Benefit Booklet
For Employees of
City of Wilmington

for

DENTAL**Blue**®

Benefit Booklet

An Independent Licensee of the Blue Cross and Blue Shield Association

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BENEFIT BOOKLET

This benefit booklet describes the City of Wilmington EMPLOYEE dental plan (the PLAN). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

The benefit plan described in this booklet is an EMPLOYEE dental plan (the PLAN). A summary of benefits, conditions, limitations and exclusions is set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the PLAN document, the PLAN document will control.

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

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WELCOME TO DENTAL BLUE

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

How To Use Your Dental Blue 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 Customer Service at the number listed on your ID CARD or in "Whom Do I 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. 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 Works" explains how to access your dental benefits.
- "When Coverage Begins And Ends" tells you, among other things, how and when to enroll in the PLAN
- "What If You Disagree With A Decision?" explains the rights available to you when BCBSNC makes 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 dental de SU EMPLEADOR le ofrece. Si usted tiene dificultad en entender alguna sección de este manual, por favor llame al ADMINISTRADOR DEL PLAN para recibir ayuda.

This section provides a summary of your Dental Blue 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 part of the ALLOWED AMOUNT that the PLAN 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 billed charge and the ALLOWED AMOUNT. For a list of PROVIDERS who have contracted with BCBSNC, see the Web site at **bcbsnc.com**.

Dental Blue - Rollover Plan
BENEFIT PERIOD - July 1, 2011 through June 30, 2012

DENTAL SERVICES	Benefits
Diagnostic and Preventive Services	100%
Basic Services	80% after dental deductible
Major Services	50% after dental deductible
Individual Dental Deductible per BENEFIT PERIOD, includes basic and major services	$50
Family Dental Deductible per BENEFIT PERIOD, includes basic and major services	$150
Dental BENEFIT PERIOD MAXIMUM per individual, includes diagnostic and preventive, basic and major services	$1,000
ANNUAL BENEFIT THRESHOLD	$500
ANNUAL ROLLOVER AMOUNT	$250
MAXIMUM ROLLOVER AMOUNT	$1,000

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

HOW DENTAL BLUE WORKS

Dental Blue 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 Customer Service at the number given in "Whom Do I Contact?" 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 billed charge and the BCBSNC ALLOWED AMOUNT if you receive DENTAL SERVICES from PROVIDERS who do not contract with BCBSNC. You are encouraged 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 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 the Web site at **bcbsnc.com** or call BCBSNC at the number listed in "Whom Do I Contact?"

Making An Appointment

Call the PROVIDER'S office and identify yourself as a Dental Blue 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 2100
Winston Salem, NC 27102-2100

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 the Web site at **bcbsnc.com** or calling BCBSNC at the number listed in "Whom Do I Contact?" For help filing a claim, call BCBSNC Dental Blue Customer Service or write to:
>
> BCBSNC
> Claims Unit
> PO Box 2100
> Winston Salem, NC 27102-2100

UNDERSTANDING YOUR SHARE OF THE COST

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

Deductibles

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

Coinsurance

Coinsurance is the sharing of charges by the PLAN and the MEMBER for COVERED SERVICES, after you have satisfied your 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	$50	$50
D. ALLOWED AMOUNT Minus Deductible (B-C)	$450	$450
E. The PLAN Pays (Coinsurance times D)	(80%) $360	(80%) $360
F. Your Coinsurance Amount (D-E)	$90	$90
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)	$140	$190

The PLAN includes a rollover option. Each BENEFIT PERIOD you may rollover a portion of the BENEFIT PERIOD MAXIMUM that you did not use to help pay for DENTAL SERVICES in future years. This is known as the ANNUAL ROLLOVER AMOUNT. In order to take advantage of the rollover option, the following rules apply:

