and Blue Shield website at *www.bcbsil.com* for examples of acceptable proof for the following qualifying events.

Special Enrollment Events:

1. You gain or lose a dependent or become a dependent through marriage, or becoming a party to a Civil Union. New coverage for you and/or your eligible spouse, party to a Civil Union and/or dependents will be effective on the date of the qualifying event, so long as you apply 31 days from the qualifying event date. If you apply any later than 31 days from the qualifying event date, coverage for your spouse, party to a Civil Union and/or dependents will be effective no later than the first day of the following month.
2. You gain or lose a dependent through birth, placement of a foster child, adoption or placement of adoption or court-ordered dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union and/or dependents will be effective on the date of the birth, placement of a foster child, adoption, or placement of adoption. However, the effective date for court-ordered eligible child coverage will be determined by Blue

Cross and Blue Shield in accordance with the provisions of the court-order.

3. You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of loss of coverage.
4. You become eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or state child health plan. You must request coverage within 60 days of such eligibility.

This "Special Enrollment Periods" provision is subject to change by Blue Cross and Blue Shield and/or applicable law or regulatory guidance, as appropriate.

Other Special Enrollment Events/Effective Dates of Coverage

You must apply for or request a change in coverage within 31 days from the date of the below other special enrollment events in order to qualify for the changes described in this "Other Special Enrollment Events" provision.

1. Loss of eligibility as a result of:
   - Legal separation, divorce or dissolution of a Civil Union;
   - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Certificate);
   - Death of an Eligible Person;
   - Termination of employment, reduction in the number of hours of employment.
2. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union and/or dependents no longer reside, live or work in the Network Service Area.
3. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union and/or dependents no longer reside, live or work in the Network Service Area, and no other coverage is available to you and/or your eligible spouse, party to a Civil Union and/or dependents.
4. You incur a claim that would meet or exceed a lifetime limit on all benefits.
5. Loss of coverage due to a policy no longer offering benefits to the class of similarly situated individuals that include you.
6. Your employer ceases to contribute towards your and/or your eligible spouse, party to a Civil Union and/or dependents' coverage (excluding COBRA continuation coverage); or
7. COBRA continuation coverage is exhausted.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application(s) including proof of such event and remittance of the appropriate premiums in

accordance with the guidelines as established by Blue Cross and Blue Shield. Your spouse, party to a Civil Union and other dependents are not eligible for a special enrollment period if your Group does not cover dependents.

This "SPECIAL ENROLLMENT PERIODS" provision is subject to change by Blue Cross and Blue Shield and/or applicable law or regulatory guidance, as appropriate.

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Eligible Person's responsibility to notify Blue Cross and Blue Shield of any change to an Eligible Person's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible family members.

YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD

You will receive a dental identification card from Blue Cross and Blue Shield. This may be in addition to your Blue Cross and Blue Shield identification card, if applicable. Your identification card contains your identification number. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact customer service or go to *www.bcbsil.com* and get a temporary card online. Always carry your identification card with you.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own dental care expenses for Covered Services are covered, not the dental care expenses of other members of your family.

FAMILY COVERAGE

If you have Family Coverage, your dental care expenses for Covered Services and those of your enrolled spouse, party to a Civil Union and your (and/or your spouse's, party to a Civil Union's) enrolled children who are under age 26 will be covered. 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.

"Child(ren)" used hereafter in this Certificate, means a natural child(ren), a stepchild(ren), an adopted child(ren), a foster child(ren), a child(ren) for whom you are the legal guardian or a child(ren) for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, 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 grandchild(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.

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

- Live within the Network; 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.

Coverage for children will end on the last day of the calendar month in which the limiting age birthday falls.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are under your legal guardianship or who are in your custody under an interim court order prior to the finalization of adoption or placement of adoption vesting temporary care, whichever comes first, and foster children will be covered. In addition, if you have children for whom you are required by court order to provide dental coverage, those children will be covered.

