BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

BLUECARE DENTAL℠ 1A

OUTLINE OF COVERAGE

Read your Contract carefully — This outline of coverage provides only a very brief description of the important features of your Contract. This is not the Contract, and only the actual Contract provisions will control. The Contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Illinois (the Plan). It is, therefore, important that you **READ YOUR CONTRACT CAREFULLY!**

This BlueCare Dental coverage is designed to provide you with economic incentives for using designated dental care providers. **Although you can go to the Dentist of your choice, your benefits under the Contract will be greater when you use the services of designated Dentists.**

The Coinsurance amounts and Benefit Period Maximum amounts listed below represent the Dental Plan's responsibility,

The Deductibles and Out-of-Pocket Maximums listed below represent your responsibility.

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

For Subscribers Age 21 and Over

COVERED SERVICES	Participating Provider	Non-Participating Provider*
Diagnostic Evaluations (Deductible waived) **Preventive Services** (Deductible waived) **Diagnostic Radiographs** (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Miscellaneous Preventive Services **Basic Restorative Services** **Non-Surgical Extractions** **Non-Surgical Periodontal Services** **Adjunctive General Services** **Endodontic Services** **Oral Surgery Services** **Surgical Periodontal Services****	80% of Maximum Allowance	50% of Maximum Allowance
Major Restorative Services** **Prosthodontic Services**** **Miscellaneous Restorative and Prosthodontic Services****	50% of Maximum Allowance	30% of Maximum Allowance
Orthodontic Services	Not Covered	

COVERED SERVICES	Participating Dentist	Non-Participating Dentist
Deductible (In/Out-of-Network accumulate together) Individual	$50	$50
Family	$150	$150
Benefit Period Maximum (In/Out-of-Network accumulate together)	$1,500	
Out-of-Pocket Maximum per Benefit Period	None	

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

** 12-month waiting period may apply.

For Subscribers Under Age 21

COVERED SERVICES	Participating Provider	Non-Participating Provider*
Diagnostic Evaluations (Deductible waived) **Preventive Services** (Deductible waived) **Diagnostic Radiographs** (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Miscellaneous Preventive Services **Basic Restorative Services** **Non-Surgical Extractions** **Non-Surgical Periodontal Services** **Adjunctive General Services** **Endodontic Services** **Oral Surgery Services** **Surgical Periodontal Services****	80% of Maximum Allowance	50% of Maximum Allowance
Major Restorative Services** **Prosthodontic Services**** **Miscellaneous Restorative and Prosthodontic Services****	50% of Maximum Allowance	30% of Maximum Allowance
Orthodontic Services		
Pediatric Orthodontic Services: **Coverage limited to an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)**	50% of Maximum Allowance	30% of Maximum Allowance
Optional Orthodontic Services: Coverage for orthodontic conditions not meeting Medical Necessity criteria established by the Plan	Not Covered	

COVERED SERVICES	Participating Dentist	Out-of-Network Dentist
Deductible (In/Out-of-Network accumulate together)		
Individual	$50	$50
Family	$150	$150
Benefit Period Maximum - Excluding any Orthodontic Services (In/Out-of-Network accumulate together)	Unlimited	
Out-of-Pocket Maximum per Benefit Period		
1 Child	$350	No Limit
2+ Children	$700	No Limit

* All benefits are based upon the Allowable Amount, which is the amount determined by BCBSIL as the maximum amounts eligible for payment of benefits. A Participating Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a Non-Participating Dentist will be based upon the same Allowable

Amount, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses, if applicable.

ELIGIBILITY

An individual may apply for coverage under the Contract if he or she is an Illinois Resident and is not currently enrolled under any other dental coverage underwritten by Blue Cross and Blue Shield of Illinois or any subsidiary or affiliate of Health Care Service Corporation. Coverage is available for the Member and his/her covered spouse or Domestic Partner (if any) under age 65 on his/her Effective Date. Coverage for a Dependent child (if applicable) may continue until their 21st birthday.

YOUR PARTICIPATING PROVIDER NETWORK

Your BlueCare Dental plan contains special provisions (Benefit reductions) which apply whenever you use Dentists who are not members of the Participating Provider Network. If you use an Non-Participating Provider, you will be responsible for the following:

- Charges for any services which are not covered under your Contract.
- Any Deductible or Coinsurance amounts which are applicable to your coverage (*including the higher Deductible and/or Coinsurance amounts which apply to Non-Participating Provider services*).
- The difference, if any, between your Dentist's "billed charges" and the Plan's Maximum Allowance Charge for the Covered Services.

The Benefits provided by the Plan and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating Provider or Out-of-Network Dentist.

Participating Dentists will 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 are responsible for the difference between the Plan's Benefit and the Dentist's charge to you, in addition to any Coinsurance and/or Deductible amounts applicable to your services.

Non-Participating Providers are Dentists who have not signed an agreement to accept the Maximum Allowance as the Benefit in full. Therefore, you are responsible for the difference between the Plan's Out-of-Network Benefit and the Dentist's billed charge to you, in addition to any Deductible and/or Coinsurance amounts applicable to your services.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Dentist or the Plan.

RENEWAL

The Contract is renewable at the option of the Plan by acceptance of premiums. The membership premiums shall be the amount determined by the Plan and filed with the Illinois Department of Insurance. The Plan has the right to change the premiums or Benefits provided by the Contract. You will be given reasonable notice of such changes. You should attach these notices to your Contract, as they will amend a part of the Contract.

NOTICE

The Contract may not fully cover all of your dental costs.

