Blue℠ Secure Dental

A Stand-Alone Dental Plan for Individual Members offered through the Group and Individual Division of BlueCross BlueShield of South Carolina

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Dear Member:

Welcome to Blue Cross® and Blue Shield® of South Carolina!

In this booklet, you'll find a complete list of dental benefits. You'll learn how to file claims and who to call when you have a question. There also are important sections explaining your benefits and commonly used terms.

Please take time to review your dental booklet carefully. It will help you make the most of your dental benefits.

We're happy to have you as a member of Blue Cross.

Sincerely,

Scott Graves
President
Blue Cross and Blue Shield Division

TABLE OF CONTENTS

Blue Secure Dental Coverage

This contract is based on federal and state laws and regulations. If laws or regulations are updated during a contract year, the contract is revised to be consistent with the updated law or regulation.

This product is intended to be fully compliant with the Affordable Care Act and any later federal or state laws. When we receive your application, we will issue you this Policy and an ID card, but the Policy will not be in effect until we receive any payment due from you, including your portion of the first month's premium.

Guaranteed Renewable Except for Stated Reasons

This Policy renews each calendar year and you can continue coverage by paying the Premium required by the first of each calendar month or within the grace period. At the end of each year, if you do not change plans during an Open Enrollment period, this plan will automatically renew.

We can cancel this Policy if:

1. You fail to pay Premiums according to the terms of the Policy; or
2. We determine you have committed an act or practice that constitutes fraud or an intentional misrepresentation of a material fact under the terms of the Policy; or
3. We decide to discontinue offering Blue℠ Secure Dental for everyone who has this Policy. If we discontinue the product, we must:
   a. Provide notice to each individual covered by this Policy of the discontinuance at least 90 days before the date the Policy is discontinued or within time frames as directed by a governmental agency;
   b. Offer each individual covered by this Policy the option to purchase other individual Health Insurance Coverage currently offered by us; and
   c. In exercising the option to discontinue the Policy or offering the option to purchase other individual coverage, we act uniformly without regard to any Health Status-related Factor.
4. If we decide to discontinue offering all products in the Individual market in South Carolina, we will provide 180 days notice to each person covered by the Policy.

At the time of renewal, we may modify this Policy for everyone who has it as long as the modification is consistent with federal and state law and effective on a uniform basis. However, we cannot cancel your Policy simply because of a change in your health.

Premiums

The benefits described are available as long as the required Premium is paid on time. We base Premiums on coverage selected, age, where you live at the time this Policy is issued, and regulatory fees and taxes as required by the Affordable Care Act. The Member Schedule shows the Premium as of the Effective Date. Premiums may only be changed at the beginning of your Benefit Period. At least 31 days prior to your new Benefit Period, you will receive notice of your new Premium and any benefit changes for the new Benefit Period. If you receive a Special Enrollment Period and select a new benefit option, your premiums may also change as of the date your benefit option changes. **If you receive an Advance Premium Tax credit, the amount you are billed each month is reduced by the tax credit you receive. If the tax credit changes at any time during the Benefit Period, your billed premium will change. This change will occur as directed by the Health Insurance Marketplace and may occur without notice to you.**

If the Member's age or residence has been misstated and if the amount of the Premiums is based on these factors, an adjustment in Premiums, coverage, or both, will be made based on the Member's true age or residence.

Your Premiums are not affected by Health-Status Related Factors, race, color, national origin, present or predicted disability, gender identity, sexual orientation, expected length of life, degree of medical dependency or quality of life.

Right to Examine Policy for Thirty Days

If you aren't satisfied with this Policy, return it to us or your agent within 30 days after it is received. All Premiums will be refunded and may be reduced by any claims that have been paid. If the Policy is returned, it will be void from the beginning. The parties will be in the same position as if no Policy had been issued. Please note however: the return of this Policy is not considered reason for a Special Enrollment Period if your coverage is purchased through the Marketplace.