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 if they were covered prior to reaching the limiting age stated above.

This coverage does not include benefits for foster children grandchildren (unless such children have been legally adopted or are under your legal guardianship).

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Becoming party to a Civil Union.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

a. Legal separation, divorce, dissolution from a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;

b. In the case of HMO coverage, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;

c. Reaching a lifetime limit on all benefits in another group health plan;

d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;

e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Becoming party to a Civil Union.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

However, an application to add a newborn to Family Coverage is not necessary if an additional premium is not required. Please notify your Group Administrator so that your membership records can be adjusted.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective no later than the first of the month after the special enrollment request is received if you apply within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

LATE APPLICANTS

If you do not apply for Family Coverage within the required number of days of the event, you can apply at any time or you can wait until your Group's annual open enrollment to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Group and Blue Cross and Blue Shield.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

Should you wish to change from Family to Individual Coverage, contact your Group Administrator.

TERMINATION OF COVERAGE

If Blue Cross and Blue Shield terminates your coverage under this Certificate for any reason, Blue Cross and Blue Shield will provide you with a notice of termination of coverage that includes the termination effective date and the reason for termination at least 30 days prior to the last day of coverage, except as otherwise provided in this Certificate.

You and your eligible spouse, party to a Civil Union and/or dependents' coverage will be terminated due to the following events and will end on the dates specified below:

1. The termination date specified by you, if you provide reasonable notice.
2. When Blue Cross and Blue Shield does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for you and/or your eligible spouse, party

to a Civil Union, and/or dependents' coverage and the grace period, if any has been exhausted.

3. You no longer live, reside or work in Blue Cross and Blue Shield's service area and/or live, reside or work in the Network Service Area.
4. Your coverage has been rescinded.
5. If you no longer meet the previously stated description of an Eligible Person.
6. If the entire coverage of your Group terminates.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of the Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this Certificate or as specified when your entire Group's coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of divorce).

Upon the death of an Eligible Person, dependents under his/her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

Other options available for continuation of coverage are explained in the Continuation of Coverage After Termination Sections of this Certificate.

Termination of a Dependent's Coverage

If one of your dependents no longer meets the description of an eligible family member as provided above under the heading "Family Coverage," his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of divorce). Coverage for children will end on the last day of the calendar month in which they reach the limiting age as shown in this Certificate.

DENTAL BENEFIT SECTION

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

As a participant in the Participating Provider Option program a directory of Participating Dentists is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at *www.bcbsil.com* for a list of Participating Dentists. While there may be changes in the directory from time to time, selection of Participating Dentists by Blue Cross and Blue Shield 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 your Group Administrator annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by Blue Cross and Blue Shield until after receipt of an Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Diagnostic and Preventive Dental Services

Your benefits for Diagnostic and Preventive Dental Services are designed to help you keep dental disease from starting or to detect it in its early stages. Your Diagnostic and Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series (including, but not limited to, one set of bitewing X-rays) every twelve months.

- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to persons under age 19 and are limited to two applications each benefit period.

Miscellaneous Dental Services

- Sealants—Benefits for sealants are only available to persons under age 19.
- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 when not part of orthodontic treatment.
- Labs and Tests—Pulp vitality tests.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Restorative Dental Services

- Amalgams (Fillings)
- Pin Retention
- Composites
- Simple Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section.

General Dental Services

- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.
- Stainless Steel Crowns

Endodontic Services

- Root canal therapy
- Pulp cap
- Apicoectomy
- Apexification
- Retrograde filling
- Root amputation/hemisection
- Therapeutic pulpotomy
- Pulpal debridement

Periodontic Services

- Periodontal scaling and root planing
- Full mouth debridement
- Gingivectomy/gingivoplasty—Your benefits are limited to one full mouth treatment per benefit period.
- Gingival flap procedure
- Osseous Surgery—Your benefits are limited to one full mouth treatment per benefit period.
- Osseous grafts
- Soft tissue grafts
- Periodontal maintenance procedures—Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.