EXCLUSIONS

No Benefits will be provided under the Contract for:

Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.

Amounts which are in excess of the Maximum Allowance.

Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.

Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders or to increase vertical dimension.

Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.

Services and supplies for any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.

Services or supplies that do not meet accepted standards of dental practice.

Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this Policy 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 Policy 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 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.

Hospital and ancillary charges.

Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.

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

Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.

Services rendered by a Dentist related to you by blood or marriage.

Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.

Services or supplies received for behavior management or consultation purposes.

Any services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental agencies provide benefits (some state or federal laws may affect how we apply this exclusion).

Charges for nutritional, tobacco or oral hygiene counseling.

Charges for local, state or territorial taxes on dental services or procedures.

Charges for the administration of infection control procedures as required by local, state or federal mandates.

Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.

Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.

Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.

Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.

Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.

Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Effective Date under the Contract; except this exclusion will not apply if such partial or full den-

ture or fixed bridge also includes replacement of a missing tooth which was extracted after your Effective Date.

Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.

Case presentations or detailed and extensive treatment planning when billed for separately.

BLUECARE DENTAL[SM]1A
SCHEDULE OF BENEFITS
For Subscribers Age 21 and Over

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

The Coinsurance amounts and Benefit Period Maximum amounts listed below represent the Dental Plan's responsibility,

The Deductibles and Out–of–Pocket Maximums listed below represent your responsibility.

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

Covered Services	Participating Provider	Non-Participating Provider*
Diagnostic Evaluations (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Preventive Services (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Diagnostic Radiographs (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Miscellaneous Preventive Services	80% of Maximum Allowance	50% of Maximum Allowance
Basic Restorative Services	80% of Maximum Allowance	50% of Maximum Allowance
Non-Surgical Extractions	80% of Maximum Allowance	50% of Maximum Allowance
Non-Surgical Periodontal Services	80% of Maximum Allowance	50% of Maximum Allowance
Adjunctive Services	80% of Maximum Allowance	50% of Maximum Allowance
Endodontic Services	80% of Maximum Allowance	50% of Maximum Allowance

Oral Surgery Services	80% of Maximum Allowance	50% of Maximum Allowance
Surgical Periodontal Services**	80% of Maximum Allowance	50% of Maximum Allowance
Major Restorative Services**	50% of Maximum Allowance	30% of Maximum Allowance
Prosthodontic Services**	50% of Maximum Allowance	30% of Maximum Allowance
Miscellaneous Restorative and Prosthodontic Services**	50% of Maximum Allowance	30% of Maximum Allowance
Orthodontic Services	Not Covered	
Deductible (per Benefit Period) (PPO/Non-PPO accumulate together)		
Individual	$50	$50
Family	$150	$150
Benefit Period Maximum (PPO/Non-PPO accumulate together)	$1,500	
Out of Pocket Maximum	None	
*All benefits are based upon the Allowable Amount, which is the amount determined by BCBSIL as the maximum amounts eligible for payment of benefits. A Participating Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a Non-Participating Dentist will be based upon the same Allowable Amount, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses, if applicable.		

**12 month waiting period may apply.

BLUECARE DENTAL[SM]1A
SCHEDULE OF BENEFITS
For Subscribers Under Age 21

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

The Coinsurance amounts and Benefit Period Maximum amounts listed below represent the Dental Plan's responsibility,

The Deductibles and Out–of–Pocket Maximums listed below represent your responsibility.

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

Covered Services	Participating Provider	Non-Participating Provider*
Diagnostic Evaluations (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Preventive Services (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Diagnostic Radiographs (Deductible waived)	100% of Maximum Allowance	70% of Maximum Allowance
Miscellaneous Preventive Services	80% of Maximum Allowance	50% of Maximum Allowance
Basic Restorative Services	80% of Maximum Allowance	50% of Maximum Allowance
Non-Surgical Extractions	80% of Maximum Allowance	50% of Maximum Allowance
Non-Surgical Periodontal Services	80% of Maximum Allowance	50% of Maximum Allowance
Adjunctive Services	80% of Maximum Allowance	50% of Maximum Allowance
Endodontic Services	80% of Maximum Allowance	50% of Maximum Allowance

Oral Surgery Services	80% of Maximum Allowance	50% of Maximum Allowance
Surgical Periodontal Services	80% of Maximum Allowance	50% of Maximum Allowance
Major Restorative Services	50% of Maximum Allowance	30% of Maximum Allowance
Prosthodontic Services	50% of Maximum Allowance	30% of Maximum Allowance
Miscellaneous Restorative and Prosthodontic Services	50% of Maximum Allowance	30% of Maximum Allowance
Orthodontic Services		
Pediatric Orthodontic Services[1]	50% of Maximum Allowance	30% of Maximum Allowance
Optional Orthodontic Services	Not Covered	
Deductible (per Benefit Period) (PPO/Non-PPO accumulate together)		
Individual	$50	$50
Family Deductible	$150	$150
Benefit Period Maximum (Excluding any Orthodontic Services) (PPO/Non-PPO accumulate together)	Unlimited	
Out of Pocket Maximum per Benefit Period		
1 child	$350	No Limit

2+ children	$700	No Limit
*All benefits are based upon the Allowable Amount, which is the amount determined by BCBSIL as the maximum amount eligible for payment of benefits. A Participating Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a Non-Participating Dentist will be based upon the same Allowable3 Amount, and it is likely that the Non-Participating Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses, if applicable.		

1Orthodontic Coverage limited to children meeting or exceeding a score of 42 from the modified Salzmann Index or meeting criteria for medical necessity.