Your Dental Care Benefit Program

Bradley University
151797

Administered by:

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

A message from

Bradley University

This booklet describes the Dental Care Plan which we provide 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 the Human Resource Department.

Sincerely,

Bradley University

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.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide 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 Prescription Drug Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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 plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE 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.

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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 benefit booklet.

DENTAL BENEFITS	
Benefit Waiting Period	None
Deductible	$50 per benefit period
Family Deductible	$150 per benefit period
Diagnostic and Preventive Care Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance, no deductible
— Non-Participating Provider	100% of the Claim Charge no deductible
Miscellaneous Dental Services Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance, no deductible
— Non-Participating Provider	100% of the Claim Charge no deductible
Restorative Dental Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the Claim Charge
General Dental Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the Claim Charge
Endodontic Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the Claim Charge
Periodontic Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the Claim Charge

Oral Surgery Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the Claim Charge
Crowns, Inlays/Onlays Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the Claim Charge
Prosthodontic Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	80% of the Claim Charge
Benefit Period Maximum	$1,000

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 benefit 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.

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

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 (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

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 regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

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 regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

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

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 the Dental Care Plan begins.

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

DENTIST.....means a duly licensed dentist operating within the scope of his or her license.

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

EMPLOYER.....means the company with which you are employed.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Dental Care Plan.

HOSPITAL.....means a facility which is 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 and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator to provide Hospital services to participants in the program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the 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 Participating Dentists 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.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

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 HOSPITAL.....SEE DEFINITION OF HOSPITAL.

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

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

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

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

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of 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.

ELIGIBILITY SECTION

This benefit booklet contains information about the dental care benefit program for the persons who:

- Meet the following definition of an Eligible Person: A full-time employee. A full-time employee is a person who is scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description of an Eligible Person and comply with the other terms and conditions of this benefit booklet, including but not limited to payment of premiums, you are entitled to the benefits of this program.

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 your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren), a child(ren) for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 will be covered. The coverage for 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 Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a disabling 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.

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

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

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

  This includes, but is not limited to, loss of coverage due to:
    a. Legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
    b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
    c. Reaching a lifetime limit on all benefits in another group health plan;
    d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
    e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
    f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

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

- Marriage.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

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

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

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

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

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

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

Late Applicants

If you do not apply for Family Coverage or to add dependents within the required number of days of the event, 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 your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this during open enrollment or due to a qualifying event. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet 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 entire coverage of your Employer terminates.

Further, 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 the 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 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 the Dental Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the 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 date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

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.

As a participant in the Participating Provider Option program you will receive a directory of Participating Dentists. While there may be changes in the directory from time to time, selection of Participating Dentists by the Claim Administrator 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 Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist.

The benefits of this section are subject to all of the terms and conditions of this benefit booklet. 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 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.
- 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)
- Pin Retention
- Composites
- Simple Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Harmful habit appliances—Benefits for harmful habit appliances are only available to persons under age 15 and will be limited to one appliance per person.

General Dental Services

- General Anesthesia/Intravenous Sedation—If 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.
- Emergency examination.
- Palliative treatment.
- Therapeutic drug injections.
- Occlusal adjustments—in conjunction with periodontal surgery and will be limited to a maximum of 4 every 3 years.
- Consultations.
- Palliative treatment.

Endodontic Services

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

Periodontic Services

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

Oral Surgery Services

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

Crowns, Inlays/Onlays Services

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

Prosthodontic Services

- Bridges
- Dentures
- Adjustments to Bridges and Dentures—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Bridge and Denture repairs
- Addition of tooth or clasp
- Reline (once every 6 months)/Rebase (once every 24 months)
- Implants
- Tissue conditioning if within 6 months of initial placement.

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

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
- Crowns, Inlays/Onlays Services
- Prosthodontic Services
- Implant 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.

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

Family Deductible

If you have Family Coverage and your family has reached the dental deductible amount of $150, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.

Benefit Payment for Dental Services

The benefits provided by the Plan 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 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 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.

Crowns, Inlays/Onlays Services - Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 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 Claim Charge.

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 Claim Charge.

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 Claim Charge 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 Claim Charge 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 Claim Charge 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 Claim Charge 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 Claim Charge after you have met your deductible.

Crowns, Inlays/Onlays Services - Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Non-Participating

Dentist will be provided at 80% of the Claim Charge 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 Claim Charge 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 100% of the Claim Charge when rendered by a Non-Participating Dentist.

Benefit Maximum

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.

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.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Plan should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Plan.

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 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 in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

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

— Services or supplies that were received prior to your Coverage Date or after the date that your coverage was terminated.

— Services and supplies from more than one Provider on the same day(s) to the extent benefits are duplicated.

— 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, except as may be provided under this benefit booklet for 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 benefit booklet if not provided in connection with a qualified cancer 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.

— Orthodontic Services.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have dental care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. 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.

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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies,

becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain your dental benefits, 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 Employee Benefits Department before going to your Dentist. The Attending Dentist's Statement is also used for pre-estimation of benefits. It is your responsibility to ensure 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 of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

DENTAL CLAIMS PROCEDURES

The Claim Administrator will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that 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 usually notify you, your valid assignee, or the your authorized representative when all information required to process a Claim in accordance with the terms of the benefit program 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 health 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 of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

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

While 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, Illinois 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 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 the 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 as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on 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 agreement between your Employer and the Claim Administrator. 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. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. 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 an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator or approved 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 Participating, Administrator, approved 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 ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Dental Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (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. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Dental Care Plan as described in this benefit booklet, 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 in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure 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 the 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 or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, 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.

