Benefit Booklet For Employees of

VANCE CHARTER SCHOOL

for

DENTAL Blue® SELECT℠

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

Dental Blue Select – 10/1/2016 - T110829001
Complete with Orthodontia $1,500 Max - DBS-09

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, visit our website at **bcbsnc-dental.com** or call BCBSNC Dental Blue Select Customer Service at the number listed on your ID CARD or in "Who to Contact?"

As you read this benefit booklet, keep in mind that any word you see in small capital letters (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."

Aviso Para AFILIADOS que no hablan ingles

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

WHO TO CONTACT?

BCBSNC Website

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

Website……..……**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:

- Any deductible and coinsurance amounts are based on the ALLOWED AMOUNT
- Coinsurance percentages shown below are the part of the ALLOWED AMOUNT that you pay.

Dental Blue Select

BENEFIT PERIOD—10/1/2016 through 9/30/2017

DENTAL SERVICES	**Your Cost**
Diagnostic and Preventive Services	0% after dental deductible
Basic Services 6-month WAITING PERIOD applies	20% after dental deductible
Major Services 12-month WAITING PERIOD applies	50% after dental deductible
LIFETIME DEDUCTIBLE per individual, applies to all services except orthodontics	$100
Dental BENEFIT PERIOD MAXIMUM per individual, applies to all services except orthodontics	$1,500
Orthodontic Services 12-month WAITING PERIOD applies	50%
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. As a MEMBER of Dental Blue Select, you have access to PROVIDERS, including contracting PROVIDERS, in and outside the state of North Carolina. If you receive DENTAL SERVICES from a contracting PROVIDER, you will only pay the coinsurance amount and any applicable deductible. However, if you receive DENTAL SERVICES from PROVIDERS who do not contract with BCBSNC, you may be responsible for the difference between the billed amount and the ALLOWED AMOUNT, in addition to the coinsurance and any applicable deductible.

While BCBSNC has arranged for the acceptance of ALLOWED AMOUNTS for COVERED SERVICES through contractual agreements with PROVIDERS, the contracting PROVIDERS are liable to the MEMBERS of this dental benefit plan for the provision of COVERED SERVICES. BCBSNC is not responsible for the provision of such COVERED SERVICES nor is it liable for the failure of the provision of the same.

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. 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 "Who to Contact?" to obtain the criteria that BCBSNC uses to determine whether the recommended services are CLINICALLY NECESSARY and eligible for coverage.

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 website at **bcbsnc-dental.com** or call BCBSNC at the number listed in "Who to Contact?"

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 – Dental Blue Select

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.

> For claim forms or help filing a claim, visit our website at **bcbsnc-dental.com** or call BCBSNC at the number listed in "Who to Contact?"

UNDERSTANDING YOUR SHARE OF THE COST

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

Deductible

A deductible is the dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable by BCBSNC. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or expenses for noncovered services. If one or more DEPENDENTS are covered, you each have an individual deductible. Refer to "Summary of Benefits" for your specific deductible amounts.

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 COVERED 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	$450	$500
C. Deductible Amount	$100	$100
D. ALLOWED AMOUNT Minus Deductible (B-C)	$350	$400
E. BCBSNC Pays (Coinsurance times D)	(80%) $280	(80%) $320
F. Your Coinsurance Amount (D-E)	$70	$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)	$170	$230

Deductible and coinsurance amounts are for example purposes only. Please refer to "Summary of Benefits" for your benefits.

Please note: If you receive DENTAL SERVICES from contracting PROVIDERS in or outside the state of North Carolina, you only pay the coinsurance amount and any applicable deductible listed below. If you receive DENTAL SERVICES from non-contracting PROVIDERS, in addition to the coinsurance and any deductible listed below, you may be responsible for the difference between the PROVIDER'S billed charge and the ALLOWED AMOUNT. For a list of contracting PROVIDERS, see our website at **bcbsnc.com**.

COVERED SERVICES

DENTAL BLUE SELECT covers only those services that are CLINICALLY NECESSARY. Exclusions and limitations apply to your coverage. See "What Is Not Covered?"

