

BENEFIT BOOKLET

For Employees of

Meredith College

for

DENTAL **Blue** SELECT™

BENEFIT BOOKLET



An independent licensee of the Blue Cross and Blue Shield Association

L1338, 10/09

Dental Blue Select-Enhanced with Ortho (06)
[Meredith College T071213001 1/1/2010]

BENEFIT BOOKLET

This benefit booklet, along with the *group contract*, is the legal contract between your *employer* and Blue Cross and Blue Shield of North Carolina. **Please read this benefit booklet carefully.**

Blue Cross and Blue Shield of North Carolina agrees to provide benefits to the qualified *subscribers* and eligible *dependents* who are listed on the Group Enrollment Application and who are accepted in accordance with the provisions of the *group contract* entered into between Blue Cross and Blue Shield of North Carolina and the *subscriber's employer*. A summary of benefits, conditions, limitations, and exclusions is set forth in this Benefit Booklet for easy reference.

Blue Cross and Blue Shield of North Carolina has directed that this Benefit Booklet be issued and signed by the President and the Secretary.



Attest:


President


Secretary

Important Cancellation Information — Please Read The Provision In This Benefit Booklet Entitled, "When Coverage Begins And Ends."

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WELCOME TO DENTAL BLUE SELECT

Welcome to Blue Cross and Blue Shield of North Carolina's Dental Blue Select plan! As a MEMBER of the Dental Blue Select plan, you will enjoy quality dental care.

How To Use Your Dental Blue Select Benefit Booklet

This benefit booklet provides important information about your benefits and can help you understand how to maximize them.

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- “Summary Of Benefits” to get an overview of your specific benefits, such as deductible, coinsurance and maximum amounts
- “COVERED SERVICES” to get more detailed information about what is covered
- “What Is Not Covered?” to see exclusions from coverage.

If you still have questions, you can call BCBSNC [Dental Blue Select] Customer Service at the number listed on your ID card or in “Whom Do I Call?”

As you read this benefit booklet, keep in mind that any word you see in small capital letters is a defined term and appears in “Glossary” at the end of this benefit booklet. The terms “we,” “us,” and “BCBSNC” refer to Blue Cross and Blue Shield of North Carolina. Common insurance terms involving your financial responsibility, such as “coinsurance” and “deductible” are defined in “Understanding Your Share Of The Cost.”

You will also want to review the following sections of this benefit booklet:

- “How Dental Blue Select Works” explains how to access your dental benefits
- “When Coverage Begins And Ends” tells you, among other things, how and when to enroll in this dental benefit plan
- “What If You Disagree With Our Decision?” explains the rights available to you when we make a decision regarding your coverage and you do not agree.

Aviso Para AFILIADOS Que No Hablan Ingles

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que el plan médico de SU EMPLEADOR le ofrece. Si usted tiene dificultad en entender alguna sección de este manual, por favor llame al ADMINISTRADOR DE SU GRUPO para recibir ayuda.

WHOM DO I CALL?

BCBSNC Web Site

To view your claims, request new ID CARDS, get benefit information or claim forms, we invite you to visit us here:

Web site.....**bcbsnc-dental.com**

BCBSNC Dental Blue Select Customer Service

For questions relating to enrollment, benefits and claims, or to request a new ID CARD, benefit booklet, claim forms or pre-treatment estimates for services:

Customer Service **1-888-471-2738** (toll free)

SUMMARY OF BENEFITS

This section provides a summary of your Dental Blue Select benefits. A more complete description of your benefits is found in “COVERED SERVICES.” Exclusions may also apply—please see “What Is Not Covered?” As you review the chart, keep in mind:

- Deductible and coinsurance amounts are based on the ALLOWED AMOUNT
- Coinsurance percentages shown in this section are the portion of the ALLOWED AMOUNT that BCBSNC pays.

Please note: BCBSNC has contracted with certain PROVIDERS for DENTAL SERVICES. If you receive DENTAL SERVICES from PROVIDERS who have contracts with BCBSNC, you only pay the coinsurance amount and any applicable deductible listed below. If you receive DENTAL SERVICES from PROVIDERS who do not contract with BCBSNC, in addition to the coinsurance and any deductible listed below, you may be responsible for the difference between the PROVIDER’S actual charge and the ALLOWED AMOUNT. For a list of PROVIDERS who have contracted with BCBSNC, see our Web site at bcbsnc-dental.com or bcbsnc.com/dentist.

	Benefits
<u>DENTAL SERVICES</u>	
Diagnostic and Preventive Services	100% after dental deductible
Basic Services	80% after dental deductible
Major Services	50% after dental deductible
12-month WAITING PERIOD applies	
LIFETIME Deductible per individual, applies to all services except orthodontics	\$100
BENEFIT PERIOD MAXIMUM per individual, applies to all services except orthodontics	\$1,500
Orthodontic Services	50%
12-month WAITING PERIOD applies	
Orthodontic LIFETIME MAXIMUM	\$1,500

See “When Coverage Begins And Ends” for more information on WAITING PERIODS.

HOW DENTAL BLUE SELECT WORKS

Dental Blue Select gives you the freedom to choose any PROVIDER that is recognized by BCBSNC as eligible. Please refer to “Summary Of Benefits” to see what deductibles or coinsurance will apply to your benefits. Also, see “Understanding Your Share Of The Cost” for an explanation of deductibles and coinsurance.

Prior to receiving services, you or your PROVIDER are encouraged to call BCBSNC Dental Blue Select Customer Service at the number given in “Whom Do I Call?” to obtain the criteria that BCBSNC uses to determine whether the recommended services are CLINICALLY NECESSARY and eligible for coverage. You may be required to pay the difference between the PROVIDER’S actual charge and the BCBSNC ALLOWED AMOUNT if you receive DENTAL SERVICES from PROVIDERS who do not contract with BCBSNC. We encourage you to discuss the cost of services with your PROVIDER before receiving services so you will be aware of your total financial responsibility.

Carry Your IDENTIFICATION CARD

Your ID CARD identifies you as a Dental Blue Select MEMBER. Be sure to carry your ID CARD with you at all times, and present it each time you seek dental care.