- A MEMBER must have at least one diagnostic and preventive service during each BENEFIT PERIOD.
- In order to qualify for the ANNUAL ROLLOVER, the total amount of paid claims for the BENEFIT PERIOD cannot exceed the ANNUAL BENEFIT THRESHOLD. See "Summary Of Benefits" for the ANNUAL BENEFIT THRESHOLD amount.
- The ANNUAL BENEFIT THRESHOLD is based on the total dollar amount of claims paid during the BENEFIT PERIOD regardless of the INCURRED date.
- The MEMBER must be covered on this PLAN for a minimum of six months in order to qualify for the rollover for the following BENEFIT PERIOD.
- Any MEMBER who is covered on this PLAN less than six months will not qualify for the rollover until the end of the following BENEFIT PERIOD.
- A MEMBER cannot exceed the MAXIMUM ROLLOVER AMOUNT listed in the "Summary Of Benefits"

MEMBERS will be notified of the balance in their individual rollover account each year. Please note that the rollover is applied to the following BENEFIT PERIOD and will vary by MEMBER.

> To get your rollover balance, please visit the Web site at **bcbsncdental.com** or call BCBSNC at the number listed in "Whom Do I Contact?"

Here's an example of a rollover plan based on the following values:

Dental BENEFIT PERIOD MAXIMUM:	$1,250
Dental ANNUAL BENEFIT THRESHOLD:	600
Dental ANNUAL ROLLOVER AMOUNT:	300
Dental MAXIMUM ROLLOVER AMOUNT:	850

Year of Coverage	BENEFIT PERIOD MAXIMUM	Rollover Balance at Beginning of BENEFIT PERIOD	Total Paid Claims During BENEFIT PERIOD	Eligible for Rollover in the Following BENEFIT PERIOD
1	$1,250	$0	$345*	Yes
2	$1,250	$300	$450*	Yes
3	$1,250	$600	$500*	Yes
4	$1,250	$850 (MAXIMUM ROLLOVER AMOUNT met)	$350*	Yes
5	$1,250	$850	$1,900*	No
6	$1,250	$200	$275**	No
7	$1,250	$200	$600*	Yes

*Total claims paid include diagnostic and preventive services
**No diagnostic and preventive services were paid during this BENEFIT PERIOD

COVERED SERVICES

Dental Blue 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 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. The 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 counts toward periodic frequency limit above)
- Cleaning - prophylaxis, including scaling and polishing above the gum line (twice each BENEFIT PERIOD)
- Topical fluoride application to prevent decay (twice each BENEFIT PERIOD, covered through age 17)
- X-rays
  - full-mouth or panoramic (limited to either one of these procedures every three years)
  - Other X-rays
    - periapical, occlusal and extroral film of a tooth (limited to allowance of a complete series per day.
    - supplemental bitewings - x-rays showing the back teeth (limit to 2 procedures per BENEFIT PERIOD)
    - vertical bitewings (limit of one set per 3 years, up to the allowance of a complete series)
- Pulp-testing - evaluation of tooth nerve (limited to one charge per visit, regardless of the number of teeth tested)
- 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 one tooth per lifetime)
- Appliance therapy - (limited to the correction of thumb sucking, only)

Basic Services

The following are COVERED SERVICES:

- Limited to oral evaluation or re-evaluation, detailed, problem focused (allowed for accidental injury only and counts toward periodic frequency limit above)
- Consultations (limit 1 procedure per one PROVIDER)
- Oral Pathology/Laboratory (limited to 1 procedure and examination per BENEFIT PERIOD)
  - Accession of tissue, gross examination, preparation and transmission of written report
  - Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report
- Sealants for first and second permanent molars for MEMBERS age 6 through 16 (one reapplication per tooth every 3 years).
- Palliative EMERGENCY treatment for relief of pain only (not covered in conjunction with other procedures, except diagnostic x-rays films
- Routine fillings to restore diseased teeth (limit of 1 restoration per 6 months)
  - amalgam - a soft silver which hardens after it is packed into the cavity (limited on one every six months)
  - composite resin or other tooth-colored filling materials (limited to one every 6 months)
  - Pin retention - per tooth, in addition to restoration
- Stainless steel crowns (limited to 1 procedure per BENEFIT PERIOD)
  - Resin based composite crown, anterior
  - Prefabricated stainless steel crown - primary tooth
  - primary anterior
  - permanent
- Retreatment of Root Canal (limited to 1 procedure per BENEFIT PERIOD and 12 months after root canal therapy)
- Denture repairs and relines (limited to repairs or adjustments done after 6 months following the initial insertion)