Your dental benefits provide coverage for the services listed below, which may be obtained from any PROVIDER of DENTAL SERVICES. For information about how to enroll 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:

- Oral evaluations
  - periodic (twice per BENEFIT PERIOD)
  - comprehensive oral or periodontal (limit one per PROVIDER and one per BENEFIT PERIOD, counts toward periodic frequency limit above)
  - limited, detailed, problem focused (twice per BENEFIT PERIOD)
- Consultations (limit one per PROVIDER, only covered if no other services except x-rays performed)
- Cleaning—prophylaxis, including scaling and polishing above the gum line (twice each BENEFIT PERIOD). NOTE: A prophylaxis performed on a MEMBER under the age of 14 will be covered as a child prophylaxis.
- Pulp-testing—evaluation of tooth nerve (limited to one charge per visit, regardless of the number of teeth tested)
- Supplemental bitewings—x-rays showing the back teeth (maximum of four films per BENEFIT PERIOD)
- Topical fluoride application to prevent decay (once each BENEFIT PERIOD, covered through age 18)
- Palliative EMERGENCY treatment for relief of pain only (twice per BENEFIT PERIOD)
- Sealants for first and second permanent molars for MEMBERS ages 6 through 15 (one reapplication per tooth every 5 years)
- Diagnostic casts—only if not related to orthodontic or prosthetic services.

Basic Services

The following are COVERED SERVICES:

- Routine fillings to restore diseased teeth including interim therapeutic restoration(limit of one restoration per tooth every two years, unless new decay appears)
  - amalgam—a soft silver which hardens after it is packed into the cavity
  - composite resin or other tooth-colored filling materials
- Simple extractions

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, one per tooth per lifetime)
  - Recementation (limit of three per lifetime, not within six months of placement)
- Surgical removal of teeth
- Complex oral surgery
  - orantral fistula closure/closure of sinus perforation (once per tooth)
  - surgical access of unerupted tooth/process to aid eruption (once per tooth)
  - transseptal fiberotomy (once per site every three years)
  - alveoloplasty (once per site every three years)
  - vestibuloplasty (once per site every three years)
  - removal of exostosis (once per site every three years)
  - incision and drainage of intraoral abscess
  - frenulectomy (once per site per lifetime)

  - excision of hyperplastic tissue or pericoronal gingiva (once per site every three years)
- Anesthesia limited to deep sedation and intravenous when CLINICALLY NECESSARY and related to covered complex surgery or surgical removal of teeth when three or more quadrants are involved
- X-rays:
  - full-mouth or panoramic x-rays for MEMBERS ages six and older (limited to once every three years unless taken for diagnosis of third molars, cysts, or neoplasms)
  - vertical bitewings (limit of 1 set per BENEFIT PERIOD, associated with periodontics)
  - periapical and occlusal x-ray of a tooth (limit to four films per BENEFIT PERIOD)
  - extraoral (two films per BENEFIT PERIOD)
- Endodontics—treatment of diseases of the nerve chamber and canals
  - pulpotomy—partial removal of a tooth's pulp and placement of medicament (once per tooth per lifetime)
  - retrograde filling (limit one per tooth)
  - root amputation (limit one per tooth)
  - endodontic therapy (once per lifetime, and retreatment once per lifetime after 12 months from initial treatment)
  - apexification—inducing root development
  - hemisection-dividing the crown and roots of a multi-rooted tooth (once per root per lifetime)
  - apicoectomy—removing the infected tip of the tooth's root (once per root per lifetime)
  - periradicular surgery – including bone graft, biological materials and guided tissue regeneration (once per root per lifetime

Pin retention (limit of once per restoration)

Treatment of the diseases of the gums and bone surrounding the teeth is periodontics. The following are covered periodontal services:

- Crown lengthening—reshaping the bone around the teeth to allow for proper prosthetic preparation (once per tooth every three years)
- Root planing and periodontal scaling—scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every three years)
- Full mouth debridement (once every five years)
- Provisional splinting (once every three years)
- Periodontal maintenance following active periodontal therapy (twice each BENEFIT PERIOD)
- Complex surgical periodontal care (limited to one complex surgical periodontal service per area every three years):
  - gingivectomy and gingivoplasty—cutting out diseased or overgrown gum tissues around the teeth
  - gingival flap procedure—soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue
  - osseous surgery—removing or reshaping the bone around the teeth through an incision of the gum
  - bone replacement graft
  - guided tissue regeneration
  - soft tissue graft/allograft/connective tissue graft
  - distal or proximal wedge
- Periodontal maintenance following active periodontal therapy (twice each BENEFIT PERIOD)
- Stainless steel crowns
  - primary posterior (one per tooth per lifetime)
  - primary anterior (one per tooth every three years)
  - permanent (one per tooth per eight years)
- Inlays, onlays, crowns (one restoration per tooth every eight) years, covered only when a filling cannot restore the tooth)
- Core build-up, cast post and core (one per tooth every eight years)
- Labial veneers, anterior only (one per tooth every five years)
- Complete dentures (once every eight years, no additional allowances for over-dentures or customized dentures)
- Removable partial dentures (once every eight years, no additional allowances for precision or semi-precision attachments or over-dentures)
- Fixed partial dentures (once every eight years, no additional allowances for removable partial dentures)

- Tissue conditioning done more than six months after initial insertion or rebasing or relining (once every 12 months per prosthesis)
- Rebasing of complete and partial dentures done more than five years after the initial insertion (once every five years)
- Crown, partial and complete denture repairs and addition of teeth to existing partial dentures (limited to repairs or adjustments done after 12 months following the initial insertion)
- Replacement of broken teeth on partial or complete denture (once per tooth every three years)
- Denture relining done more than six months after the initial insertion (once every two years)
- Recementing or rebonding of inlays, crowns and/or fixed partial dentures
- Occlusal guard, for treatment of bruxism only (once every five years)

Orthodontic Services

Benefits for a comprehensive orthodontic treatment are covered for all eligible MEMBERS through age 18. If you receive orthodontic treatment before your EFFECTIVE DATE, benefits may be available for further orthodontic services as long as you have satisfied any applicable WAITING PERIOD. 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 divided into multiple payments. The first payment is 50 percent of your initial payment, but no more than half of the LIFETIME MAXIMUM for orthodontics. This is followed by monthly coinsurance payments based on the existing treatment plan, up to the LIFETIME MAXIMUM for orthodontics. 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. 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 procedures. For example, gold, titanium and high noble metal restorations and prosthodontics will be covered at the level of noble metal procedures.

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 or payment:

	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 - Implants (if applicable)	- Conventional endodontics on permanent teeth and retreatments	- Surgical extractions - Impactions	- General - IV sedation
Information Required for Claim Processing	- Pre-operative x-ray(s)	- Periodontal charting - Pre-operative x-ray(s) - Narrative Report (Explanation)	- 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-DBS
Claims Unit
PO Box 2400
Winston Salem, NC 27102-2400

When You File a Claim

In order to process your claim, BCBSNC may need additional 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.

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. 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, except as specifically covered by your dental benefit plan
- 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

DENTAL SERVICES related to an **accidental injury**.

Acupuncture and acupressure

Administrative charges billed by a PROVIDER, including charges for cancelled or missed appointments, completion of a claim form, obtaining dental records, late payments and telephone charges

Costs in excess of the **ALLOWED AMOUNT**

Anesthesia, including local, regional block, trigeminal division block, nitrous oxide, analgesia, anxiolysis non-intravenous conscious sedation, except as otherwise covered by your dental benefit plan. Evaluation for deep sedation or general **anesthesia.**

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

Brush biopsy

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

Cleaning and inspection of a removable appliance

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

Indirect resin-based composite **crowns**

Temporary or provisional **crowns** and pontics

Removal of odontogenic and nonodontogenic **cysts**

Cytology sample

D

Dental procedures not directly associated with dental disease

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

Interim **dentures**

Removable unilateral partial **denture** (one-piece cast metal), including clasps and teeth.