For ID card requests, please visit our Web site at **bcbsnc-dental.com** or call BCBSNC at the number listed in “Whom Do I Call?”

Making An Appointment

Call the PROVIDER’S office and identify yourself as a Dental Blue Select MEMBER. If you cannot keep an appointment, call the PROVIDER’S office as soon as possible. Charges for missed appointments, which PROVIDERS may require as part of their routine practice, are not covered.

How To File A Claim

If you choose contracting PROVIDERS, they will file claims for you. Otherwise, you may be responsible for paying for care at the time of service and filing claims to BCBSNC for reimbursement. When you file a claim, mail the completed claim form to:

BCBSNC
Claims Unit
PO Box 2400
Winston Salem, NC 27102-2400

Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.

You may obtain a claim form by visiting our Web site at **bcbsnc-dental.com** or calling BCBSNC at the number listed in “Whom Do I Call?” For help filing a claim, call BCBSNC Dental Blue Select Customer Service or write to:

BCBSNC
Claims Unit
PO Box 2400
Winston Salem, NC 27102-2400

UNDERSTANDING YOUR SHARE OF THE COST

This section explains how you and BCBSNC share the cost of your dental care.

Deductibles

The LIFETIME deductible is the dollar amount you must incur for COVERED SERVICES before benefits are payable by BCBSNC. This amount is accumulated only once during a continuous coverage period. If one or more DEPENDENTS are covered under Dental Blue Select, you each have an individual LIFETIME deductible. All services are subject to the LIFETIME deductible except for orthodontics. See “Summary Of Benefits” for your specific LIFETIME deductible amounts.

Coinsurance

Coinsurance is the sharing of charges by BCBSNC and the MEMBER for COVERED SERVICES, after you have satisfied your LIFETIME deductible. You **are responsible** for any portion of the charge over the ALLOWED AMOUNT, which does not apply to your deductible or coinsurance.

Here is an example of what your costs could be for COVERED SERVICES from a PROVIDER who has a contract with BCBSNC, compared to a PROVIDER who does not contract with BCBSNC.

	Contracting	Not Contracting
A. Total Bill	\$550	\$550
B. ALLOWED AMOUNT	\$500	\$500
C. Deductible Amount	\$100	\$100
D. ALLOWED AMOUNT Minus Deductible (B-C)	\$400	\$400
E. BCBSNC Pays (Coinsurance times D)	(80%) \$320	(80%) \$320
F. Your Coinsurance Amount (D-E)	\$80	\$80
G. Amount You Owe Over ALLOWED AMOUNT	\$0 (charges limited to ALLOWED AMOUNT)	\$50 (difference between Total Bill and ALLOWED AMOUNT)
H. Total Amount You Owe (C+F+G)	\$180	\$230

Deductible and coinsurance amounts are for example purposes only. Please refer to “Summary Of Benefits” for your benefits.

COVERED SERVICES

Dental Blue Select covers only those services that are CLINICALLY NECESSARY.

Exclusions and limitations apply to your coverage. See “Benefit Limitations” and “What Is Not Covered?”

Your dental benefits provide coverage for the services listed below, which may be obtained from any PROVIDER. For information on enrolling for dental coverage, see “When Coverage Begins And Ends.”

Diagnostic And Preventive Services

Many dental expenses result from problems that could have been prevented by regular checkups. Your dental plan helps you avoid such expenses by providing benefits for preventive services.

The following are COVERED SERVICES:

- Routine oral examinations (twice per BENEFIT PERIOD)
- Cleaning - prophylaxis, including scaling and polishing above the gum line (twice each BENEFIT PERIOD)
- Pulp-testing - evaluation of tooth nerve (limited to one charge per visit, regardless of the number of teeth tested)
- Supplemental bitewing x-rays—x-rays showing the back teeth (once each BENEFIT PERIOD)
- Topical fluoride application to prevent decay (once each BENEFIT PERIOD, covered through age 18)
- Palliative EMERGENCY treatment for relief of pain only and EMERGENCY oral examinations, not including permanent restorations or services
- Sealants for first and second permanent molars for MEMBERS age 5 through 15 (one reapplication per tooth every 36 months).

Basic Services

The following are COVERED SERVICES:

- Routine fillings to restore diseased teeth
 - amalgam—a soft silver which hardens after it is packed into the cavity
 - composite resin or other tooth-colored filling materials
- Simple extractions
- Full-mouth or panoramic x-rays (limited to once every 36 months unless taken for diagnosis of third molars, cysts, or neoplasms)
- Periapical x-ray of a tooth
- Endodontics—treatment of diseases of the nerve chamber and canals:
 - pulpotomy—partial removal of a tooth’s pulp and placement of medicament
 - root canal treatments
 - hemisection-dividing the crown and roots of a multi-rooted tooth
 - apicoectomy – removing the infected tip of the tooth’s root
- Periodontics – treatment of the diseases of the gums and bone surrounding the teeth:
 - Gingival curettage—scraping or cleaning the inner gum tissues surrounding the teeth
 - Gingivectomy and gingivoplasty—cutting out diseased or overgrown gum tissues around the teeth (once every 36 months per site or quadrant)
 - Osseous surgery—removing or reshaping the bone around the teeth through an incision of the gum (once every 36 months per site or quadrant)
 - Crown lengthening—reshaping the bone around the teeth to allow for proper prosthetic preparation (once every 36 months per site or quadrant)
 - Mucogingivoplastic surgery—reconstructing the gum surface and mucous membrane
 - Root planing and periodontal scaling—scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every 24 months)
 - Periodontal maintenance (twice within 12 months)
 - Periodontal exam and consultations (twice each BENEFIT PERIOD).

Major Services

A DENTIST may use an artificial device to restore your natural teeth or treat diseases of the gum and tissues around the teeth. Please note, treatment of crowns, bridges, or gold restorations is deemed INCURRED when the tooth is prepared for the procedure.

