Benefit Booklet

For Employees of NC CONFERENCE OF THE UNITED METHODIST CHURCH

for

DentalBlue®

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

L1338, 7/13

BENEFIT BOOKLET

This benefit booklet describes the NC CONFERENCE OF THE UNITED METHODIST CHURCH 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 benefit 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.

Amendment and/or Termination of the PLAN

The PLAN SPONSOR expects this PLAN to be continued indefinitely, but the PLAN SPONSOR reserves the right to terminate the PLAN at any time with respect to its EMPLOYEES by a written instrument signed by an officer of the PLAN SPONSOR. Such termination may be made without the consent of the MEMBERS, or any other persons. The PLAN SPONSOR also reserves the right to amend the PLAN, including reduction or elimination of benefits or COVERED SERVICES. Amendments shall be made only in accordance with the provisions of the PLAN. The PLAN ADMINISTRATOR will provide notice to MEMBERS within sixty days of the adoption of any amendment that results in a material reduction in COVERED SERVICES or benefits.

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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, visit Blue Cross NC's website at **www.BlueConnectNC.com** or call Blue Cross NC Dental Blue 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. Common insurance terms involving your financial responsibility, such as "coinsurance" and "deductible" are defined in "Understanding Your Share of the Cost."

No Assignment of Benefits

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. Blue Cross NC will not recognize any such assignment, and any attempted assignment is void if performed without Blue Cross NC's prior written consent. Blue Cross NC may pay a PROVIDER directly. For example, Blue Cross NC pays contracting PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with Blue Cross NC, and not through this dental benefit plan. Under this dental benefit plan, Blue Cross NC has the sole right to determine whether payment for services is made to PROVIDER, to EMPLOYEE or allocated among both. Blue Cross NC'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 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. For more information, please see "Additional Terms of Your Coverage."

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
- "Need to Appeal A Decision?" explains the rights available to you when Blue Cross NC makes a decision regarding your coverage and you do not agree.

WHO TO CONTACT?

Blue Cross NC Website

To view your claims, change your address, request new ID CARDS, get benefit information or claim forms, visit Blue Cross NC's website:

Website..... **www.BlueConnectNC.com**

Blue Cross NC 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:

.....1-877-258-3334 (toll free)

COBRA Administrator

Not Provided.....(000) 000-0000 (toll free)

SUMMARY OF BENEFITS

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 you pay
- Deductibles for basic and major services received from contracting and non-contracting PROVIDERS are combined
- BENEFIT PERIOD MAXIMUMS for preventive, basic and major services are combined.

Please note: Blue Cross NC has contracted with certain PROVIDERS for DENTAL SERVICES. If you receive DENTAL SERVICES from PROVIDERS who have contracts with Blue Cross NC 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 PROVIDERS who do not contract with Blue Cross NC, 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 Blue Cross NC, see Blue Cross NC's website at www.BlueConnectNC.com.

Dental Blue – Traditional Plan

BENEFIT PERIOD – 01/01/2021 THROUGH 12/31/2021

DENTAL SERVICES	Your Cost
Diagnostic and Preventive Services	0%
Basic Services	20%
Major Services	50%
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, and basic and major services	$1,500
Orthodontic Services	50%
Orthodontic LIFETIME MAXIMUM	$1,500

If your Plan includes the option of prior plan carryover, Blue Cross NC will apply to the dental benefit plan, any amount that has been accrued toward the deductible, annual maximum benefit and/or rollover while covered under the Group's prior dental benefit plan.

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. As a MEMBER of Dental Blue, you have access to PROVIDERS in and outside the state of North Carolina. The PLAN has a relationship with other Blue Cross and Blue Shield licensees to provide DENTAL SERVICES 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 Blue Cross NC, you may be responsible for the difference between the billed amount and the ALLOWED AMOUNT, in addition to the coinsurance and any applicable deductible.

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. Please refer to "Summary of Benefits" to see what deductibles or coinsurance may 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 Blue Cross NC Dental Blue Customer Service at the number given in "Who to Contact?" to obtain the criteria that Blue Cross NC 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 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 Blue Cross NC's website at **www.BlueConnectNC.com** or call Blue Cross NC at the number listed in "Who to 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 Blue Cross NC for reimbursement. When you file a claim, mail the completed claim form to:

Blue Cross NC
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.

For claim forms or help filing a claim, visit Blue Cross NC's website at **www.BlueConnectNC.com** or call Blue Cross NC at the number listed in "Who to Contact?"