Important Notice Concerning Statements in Your Application for Insurance

The Application is a part of your Policy. If a statement on your Application or enrollment records is an intentional misrepresentation of material facts related to your eligibility for coverage, or you perform an act or practice that constitutes fraud, we may have grounds to rescind the Policy. A rescission does not include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay Premiums. If the Policy is rescinded, we will provide 30 days written notice and refund Premiums; your refund may be reduced by any claims that have been paid. After this Policy has been in force for two years, we cannot use any statement made in any Application (unless fraudulent) to void the Policy or deny any claim incurred after the two-year period.

This Policy contains a requirement for Preauthorization of certain services.

The Policyholder hereby expressly acknowledges understanding this Policy is solely with Blue Cross and Blue Shield of South Carolina, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as an agent of the Association. The Policyholder further acknowledges and agrees to have not entered into this Policy based on representations by any person other than Blue Cross and Blue Shield of South Carolina. No person, entity or organization other than Blue Cross and Blue Shield of South Carolina shall be held accountable or liable to the Policyholder for any of Blue Cross and Blue Shield of South Carolina's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this Policy.

This Policy is a complete description of the benefits and terms of your Blue Dental coverage, fully insured by Blue Cross. As you read this Policy, you will see defined words begin with a capital letter. You can find some of these words in the *Definitions* section of this booklet.

Your dental coverage is designed to help you with the cost of:

- Preventive Care
- Restorative Care
- Major Restorative Care
- Orthodontic Care; medically necessary Orthodontia is only available for Members age 18 and under.

How to Contact Us

How to Get Help

For Member Services and Dental Claim Inquiries:
When you have questions about your coverage, we're here to help you.

Telephone Numbers:

Membership:
1-855-404-6752
Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time

Dental Claims:
(803) 788-2571 from the Columbia area
1-800-222-7156 from all other areas

Mailing Address:

Dental Claims Service Center
Blue Cross and Blue Shield of South Carolina
P.O. Box 100300
Columbia, SC 29202

Web site Address:

www.SouthCarolinaBlues.com, then log on to "My Health Toolkit"

Email Address:

Membership.enrollment@bcbssc.com

Your Fastest Place for Answers – www.SouthCarolinaBlues.com

If you have access to the Internet, then you'll love our Web site. Here you can find quick and easy answers to your dental coverage questions any time day or night. When you go to www.SouthCarolinaBlues.com, you'll find useful tools that can help you better understand your coverage.

Here are some of the things you can do on our Web site:

- Learn more about our products and services
- Understand your coverage with helpful tips in our interactive Insurance Classroom
- Stay informed with all the latest Blue Cross news, including press releases and legislative issues
- Links to other health-related Web sites
- Use "My Health Toolkit"
- Locate a network Dental Provider; https://www.southcarolinablues.com/links/providers/BlueSecureDental

You can get to "My Health Toolkit" from www.SouthCarolinaBlues.com to:

- Check your eligibility
- Check on Predetermination of Benefits status
- Find out if we've processed your claims
- Order a new ID card
- Ask a Member Services Representative a question through secure e-mail
- View your Explanation of Benefits (EOB)

You can do all this and more when you use our convenient and secure My Health Toolkit feature.

Here's how My Health Toolkit works:

1. Log on to www.SouthCarolinaBlues.com.
2. Select My Health Toolkit. The first time you use My Health Toolkit, you'll need to create a profile.
3. Choose "Create a new member profile." First, read the "Terms and Conditions" page. Then, select Blue Cross and Blue Shield of South Carolina, enter some basic information and choose your username and password.
4. Submit the information.

After the first time, you'll only need to enter your username and password to access the system. If you forget either one, don't worry — just verify some information to get going again!

You're now ready to access My Health Toolkit. Simply choose the task you want from the list on the left side of the screen. When you're finished, just "Exit" to return to the rest of our Web site. It's fast. It's easy. It's secure. And, it's only for our Members. Log on today to www.SouthCarolinaBlues.com and try My Health Toolkit!