The following are COVERED SERVICES:

- Space maintainers—devices to keep space from closing after loss of a primary (baby) tooth so a permanent tooth will have room to grow (limited to DEPENDENTS through age 15)
- Oral surgery including surgical removal of teeth and maxillary or mandibular intrabony cysts and procedures performed for the preparation of the mouth for dentures
- Anesthesia when CLINICALLY NECESSARY and related to covered surgery
- Placement of dental implants, implant-supported abutments and prostheses
- Stainless steel crowns
- Crowns not part of bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Inlays - not part of a bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Onlays - not part of bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Full dentures (once every 60 months, no additional allowances for over-dentures or customized dentures)
- Partial dentures (once every 60 months, no additional allowances for precision or semi-precision attachments)
- Fixed bridges (once every 60 months)
- Denture relining done more than six months after the initial insertions (once each BENEFIT PERIOD)
- Fixed bridge and denture repairs (limited to repairs or adjustments done within 12 months after the initial insertion)
- Recementing of inlays, crowns and/or bridges.

Orthodontic Services

Benefits for a comprehensive orthodontic treatment are covered for all eligible MEMBERS through age 18. The following are COVERED SERVICES and considered part of comprehensive orthodontic care:

- Diagnosis, including the examination, study models, x-rays, and other aids needed to define the problem
- Appliance—a device worn during the course of treatment. Coverage includes the design, making, placement and adjustment of the device. Benefits are not provided to repair or replace an appliance.
- Treatment may include Phase I or Phase II treatment. Phase I treatment is minor orthodontic treatment and can be paid in one total fee when treatment begins. Phase II treatment is comprehensive orthodontics and is paid based on the orthodontic treatment plan consisting of an initial payment no greater than 30 percent of the total charge of the orthodontic treatment plan and monthly payments based on the existing treatment plan. In order for benefits to continue throughout the treatment plan, this dental benefit plan must remain in effect, the MEMBER must remain enrolled on the plan, and the MEMBER'S LIFETIME MAXIMUM must not be met.

Alternate Course Of Treatment

In all cases involving services in which either you or your PROVIDER selects a course of treatment, benefits will be based on the procedures that are consistent with professional standards of dental practice for the dental condition.

Pre-Treatment Estimate Of Benefits

When the charges from a DENTIST for a proposed course of treatment are expected to be over \$250, a pre-treatment estimate of benefits is strongly recommended before any services are performed. You or your

DENTIST can mail information to BCBSNC for a pre-treatment estimate of benefits. BCBSNC will provide information on the portion of the charges that will be allowed.

This chart lists documentation required for a pre-treatment estimate:

	Single Unit Fixed Restorations	Periodontics	Multiple Unit Fixed Restorations	Endodontics	Oral Surgery	Anesthesia
Description	- Crowns - Build-ups - Post and cores	- Root planing and osseous surgery	- Abutments - Pontics	Conventional endodontics on permanent teeth and retreatments	- Surgical extractions - Impactions	- General - IV sedation
Information Required for Claim Processing	Pre-operative x-ray(s)	- Pre-operative x-rays - Periodontal charting	Pre-operative x-rays (full arch)	Pre- and post-operative x-rays	Pre-operative x-ray(s)	- Type - Duration of agent

Please mail the information to:

BCBSNC

Claims Unit

PO Box 2400

Winston Salem, NC 27102-2400

When You File A Claim

In order to process your claim, BCBSNC may need information and require proof of the condition and treatment of your teeth or mouth. For example, BCBSNC may request your complete dental chart, including:

- Previous dental work
- Itemized bills
- Materials and treatment
- X-rays
- Lab report
- Casts, molds, photographs or study models.

Benefit Limitations

- Replacement of complete or partial dentures, fixed bridgework or crowns within 60 months of initial or supplemental placement.
- Denture relines for complete or partial conventional dentures are not covered for six months following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures are not covered for six months after insertion of the full or partial denture. After this specified WAITING PERIOD, relines are covered once every 12 months.
- One hard-tissue periodontal surgery and one soft-tissue periodontal surgery per surgical area are covered within a three-year period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
- Osseous grafts, with or without resorbable or nonresorbable Guided Tissue Replacement (GTR), are covered once every 36 months per quadrant or surgical site
- Retreatment of a previous root canal, unless the original root canal has been in place for at least 12 months
- Clinical situations that can be effectively treated by a more cost-effective, clinically acceptable, alternative procedure will be assigned a benefit based on the less costly procedure
- Full-mouth debridement is limited to once every 36 months.

WHAT IS NOT COVERED?

This section describes exclusions to your dental benefits, starting with general exclusions and then the remaining exclusions listed in alphabetical order. In addition, limitations to certain benefits are described in “Benefit Limitations” on the previous page. Your dental benefit plan does not cover services, supplies, drugs or charges for:

- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible for the specific dental charge (1) according to a final adjudication of the claim under a state’s workers’ compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this dental benefit plan
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group. Services in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM, if applicable
- Services received or begun prior to the MEMBER’S EFFECTIVE DATE of coverage
- A benefit, drug, service or supply not specifically listed as covered in this benefit booklet

In addition, your dental benefit plan does not cover the following services, supplies, drugs or charges:

A

Acupuncture and acupressure

Costs in excess of the **ALLOWED AMOUNT**

Administrative charges billed by a PROVIDER, including charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, obtaining dental records, and late payments

Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature

B

Placement of fixed **bridgework** solely for the purpose of achieving periodontal stability

C

Claims not submitted to BCBSNC within 18 months of the date the charge was INCURRED, except in the absence of legal capacity of the MEMBER

Services or supplies deemed not **CLINICALLY NECESSARY**

Side effects and **complications** of noncovered services, except for EMERGENCY SERVICES in the case of an EMERGENCY

Treatment of **CONGENITAL malformations** of hard or soft tissue, including excision, except when procedures are performed in order to restore normal function to minor children with **CONGENITAL** defects and anomalies

Convenience items such as, but not limited to, devices and equipment used for environmental control, heating pads, hot water bottles, ice packs and personal hygiene items

COSMETIC or aesthetic services, except when procedures are performed in order to restore normal function to minor children with **CONGENITAL** defects and anomalies