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, or expenses for noncovered services. If one or more DEPENDENTS are covered, you each have an individual deductible. If there is a family deductible, the family deductible is non-aggregating – three family members must each meet the individual deductible prior to meeting the 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 Blue Cross NC, compared to a PROVIDER who does not contract with Blue Cross NC.

	Contracting	Not Contracting
a) Total Bill	$550	$550
b) ALLOWED AMOUNT	$450	$500
c) Deductible Amount	$50	$50
d) ALLOWED AMOUNT Minus Deductible (B-C)	$400	$450
e) The PLAN Pays (Coinsurance times D)	(80%) $320	(80%) $360
f) Your Coinsurance Amount (D-E)	$80	$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)	$130	$190

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 in the "Summary of Benefits." If you receive DENTAL SERVICES from non-contracting PROVIDERS, in addition to the coinsurance and any deductible listed in the "Summary of Benefits", you may be responsible for the difference between the PROVIDER'S billed charge and the ALLOWED AMOUNT. For a list of contracting PROVIDERS, see Blue Cross NC's website at **www.BlueCrossNC.com** and click on 'Find a Doctor'.

COVERED SERVICES

Dental Blue 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. 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 one per BENEFIT PERIOD, counts toward periodic frequency limit above)
  - limited, detailed, problem focused (twice per BENEFIT PERIOD)
- Consultations (one per PROVIDER, only covered if no other services except x-rays performed)
- Cleaning – prophylaxis (twice each BENEFIT PERIOD). NOTE: A prophylaxis performed on a MEMBER under the age of 14 will be covered as a child prophylaxis.
- X-rays:
  - full-mouth or panoramic for MEMBERS ages 6 and older (limited to once every three years unless taken for diagnosis of third molars, cysts, or neoplasms)
  - supplemental bitewing x-rays (maximum of four films per BENEFIT PERIOD)
  - vertical bitewings (limit of one set per BENEFIT PERIOD, associated with periodontics)
  - periapical and occlusal x-ray of a tooth (limited to four films per BENEFIT PERIOD)
  - extraoral (two films per BENEFIT PERIOD)
- Pulp-testing (limited to one charge per visit, regardless of the number of teeth tested)
- Topical fluoride application (twice each BENEFIT PERIOD, covered through age 18)
- Interim caries arresting medicament - Limit of one application per tooth, per lifetime for posterior primary teeth only. Covered through age 6.
  - Silver diamine fluoride
- Palliative EMERGENCY treatment for relief of pain only (limit of two per BENEFIT PERIOD)
- Sealants for first and second permanent molars for MEMBERS ages 6 through 15 (one reapplication per tooth every 5 years)
- Space maintainers – devices to keep space from closing after loss of a primary tooth (limited to DEPENDENTS through age 15, one tooth per lifetime)
  - Recementation (limit of three per lifetime, not within six months of placement)

- 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
  - composite resin
- Simple extractions
- Surgical extractions
- Complex oral surgery:
  - oroantral fistula closure/closure of sinus perforation (once per tooth)
  - surgical access of unerupted tooth 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 oral surgery or surgical extractions when three or more quadrants are involved
- Infiltration of sustained release therapeutic drug (single or multiple sites) when related to basic oral surgery and received on same date, covered once per site
- Stainless steel crowns
  - primary posterior (one per tooth per lifetime)
  - primary anterior (one per tooth every three years)
  - permanent (one per tooth every eight years)
- Endodontics
  - pulpotomy (once per tooth per lifetime)
  - retrograde filling (limit one per root)
  - root amputation (limit one per root)
  - endodontic therapy (once per lifetime and retreatment once per lifetime after 12 months from initial treatment)
  - apexification
  - hemisection (once per root per lifetime)

  - apicoectomy (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)

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 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)
- Fixed partial dentures (once every eight years, no additional allowances for removable partial dentures)
- Tissue conditioning done more than six months after initial delivery or rebasing or relining (once per 12 months per prosthesis)
- Denture relining done more than six months after the initial delivery (once every two years)
- Rebasing of complete and partial dentures done more than five years after the initial delivery (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 delivery)
- Replacement of broken teeth on partial or complete denture (once per tooth every three years)
- Recementing or rebonding of inlays, onlays, crowns and/or fixed partial dentures
- Occlusal guard, for treatment of bruxism only (once every five years)