Application of **desensitizing** material

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

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**

I

Incision and drainage of an extraoral soft tissue

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

L

Destruction of **lesions** by physical or chemical method

M

Maxillofacial prosthesis

Services covered under your **medical plan**

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. This includes any services, procedures or supplies associated with COSMETIC services, INVESTIGATIONAL services, and services deemed not CLINICALLY NECESSARY

O

Office visits for purposes of observation or presentation of treatment plan

Repair, replacement, rebonding, or recementing of **orthodontic appliances** or retainer

P

Periodontal-related services such as anatomical crown exposure, apically positioned flap, surgical revisions and unscheduled charges

3D **photographic** images

Temporary or provisional **pontic**

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

Pulp cap, direct or indirect

R

Radiographs or diagnostic imaging not specifically stated as covered are considered noncovered, such as skull and bone survey

Tooth **reimplantation** or transplantation from one site to another

Removal of foreign bodies or non-vital bones

Risk Assessment and documentation associated with caries

S

Sales tax

Services related to the **salivary gland**

Screenings to determine whether a MEMBER needs to be seen by a DENTIST for diagnosis

Sealant Repair

Services or supplies that are:

- Not performed by or upon the direction of a DENTIST or other PROVIDER
- Available to a MEMBER without charge
- An inherent component of a covered DENTAL SERVICE

Surgical procedures, surgical placement of temporary anchorage device, LeFort, emergency tracheotomy and synthetic graft

T

Temporomandibular joint (TMJ) treatment, either bilateral or unilateral, and any associated services such as arthrogram including injections, TMJ films, tomographic survey, temporomandibular therapy, and occlusal orthotic devices

Tests, exams, and oral pathology laboratory not specifically listed as a COVERED SERVICE

V

Reconstruction of a patient's correct **vertical dimension of occlusio**n (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 an existing marriage that is legally recognized under any state law
- Your, or your spouse's DEPENDENT CHILDREN through the end of the month of their 26th birthday.
- A DEPENDENT CHILD who is and continues to be 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 end of eligibility for DEPENDENT CHILDREN. 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 BENEFIT PERIOD may be different from your dental BENEFIT PERIOD. If you are subject to dental WAITING PERIODS, your WAITING PERIOD may vary if you are a timely or late enrollee. WAITING PERIODS are waived for newborns added up to 30 days after their first birthday. WAITING PERIODS do not apply to adoptive children, FOSTER CHILDREN, and children who are added as a result of a court order such as a Qualified Medical Child Support Order (QMCSO).

You are a timely enrollee if you apply for coverage and/or add DEPENDENTS:

- within 30 days of when you first become eligible for coverage, or
- within 30 days following a qualifying event, or
- during a designated enrollment period.

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, court order, 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) and apply for coverage under this dental benefit plan within 60 days.

WAITING PERIODS

If you and your DEPENDENTS do not apply as timely enrollees as stated above, you are considered late enrollees. See the chart below for WAITING PERIODS that apply before benefits will be paid under this benefit plan.

Benefit	WAITING PERIODS – Timely Enrollees	WAITING PERIODS – Late Enrollees
Diagnostic and Preventive	None	None
Basic	6 months	12 months
Major	12 months	24 months
Orthodontic	12 months	24 months

WAITING PERIODS are waived, or reduced by the number of months of prior coverage, for 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 fill out any required forms.

For coverage to be effective on the first day of the month following the date the DEPENDENT becomes eligible, your form must be completed within 30 days after the DEPENDENT becomes eligible. However, if you are adding a newborn child, a FOSTER CHILD, or a child legally placed for adoption , and adding the DEPENDENT CHILD would not change your coverage type or premiums, the change will be effective on the date the child becomes eligible, as long as the coverage was effective on that date. In these cases, notice is not required by BCBSNC within 30 days after the child becomes eligible, but it is important to provide notification as soon as possible.

DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when a spouse is no longer eligible due to divorce or death. Failure to timely notify your GROUP ADMINISTRATOR of the need to remove a DEPENDENT could result in loss of eligibility for continuation of coverage.

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 participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and applicable period of the QMCSO. A copy of the QMCSO procedures may be obtained free of charge from your GROUP ADMINISTRATOR.

Types of Coverage

This is the types of coverage available:

Option 04

- EMPLOYEE-only coverage—The dental benefit plan covers only you
- EMPLOYEE-spouse coverage—The dental benefit plan covers you and your legal spouse
- EMPLOYEE-children coverage—The dental benefit plan covers you and your DEPENDENT CHILDREN
- Family coverage—The dental benefit plan covers you, your spouse 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 fill out 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.