Services received either before or after the **coverage period** of your dental benefit plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination, except as specifically covered by your dental benefit plan

D

Dental procedures not directly associated with dental disease

Dental procedures not performed in a **dental setting**

Drugs or medications, obtainable with or without a **PRESCRIPTION**, unless they are dispensed and utilized in the dental office during the patient visit

E

Services primarily for **educational** purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by your dental benefit plan

Equipment and devices used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps

EXPERIMENTAL procedures, including pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics

F

Setting of **facial bony fractures** and any treatment associated with the dislocation of facial skeletal hard tissue

H

DENTAL SERVICES provided in a **HOSPITAL**

Hypnosis except when used for control of acute or chronic pain

I

Incision and drainage for an abscessed tooth if the tooth is removed on the same date of service

Services that are **INVESTIGATIONAL** services in nature or obsolete, including any service, drugs, procedure or treatment directly related to an **INVESTIGATIONAL** treatment

N

Treatment of malignant or benign **neoplasms**, cysts, or other pathology, except for excisional removal. (Hard or soft tissue biopsies of neoplasms, cysts, or hard or soft tissue growth of unknown cellular makeup are not excluded.)

Services that would not be necessary if a **noncovered service** had not been received, except for EMERGENCY SERVICES in the case of an EMERGENCY

O

Occlusal guards for any purpose other than control of habitual grinding

P

Fixed or removable **prosthodontic restoration** procedures for complete oral rehabilitation or reconstruction

Care or services from a PROVIDER who:

- Cannot legally provide or legally charge for the services or services are outside the scope of the PROVIDER'S license or certification
- Provides and bills for services from a licensed dental care professional who is in training
- Is in a MEMBER'S immediate family
- Is not recognized by BCBSNC as an eligible PROVIDER

S

Services or supplies that are:

- Not performed by or upon the direction of a dentist or other provider
- Available to a MEMBER without charge

Surgery for psychological or emotional reasons

T

Temporomandibular joint (TMJ) treatment, either bilateral or unilateral

Travel, whether or not recommended or prescribed by a doctor or other licensed dental care professional

V

Reconstruction of a patient's correct **vertical dimension of occlusion (VDO)**, and related procedures

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind

WHEN COVERAGE BEGINS AND ENDS

EMPLOYEES shall be added to coverage no later than 90 days after their first day of employment. The term "EMPLOYEE" means a nonseasonal person who works full-time, 30 or more hours per week and is otherwise eligible for coverage. However, your EMPLOYER may establish additional criteria you must meet before you are eligible for coverage. This may include satisfying a probationary period before your coverage begins. Your EMPLOYER may allow eligibility to extend to other persons, such as retirees or part-time EMPLOYEES.

For DEPENDENTS to be covered under this dental benefit plan, you must be covered and your DEPENDENT must be one of the following:

- Your spouse, under a legally valid, existing marriage between persons of the opposite sex
- Your domestic partner, so long as you and your domestic partner have attested to the GROUP ADMINISTRATOR, in writing to the following:
 1. That you and your domestic partner are both mentally competent
 2. That you and your domestic partner are both at least the age of consent for marriage in the state of North Carolina
 3. That you and your domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in North Carolina
 4. That you and your domestic partner are not married to anyone else
 5. That you and your domestic partner are mutually responsible for the cost of basic living expenses as evidenced by joint home ownership, common investments, or some other similar evidence of financial interdependence
 6. That you and your domestic partner live together and intend to do so permanently
 7. That you do not currently have a domestic partner covered under this dental benefit plan
 8. That you have not had a domestic partner covered under this dental benefit plan at any time within the past twelve months before adding this domestic partner unless the previous domestic partnership was terminated by death.

The conditions listed in 2-8 above must remain true and correct for your domestic partner to remain an eligible DEPENDENT under the terms of this coverage.

- Your or your spouse's or your domestic partner's unmarried DEPENDENT CHILDREN to their 26th birthday, including newborn children from date of birth, stepchildren, grandchildren if living in the home of the SUBSCRIBER and the SUBSCRIBER has legal guardianship, adoptive children from date of placement for adoption, and FOSTER CHILDREN from date of placement in the foster home. Your EMPLOYER may require proof that your DEPENDENT CHILD meets the eligibility requirements.
- An unmarried DEPENDENT CHILD who is either mentally retarded or physically handicapped and incapable of self-support may continue to be covered under the dental benefit plan regardless of age if the condition exists and coverage is in effect when the child reaches the age of 26. The handicap must be medically certified by the child's doctor and may be verified annually by BCBSNC.

Enrolling In This Dental Benefit Plan

It is very important to know when you and your DEPENDENTS may apply for coverage. Your medical enrollment period does not apply to dental enrollment.

You are a timely enrollee if you apply for coverage and/or add DEPENDENTS within a 30day period of when you first become eligible for coverage under this dental benefit plan or within 30 days following a qualifying event as described below. Once dental coverage has terminated, regardless of the reason, you may not re-enroll, unless a qualifying event occurs.

If you apply for coverage at a time which does not qualify you or your DEPENDENTS as timely enrollees as stated above, then you are considered late enrollees. Late enrollees have no WAITING PERIOD for diagnostic and preventive services. For all other DENTAL SERVICES, where timely enrollees have no WAITING PERIOD, late enrollees have a 12-month WAITING PERIOD. Where timely enrollees have WAITING PERIODS, these WAITING PERIODS are doubled for late enrollees. See "WAITING PERIODS."

The following are considered qualifying events:

- You or your DEPENDENTS become eligible for coverage under this dental benefit plan
- You get married or obtain a DEPENDENT through birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose other coverage under another dental benefit plan, and each of the following conditions is met:
 - you and/or your DEPENDENTS are otherwise eligible for coverage under this dental benefit plan, and
 - you and/or your DEPENDENTS were covered under another dental benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
 - you and/or your DEPENDENTS lose coverage under another dental benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, divorce, loss of DEPENDENT status, death of the employee, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) offered dental benefit plan not providing benefits in your service area and no other dental benefit plans are available, or v) the termination of employer contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) discontinuance of the benefit plan to similarly situated individuals
- You or your DEPENDENTS lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this dental benefit plan within 60 days
- You or your DEPENDENTS become eligible for premium assistance with respect to coverage under this dental benefit plan under Medicaid or the Children's Health Insurance Program (CHIP).