Periodontics - treatment of the diseases of the gums and bone surrounding the teeth. The following are covered periodontal services:

- Crown lengthening (once per tooth every three years per site or quadrant)
- Root planing and periodontal scaling – active periodontal therapy (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
  - gingival flap procedure
  - osseous surgery
  - bone replacement graft
  - guided tissue regeneration
  - soft tissue graft/allograft/connective tissue graft
  - distal or proximal wedge

Orthodontic Services

Benefits for a comprehensive orthodontic treatment are covered for all 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 diagnostic aids needed to define the problem
- Appliance – coverage includes the design, making, placement and adjustment of the appliance or device. Benefits are not provided to repair or replace an appliance or device.
- 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 benefit 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, the PLAN must remain in effect, monthly maintenance claims must be submitted to the carrier, the MEMBER must remain enrolled on the PLAN and the MEMBER'S orthodontic 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 Blue Cross NC for a PRE-TREATMENT ESTIMATE of benefits. Blue Cross NC 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:

	Restorations Single Unit Fixed	Periodontics	Restorations Multiple Unit Fixed	Endodontics	Oral Surgery	Anesthesia
Description	• Crowns, Inlays, Onlays • Build-ups • Cast post and cores	• Root planing and scaling • Osseous surgery	• Abut ments • Implant (if covered) • Pontics	• Conv entional endo dontcs and retreatments	• Surgical extractions (including impactions) • Complex oral surgery	• General/ Deep • IV sedation
Information Required for Claim Processing	• Pre-operative x-ray(s)	• Perio dontal charting • Pre-operative x-ray(s) • Date of active therapy • Narrative Report for surgery	• Pre-operative x-ray(s) (full arch)	• Pre- and post-operative x-ray(s)	• Pre-operative x-ray(s) • Narrative Report	• Type used • Duration in 15 minute intervals • Narrative Report

Please mail the information to:

Blue Cross NC
Claims Unit
PO Box 2100
Winston Salem, NC 27102-2100

When You File a Claim

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

- Dates of previous dental work
- Itemized bills
- X-rays
- Lab report
- Diagnostic casts, photographs or study models.

WHAT IS NOT COVERED?

This section describes exclusions to the PLAN, starting with general exclusions and then the remaining exclusions listed in alphabetical order. 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.
- Any benefit, drug, service, supply, test or charge that is duplicative or inclusive to other COVERED SERVICES.

In addition, this PLAN does not cover the following services, supplies, drugs or charges:

A

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

Acupuncture and acupressure

Administrative charges including, but not limited to: charges billed by a PROVIDER, charges for cancelled or missed appointments, completion of a claim form, obtaining dental records, late payments, telephone charges, shipping and handling and taxes

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.**

WHAT IS NOT COVERED? *(cont.)*

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 Blue Cross NC 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

Cone beam including the interpretation and post processing of images

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, 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 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

Indirect resin-based composite **crowns**

Temporary or provisional **crowns** and pontics

Removal of odontogenic and nonodontogenic **cysts**

Cytology sample

D

Placement of **dental implants**, and any related services. This includes pharmacological regimens.

Dental procedures not directly associated with dental disease

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

Interim **denture**

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 the 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

WHAT IS NOT COVERED? *(cont.)*

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, and surgical revisions

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, i.e. 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**

Sealant repair

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

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 COVERED SERVICES

V

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

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

WHEN COVERAGE BEGINS AND ENDS

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 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 in accordance with North Carolina law, is and continues to be intellectually or physically disabled 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 disability must be medically certified by the child's doctor and may be verified annually by Blue Cross NC.

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 or administrative 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 life event (QLE).

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

See also "Adding or Removing a DEPENDENT." You may also apply for coverage and/or add DEPENDENTS within a 30-day period following any of the QLEs listed below unless otherwise noted. A QLE for one individual within a family qualifies as an event for the MEMBER and all family members, regardless of current enrollment. Coverage is effective no later than the first day of the first month following a completed request for enrollment.

The following are considered QLEs:

- You or your DEPENDENTS become eligible for coverage under the PLAN
- You get married or obtain a DEPENDENT through birth, court or administrative 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 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) the 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	12 months

Major	None	12 months
Orthodontic	None	12 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 FOSTER CHILD, a child placed by a court or administrative order or a child legally placed for adoption, 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 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 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 the PLAN ADMINISTRATOR.

