



Outline of Coverage

- I. Read this outline of coverage carefully. An outline of coverage provides a very brief description of some important features of the BlueCare Dental PPO Rider. This outline of coverage is not the insurance rider and only the actual rider provisions will control. The rider itself sets forth, in detail, the rights and obligations of you, your provider and BCBSIL. It is, therefore, important that You **READ YOUR RIDER CAREFULLY!**
- II. The rider is designed to provide you with coverage for diagnostic and preventive care, as well as almost every form of specialty dental treatment. If you are applying for this coverage in conjunction with individual health coverage and your application for health coverage has been denied, your application for coverage under the BlueCare Dental PPO Rider will also be denied.
- III. **BENEFITS** – After applying for coverage and being approved for the coverage, you will receive a document called the BlueCare Dental PPO Rider. It will explain benefits summarized in this outline of coverage.

The member's share of the cost is determined by whether care is received from an in-network or out-of-network dentist. The BlueCare Dental PPO Rider accesses providers in the preferred provider network.

Although you can go to any dentist of your choice, your benefits under BlueCare Dental PPO Rider will be greater when you use the services of an in-network dentist.

Deductible Per Calendar Year	Maximum Benefit Per Calendar Year	
Applicable to Coverage Level-3 Services only. • \$50 per member • \$150 per family	The maximum dental benefits for all coverages, except orthodontic procedures. • \$1,500 per member	
Basic Benefit Provisions	BlueCare DENTAL PPO	
The following is a listing of common services available through Your BlueCare Dental PPO Rider.	In-Network Dentist	Out-of-Network Dentist*
Coverage Level-1 Services include: Diagnostic Evaluations Preventive Services Diagnostic Radiographs Miscellaneous Preventive Services	100% of Maximum Allowance	50% of Maximum Allowance
Coverage Level-2 Services include: Basic Restorative Services Non-Surgical Extractions Adjunctive Services	80% of Maximum Allowance	50% of Maximum Allowance
Coverage Level-3 Services include: Endodontic Services Surgical Periodontal Services Non-surgical Periodontal Services Oral Surgery Services Major Restorative Services** Prosthodontic Services** Miscellaneous Restorative and Prosthodontic Services**	50% of Maximum Allowance after Deductible	50% of Maximum Allowance after Deductible
Dental Services Discounts	In-Network Dentist	Out-of-Network Dentist
Orthodontia As a covered member of a BlueCare Dental PPO plan, you can also take advantage of a discount up to 20% on orthodontic services, up to a maximum savings of \$1,000, when you receive services from an in-network dentist.	Up to a maximum savings of \$1,000	Not Available
* For services received from an out-of-network dentist, the claimant will be responsible for any difference between the dentist's charges and the maximum allowance. The maximum allowance is based on negotiated fees. Further information regarding the maximum allowance and network status of dentists is available by calling the toll-free number on the back of your ID card.		
** Benefit Waiting Period — You must be continuously covered under your rider for twelve (12) months before being eligible for the following covered services: (1) Major Restorative Services; (2) Prosthodontic Services and (3) Miscellaneous Restorative and Prosthodontic Services.		

Dependent coverage

Unmarried dependent children are covered under age 26 or under age 30 if a military veteran.

IV. Limitations and Exclusions

Exclusions

The following exclusions are applicable:

Dental procedures which are not Medically Necessary.

PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THIS BLUECARE DENTAL PPO RIDER PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT BLUE CROSS AND BLUE SHIELD OF ILLINOIS DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of Blue Cross and Blue Shield of Illinois, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of Blue Cross and Blue Shield of Illinois, for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you. The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

Special Limitations

No benefits will be provided under the BlueCare Dental PPO Rider for:

1. Services or supplies not specifically listed as covered services, or when they are related to a non-covered service.
2. Dental services which are performed for cosmetic purposes, including but not limited to, bleaching teeth and grafts to improve esthetics.
3. Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders or to increase vertical dimension, unless specifically mentioned in the rider.
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. 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.
6. Services or supplies that do not meet accepted standards of dental practice.
7. Investigational/Experimental Services and Supplies and all related services and supplies.
8. Hospital and ancillary charges.
9. Implants and any related services and supplies (other than crowns) associated with the placement and care of implants, unless specifically mentioned in this benefit section.
10. 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.
11. Services or supplies for which "discounts" or waiver of deductible or coinsurance amounts are offered.
12. Services rendered by a dentist, or other dental provider (such as a hygienist), who is related to you by blood or marriage.
13. 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.
14. Services or supplies received for behavior management or consultation purposes.
15. 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.
16. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 _ 1-1 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.

17. Charges for nutritional, tobacco, and oral hygiene counseling.
18. Charges for local, state or territorial taxes on dental services or procedures.
19. Charges for the administration of infection control procedures as required by local, state, or federal mandates.
20. Orthodontic services and supplies.
21. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
22. Charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form or forwarding requested records or X-rays.
23. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions or preparations.
24. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
25. 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.
26. Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your coverage date under your rider; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your coverage date.
27. Any services, treatments or supplies included as an eligible benefit under other hospital, medical and/or surgical coverage.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under your medical plan and/or under the BlueCare Dental PPO Rider should terminate, benefits will continue for any dental covered services, except for periodontal treatment, described in the benefit section of the BlueCare Dental PPO Rider 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 medical plan or dental rider.