WAITING PERIODS

There is no WAITING PERIOD for MEMBERS to receive benefits for diagnostic and preventive or basic services, except for late enrollees as described above. However, there is a 12-month WAITING PERIOD for major services and a 12-month WAITING PERIOD for orthodontic services. These WAITING PERIODS are doubled for late enrollees. Eligible children who are added as a result of a court order are not subject to a WAITING PERIOD. WAITING PERIODS are waived or reduced by the number of months of prior coverage for timely enrollees who can show proof of prior dental coverage. However, WAITING PERIODS will not be waived or reduced if more than 63 days have passed between the termination of the prior coverage and your enrollment date of this coverage. The enrollment date is the first day of coverage under this dental benefit plan or the first day of any probationary period, whichever is earlier.

Adding Or Removing A DEPENDENT

Do you want to add or remove a DEPENDENT? You must notify your GROUP ADMINISTRATOR and BCBSNC and complete any required forms. Failure to timely notify your GROUP ADMINISTRATOR of the need to remove a DEPENDENT could result in loss of eligibility for continuation of coverage.

For coverage to be effective on the first day of the month following the date the DEPENDENT becomes eligible, the proper form must be completed within 30 days after the DEPENDENT becomes eligible. Newborns added up to 30 days after their first birthday will have no WAITING PERIOD.

If you are adding a newborn child, a child legally placed for adoption or a FOSTER CHILD, and adding the DEPENDENT CHILD would not change your coverage type or the amount of premiums that are owed, the change will be effective on the date the child becomes eligible, as long as the 30th day after the first birthday or date of placement occurs after the coverage is effective. Notice is not required by BCBSNC within 30 days after the child becomes eligible; however, it is important to provide notification as soon as possible.

You may remove DEPENDENTS from your coverage by contacting your GROUP ADMINISTRATOR and completing the proper form. DEPENDENTS must be removed from coverage when they are no longer

eligible, such as when a child is no longer eligible due to age, marriage or when a spouse is no longer eligible due to divorce or death.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is any judgment, decree or order that is issued by an appropriate court or through an administrative process under state law that: (1) provides for coverage of the child of a MEMBER under BCBSNC; and (2) is either issued according to state law or a law relating to medical child support described in Section 1908 of the Social Security Act. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. A copy of the QMCSO procedures may be obtained free of charge from your GROUP ADMINISTRATOR.

Type[s] Of Coverage

These are the types of coverage available:

- Employee-only coverage—The dental benefit plan covers only you
- Employee-spouse coverage—The dental benefit plan covers you and your spouse or domestic partner
- Employee-children coverage—The dental benefit plan covers you and your DEPENDENT CHILDREN
- Family coverage—The dental benefit plan covers you, your spouse or domestic partner and your DEPENDENT CHILDREN.

Reporting Changes

Have you moved, added or changed other dental coverage, changed your name or phone number? If so, contact your GROUP ADMINISTRATOR and complete the proper form. It will help us give you better service if BCBSNC is kept informed of these changes.

Continuing Coverage

Under certain circumstances, your eligibility for coverage under this dental benefit plan may end. You may have certain options such as continuing dental insurance under this dental benefit plan.

Continuation Under Federal Law

Under a federal law known as COBRA, if your employer has 20 or more employees, you and your covered dependents can elect to continue coverage for up to 18 months by paying applicable fees to the employer in the following circumstances:

- Your employment is terminated (unless the termination is the result of gross misconduct)
- Your hours worked are reduced, causing you to be ineligible for coverage.

In addition to their rights above, dependents will be able to continue coverage for up to 36 months if their coverage is terminated due to:

- Your death
- Divorce
- Your entitlement to Medicare
- A dependent child ceasing to be a dependent under the terms of this coverage

Children born to or placed for adoption with you during the continuation coverage period are also eligible for the remainder of the continuation period.

Please note that Federal law defines marriage as the legal union between a man and a woman, so domestic partners and children of the [same sex] domestic partner are not eligible for COBRA benefits. All references to dependents in this section do not apply to a domestic partner or their children.

If you are a retired employee and your employer allows coverage to extend to retirees under this dental benefit plan, and you, your spouse and your dependents lose coverage resulting from a bankruptcy proceeding against your employer, you may qualify for continuation coverage under COBRA. Contact your group administrator for conditions and duration of continuation coverage.

In addition, you and/or your dependents, who are determined by the Social Security Administration to be disabled, may be eligible to extend their 18-month period of continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice must be provided to the group administrator within 60 days of the determination of disability by the Social Security Administration and prior to the end of the original 18-month period of continuation coverage. In addition, notice must be provided to the group administrator within 30 days after the later of the date of determination that the individual is no longer disabled or the date of the initial notification of this notice requirement.

You or your dependents must notify the group administrator within 60 days of the following qualifying events:

- Divorce
- Ineligibility of dependent child.

You and/or your dependents will be offered continuation coverage within 14 days of the date that the COBRA administrator is notified of one of these events resulting in the termination of your coverage. Eligible persons have 60 days to elect or reject continuation coverage. Following election, applicable fees must be paid to the COBRA administrator within 45 days.

Continuation coverage will end at the completion of the applicable continuation period or earlier if:

- Your employer ceases to provide a dental benefit plan to employees
- The continuing person fails to pay the monthly fee on time
- The continuing person obtains coverage under another group plan, unless the new group plan excludes or limits coverage for pre-existing conditions and the continuing person does not have enough prior creditable coverage to satisfy any new waiting period for pre-existing conditions that would apply. (In this case, continuation coverage will be the secondary payer, with the exception of claims for pre-existing conditions. Continuation coverage will be the primary payer of claims for pre-existing conditions.)

If you are covered by this dental benefit plan and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult your group administrator. Your group administrator will advise you about the continuation of coverage and reinstatement of coverage under this dental benefit plan as required under USERRA.