Types of Coverage

These are the types of coverage available:

- EMPLOYEE-only coverage—The PLAN covers only you
- EMPLOYEE-child coverage—The PLAN covers you and one DEPENDENT CHILD
- 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 Blue Cross NC 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 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 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, Blue Cross NC 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 DEPENDENTS must notify the PLAN ADMINISTRATOR within 60 days of the following QLEs:

- Divorce
- Legal separation
- 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 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

Blue Cross NC 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 Blue Cross NC deducts the amount for any claims paid.)
- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to Blue Cross NC 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.

UTILIZATION MANAGEMENT

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 Blue Cross NC's ADVERSE BENEFIT DETERMINATION of a requested treatment or dental care service, along with an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a clinical director from Blue Cross NC make a final decision of all ADVERSE BENEFIT DETERMINATIONS of service that were based upon CLINICAL NECESSITY
- Request a review of an ADVERSE BENEFIT DETERMINATION through the appeals process.
- Have an authorized representative seek 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 name an authorized representative, "you" under the "UTILIZATION MANAGEMENT" section means "you or your authorized representative." Your representative will also receive all notices and benefit determinations.

Blue Cross NC's Responsibilities

As part of all UM decisions, Blue Cross NC will:

- Limit what Blue Cross NC asks from you or your PROVIDER to information that is needed to review the service in question
- Ask for all information necessary to make the UM decision, including pertinent clinical information
- Give you and your PROVIDER timely notification of the UM decision consistent with applicable state and federal law and the PLAN.

In the event that Blue Cross NC does not receive all needed information to approve coverage for a DENTAL SERVICE within set time frames, Blue Cross NC will let you know of an ADVERSE BENEFIT DETERMINATION in writing. The notice will explain how you may appeal the ADVERSE BENEFIT DETERMINATION.

Retrospective Reviews

Blue Cross NC reviews the coverage of DENTAL SERVICES after you receive them (retrospective reviews). Retrospective review may include a review to see if services received in an EMERGENCY setting qualify as an EMERGENCY. All decisions will be based on CLINICAL NECESSITY and whether the service received was a benefit under this dental benefit plan.

Blue Cross NC will make all retrospective review decisions and let you and your PROVIDER know of its decision within a reasonable time but no later than 30 calendar days from the date Blue Cross NC received the request for coverage. If more information is needed before the end of the initial 30-day period, Blue Cross NC will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as Blue Cross NC gets the requested information, or at the end of the 90 days, whichever is earlier, Blue Cross NC will make a decision within 15 calendar days. Regardless if additional information is needed, in the event of a NONCERTIFICATION, Blue Cross NC will let you and your PROVIDER know in writing within five business days after making the NONCERTIFICATION.

NEED TO APPEAL A DECISION?

In addition to the UTILIZATION MANAGEMENT (UM) program, Blue Cross NC offers a voluntary appeals process for MEMBERS. An appeal is another review of your case.

If you want to appeal an ADVERSE BENEFIT DETERMINATION, you can request that Blue Cross NC review the decision through the appeals process. The process 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 name an authorized representative, "you" under this section means "you or your authorized representative." Your representative will also receive all notices and benefit determinations from the appeal.

You may also ask for, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. Appeals have been delegated to a third party vendor. Please see the end of this section for contact information. References to Blue Cross NC throughout this section refer to Blue Cross NC or the designee.

Steps to Follow in the Appeals Process

There are set time frames for filing an appeal and for letting you or your PROVIDER know of the decision. You must request the review in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date listed on your Explanation of Benefits.

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 Blue Cross NC's website at **www.BlueConnectNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

All information related to a request for a review through Blue Cross NC's appeals process should be sent to:

Blue Cross NC
Claims Unit
PO Box 2100
Winston Salem, NC 27102-2100

After a request for review, a staff member who works in a separate department from the staff members who denied your first request will look at your appeal. The appeals staff members have not reviewed your case or information before.

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 about whether a certain treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not CLINICALLY NECESSARY or appropriate,

Blue Cross NC shall seek advice from a health care professional with an appropriate level of training and expertise in the field of dentistry involved (as determined by the PLAN). The health care professionals have not reviewed your case or information before.

You will have exhausted the PLAN'S internal appeal process after pursuing an appeal.

Timeline for Appeals

For appeals about an ADVERSE BENEFIT DETERMINATION, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date listed on your Explanation of Benefits.