  - Replacement of broken teeth per tooth
- Crown, partial and complete denture repairs and addition of teeth to existing partial dentures (limited to repairs adjustments done after 6 months following the initial insertion)
- Complex oral surgery
  - oroantral fistula closure /closure of sinus perforation
  - surgical access of unerupted tooth/process to aid eruption
  - transseptal fiberotomy alveoloplasty
  - vestibuloplasty
  - removal of exostosis
  - incision and drainage of abscess intraoral/extraoral soft tissue
  - frenulectomy/Frenulopasty
  - excision of hyperplastic tissue or pericornal gingival
  - Excision of benign or malignant lesion up to 1.25 cm
  - Excision of benign or malignant lesion greater than 1.25 cm
  - Excession of benign or malignant lesion, complicated
  - Removal of benign odontogenic/nonodontogenic cyst or tumor up to 1.25 cm
  - Removal of benign odontogenic/nonodontogenic cyst or tumor greater than 1.25 cm
  - Surgical reduction of fibrous tuberosity
  - Sialolithotomy
  - Closure of salivary fistula
  - Biopsy of oral tissue - hard (bone, tooth)
  - Biopsy of oral tissue - soft
  - Exfoliative cytological sample collection
  - Brush biopsy - transepithelial sample collection
  - Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
  - Complicated suture - greater than 5 cm
- Anesthesia limited to deep sedation and intravenous when CLINICALLY NECESSARY and related to covered complex surgery
- Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
- Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization
- Simple extractions
  - Surgical removal of teeth
- Oral surgery including surgical removal of teeth and maxillary or mandibular intrabony cysts and procedures performed for the preparation of the mouth for dentures
- Periapical x-ray of a tooth
- Denture relining done more than six months after the initial insertions
- Periodontal maintenance (2 procedures per BENEFIT PERIOD and counts towards your cleaning frequency limit listed above)
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Destruction of lesion(s) by physical or chemical method, by report
- Radical resection of maxilla or mandible
- Incision and drainage of abscess - intraoral soft tissue
- Partial ostectomy/sequestrectomy for removal of non-vital bone
- Maxillary sinusotomy for removal of tooth fragment or foreign body
- Endodontics - treatment of diseases of the nerve chamber and canals
  - pulpotomy - partial removal of a tooth's pulp and placement of medicament
  - retrograde filling, per root
  - root amputation, per root
  - 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)
- Full mouth debridement (limited to one every 5 years)

Major Services

A DENTIST may use an artificial device to restore 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:
- Inlays, onlays, crowns (one restoration per tooth every five years, covered core build up, cast pore and core)
- Crown, partial and complete denture repairs and addition of teeth to existing partial dentures.