If you have any questions about your COBRA rights or continuation of coverage, please contact your group administrator.

Termination Of MEMBER Coverage

A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends.

A MEMBER'S coverage will be terminated immediately by BCBSNC for the following reasons:

- Fraud or material misrepresentation by the EMPLOYEE or DEPENDENTS
- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this dental benefit plan, or uses another person's ID CARD.

UTILIZATION MANAGEMENT

BCBSNC has a UTILIZATION MANAGEMENT (UM) program which looks at whether DENTAL SERVICES are CLINICALLY NECESSARY, provided in the proper setting and for a reasonable length of time.

Rights And Responsibilities Under The UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for BCBSNC's denial of a requested treatment or dental care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a clinical director from BCBSNC make a final determination of all denials of service that were based upon CLINICAL NECESSITY
- Request a review of denial of benefit coverage through our GRIEVANCE process.
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under the "UTILIZATION MANAGEMENT" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC will:

- Limit what we request from you or your PROVIDER to information that is needed to review the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your PROVIDER prompt notification of the UM decision consistent with North Carolina law and your dental benefit plan.

In the event BCBSNC does not receive sufficient information to approve coverage for a DENTAL SERVICE within specified time frames, BCBSNC will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the UM decision.

Retrospective Reviews

BCBSNC reviews the coverage of DENTAL SERVICES after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an EMERGENCY setting qualify as an EMERGENCY. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. When the decision is to deny benefit coverage, BCBSNC will notify you and your PROVIDER in writing within five business days of the decision. All decisions will be based on CLINICAL NECESSITY and whether the service received was a benefit under this dental benefit plan. BCBSNC may take an extension of up to 15 days if additional information is needed. Before the end of the initial 30-day period, BCBSNC will notify you of the extension, the information needed, and the date by which BCBSNC expects to make a decision. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new dental technology, procedures and equipment. These policies allow us to determine the best services and products to offer our MEMBERS. They also help us keep pace with the ever-advancing dental field. Before implementing any new or revised policies, we review professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. We then seek additional input from PROVIDERS who know the needs of the patients they serve.

WHAT IF YOU DISAGREE WITH OUR DECISION?

In addition to the UM program, BCBSNC offers a GRIEVANCE procedure for our MEMBERS. GRIEVANCES include dissatisfaction with a claims denial or any of our decisions (including an appeal of a noncertification decision), policies or actions related to the availability, delivery or quality of DENTAL SERVICES. If you have a GRIEVANCE, you have the right to request that BCBSNC review the decision through the GRIEVANCE process. The GRIEVANCE process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). If your EMPLOYER is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The GRIEVANCE Process

For each step in this process, there are specified time frames for filing a GRIEVANCE and for notifying you or your PROVIDER of the decision. The review must be requested in writing, within 180 days of a NONCERTIFICATION or denial of benefit coverage (the initial claim denial or the first level GRIEVANCE review decision). Any request for review should include:

- SUBSCRIBER'S ID number
- SUBSCRIBER'S name
- Any other information that may be helpful for the review.
- Patient's name
- The nature of the GRIEVANCE

To request a form to submit a request for review, visit our Web site at bcbsnc-dental.com or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

All correspondence related to a request for a review through BCBSNC'S GRIEVANCE process should be sent to:

BCBSNC

Claims Unit

PO Box 2400

Winston Salem, NC 27102-2400

If your EMPLOYER is subject to ERISA, following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the GRIEVANCE, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not CLINICALLY NECESSARY or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

Some rights are noted below as limited to MEMBERS whose dental benefit plan is subject to ERISA. Please contact your GROUP ADMINISTRATOR for more information.

First Level GRIEVANCE Review

BCBSNC will provide you with the name, address and phone number of the GRIEVANCE coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials. For GRIEVANCES concerning quality of care, an acknowledgement will be sent by BCBSNC within three business days.

Although you are not allowed to attend a first level GRIEVANCE review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level GRIEVANCE Review

If your dental benefit plan is subject to ERISA, the first level GRIEVANCE review is the only level that you must complete before you can pursue your GRIEVANCE in an action in federal court.

Otherwise, if you are dissatisfied with the first level GRIEVANCE review decision, you have the right to a second level GRIEVANCE review. Second level GRIEVANCES are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level GRIEVANCE review, the following information will be given to you:

- Name, address and telephone number of the GRIEVANCE coordinator
- A statement of your rights, including the right to:
 - request and receive from us all information that applies to your case
 - attend the second level GRIEVANCE review meeting
 - present your case to the review panel
 - submit supporting material before and at the review meeting
 - ask questions of any member of the review panel
 - be assisted or represented by a person of your choosing, including a family member, an EMPLOYER representative, or an attorney
 - pursue other voluntary alternative dispute resolution options (limited to MEMBERS whose dental benefit plan is subject to ERISA).

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level GRIEVANCE review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your GRIEVANCE even if you do not attend the meeting. A written decision will be issued to you within seven business days of the review meeting.

Notice of Decision

The following information only applies to MEMBERS whose dental benefit plan is subject to ERISA. If any claim shall be wholly or partially denied at either the first level GRIEVANCE or the second level GRIEVANCE review, a written notice shall be provided to the MEMBER worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific dental benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on CLINICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the dental benefit plan to the MEMBER'S medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits To Which MEMBERS Are Entitled

The only legally binding benefits are described in this benefit booklet, which is part of the GROUP CONTRACT between BCBSNC and your EMPLOYER. The terms of your coverage cannot be changed or waived unless BCBSNC agrees in writing to the change.

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits and the right to receive payment cannot be transferred to another person. At the option of BCBSNC, payment for services will be made to the PROVIDER of the services, or BCBSNC may choose to pay the SUBSCRIBER. The MEMBER is responsible for paying the PROVIDER in full and filing a claim unless the PROVIDER agrees to accept assignment of benefits. In this case the MEMBER must sign the claim form indicating that benefits have been assigned to the PROVIDER.

