

Employers Participating in the Farm
Credit Consolidated Benefit Plans

Your Dental Care Benefit Program
Basic Plan

A message from

Employers Participating in the Farm Credit Consolidated Benefit Plans

This booklet describes the Dental Care Plan provided to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your dental care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your dental care benefits. If you want more information or have any questions about your dental care benefits, please contact your Benefits Department.

Sincerely,

Employers Participating in the Farm Credit
Consolidated Benefit Plans

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator 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 “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

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BENEFIT HIGHLIGHTS

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

DENTAL BENEFITS

Deductible	\$50 per benefit period
Diagnostic and Preventive Care 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*

Prosthodontic Services

Benefit Payment Level

- Participating Provider 80% of the Maximum Allowance
- Non-Participating Provider 80% of the U&C Fee*

Benefit Period

Maximum \$750

*Usual and Customary Fee

DEFINITIONS SECTION

Throughout this benefit booklet, 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 booklet, 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.

CLAIM.....means notification in a form acceptable to the Claim Administrator 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, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with 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 the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. 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 the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

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 or Physician 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 Dental Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet to which benefits will be provided.

DENTIST.....means a duly licensed dentist.

A “Participating Dentist” means a Dentist who has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a Participating Provider Option Dental program to provide services to you at the time you receive the services.

A “Non-Participating Dentist” means a Dentist who does not have a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a Participating Provider Option Dental program to provide services to participants in the Participating Provider Option program.

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

HOSPITAL.....means a duly licensed institution 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. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

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

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, 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.

MAXIMUM ALLOWANCE.....means the amount determined by the Claim Administrator, 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 Dentists, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

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.

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

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

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 the Claim Administrator, which is based on the fee which the Physician or Dentist who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians or 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 the Claim Administrator 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 the Claim Administrator.

ELIGIBILITY SECTION

This benefit booklet contains information about the Dental Care Plan for persons who meet the following description of an Eligible Person: An Eligible Person means an active part-time employee, full-time employee, employee receiving severance benefits, retiree under the age of 65, and a former employee on disability. An active part-time employee means a person who is scheduled to work a minimum of 20 hours per week on a consistent basis and who is on the permanent payroll of the Employer. An active full-time employee means a person who is scheduled to work a minimum of 32 hours per week on a consistent basis and who is on the permanent payroll of the Employer.

If you meet this description of an Eligible Person, have applied for this coverage and have received a dental ID card, then you are entitled to the benefits described in this benefit booklet.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only expenses you incur for Covered Services are covered.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE

You can change from Individual to Family Coverage, either because of:

- marriage
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under this Health Care Plan and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application for this change within 31 days of the marriage, birth, adoption, interim court order of adoption or placement of adoption vesting temporary care or obtaining legal guardianship, your Family Coverage will be effective from the date of the marriage, birth, adoption, interim court order of adoption or placement of adoption or legal guardianship.

If you make application for Family Coverage within 31 days of the termination of previous health coverage, your Family Coverage will be effective from the date you make application for coverage.

If you do not make application for Family Coverage within those 31 days, you will have to wait until your Group's annual open enrollment period to make those

changes. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

FAMILY COVERAGE

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 19 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 25. The coverage for unmarried children will end on the last day of the month in which the limiting age is reached.

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

Any children who are dependent upon you or other care providers for support and maintenance 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.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

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

ADDING DEPENDENTS TO FAMILY COVERAGE

You can add additional dependents to your Family Coverage, either because of:

- marriage
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under this Health Care Plan and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application to add additional dependents to your Family Coverage within 31 days of the marriage, birth, adoption, interim court order of adoption or placement of adoption vesting temporary care or legal guardianship, coverage for your dependents will be effective from the date of the marriage, birth, adoption, interim court order of adoption or placement of adoption or legal guardianship. However, an application to add a newborn to Family Coverage is not necessary if an additional premium is not required. Please notify your Employee Benefits Department so that your membership records can be adjusted.

If you make application to add dependents to your Family Coverage within 31 days of the termination of previous health coverage, your dependents coverage will be effective from the date you make application for coverage.

If you do not make application to add additional dependents (other than a newborn for whom no additional premium is required) to your Family Coverage within those 31 days, you will have to wait until your Employer's annual open enrollment period to make those changes. Such changes will be effective on a date that has been mutually agreed to by the Claim Administrator.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this Dental Care Plan if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the Dental Care Plan of your Employer terminates.

Termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of your Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of the termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Dental Care Plan. However, termination of the Employer agreement with the Claim Administrator and/or your coverage under this Dental Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the end of the month in which the event occurs (for example, date of marriage, date of divorce, limiting age is reached).

DENTAL BENEFIT SECTION

Your employer has chosen the Claim Administrator'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.

The benefits of this section are subject to all of the terms and conditions of this Dental Care Plan. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet 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 the Claim Administrator 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 and non-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 every thirty-six (36) months. Routine bitewing X-rays are limited to two sets per benefit period. Any additional full mouth X-rays are subject to Medical Necessity.
- 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 and are limited to one application per tooth every two years.

- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when 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)
- Temporary/sedative
- Pin Retention
- Composites
- Simple Extractions, except as specifically excluded under “Special Limitations” of this Benefit Section.
- Consultations
- Occlusal/night guard
- Occlusal adjustment

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

Prosthodontic Services

- Prosthodontic adjustments, repairs, rebase and relines
- Prosthodontic recementing

Prosthodontic adjustments, repairs, rebase, and relines are limited to one every 36 months.

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 \$50 deductible. This deductible applies to:

- Restorative Dental Services
- General Dental Services
- Endodontic Services
- Periodontic Services
- Oral Surgery Services

- Prosthodontic Services

In other words, after you incur eligible charges of more than \$50 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.

Benefit Payment for Dental Services

The benefits provided by the Claim Administrator 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 the Claim Administrator 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 Claim Administrator 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 the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Claim Administrator 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 Employer, your Dentist or the Claim Administrator.

Participating Dentists

Diagnostic and Preventive 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.

Prosthodontic Services – Benefits for Prosthodontic 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.

Non-Participating Dentists

Diagnostic and Preventive 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.

Prosthodontic Services – Benefits for Prosthodontic 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.

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 \$750. This is an individual maximum. There is no family maximum.

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 the Claim Administrator.

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. The Claim Administrator 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.
6. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.
7. 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.
8. Myofunctional therapy and appliances for thumb sucking.
9. Orthognathic surgery.

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, THE HEALTH CARE PLAN 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 THE CLAIM ADMINISTRATOR DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Claim Administrator, 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.

- Services or supplies that are not specifically mentioned in this benefit booklet.
- 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 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.
- 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.
- Investigational Services and Supplies and all related services and supplies, other than the cost of routine patient care associated with Investigational

cancer treatment, if those services or supplies would otherwise be covered under the benefit booklet if not provided in connection with an approved clinical trial program.

- 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 covered separately under this Dental Care Plan.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health/dental care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled under this Health Care Plan. In other words, the total payment from all of your coverages together will never be less than what would have been paid under this Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

4. In order to prevent duplicate payment of benefits for a Claim, the Claim Administrator uses the following process to determine benefits when it is the secondary payor.
 - determines what the payment for service would be following the payment provisions of this coverage; and
 - deducts from this resulting amount the amount paid by the primary payor. The difference is the amount that will be paid under this coverage.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain your dental benefits under this Dental Care Plan, it is necessary for a Claim to be filed with the Claim Administrator.

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 the Claim Administrator.

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
P.O. Box 23059
Belleville, Illinois 62223-0059

Claims must be filed with the Claim Administrator within 12 months from the date your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

DENTAL CLAIM PROCEDURES

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator 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. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator 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 the Claim Administrator 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. The Claim Administrator 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 the Claim Administrator. The Claim Administrator 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
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 the Claim Administrator 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. The Claim Administrator 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 the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

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

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. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (“Administrator’s Providers”) in its service area to provide and pay for dental care services to all persons entitled to dental care benefits under dental policies and contracts to which the Claim Administrator is a party, including all persons covered under this Dental Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

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

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

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Dental Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. The Claim Administrator 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 the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person’s claim for benefits under this Dental Care Plan 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 Dental Care Plan 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.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.
- b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator 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 the Claim Administrator. Any contractual relationship between a Physician and a Administrator Hospital or other Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
- c. The use of an adjective such as Administrator 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 Administrator, Participating or any similar modifier or the use of a term such as Non-Administrator 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 Employer (other than as an individual Covered Person) or your Employer's Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under this Dental Care Plan must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

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

6. 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 Dental Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator 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 the Claim Administrator 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 the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

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Effective Date: January 1, 2006