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
- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report (limited to 2 of any procedures per 2 years)
- Root planing and periodontal scaling - scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every 2 years)
- Surgical Periodontics care (limited to one complete surgical periodontal service per area every 3 years)
  - Gingivectomy or 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, including root planning
  - Ossesous surgery - removing or reshaping the bone around the teeth through an incision
  - Bone replacement graft
  - Guided tissue regeneration
  - Soft tissue graft/allograft/connective tissue graft
  - Distal or proximal wedge
  - Biological materials to aid in soft and osseous tissue regeneration
- Complete dentures (once evry 5 years, no additional allowances for over dentures or customized dentures
- Removal partial dentures (once every 5 years, no additional allowances for precision or semi-precision attachments)
- Fixed partial dentures (once every 5 years, no additional allowances for removable partial dentures)
- Replacement of all teeth and acrylic on cast metal framework (maxillary or mandibular) denture (1 procedure per every 5 years)
- Interim complete or partial denture (maxillary/madibular)
- Overdenture complete or partial by report
- Implant/abutment supported fixed or removable denture for completely edentulous arch, includes adjustments within 6 months after placement date
- Implant/abutment supported fixed or removble denture for partially edentulous arch, includes adjustments within 6 months after placement date
- Fixed partial crown, replacement limited to 1 procedure per 5 years
- Fixed partial inlay/onlay, replacement limited to 1 procedure per 5 years
- Fixed partial pontic, replacement limited to 1 procedure per 5 years
- Implant supported crown, replacement limited to 1 procedure per 5 years
- Implant supported retainer, replacement limited to 1 procedure per 5 years
- Occlusal adjustment, covered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease

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)	- Periodontal charting - 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
Claims Unit
PO Box 2100
Winston Salem, NC 27102-2100

When You File A Claim

In order to process a 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 5 years of initial or supplemental placement.
- Denture relines for complete or partial conventional dentures are not covered for a period of 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 a period of six months after insertion of the full or partial denture. After this specified 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 non-resorbable guided tissue replacement (GTR), are covered once every 3 years 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
- Replacement of crowns, bridges and fixed or removable prosthetic appliances inserted prior to plan coverage until the patient has been eligible under the plan for 12 continuous months If loss of a tooth requires the addition of a clasp, pontic and/or abutment within this 12 month period, the Plan is responsible only for the procedures associated with the modification.

- Replacement of missing natural teeth lost prior to the effective date of coverage or during the initial 12 month period of coverage until the patient has been eligible for 12 continuous months
- Full-mouth debridement is limited to once every 3 years.

WHAT IS NOT COVERED?

This section describes exclusions to the PLAN, 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. The 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 MEMBER, 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 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 the PLAN
- A benefit, drug, service or supply not specifically listed as covered in this benefit booklet.

In addition, this 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

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

Services received either before or after the **coverage period** of the 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 the PLAN

D

Dental procedures not directly associated with dental disease

Placement of **dental implants**, implant-supported abutments and prostheses and any related services. This includes pharmacological regimens and restorative materials

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

O

Occlusal guards for any purpose other than control of habitual grinding

Orthodontic services

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.

MEMBERS shall be added to coverage no later than 90 days after their first day of employment. The term "MEMBER" 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. The EMPLOYER may allow eligibility to extend to other persons, such as retirees.

For DEPENDENTS to be covered under the 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 or your spouse's DEPENDENT CHILDREN to their 26th birthday. Your EMPLOYER may require proof that your DEPENDENT CHILD meets the definition of DEPENDENT CHILD as outlined in "Glossary".
- A DEPENDENT CHILD who is either mentally retarded or physically handicapped and incapable of self-support may continue to be covered under the 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 The 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.

The following are considered qualifying events:

- You or your DEPENDENTS become eligible for coverage under the 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 the 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 the PLAN within 60 days.
    - You or your DEPENDENTS become eligible for premium assistance with respect to coverage under the PLAN under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this 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	None	None
Major	6 months	6 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 the 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 PLAN ADMINISTRATOR and fill out any required forms. Failure to timely notify your PLAN 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 date the DEPENDENT becomes eligible, the proper form must be completed within 30 days after the *dependent* becomes eligible.

However, 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 coverage was effective on that date. In these cases, notice is not required by the PLAN ADMINISTRATOR within 30 days after the child becomes eligible; however, 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, marriage or when a spouse is no longer eligible due to divorce, legal separation or death.

Failure to timely notify your PLAN 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 the PLAN, 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 the PLAN ADMINISTRATOR.