If a MEMBER resides with a custodial parent or legal guardian who is not the SUBSCRIBER, BCBSNC will, at its option, make payment to either the PROVIDER of the services or to the custodial parent or legal guardian for services provided to the MEMBER. If the SUBSCRIBER or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the PROVIDER.

Benefits for COVERED SERVICES specified in this dental benefit plan will be provided only for services and supplies that are performed by a PROVIDER as specified in this dental benefit plan and regularly included in the ALLOWED AMOUNT. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under this dental benefit plan.

Any amounts paid by BCBSNC for noncovered services or that are in excess of the benefit provided under your Dental Blue Select coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a MEMBER'S future claims payments. This can result in a reduction or elimination of future claims payments. BCBSNC will recover amounts we have paid for work related accidents, injuries, or illnesses covered under state workers' compensation laws upon a final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the MEMBER, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

PROVIDERS are independent contractors, and they are solely responsible for injuries and damages to MEMBERS resulting from misconduct or negligence.

BCBSNC's Disclosure Of Protected Health Information (PHI)

At BCBSNC, we take your privacy seriously. We handle all PHI as required by state and federal laws and regulations and accreditation standards. We have developed a privacy notice that explains our procedures.

To obtain a copy of the privacy notice, visit our Web site at bcbsnc-dental.com or call BCBSNC at the number listed in "Whom Do I Call?"

PROVIDER Reimbursement

Benefits are paid based on the ALLOWED AMOUNT. MEMBERS are responsible for any amounts over the ALLOWED AMOUNT if services are performed by a PROVIDER who does not contract with BCBSNC, i.e., deductibles, coinsurance and charges not covered by BCBSNC, such as amounts above benefit maximums. MEMBERS are responsible for the full cost of noncovered services. PROVIDERS who do not contract with BCBSNC may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Notice Of Claim

BCBSNC will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to BCBSNC within 18 months after the MEMBER INCURS the COVERED SERVICE, except in the absence of legal capacity of the MEMBER. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice Of Benefit Determination

The following information only applies to MEMBERS whose dental benefit plan is subject to ERISA. BCBSNC will provide an explanation of benefits determination to the MEMBER or the MEMBER'S authorized representative within 30 days of receipt of the notice of claim. BCBSNC may take an extension of up to 15 additional days to complete

the benefits determination if additional information is needed. If BCBSNC takes an extension, we will notify the MEMBER or the MEMBER’S authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reasons(s) for the denial of benefits
- Reference to the benefit booklet sections on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the member’s right to bring a civil action under Section 502(a) of ERISA following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on CLINICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the dental benefit plan to the member’s medical circumstances, or a statement that this will be provided without charge upon request.

Upon receipt of a denial of benefits, you have the right to file a GRIEVANCE with BCBSNC. See “What If You Disagree With Our Decision?” for more information.

Limitation Of Actions

NON-ERISA No legal action may be taken to recover benefits for 60 days after the Notice of Claim has been given as specified above and until you have exhausted all administrative remedies, including following the GRIEVANCE process. **ERISA** If your dental benefit plan is subject to ERISA, you must only exhaust the first level GRIEVANCE review process following the Notice of Claim requirement. Please see “What If You Disagree With Our Decision?” for details regarding the GRIEVANCE review process.

No legal action may be taken later than three years from the date services are INCURRED. However, if you are authorized to pursue an action in federal court under ERISA, and you choose to pursue a second level GRIEVANCE review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group insurance plan, BCBSNC may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a MEMBER is covered by more than one group insurance plan, benefits under one group insurance plan are determined before the benefits are determined under the second group insurance plan. The group insurance plan that determines benefits first is called the primary group insurance plan. The other group insurance plan is called the secondary group insurance plan.

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the dental care service. Most group dental insurance plans include a COB provision. COB is explained in more detail in the GROUP CONTRACT between your EMPLOYER and BCBSNC; however, the rules used to determine which plan is primary and secondary are listed in the following chart. The “participant” is the person who is signing up for group insurance coverage.

When a person is covered by 2 group dental plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	Yes	
	The plan with COB is		Yes
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	Yes	
	The plan covering the person as a dependent is		Yes
The person is covered as a dependent child	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	Yes	

under both plans, including when parents are divorced or separated and share joint custody	The plan of the parent whose birthday is later in the calendar year is		Yes
	NOTE: WHEN THE PARENTS HAVE THE SAME BIRTHDAY, THE PLAN THAT COVERED THE PARENT LONGER IS	Yes	
The person is covered as a dependent child and parents are divorced or separated with no court decree for coverage	The custodial parent's plan is	Yes	
	The plan of the spouse of the custodial parent is		Yes
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	Yes	
	The non-custodial parent's plan is		Yes
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	Yes	
	The plan of the other parent is		Yes
	NOTE: IF THERE IS A COURT DECREE THAT REQUIRES A PARENT TO ASSUME FINANCIAL RESPONSIBILITY FOR THE CHILD'S HEALTH CARE COVERAGE, AND BCBSNC HAS ACTUAL KNOWLEDGE OF THOSE TERMS OF THE COURT DECREE, BENEFITS UNDER THAT PARENT'S HEALTH BENEFIT PLAN ARE	Yes	
The person is covered as a laid-off or retired employee or that employee's dependent, on one of the plans	The plan that covers a person other than as a laid-off or retired employee or as that employee's dependent	Yes	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee		Yes
	NOTE: THIS RULE DOES NOT APPLY IF IT RESULTS IN A CONFLICT IN DETERMINING ORDER OF BENEFITS		
The person is the participant in two active group dental plans and none of the rules above apply	The plan that has been in effect longer is	Yes	
	The plan that has been in effect the shorter amount of time is		Yes

NOTE: If either the primary or the secondary plan covers a particular service, where BCBSNC is the secondary plan, BCBSNC will coordinate benefits for that service based on the benefits of the secondary coverage. However, if neither the primary nor secondary plan covers a particular service, the member will be responsible for payment for that service.

BCBSNC may request information about the other plan from the member. A prompt reply will help us process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group benefit plans, benefits for covered services are still subject to program requirements, such as certification procedures.