**Please note: Some information may not be currently available from My Health Toolkit. For weekly maintenance, My Health Toolkit is not available on Sunday evenings from 5 p.m. until 10 p.m.*

Eligibility and Coverage

Eligibility

Every Qualified Individual or Enrollee who applies for coverage during a Special or Open Enrollment Period will be accepted for coverage if the applicant is a South Carolina Resident. Children are eligible to enroll for coverage as a Dependent through age 25 through the end of the Benefit Period. Gaining or losing a Dependent in your household may affect your eligibility for Premium Tax Credits and your eligibility for a Special Enrollment.

Certain Covered Services that are considered Essential Health Benefits are provided to individuals under the age of 19 through the end of the Benefit Period.

Effective Date of Coverage

The date on which coverage for a Member begins under this Policy is called the **Effective Date**. Your Effective Date is shown on your Member Schedule.

You may enroll in coverage every year during the annual Open Enrollment Period. You may enroll at other times during the year only if you qualify for a **Special Enrollment** such as one of the situations described below. **If you voluntarily cancel your dental coverage under this Policy or it is cancelled for non-payment of premiums, you may not be eligible to re-enroll until the next Open Enrollment Period.**

Special Enrollment

A **Special Enrollment** occurs when you fall into one of the situations described below. In all situations, you must be a Qualified Individual, an Enrollee or Dependent to enroll. If you believe you meet the requirements for a Special Enrollment, you can:

- Contact the Health Insurance Marketplace
- Enroll on www.Healthcare.gov
- Contact your agent
- Visit a Blue Retail Center
- Enroll on SouthCarolinaBlues.com

Note: Special Enrollment Periods (SEP) are defined and regulated by federal regulation. Changes to the regulations may override the information shown below. This is not an all-inclusive list. You are not entitled to an SEP if your prior coverage did not qualify as minimum essential coverage or if you did not have coverage within 60 days of the triggering event.

A Special Enrollment must be requested within 60 days of the triggering event. We may request documentation to confirm you had a qualifying event and that you are entitled to a Special Enrollment Period.

Situations that do not qualify for a Special Enrollment Period:

- Being terminated from other coverage for not paying premiums or for fraud
- Divorce or death of a family member without a resulting loss of coverage
- Moving solely for medical treatment or vacation
- Changing from one legally present status to another (e.g. consumer who becomes a U.S. citizen who was previously a lawfully present individual)

Effective Date for Special Enrollment –

Most Special Enrollments are eligible to receive coverage beginning the 1st day of the month after the selection.

Some Special Enrollments are eligible for other or additional Effective Date options. Examples include:

- For birth, adoption, placement for adoption or foster care, or as a result of a court order, your coverage Effective Date will be the date of the event, unless you specifically choose to begin coverage on the first day of the month following the date of birth, adoption, placement, or court order.
- For marriage, your coverage Effective Date is the first of the month following your selection of a plan; for example, if you get married on January 31st and immediately request coverage, your coverage will be effective February 1st. If you wait to request coverage until February 1st, coverage will be effective March 1st.
- For a loss of Minimum Essential Coverage, the Effective Date depends on when you request coverage and the date the loss of coverage occurs. You have 60 days before and 60 days after the loss of Minimum Essential Coverage to make a plan selection. The Effective Date, though, will always be the first day of the month after plan selection, or the date you lose coverage, whichever comes last.

Example: You are told on April 3 that you will lose minimum essential coverage on May 31. You can choose a plan at any time prior to May 31 and your new coverage will be effective on June 1. However, if you choose a new plan after you have lost Minimum Essential Coverage, your new plan will be effective on the first of the month following your plan selection.

- If you gain access to an individual coverage HRA (ICHRA) or a qualified small employer HRA (QSEHRA) that can be used for dental plans, your coverage effective date will be the first day of the month following plan selection, unless plan selection occurs on the first of the month. For example, if you gain access to an ICHRA or QSEHRA as of July 1 and you select a plan on or before July 1, coverage will begin that day. If you select a plan on July 2, coverage will be effective August 1.

Adding your Spouse

You may add your new spouse during a Special or Open Enrollment Period by enrolling and paying the additional full Premium required. Your spouse will not be covered until we receive the enrollment and required Premium.