Types Of Coverage

These are the types of coverage available:

- Employee-only coverage - The PLAN covers only you
- Employee-spouse coverage - The PLAN covers you and your spouse
- Employee-children coverage - The PLAN covers you and your DEPENDENT CHILDREN
- Family coverage - The 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 PLAN ADMINISTRATOR and fill out the proper form. It will help assure better service if BCBSNC is kept informed of these changes.

Continuing Coverage

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

You and your covered DEPENDENTS [of any employer-size 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 the 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 PLAN 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 the 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 or legal separation
- 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.

If you are a retired employee and your EMPLOYER allows coverage to extend to retirees under this 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 PLAN 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 PLAN 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 PLAN 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 DEPENDENT'S must notify the PLAN ADMINISTRATOR within 60 days of the following qualifying events:

- Divorce

- Legal separation
- Ineligibility of a 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 PLAN and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult your PLAN ADMINISTRATOR. Your PLAN ADMINISTRATOR will advise you about the continuation of coverage and reinstatement of coverage under this PLAN as required under USERRA.

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

Termination Of *Member* Coverage

BCBSNC will terminate coverage under the PLAN in accordance with eligibility information provided by the EMPLOYER. A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends.

Termination For Cause

A MEMBER'S coverage under the PLAN will be terminated immediately for the following reasons:

- Fraud or intentional misrepresentation of a material fact by a MEMBER or DEPENDENT. (this may result in termination retroactively to the EFFECTIVE DATE of your policy; any premiums paid will be returned unless BCBSNC deducts the amount
- 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 PLAN, or uses another person's ID CARD.

The PLAN 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 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 the appeal 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 BCBSNC requests 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 the 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 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 more 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.

Further Review Of UTILIZATION MANAGEMENT Decisions

If you receive a noncertification as part of the prior review process, you have the right to request that BCBSNC review the decision through the appeals process. See "What If You Disagree With A Decision?"

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 BCBSNC to determine the best services and products to offer MEMBERS. They also help keep pace with the ever-advancing dental field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from PROVIDERS who know the needs of the patients they serve.

In addition to the UM program, BCBSNC offers an appeals process for 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).

Steps To Follow In The Appeals Process

For each step in this process, there are specified time frames for filing an appeals and for notifying you or your PROVIDER of the decision. The type of ADVERSE BENEFIT DETERMINATION will determine the steps that you will need to follow in the appeals process. For all appeals, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION. Any request for review should include:

- MEMBER'S ID number
- MEMBER'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 the Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

All correspondence related to a request for a review through BCBSNC's appeals process should be sent to:
BCBSNC
Claims Unit
PO Box 2100
Winston Salem, NC 27102-2100

Quality Of Care Complaints

For quality of care complaints, an acknowledgement will be sent by BCBSNC within ten business days.

First Level Appeals Review

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 review, you may provide and/or present written or oral 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.

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 Appeals Review

If you are dissatisfied with the first level appeal review decision, you have the right to a second level appeal review. 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 all information that applies to your appeal from BCBSNC
  - attend the second level appeal 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.

The second level appeal 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 appeal. 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 appeals even if you do not attend the meeting. A written decision will be issued to you within seven business days of the review meeting.

Benefits To Which MEMBERS Are Entitled

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 the PLAN, payment for services will be made to the PROVIDER of the services, or the PLAN may choose to pay the EMPLOYEE. 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 EMPLOYEE, 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 EMPLOYEE or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the PROVIDER.

Benefits for COVERED SERVICES specified in the PLAN will be provided only for services and supplies that are performed by a PROVIDER as specified in the 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 the PLAN.

Any amounts paid by the PLAN for noncovered services or that are in excess of the benefit provided under your Dental Blue 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.

Amounts paid by the PLAN for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered 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.

In addition, under certain circumstances, if BCBSNC pays the PROVIDER amounts that are your responsibility, such as deductible, copayments or coinsurance, BCBSNC may collect such amounts directly from you.