GLOSSARY

ALLOWED AMOUNT

The charge that BCBSNC determines is reasonable for COVERED SERVICES provided to a MEMBER. The allowed amount will be the lesser of the PROVIDER'S actual charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable PROVIDERS for similar services under a similar dental benefit plan. Some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

BENEFIT PERIOD

The period of time, as stated in the "Summary Of Benefits" and GROUP CONTRACT, during which charges for COVERED SERVICES provided to a MEMBER must be INCURRED in order to be eligible for payment by BCBSNC. A charge shall be considered INCURRED on the date the service or supply was provided to a MEMBER.

BENEFIT PERIOD MAXIMUM

The maximum amount of charges for COVERED SERVICES or number of visits in a BENEFIT PERIOD that will be covered on behalf of a MEMBER. Services in excess of a benefit period maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

CERTIFICATION

The determination by BCBSNC that services, materials or drugs have been reviewed and, based on the information provided, satisfy our requirements for CLINICALLY NECESSARY services and supplies, appropriateness, dental care setting, level of care and effectiveness.

CLINICALLY NECESSARY (or CLINICAL NECESSITY)

Those COVERED SERVICES, materials or supplies that are:

- a) Provided for the diagnosis, treatment, cure, or relief of a dental condition, illness, injury, or disease; and not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes, except as specifically covered by your dental benefit plan,
- b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a dental condition, illness, injury, disease, or its symptoms,
- c) Within generally accepted standards of dental care in the community, and
- d) Not solely for the convenience of the insured, the insured's family, or the PROVIDER.

For clinically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings, materials or supplies when determining which of the services, materials or supplies will be covered and in what setting clinically necessary services are eligible for coverage.

CONGENITAL

Existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COSMETIC

To improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a COVERED SERVICE. This also does not include reconstructive surgery to correct CONGENITAL or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S)

A service, material, drug, supply or equipment specified in this benefit booklet for which MEMBERS are entitled to benefits in accordance with the terms and conditions of this dental benefit plan. Any services in excess of a BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM are not covered services.

DENTAL SERVICE(S)

Dental care or treatment provided by a DENTIST or other professional PROVIDER in the DENTIST'S office to a covered MEMBER while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTIST

A dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide DENTAL SERVICES, perform dental surgery or administer anesthetics for dental surgery. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DEPENDENT

A MEMBER other than the SUBSCRIBER as specified in "When Coverage Begins And Ends."

DEPENDENT CHILD(REN)

The covered child(ren) of a SUBSCRIBER or spouse domestic partner] up to the maximum DEPENDENT age, as specified in "When Coverage Begins And Ends."

EFFECTIVE DATE

The date on which coverage for a MEMBER begins, according to "When Coverage Begins And Ends."

EMERGENCY

Dental condition or symptom resulting from a dental disease which arises suddenly and in the judgment of a reasonable person, requires immediate care and treatment and such treatment is sought or received within 24-hours of onset.

EMPLOYEE

The person who is eligible for coverage under this dental benefit plan due to employment as determined by the EMPLOYER, and who is enrolled for coverage.

EMPLOYER

name of group.

ERISA

The Employee Retirement Income Security Act of 1974.

EXPERIMENTAL

See INVESTIGATIONAL.

FOSTER CHILD(REN)

Children under age 18 i) for whom a guardian has been appointed by a clerk of superior court of any county in North Carolina or ii) whose primary or sole custody has been assigned by order of a court with proper jurisdiction and who are residing with a person appointed as guardian or custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short-term basis.

GRIEVANCE

Grievances include dissatisfaction with a claims denial or any of our decisions (including an appeal of a noncertification decision), policies or actions related to the availability, delivery or quality of DENTAL SERVICES.

GROUP ADMINISTRATOR

A representative of the EMPLOYER designated to assist with MEMBER enrollment and provide information to SUBSCRIBERS and MEMBERS concerning the dental benefit plan.

GROUP CONTRACT

The agreement between BCBSNC and the EMPLOYER. It includes the master group contract, the benefit booklet(s) and any exhibits, the group enrollment application and dental questionnaire when applicable.

HOSPITAL

An accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located, or a state tax-supported institution. All services performed must be within the scope of license or certification to be eligible for reimbursement.

IDENTIFICATION CARD (ID Card)

The card issued to our SUBSCRIBERS upon enrollment which provides group/MEMBER identification numbers, names of the MEMBERS, applicable copayments and/or coinsurance, and key phone numbers and addresses.

INCURRED

The date on which a MEMBER receives the service, drug, equipment or supply for which a charge is made.

INVESTIGATIONAL (EXPERIMENTAL)

The use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug or device that BCBSNC does not recognize as standard dental care of the condition, disease, illness, or injury being treated.

The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

- a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
- b) There is insufficient or inconclusive scientific evidence in peer-reviewed dental literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
- c) There is inconclusive evidence that the service or supply has a beneficial effect on dental outcomes
- d) The service or supply under consideration is not as beneficial as any established alternatives
- e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on dental outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.

LIFETIME DEDUCTIBLE

The specified dollar amount for certain COVERED SERVICES that the MEMBER must incur before benefits are payable for the remaining COVERED SERVICES. The deductible must be met only once for a **continuous** coverage period.

The deductible does not include MEMBER coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum and expenses for noncovered services.

LIFETIME MAXIMUM

The maximum amount of COVERED SERVICES that will be reimbursed on behalf of a MEMBER while covered under this dental benefit plan. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

MEMBER

A SUBSCRIBER or DEPENDENT, who is currently enrolled in this dental benefit plan and for whom premiums are paid.

PROVIDER

An individual or entity, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

SUBSCRIBER

The person who is eligible for coverage under this dental benefit plan due to employment and who is enrolled for coverage.

UTILIZATION MANAGEMENT (UM)

A set of formal processes that are used to evaluate the CLINICAL NECESSITY, quality of care, cost-effectiveness and appropriateness of many DENTAL SERVICES, including procedures, treatments, devices, materials, PROVIDERS and facilities.

WAITING PERIOD

The amount of time that must pass before a MEMBER is eligible to be covered for benefits under the terms of this dental benefit plan.