END OF BENEFIT BOOKLET

The information which follows is provided to you by Bradley University. The Claim Administrator is not responsible for its contents.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
PLAN ADMINISTRATION INFORMATION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your benefit booklet/Certificate. Your Plan Administrator has determined that this information together with the information contained in your benefit booklet/Certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Blue Cross and Blue Shield is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan: Bradley University Employee Health Benefit Plan

Plan Sponsor: Bradley University, Human Resource Department, 1501 West Bradley Ave., Peoria, IL 61625

Employer Identification Number: 37-0661494

Plan Number: 503

Plan Administrator: Bradley University, Human Resource Department, 1501 West Bradley Ave., Peoria, IL 61625

Type of Plan: a welfare benefits plan providing medical and other benefits that is subject to the provisions of ERISA.
Type of Plan Administration: The health care benefit program is administered in accordance with the Plan document and an administrative services agreement with Blue Cross Blue Shield of Illinois.

Claim Administration:

Claims for benefits should be directed to**:**

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

Agent For Service of Legal Process: Bradley University, Human Resource Department, 1501 West Bradley Ave., Peoria, IL 61625

Eligibility:
To be eligible to be enrolled in this Plan as a Covered Employee, an individual must:

- be a full-time Employee who is actively working for the Employer at least thirty (30) hours per week; or
- be a retired Employee who is at least age sixty-two (62) or older with ten (10) or more years of service with the Employer and at retirement is, and continues to be, enrolled in the Plan; or
- be, at the discretion of Bradley University and as approved by the president, a retired Employee who is at least age fifty-five (55) or older with ten (10) or more years of service with the Employer who is offered to continue health benefits following severance of employment by negotiated contract; or
- be an eligible Employee who was totally disabled and covered by the Plan on September 30, 2003, and who must remain totally disabled and continue to make any contribution required for coverage in order to remain eligible; and
- meet any eligibility criteria specified by the Plan Sponsor in this document; and
- complete and submit a written application for coverage, if necessary, to the Plan Sponsor.

The Plan also covers retiree's and employee's legal spouse, domestic partner, and other eligible dependents.

Leased, seasonal or part-time employees of the Employer and retired or other employees who do not meet the above eligibility requirements are not eligible for coverage under the Plan.

Waiting Period:
Newly Hired Employees: A newly hired employee who is eligible for Coverage and enrolls for such Coverage upon becoming employed with Bradley University shall be covered under this Plan as of the first day his or her completed application for enrollment is received by the Employer, provided s/he is properly enrolled in the Plan within thirty-one (31) days of the date s/he satisfies the eligibility requirements outlined above.

Open Enrollment Period: Open Enrollment will occur once per year. An employee who is eligible for coverage under this Plan and enrolls for such coverage during a Group Open Enrollment Period shall be covered under this Plan as of the date established by the Employer.

Benefits and Administration: The Plan Administrator has the complete discretionary authority to determine eligibility and entitlement to Plan benefits and to interpret the terms of the Plan, including the making of factual determinations. The decisions of the Plan Administrator are final and conclusive with respect to all questions relating to the Plan.

The Claims Administrator does not serve as an insurer but as a claims processor. Claims for benefits are sent to the Claims Administrator. It processes the claims, then requests and receives funds from the Plan to pay the claims.

Minimum Maternity Benefits:

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan

or the insurance issuer for prescribing a length of stay in excess of the above periods.

Loss of Benefits:
Participant coverage shall terminate upon the occurrence of any one of the following events:

- If the Plan Sponsor terminates the Plan in accordance with applicable law and regulations.
- If Participant no longer meets the eligibility requirements set forth in this Plan.
- If the Participant materially violates the terms of the Plan.
- If the Participant participates in fraudulent or criminal behavior.
- If the Participant knowingly misrepresents or gives false information on any enrollment application form which is material to the Plan's acceptance of such application.

Contributions: Contributions for the Plan are made in part by the Plan Sponsor and in part by employees/retirees.

Funding Arrangements: The Plan is self-funded by the Group.

Plan Year: October – September
Benefit Year: January - December

How To Get Your Benefits:

This information is explained in the section of the booklet entitled "How To File a Claim."

Claims Procedure:

This information is explained in the section of the booklet entitled "How To File a Claim."

Claim Review Procedure:

This information is explained in the section of the booklet entitled "How To File a Claim."

Claims Appeal Procedure:

This information is explained in the section of the booklet entitled "How To File a Claim."

Statement of ERISA Rights:

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

a. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the plan or exercising your rights under ERISA.

Enforce Your Rights:

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it

should happen the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance With Your Questions:

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA):

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the "uniformed services", which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

you held the job prior to service;

you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;

your cumulative period of service did not exceed five years;

you were not released from service under dishonorable or other punitive conditions; and

you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

For less than 31 days of service − by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;

For 31 to 180 days of service − you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;

For 181 days or more of service − you must apply for reemployment no later than 90 days after completion of military service;

For service-connected injury or illness − reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Illinois para informacion o para someter una queja al: 1-800-892-2803. Usted tambien puede escribir a Blue Cross and Blue Shield of Illinois al: P. O. Box 805107, Chicago, Illinois 60680-4112.

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