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)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures.

> To obtain a copy of the privacy notice, visit the Web site at **bcbsnc.com** or call BCBSNC at the number listed in "Whom Do I Contact?"

Administrative Discretion

BCBSNC has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC dental policies are guides considered when making coverage determinations.

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 the PLAN, 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.

Right Of Recovery Provision

Immediately upon paying or providing any benefit under the PLAN, the PLAN shall be subrogated to all rights of recovery a MEMBER has against any party potentially responsible for making any payment to a MEMBER due to a MEMBER'S injuries, illness or condition, to the full extent of benefits provided or to be provided by the PLAN.

In addition, if a MEMBER receives any payment from any potentially responsible party as a result of an injury, illness or condition, the PLAN has the right to recover from, and be reimbursed by, the MEMBER for all amounts the PLAN has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. The MEMBER agrees that if the MEMBER receives any payment from any potentially responsible party as

a result of an injury or illness, the MEMBER will serve as a constructive trustee over the funds for the benefit of the PLAN. Failure to hold such funds in trust will be deemed a breach of the MEMBER'S fiduciary duty to the PLAN.

Further, the PLAN will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a MEMBER receives from any third party, any third party's insurer or any other source as a result of the MEMBER'S injuries. The lien is in the amount of benefits paid by the PLAN for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a MEMBER due to a MEMBER'S injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the PLAN including, but not limited to, the MEMBER, the MEMBER'S representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the PLAN.

The MEMBER acknowledges that the PLAN'S recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the PLAN before any other claim for the MEMBER'S damages. The PLAN shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the PLAN will result in a recovery to the MEMBER which is insufficient to make the MEMBER whole or to compensate the MEMBER in part or in whole for the damages sustained. It is further understood that the PLAN will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the PLAN is not required to participate in or pay court costs or attorney fees to any attorney hired by the MEMBER.

The terms of this entire right of recovery provision shall apply and the PLAN is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the MEMBER identifies the medical benefits the PLAN provided. The PLAN is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The MEMBER acknowledges that BCBSNC has been delegated authority by the PLAN ADMINISTRATOR to assert and pursue the right of subrogation and/or reimbursement on behalf of the PLAN. The MEMBER shall fully cooperate with BCBSNC's efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify BCBSNC in writing of the MEMBER'S intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the MEMBER. The MEMBER shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The MEMBER shall do nothing to prejudice the PLAN 'S recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the PLAN.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the MEMBER and the PLAN agree that the PLAN ADMINISTRATOR shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The MEMBER agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the PLAN, the MEMBER hereby submits to each such jurisdiction, waiving whatever rights may correspond to the MEMBER by reason of the MEMBER'S present or future domicile.

Notice Of Claim

The PLAN 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.

Limitation Of Actions

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 appeals process. Please see "What If You Disagree With A Decision?" for details regarding the appeals process.

No legal action may be taken later than three years from the date services are INCURRED.

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. 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	√	
	The plan with COB 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, including when parents are divorced or separated and share joint custody	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 and parents are divorced or separated 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		√
The person is covered as a dependent child and coverage is stipulated in a court decree (***Note:*** *You may be required to submit a copy of the court order or legal documentation in this instance.*)	The plan of the parent primarily responsible for health 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 health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's health benefit plan are	√	
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	√	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee		√
	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: If either the primary or the secondary plan covers a particular service, where the PLAN is the secondary plan, the PLAN 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 BCBSNC 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.

Programs Outside Your Regular Benefits

The PLAN ADMINISTRATOR and BCBSNC may add programs that are outside your regular benefits. These programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Service programs for members identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
- Wellness programs, including discounts on goods and services from other companies including certain types of PROVIDERS
- Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to PROVIDERS suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options
- Opportunities to qualify for gift items (such as exercise equipment and clothing) based on submitting activity diaries that record exercise activities or preventive health behaviors
- Quarterly, semi-annual, and/or annual drawings for gifts, which may include club memberships and trips to special events, based on submitting activity diaries
- Charitable donations made on your behalf by BCBSNC
- Discounts or other savings on retail goods and services.