	Appeal
Blue Cross NC Contacts You	Within 3 business days after receipt of request
Notice of Decision	30 days after receipt of request

First Level Appeal

Blue Cross NC will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. Blue Cross NC 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. Blue Cross NC asks that you send all of the written material you feel is necessary to make a decision. Blue Cross NC will use the material provided in the request for review, along with other available information, to reach a decision. If your appeal is due to a NONCERTIFICATION, your appeal will be reviewed by a North Carolina licensed DENTIST who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information or rationale that Blue Cross NC may use in making a decision, so that you may 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 Blue Cross NC received the request. You may then request all information that was relevant to the review.

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.

Notice of Decision

If any claim shall be wholly or partially denied at the first 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 reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits upon request at no additional cost
- 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 this will be upon request at no charge
- 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 at no cost upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Delegated Appeals

Blue Cross NC delegates responsibility for the appeal to ACS Benefit Services, Inc. (ACS). ACS is a wholly owned subsidiary of Blue Cross NC, but operates as a separate, independent company from Blue Cross NC. Please forward written appeals to:

ACS Benefit Services, Inc.
PO Box 2100
Winston Salem, NC 27102-2100

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits to which MEMBERS are Entitled

If a MEMBER resides with a custodial parent or legal guardian who is not the EMPLOYEE, Blue Cross NC 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. Blue Cross NC 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 Blue Cross NC. Blue Cross NC 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 Blue Cross NC in writing that there has been a final adjudication or settlement.

In addition, under certain circumstances, if Blue Cross NC pays the PROVIDER amounts that are your responsibility, such as deductible, copayments or coinsurance, Blue Cross NC 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.

Blue Cross NC's Disclosure of Protected Health Information (PHI)

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

> To obtain a copy of the privacy notice, visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC at the number listed in "Who to Contact?"

Administrative Discretion

Blue Cross NC 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. Blue Cross NC 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 Blue Cross NC, 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 Blue Cross NC may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with Blue Cross NC.

Right of Recovery Provision

The provisions of this section apply to all current or former PLAN participants and also to the parents, guardian, or other representative of a DEPENDENT CHILD who incurs claims and is or has been covered by the PLAN. The PLAN'S right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "MEMBER" includes anyone on whose behalf the PLAN pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the PLAN.

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 PLAN is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the PLAN'S subrogation and reimbursement interest are fully satisfied.

The right of subrogation means the PLAN is entitled to pursue any claims that the MEMBER may have in order to recover the benefits paid by the PLAN. 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. The PLAN may assert a claim or file suit in the MEMBER'S name and take appropriate action to assert its subrogation claim, with or without your consent. The

PLAN is not required to pay the MEMBER part of any recovery it may obtain, even if it files suit in the MEMBER'S name.

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. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the PLAN'S subrogation and reimbursement interest are fully satisfied.

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.

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. In order to secure the PLAN'S recovery rights, the MEMBER agrees to assign to the PLAN any benefits or claims or rights of recovery they have under any automobile policy or other coverage, to the full extent of the PLAN'S subrogation and reimbursement claims. This assignment allows the PLAN to pursue any claim the MEMBER may have, whether or not they choose to pursue the claim.

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 potentially 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 is not required to participate in or pay court costs or attorney fees to any attorney hired by the MEMBER to pursue their damage claim

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 dental benefits the PLAN provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The PLAN is entitled to recover from **any and all** settlements or judgments, even those designated

as pain and suffering or non-economic damages and/or general damages only. The PLAN'S claim will not be reduced due to your own negligence.

The MEMBER acknowledges that Blue Cross NC 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 Blue Cross NC's efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify Blue Cross NC 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 insurance company or 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 and their agents agree to provide the PLAN or its representatives notice of any recovery the MEMBER or the MEMBER'S agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, the MEMBER and the MEMBER'S agents shall provide notice prior to any disbursement of settlement or any other recovery funds obtained. The MEMBER shall provide all information requested by Blue Cross NC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as Blue Cross NC may reasonably request and all documents related to or filed in personal injury litigation. 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.

The MEMBER acknowledges that the PLAN has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The PLAN reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The MEMBER acknowledges that the PLAN has notified them that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

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 Blue Cross NC 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. By accepting such benefits, the member agrees to pay all attorneys' fees the plan incurs in successful attempts to recovery amounts the plan is entitled to under this section.

Notice of Claim

The PLAN will not be liable for payment of benefits unless proper notice is furnished to Blue Cross NC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to Blue Cross NC 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 Blue Cross NC to determine benefits.