Adding a Child

If you or your spouse gives birth, adopts a child or a child is placed with you or your spouse for foster care or legal guardianship while this Policy is in force, or if you are ordered to provide coverage as the result of a court order, then the child is eligible to receive benefits for Medically Necessary covered services and supplies from the moment of birth, adoption, placement, or court order. This includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications arising from a premature birth. You must add the child within 60 days of the birth, adoption or placement along with payment of the appropriate Premium in order for the coverage to be effective from the moment of birth, adoption or placement. Claims for services or benefits cannot be processed until the child is added to the coverage and the applicable premium has been received.

Dependents added to your coverage during a special enrollment will be covered on the same basis as any other dependent, from these dates:

1) from the moment of birth when born or when a decree of adoption has been entered into by you or your spouse within 60 days after the date of the child's birth and you or your spouse has temporary custody;
2) on the date the adoption proceedings have been completed and a decree of adoption is entered into within one year from the institution of proceedings, unless extended by order of the court by reason of special needs of the child;
3) from the date of placement for adoption or foster care;
4) on the date the court enters the child support or other court order (may be the date the judge signed the order, or the date the clerk of court enters the order);
5) the first of the month following plan selection;
6) on the Effective Date of this Policy, if plan selection occurs after the date that allows a special enrollment.

A child is considered "adopted" or as being under legal guardianship (foster care) on the date the child is placed in your home. The child is no longer considered "adopted" or under your legal guardianship on the date placement is

disrupted and the child is removed from placement with you or your spouse. A dependent covered under a court order is no longer eligible for coverage if a later court order transfers responsibility for coverage to any other person. Terminations will be effective as outlined below.

Premium Payment

The Premium is the amount that must be paid for your dental insurance or plan. The Premium for this Policy is due on the 1st of each month. If you are eligible for an Advance Premium Tax Credit, the amount you are billed each month may be reduced by the tax credit. If your tax credit changes during the Benefit Period, the amount you are billed will change to reflect the new tax credit.

You are responsible for all Premiums due for your coverage, including for dependents included on your coverage. ***We will not accept payment of your premiums from any health or dental care provider, health agency, health entity, public or private institution or any other person or entity which does not have an insurable interest.*** We accept premium payments and co-payments only from you or
(a) Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
(b) Indian tribes, tribal organizations or urban Indian organizations; and
(c) State and Federal Government programs.

You may pay your Premiums electronically or we will bill you monthly. At any time, we may notify you that no premium is due for coverage for a certain period of time. The notification will include the reason for the waiver of premium and the length of time the waiver is in effect. This can occur when we need to refund money to you. We are under no obligation to waive your premium and the fact that we may do so does not obligate us to waive premium in the future.

Grace Period

This Policy has a Grace Period for Premium payments. This means if your Premium is not paid on or before the date it is due, it may be paid during the Grace Period. If the Premium has not been paid by 12:01 a.m. of the day following the end of the Grace period, your coverage will automatically terminate without further notice to you. Any claims paid after the last Premium paid date does not extend this coverage.

Grace Period for Coverage with an Advance Premium Tax Credit (APTC) – If you have paid at least one month's Premium and received the Advanced Premium Tax Credit, your Grace period is three months. Benefits will be provided according to your coverage during the first month of the Grace Period. Benefits are not allowed for services provided during the second and third month of the Grace Period until your Premium is paid in full. Premiums not fully paid by the end of the Grace Period will cause this Policy to terminate. Coverage will end on the first day of the second month of the three-month Grace Period. In order for your account to be considered out of the Grace Period, you must pay your total premium due. Any claims you incurred during the period Premiums were unpaid may be submitted to us for processing under the benefits of this Policy. If your coverage is cancelled for non-payment of Premium, you will not be eligible to purchase a Marketplace plan until the next Open Enrollment, unless you have a qualifying event that allows you a Special Enrollment Period, such as marriage, the birth of a child, or a similar event. During this uninsured period, you will be responsible for paying your medical bills.

Example: You enroll in coverage on January 1. You miss your April Premium payment, but on May 15, you send in one month's Premium. You are not able to make another Premium payment. On July 1, your coverage will be cancelled back to April 1. You have a Grace Period of three months, but at the end of three months, your Premiums must be paid in full or coverage is cancelled.