These discounts on goods and services may not be provided directly by the PLAN or BCBSNC, but may instead be arranged for your convenience. These discounts are outside the PLAN benefits. Neither the PLAN nor BCBSNC is liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside your dental plan benefits. Neither the PLAN nor BCBSNC is not liable for third party PROVIDERS' negligent provision of the gifts. The PLAN ADMINISTRATOR may stop or change these programs at any time.

ADVERSE BENEFIT DETERMINATION
A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit resulting from the application of any utilization review, as well as 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 medically necessary or appropriate. Rescission of coverage and initial eligibility determinations are also included as adverse benefit determinations.

ALLOWED AMOUNT
The maximum amount that BCBSNC determines is to be paid 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.

ANNUAL BENEFIT THRESHOLD
The dollar amount that your total claims paid during a BENEFIT PERIOD cannot exceed in order to qualify for the annual rollover.

ANNUAL ROLLOVER AMOUNT
The unused portion of a MEMBER'S BENEFIT PERIOD MAXIMUM that may be rolled over for use in future years.

BENEFIT ADMINISTRATOR
A representative designated to assist with MEMBER enrollment and provide information to EMPLOYEES and MEMBERS concerning the PLAN.

BENEFIT PERIOD
The period of time, as stated in the "Summary Of Benefits," during which charges for COVERED SERVICES provided to a MEMBER must be INCURRED in order to be eligible for payment by the PLAN. 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 BCBSNC's 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 the 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 the PLAN. Any services in excess of a BENEFIT PERIOD 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 EMPLOYEE as specified in "When Coverage Begins And Ends."

DEPENDENT CHILD(REN)

A child under age 26 who is the EMPLOYEE'S biological child, a stepchild who lives with the EMPLOYEE, a legally adopted child (or child placed with the MEMBER and/or spouse for adoption), a FOSTER CHILD, or any other child for whom legal guardianship has been awarded to EMPLOYEE and/or spouse.

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 the PLAN due to employment as determined by the EMPLOYER, and who is enrolled for coverage.

EMPLOYER

City of Wilmington.

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.

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 MEMBERS upon enrollment which provides EMPLOYER/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 MAXIMUM

The maximum amount of COVERED SERVICES that will be reimbursed on behalf of a MEMBER while covered under the 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.

MAXIMUM ROLLOVER AMOUNT

The maximum dollar amount that can be kept in a rollover account.

MEMBER

An EMPLOYEE or DEPENDENT, who is currently enrolled in the PLAN and for whom premiums are paid.

NONCERTIFICATION

An ADVERSE BENEFIT DETERMINATION by BCBSNC that a service covered under the PLAN has been reviewed and does not meet BCBSNC's requirements for MEDICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of EMERGENCY SERVICES and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is EXPERIMENTAL, INVESTIGATIONAL or COSMETIC is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

PLAN

The EMPLOYER dental plan established by City of Wilmington to provide dental benefits for participants.

PLAN ADMINISTRATOR

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

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.

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 the PLAN.

BCBSNC Web Site

To change your address, request new ID CARDS, get benefit information or claim forms, visit the BCBSNC Web site:

Web site.. **bcbsnc.com**

To view your claims, visit the BCBSNC Web site:

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

BCBSNC Customer Service

For questions about your benefits or claims, claim form requests, or to request pre-treatment estimates for services:
.... 1-800-305-6638 (toll free)

For questions about membership or to request a new ID CARD, claim forms or a benefit booklet:
.... 1-877-275-9787 (toll free)

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City of Wilmington
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DENTALBlue®

City of Wilmington

Group Effective Date:
July 1, 2011

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

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