Notice of Benefit Determination

Blue Cross NC 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. Blue Cross NC may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If Blue Cross NC takes an extension, Blue Cross NC 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 Blue Cross NC receives the requested information, or at the end of the 90 days, whichever is earlier, Blue Cross NC 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
- 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 PLAN to the MEMBER'S clinical circumstances, or a statement that this will be provided without charge upon request.

Upon receipt of a denial of benefits, you have the right to appeal an ADVERSE BENEFIT DETERMINATION with Blue Cross NC. See "Need to Appeal A Decision?" for more information.

Limitation of Actions

If the PLAN is subject to ERISA, you must exhaust the first level appeal process before bringing any legal action to recover benefits. **No legal action to recover benefits may be brought later than one year from the date your claim for benefits is denied at the end of the appeals process.**

If the PLAN is not subject to ERISA, no legal action may be brought to recover benefits until you have exhausted all administrative remedies. No legal action may be taken later than three years from the date services are INCURRED.

Please see "Need to Appeal a Decision?" for details regarding the appeals process.

Evaluating New Technology

In an effort to allow for continuous quality improvement, Blue Cross NC has processes in place to evaluate new dental technology, procedures and equipment. These policies allow Blue Cross NC 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, Blue Cross NC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. Blue Cross NC then seeks additional input from PROVIDERS who know the needs of the patients they serve.

Coordination of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group insurance plan, the PLAN 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 Blue Cross NC under the PLAN takes into account whether or not the PROVIDER is a contracting PROVIDER. If this PLAN is the secondary plan, and the MEMBER uses a contracting PROVIDER, the PLAN 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 health benefit 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.

Blue Cross NC, on behalf of the PLAN 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 from other group health plans are taken into account, **benefits for COVERED SERVICES under this PLAN are still subject to program requirements, such as certification procedures.**

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

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	√	

When a person is covered by 2 group dental plans, and	Then	Primary	Secondary
	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 Blue Cross NC 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 or administrative order or legal documentation in these instances.

GLOSSARY

These definitions will help you understand the PLAN. Please note that some of these terms may not apply to the PLAN.

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 CLINICALLY NECESSARY or appropriate. Rescission of coverage and initial eligibility determinations are also included as adverse benefit determinations.

ALLOWED AMOUNT

The maximum amount that Blue Cross NC 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 Blue Cross NC 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 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 dollar amount 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 Blue Cross NC that services, materials or drugs have been reviewed and, based on the information provided, satisfy Blue Cross NC'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, Blue Cross NC 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 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 Blue Cross NC 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, until the end of the month of their 26th birthday, who is either: 1) the EMPLOYEE'S biological child, stepchild, legally adopted child (or child placed with the EMPLOYEE and/or spouse for adoption), FOSTER CHILD, or 2) child for whom legal guardianship has been awarded to the EMPLOYEE and/or spouse, or 3) a child for whom the EMPLOYEE and/or spouse has been required by a court- or administrative order 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 the PLAN due to employment as determined by the EMPLOYER, and who is enrolled for coverage.

EMPLOYER

NC CONFERENCE OF THE UNITED METHODIST CHURCH

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 a court or administrative order 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 EMPLOYEES upon enrollment which provides EMPLOYER/MEMBER identification numbers, name of EMPLOYEE, applicable copayments and/or coinsurance, and key benefit information, 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 Blue Cross NC does not recognize as standard dental care of the condition, disease, illness, or injury being treated. The following criteria are the basis for Blue Cross NC'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 Blue Cross NC'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 Blue Cross NC 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 Blue Cross NC but are not determinative or conclusive.

LIFETIME MAXIMUM

The maximum amount of certain 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. See "Summary of Benefits" for any limits that may apply.

MEMBER

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

NONCERTIFICATION

An ADVERSE BENEFIT DETERMINATION by Blue Cross NC that a service covered under the PLAN has been reviewed and does not meet Blue Cross NC's requirements for CLINICAL NECESSITY, appropriateness, dental 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.

PRE-TREATMENT ESTIMATE

A voluntary request for a projection of dental benefits and estimated payment for dental services.

PLAN

The EMPLOYER dental plan established by NC CONFERENCE OF THE UNITED METHODIST CHURCH 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.

PLAN SPONSOR

NC CONFERENCE OF THE UNITED METHODIST CHURCH

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.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.