Oral Surgery Services

- Surgical tooth extraction
- Alveoloplasty
- Vestibuloplasty
- Other necessary dental surgical procedures

Crowns, Inlays/Onlays Services

- Prefabricated post and cores
- Cast post and cores
- Crowns, inlays/onlays repairs
- Recementation of crowns, inlays/onlays

Prosthodontic Services

- Bridges
- Dentures
- Adjustments to Bridges and Dentures—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Bridge and Denture repairs
- Addition of tooth or clasp
- Reline/Rebase

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable.

Implants

Orthodontic Dental Services

Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. These benefits are subject to the lifetime maximum and limited as follows:

- Benefits are only available for dependent children under the age of 26.
- Benefits for orthodontic treatment will be available over the Course of Treatment.
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

Deductible

Each benefit period, you must satisfy a $100 deductible. This deductible applies to:

- Restorative Dental Services
- General Dental Services
- Endodontic Services
- Periodontic Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services
- Implants
- Orthodontic Dental Services

In other words, after you incur eligible charges of more than the deductible amount for the Covered Services listed above in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

If you have any expenses during the last three months of a benefit period which were or could have been applied to that benefit period's deductible, these expenses will also count as credit toward the deductible of the next benefit period.

Family Deductible

If you have Family Coverage and your family has reached the dental deductible amount of $200, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.

Benefit Payment for Dental Services

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Dentist.

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service–that is, your Coinsurance amounts and deductible.

Non-Participating Dentists are Dentists who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Blue Cross and Blue Shield benefit payment and such Dentist's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Group Administrator, your Dentist or Blue Cross and Blue Shield.

Participating Dentists

Diagnostic and Preventive Dental Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Implants – Benefits for Implants described in this Dental Benefits Section received from a Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Orthodontic Dental Services – Benefits for Orthodontic Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Non-Participating Dentists

Diagnostic and Preventive Dental Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 100% of the Usual and Customary Fee.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 100% of the Usual and Customary Fee.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Usual and Customary Fee after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Usual and Customary Fee after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Usual and Customary Fee after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Usual and Customary Fee after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Usual and Customary Fee after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Usual and Customary Fee after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Usual and Customary Fee after you have met your deductible.

Implants – Benefits for Implants described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Usual and Customary Fee after you have met your deductible.

Orthodontic Dental Services – Benefits for Orthodontic Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Usual and Customary Fee after you have met your deductible.

Emergency Care

Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at 100% of the Maximum Allowance when rendered by a Participating Dentist or at 100% of the Usual and Customary Fee when rendered by a Non-Participating Dentist.

Benefit Maximum

The maximum amount available for you in dental benefits each benefit period is $2,000. This is an individual maximum. There is no family maximum.

This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a lifetime maximum of $1,000.

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations 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, as reasonably determined by Blue Cross and Blue Shield.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. Blue Cross and Blue Shield will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders, unless specifically mentioned in this benefit section.
3. Oral Surgery for the following procedures:
   - — surgical services related to a congenital malformation;
   - — surgical removal of complete bony impacted teeth;
   - — excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   - — excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands

or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Certificate should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment and orthodontic treatment, described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Certificate. However, if orthodontic treatment is in progress at the time this Certificate terminates, benefits will continue through the end of the month in which your coverage terminates.

EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Dental Procedures Which Are Not Medically Necessary.**

PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THIS CERTIFICATE 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 as defined by this Certificate.

— Services or supplies that are not specifically mentioned in this Certificate.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received except in the case of Medicare, 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.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with a qualified clinical cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.

— Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent has health 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 Certificate, 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 the above definition unless your stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program.

When a Benefit Program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

BENEFIT PROGRAM.....means any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

(ii) 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 (i) or (ii) 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 program.

