Rider To The
Blue Cross And Blue Shield Certificate
Dental Care Benefit Program

Effective May 19, 2006, the Certificate to which this Rider is attached and becomes a part, is amended as stated below.

NOTICE

The following provision is added to the Notice section in your Dental Certificate:

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, 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. 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.

BENEFIT PAYMENT LEVELS

The Benefit Payment Levels described in the Benefit Highlights and Dental Benefit Section in your Dental Certificate are changed to the following:

Preventive Services
Benefit Payment Level
— Participating Provider 100% of the Maximum Allowance
— Non-Participating Provider 100% of the U&C Fee*

Primary Services
Benefit Payment Level
— Participating Provider 80% of the Maximum Allowance after deductible
— Non-Participating Provider 80% of the U&C Fee* after deductible
Major Services
Benefit Payment Level

- Participating Provider  50% of the Maximum Allowance after deductible
- Non-Participating Provider  50% of the U&C Fee* after deductible

Orthodontic Services
Benefit Payment Level

- Participating Provider  50% of the Maximum Allowance
- Non-Participating Provider  50% of the U&C Fee*

**DENTAL BENEFIT SECTION**

The first paragraph in the **Dental Benefit Section** of your Dental Certificate is deleted and replaced with the following:

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 will be available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at [www.bcbsil.com](http://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 Enrollment 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 following provision is added to the **Benefit Payment for Dental Covered Services** in your Dental Certificate:

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 Dentist or Blue Cross and Blue Shield.

The first paragraph in the Benefit Maximums provision of your Dental Certificate is deleted and replaced with the following:

The maximum amount available for you in dental benefits each benefit period is $1,000. This is an individual maximum. There is no family maximum.

EXCLUSIONS—WHAT IS NOT COVERED

The Investigational Services exclusion provision in your Dental Certificate is deleted and replaced with the following:

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 Certificate if not provided in connection with an approved clinical trial program.

COORDINATION OF BENEFITS SECTION

The Coordination of Benefits provision in your Dental Certificate is deleted and replaced with the following:

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. 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 ign-
ored.

6. Continuation Coverage

If a person whose coverage is provided under a right of continuation pur-
suant 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.

7. 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 pur-
   pose 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.

If you are eligible for Medicare Part B, the benefits of this Benefit Program
may be reduced taking into consideration the amount that would be pay-
right for an Allowable Expense under Medicare Part B whether or not you have enrolled in Part B and/or received payment from Medicare.

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.

GENERAL PROVISIONS

1. The second paragraph of the General Provisions in your Dental Certificate is deleted and replaced with the following:

   In the case of Physicians and 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. Nei-
ther the Group 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**, paragraph (a) of this provision in your Dental Certificate is deleted and replaced with the following:

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. 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.

3. **Your Provider Relationships**, paragraph (c) of this provision is deleted and replaced, in addition paragraph (d) has been added to your Dental Certificate:

   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.

**DEFINITIONS SECTION**

The definition for **Dentist** in your Dental Certificate is replaced with the following:

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

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 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 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 services to participants in the Participating Provider Option program.

The definition for **Investigational or Investigational Services and Supplies** in your Dental Certificate is replaced with the following:

**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.

The following definitions are added to the Definitions Section in your Dental Certificate:

**COINSURANCE**.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

**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.

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

**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 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.

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

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

Attest: Health Care Service Corporation
Secretary President
(Blue Cross and Blue Shield of Illinois)