You and your covered DEPENDENTS of any size employer group may have the option to continue group coverage for 18 months from the date that you and/or your DEPENDENTS cease to be eligible for coverage under this dental benefit plan. You and your DEPENDENTS are not eligible for continuation if:

- Your insurance terminated because you failed to pay the appropriate contribution
- You or your DEPENDENTS are eligible for another group dental benefit plan
- You were covered less than three consecutive months prior to termination.

You and/or your DEPENDENTS must notify the GROUP ADMINISTRATOR if you or your DEPENDENTS intend to continue coverage and pay the applicable fees within 60 days following the end of eligibility. Upon receipt of the notice of continuation and applicable fees, BCBSNC will reinstate coverage back to the date eligibility ended. These continuation benefits run concurrently and not in addition to any applicable federal continuation rights described below, that you may have.

Continuation of coverage under this dental benefit plan 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
- The continuing person obtains similar coverage under another group 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.

Domestic partners and children of the domestic partner are not eligible for COBRA benefits under federal law. 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 may 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 ADVERSE BENEFIT DETERMINATION 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 ADVERSE BENEFIT DETERMINATIONS of service that were based upon CLINICAL NECESSITY
- Request a review of an ADVERSE BENEFIT DETERMINATION through our appeals process. See "What If You Disagree with Our Decision?"
- 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:

- Provide you and your PROVIDER with a toll-free telephone number to call UM review staff when CERTIFICATION of a dental care service is needed
- 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 applicable state and federal law and your dental benefit plan.

In the event that BCBSNC does not receive sufficient information to approve coverage for a DENTAL SERVICE within specified time frames, BCBSNC will notify you of an ADVERSE BENEFIT DETERMINATION in writing. The notice will explain how you may appeal the ADVERSE BENEFIT DETERMINATION.

Retrospective Reviews (Post-Service)

BCBSNC reviews the coverage of DENTAL SERVICES after you receive them (retrospective/post-service 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 and your PROVIDER of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. In the event of an ADVERSE BENEFIT DETERMINATION, 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. If more information is needed before the end of the initial 30-day period, BCBSNC will notify you 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.

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 an appeals process for our MEMBERS.

If you want to appeal an ADVERSE BENEFIT DETERMINATION, you have the right to request that BCBSNC review the decision through the appeals process. The appeals 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 Appeals Process

For each step in this process, there are specified time frames for filing an appeal and for notifying you or your PROVIDER of the decision. You must request the review in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date indicated on your Explanation of Benefits.

Any request for review should include:

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

To request a form to submit a request for review, visit our website at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

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

BCBSNC – Dental Blue Select

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 appeal, 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 dentistry involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

First Level Appeal BCBSNC will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials.

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. 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 may receive, in advance, any new information that BCBSNC may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

BCBSNC will send you notification of the decision in clear written terms, 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. BCBSNC delegates responsibility for the first level appeal to ACS Benefit Services, Inc. (ACS). ACS is a wholly owned subsidiary of BCBSNC, but operates as a separate, independent company from BCBSNC. Please forward written appeals to:

ACS Benefit Services, Inc.
PO Box 2400
Winston Salem, NC 27102-2400

Second Level Appeal

If your EMPLOYER is subject to ERISA, the first level appeal is the only level that you must complete before you can pursue your appeal in an action in federal court.

Otherwise, if you are dissatisfied with the first level appeal decision, you have the right to a second level appeal. Second level appeal is provided by BCBSNC.

Second level appeals 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 appeal, BCBSNC will send you an acknowledgement letter which will include the following:

- Name, address and telephone number of the appeals coordinator
- A statement of your rights, including the right to:
  - request and receive from us all information that applies to your appeal
  - participate in the second level appeal meeting
  - present your case to the review panel
  - submit supporting material before and during 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 as applicable (limited to MEMBERS whose EMPLOYER is subject to ERISA).

The second level appeal meeting, which will be conducted by a review panel coordinated by BCBSNC using external DENTISTS and/or benefit experts, will be held within 45 days after BCBSNC receives a second level appeal. You will receive notice of the meeting date and time at least 15 days before the meeting, which will be held by teleconference. You have the right to a full review of your appeal even if you do not participate in 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 EMPLOYER is subject to ERISA. If any claim shall be wholly or partially denied at either the first level appeal or the second level appeal, 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 clinical circumstances, or a statement that such explanation will be provided without charge upon request
- 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 under this dental benefit plan cannot be transferred or assigned to any other person or entity, including any PROVIDERS. BCBSNC may pay a PROVIDER directly. For example, BCBSNC pays contracting PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with BCBSNC, and not through this dental benefit plan. Under this dental benefit plan, BCBSNC has the sole right to determine whether payment for services is made to PROVIDER, to SUBSCRIBER or allocated among both.. BCBSNC's decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under this dental benefit plan, including but not limited to benefits, payments, or procedures. The MEMBER is responsible for paying the PROVIDER in full and filing a claim.