CLAIM DETERMINATION PERIOD.....means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Benefit Program, or any part of a year 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 which 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 which applies:

1. Non-Dependent or Dependent

   The benefits of the Benefit Program which covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the Benefit Program which 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, called "parents:"

   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 program which covered the parents longer are determined before those of the program which 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 the 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 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 paragraph 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 Blue Cross and Blue Shield 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/her own coverage as a dependent under a spouse's plan, rule 8, "Length of Coverage" applies. In the event the dependent's child coverage under the spouse's plan began on the same date as the dependent's child 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's child parent or parents and the dependent's spouse.

6. Active or Inactive Employee

The benefits of a Benefit Program which 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 which covered 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 is ignored.

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.

   If the other Benefit Program does not contain the order of benefits determination described within this rule, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

8. Length of Coverage

   If none of the above rules determines the order of benefits, the benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which 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 the sum of:

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

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

When the benefits of this Benefit Program are reduced as described above, 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. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give Blue Cross and Blue Shield any facts it needs to pay the Claim.

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, Blue Cross and Blue Shield may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Benefit Program. Blue Cross and Blue Shield 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 Blue Cross and Blue Shield is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons 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.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws)

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 an Eligible Person or the former party to a Civil Union with a retired Eligible Person 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 an Eligible Person who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under 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 an Eligible Person or spouse of a retired Eligible Person**

If the coverage of the spouse of an Eligible Person should terminate because of the death of the Eligible Person, a divorce from the Eligible Person, or the retirement of an Eligible Person, the former spouse or retired Eligible Person'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 Eligible Person or spouse of a retired Eligible Person only if you provide the employer of the Eligible Person with written notice of the dissolution of marriage or Civil Union, the death or retirement of the Eligible Person within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the dissolution of your marriage or Civil Union to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group Number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents 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.

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 Eligible Person under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Eligible Person. 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 Eligible Persons 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 Eligible Person, 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 Eligible Person 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 Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the

Eligible Person's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.

c. the date on which you remarry.

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

   c. the date on which you remarry or enter into 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 Eligible Person 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 an Eligible Person**

If the coverage of a dependent child should terminate because of the death of the Eligible Person 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 Eligible Person only if you, or a responsible adult acting on your behalf as the dependent child, provide the employer of the Eligible Person with written notice of the death of the Eligible Person 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 Eligible Person 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 Eligible Person will give written notice to Blue Cross and Blue Shield of the death of the Eligible Person 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 Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, 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 Eligible Person under this Certificate as a result of the death of the Eligible Person 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 Eligible Persons 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 Eligible Person, plus
    b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person 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 Eligible Person.
   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 Eligible Person 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 as specified in 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 section 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 an Eligible Person 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 the party to a Civil Union or the dependent child of a party to a Civil Union and you lose coverage under this Certificate, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or to a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION RIGHTS UNDER COBRA section, 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 section 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 RIGHTS UNDER COBRA. See your employer or Group 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/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/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 Web site at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

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.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain your dental benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield.

To file a Claim, obtain an Attending Dentist's Statement from your Group Administrator before going to your Dentist. The Attending Dentist's Statement is also used for pre-estimation of benefits. It is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

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

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

Claims must be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.) Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.

DENTAL CLAIM PROCEDURES

Blue Cross and Blue Shield 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 Blue Cross and Blue Shield does not process a Claim within this 30–day period, you 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. Blue Cross and Blue Shield will usually notify you or the valid assignee when all information required to process 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 Certificate.)

If the Claim is denied in whole or in part, you will receive a notice from Blue Cross and Blue Shield 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 appeal, and (4) an explanation of how you may have the Claim reviewed by Blue Cross and Blue Shield if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. Blue Cross and Blue Shield will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to Blue Cross and Blue Shield. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

While Blue Cross and Blue Shield will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. Blue Cross and Blue Shield will give you a written decision within 60 days after it receives your request for review.

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

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

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

GENERAL PROVISIONS

1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan 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 Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider, or
- pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Dentists, the calculation of any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the lesser of the Maximum Allowance or Provider's Claim Charge for Covered Services rendered to you. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to the Plan.

a. Suppose you received Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the Provider to let him/her know that you are covered by the Plan.

b. The Provider has negotiated with the Host Blue a price of $80, even though the Provider's standard charge for this service is $100. In this example, the Provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Plan and indicates that the negotiated price for the Covered Service is $80. The Plan would then base the amount you must pay for the service — the amount applied to your deductible, if any, and your Coinsurance percentage — on the $80 negotiated price, not the $100 Billed Charge.

d. So, for example, if your Coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

Non-Participating Health Care Providers Outside the Plan's Service Area

Liability Calculation

a. In General

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for Non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

b. Exceptions

In some exception cases, the Plan may, but is not required to, negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the Certificate for non–participating Providers located inside our service area (and described in Section (a) above); or
2. The following:
   (i) For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or
   (ii) For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment Blue Cross and Blue Shield of Illinois will make for the Covered Services as set forth in this paragraph.

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing and/or Care Coordinator Fees that are a

part of such an arrangement, except when Host Blue passes these fees to the Plan through average or fee schedule adjustments.

If the Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the employer on your behalf, the Plan will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted for the BlueCard Program.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Plan will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you.

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1-800-810-Blue (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

If the Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the employer on your behalf, the Plan will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted for the BlueCard Program.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin Claims processing. However if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain Preauthorization for non-emergency Inpatient services.**

- **Outpatient Services**

  Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Plan, the service center or online at *www.bcbsglobalcore.com*. If you need assistance with your Claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

For the home delivery pharmacy and specialty pharmacy program partially owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery pharmacy and/or specialty pharmacy program. Blue Cross and Blue Shield pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

"Weighted Paid Claim" refers to the methodology of counting Claims for purposes of determining Blue Cross and Blue Shield's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim is weighed in 34 day supply increments so a 1-34 days' supply is considered one weighted claim, a 35-68 days' supply is considered two weighted claims and the pattern continues up to 6 weighted claims for 171 or more days' supply. Blue Cross and Blue Shield pays Prime a Program Management Fee ("PMF") on a per weighted claim days' supply.

The amounts received by Prime from Blue Cross and Blue Shield, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Blue Cross and Blue Shield (as described above), administrative fees charge by Prime to pharmacies and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be five and a half percent, (5.5%) of the total sales for all rebatable products of such manufacturer dispensed during any

given calendar year to members of Blue Cross and Blue Shield and other Blue Plan operating divisions.

3. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Certificate, Blue Cross and Blue Shield has the right to make any benefit payment either to you or directly to the Provider of the Covered Services, unless reasonable evidence of a properly executed and enforceable assignment of benefit payment has been received by Blue Cross and Blue Shield. For example, Blue Cross and Blue Shield may pay benefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

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

c. Except for the assignment of benefit payment described above, neither this Certificate nor a covered person's claim for benefits under this Certificate is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a covered person. Coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

4. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.

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

c. The use of an adjective such as Plan or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. 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 Provider.

d. Each Provider provides covered services only to you and does not deal with or provide any services to your Group (other than as an individual covered person) or your Group's ERISA Health Benefit Program.

5. AGENCY RELATIONSHIPS

The Group is your agent under this Certificate. The Group is not the agent of Blue Cross and Blue Shield.

All information you and your Group provides to Blue Cross and Blue Shield will be relied upon as accurate and complete. Your Group must promptly notify Blue Cross and Blue Shield of any changes to such information.

6. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Certificate must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records. Blue Cross and Blue Shield may also provide such notices electronically to extent permitted by law.

7. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate. 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 Blue Cross and Blue Shield in accordance with the requirements of this Certificate.