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 website at **bcbsnc.com** or call BCBSNC at the number listed in "Who to Contact?"

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.

Premium Payment

If premium payments are not received by BCBSNC within [30] days of the end of the last paid-through date, the MEMBER'S coverage will automatically terminate as of that date. If BCBSNC does not exercise its right to automatically terminate on the 30th day, BCBSNC will retain the right to terminate immediately for nonpayment upon written notice to the GROUP.

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 EMPLOYER 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 more 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 reason(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 clinical circumstances, or a statement that this will be provided without charge upon request.

You have the right to appeal an ADVERSE BENEFIT DETERMINATION with BCBSNC. See "What If You Disagree with Our Decision?" for more information.

Limitation of Actions

If your EMPLOYER is subject to ERISA, you must only exhaust the first level appeals process following the Notice of Claim requirement. Please see "What If You Disagree With Our Decision?" for details regarding the appeals 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 appeal, 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 take into account benefits paid by 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.

Please note that COB also applies to pediatric dental services where the group health insurance plan will be primary to a dental insurance plan.

Payment by BCBSNC under your dental benefit plan takes into account whether or not the PROVIDER is a contracting PROVIDER. If this benefit plan is the secondary plan, and the MEMBER uses a contracting PROVIDER, BCBSNC will coordinate up to the ALLOWED AMOUNT. The contracting PROVIDER has agreed to accept the ALLOWED AMOUNT as payment in full.

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.

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 the provision is	√	
	The plan with the provision is		√
The person is the participant under one plan and a DEPENDENT under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a DEPENDENT is		√
The person is covered as a DEPENDENT CHILD under both plans, and parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD'S dental coverage; or 3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD'S dental coverage	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	√	
	The plan of the parent whose birthday is later in the calendar year is		√
	Note: When the parents have the same birthday, the plan that covered the parent longer is	√	
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/ separated or not living together with no court decree* for coverage	The custodial parent's plan is	√	
	The plan of the spouse of the custodial parent is		√
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	√	
	The non-custodial parent's plan is		√
	Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.*		

The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*	The plan of the parent primarily responsible for dental coverage under the court decree is	√	
	The plan of the other parent is		√
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's dental coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's dental benefit plan are	√	
The person is covered as a laid-off or retired EMPLOYEE or that EMPLOYEE'S DEPENDENT on one of the plans, including coverage under COBRA	The plan that covers a person other than as a laid-off or retired employee or as that employee's dependent is	√	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee is		√
	Note: This rule does not apply if it results in a conflict with any of the other rules for 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	√	
	The plan that has been in effect the shorter amount of time is		√

Note: You may be required to submit a copy of the court order or legal documentation in these instances.

GLOSSARY

ADVERSE BENEFIT DETERMINATION
A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit, including one that results from the application of any utilization review, or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be EXPERIMENTAL or INVESTIGATIONAL or not CLINICALLY NECESSARY or appropriate. Rescission of coverage is also included as an adverse benefit determination.

ALLOWED AMOUNT
The maximum amount that BCBSNC determines is reasonable for COVERED SERVICES provided to a MEMBER. The allowed amount will be the lesser of the PROVIDER'S billed charge or a 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)
A child, until the end of the month of their 26th birthday, who is either: 1) the SUBSCRIBER'S biological child, stepchild, legally adopted child (or child placed with the SUBSCRIBER and/or spouse for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to the SUBSCRIBER and/or spouse, or 3) a child for whom the SUBSCRIBER and/or spouse has been court-ordered to provide coverage. The spouse or children of a dependent child are not considered DEPENDENTS.

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
VANCE CHARTER SCHOOL

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.

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, name of SUBSCRIBER, 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 U.S. 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 or 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.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY ：1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。