8. INFORMATION AND RECORDS

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and 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 Certificate, (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 Blue Cross and Blue Shield or its agent, and agree that any such Provider, person or other entity may

furnish to Blue Cross and Blue Shield 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, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield and/or your employer or Group Administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

9. PHYSICAL EXAMINATION AND AUTOPSY

Blue Cross and Blue Shield, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

10. VALUE BASED DESIGN PROGRAMS

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

Blue Cross and Blue Shield makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/ identity repair and insurance to help protect your information. These identity theft protection services are currently provided by Blue Cross and Blue Shield's designated outside vendor and acceptance or declination of these services is optional to you. If you wish to accept such identity theft protection services you will need to individually enroll in the program online at *www.bcbsil.com* or telephonically by calling the toll-free telephone number on your identification card. Services may automatically end if you are no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice and Blue Cross and Blue Shield does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this Certificate.

Contact your employer for additional information regarding any value based programs offered by your employer.

11. CONFORMITY WITH STATE STATUTES

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

12. MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise from involuntary termination of your health coverage sponsored by your Group but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to, you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under this Certificate your Group has with Blue Cross and Blue Shield to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

13. ENTIRE CONTRACT

The entire contract consists of Group Policy, including the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Policy, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Group Policy, to extend the time for payment of premiums, or to waive any of the rights or requirements of Blue Cross and Blue Shield. No modifications of the Group Policy will be valid unless evidenced by an endorsement or amendment of the Group Policy, signed by an officer of Blue Cross and Blue Shield and delivered to the Group.

14. OVERPAYMENT

If your Group's benefit plan or Blue Cross and Blue Shield pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or was made in error ("overpayment"), your Group's plan and Blue Cross and Blue Shield has the right to obtain a refund of the overpayment amount from: (a) the person to or for whom, such benefits were paid, or (b) any insurance company or plan, or:

a. any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

b. If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any overpayment due up to an amount equal to the overpayment, from:

   (i) Any future benefit payment owed to any person or entity under this Certificate, whether for the same or a different member; or

   (ii) Any future benefit payment owed to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program; or

   (iii) Any future benefit payment owed to any person or entity under another Blue Cross and Blue Shield insured Group benefit plan or individual policy; or

   (iv) Any future benefit payment, or other payment, owed to any person or entity; or

   (v) Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, Blue Cross and Blue Shield has the right to reduce your Group's benefit plan or policy's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield plan's or policy's overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

RIDER TO THE CERTIFICATE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

The Certificate to which this Rider is attached and becomes a part, is hereby amended as follows:

If you are a public employee and are eligible for continued group accident and health insurance under Sections 367g, 367h and 367j of the Illinois Insurance Code, you may establish and maintain such continued group health insurance coverage under this Certificate, if you meet the following conditions:

1. You and your eligible dependents, must have been insured under this Certificate on the day immediately preceding the effective date of eligibility for continued group health insurance.
2. Once properly established, continued group health insurance under this Certificate may be maintained by you or your surviving spouse or surviving party to a Civil Union, until the loss of eligibility as specified in Sections 367g, 367h and 367j of the Insurance Code. It shall be your responsibility to inform Blue Cross and Blue Shield of the loss of eligibility.
3. The election by you or your surviving spouse or surviving party to a Civil Union, to obtain a conversion policy as described in the conversion provisions of this Certificate shall terminate any right to continue group coverage according to Sections 367g, 367h and 367j of the Insurance Code. No reinstatement of continued group coverage shall be permitted after such conversion has been effected or if the continued group coverage provided by this Rider has been terminated for any reason.
4. If a timely and valid election of continued group coverage has been made, you must remit the total monthly premium payment required to establish and maintain such coverage, whether such total monthly premium is contributed by you, deducted from a pension payment or paid directly to your Group by you.

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

Blue Cross and Blue Shield of Illinois,
a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company



BCBSIL President



BlueCross BlueShield of Illinois

*Experience. Wellness. Everywhere.*SM

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www.bcbsil.com

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