Grace Period for Coverage without an Advance Premium Tax Credit – If you did not receive an Advanced Premium Tax Credit, the Grace Period is 31 days. Benefits will not be allowed during the grace period until Premiums are paid. Premiums not fully paid by the end of the 31-day Grace Period will cause this Policy to terminate. Coverage will end on the Premium due date for the 31-day Grace Period.

Reinstatement
If any Premium is not paid within the Grace Period, the Policy will lapse automatically without further notice to you.

If you purchased your Policy through the Health Insurance Marketplace, you are not eligible for reinstatement. If your coverage is cancelled for non-payment of Premium, you will not be eligible to purchase a Marketplace plan until the next Open Enrollment, unless you have a qualifying event that allows you a Special Enrollment Period, such as marriage, the birth of a child, or a similar event. During this uninsured period, you will be responsible for paying your medical bills.

For all other Members, we may reinstate the Policy, if:
a. You request reinstatement; and
b. The unpaid Premium is not more than 60 days overdue; and
c. You pay all overdue and currently due Premiums; and
d. We approve your request for reinstatement.

The Policy will be reinstated on the date the Policy lapsed, if requirements (a) through (d) above have been met. If your request is not approved, we will refund the Premium submitted. After the Policy is reinstated, both parties will have the same rights as existed just before the due date. Any claims you incurred during the period Premiums were unpaid may be submitted to us for processing under the benefits of this Policy. Any amendments to the Policy will still apply and remain effective after reinstatement.

Non-Discrimination
Receiving APTC does not affect your eligibility for this coverage or the amount of your Premiums, nor does this tax credit prevent you from taking any action to enforce your rights under applicable law.

Health Status-Related Factors will not affect your eligibility for this coverage; this includes race, color, national origin, present or predicted disability, sex, degree of medical dependency or quality of life. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. If you have questions about your coverage, please contact Member Services at the number shown in the "How to Contact Us" section for more information.

Premiums may not be increased, coverage cannot be denied and wellness incentives may not be reduced or withheld based on the lawful ownership, possession, use or storage of a firearm or ammunition.

Termination of Insurance
Coverage will end at 12:01 a.m. Eastern Standard Time:
1. Within 14 days after we receive your request or on the date you request, if later; or
2. The last day of the month following the month you receive notice from the Health Insurance Marketplace you or a dependent is no longer eligible for coverage offered through the Health Insurance Marketplace;
3. On the date this Policy is no longer considered a Qualified Health Plan or is non-renewed;
4. On the date the Policy lapses due to non-payment of Premiums as determined by the Grace Period;
5. On the Policy Effective Date if rescinded; or
6. If you are determined to be no longer eligible for coverage, your coverage in the plan will end on the last day of the month following the month in which you received notice of your ineligibility.
7. If you and your spouse divorce, your spouse's coverage will end on the Premium due date following the date of divorce.
8. For a Dependent other than a spouse who reaches age 26, coverage will terminate at the end of the benefit period in which the Dependent reaches age 26. An Incapacitated child's coverage, however, will not end simply because he or she reaches age 26.
9. If we receive a termination from the Health Insurance Marketplace/FFM, the termination will be effective as of the date specified by the Marketplace/FFM.
10. If you move out of the State of South Carolina.

For this coverage to be considered a Qualified Health Plan, BlueCross must be determined to be a Qualified Health Plan issuer and the plan must be certified that it meets all the requirements of the Health Insurance Marketplace regulations. If

BlueCross receives notification either that it is no longer certified or the plan is no longer considered qualified, your coverage will not end until we have notified you and you have had the opportunity to enroll in other coverage. If we decide to not seek recertification of this Plan, we will give you 90-days written notice and coverage will not end until the end of your Benefit Period.

We will provide benefits to the end of the period for which we accepted Premiums or as required by the Health Insurance Marketplace.

We will not cancel this Policy retroactively and refund any Premium, whether or not you had any claims during that period of time except in case of death or when coverage is rescinded.

Continuation of Coverage for Your Former Spouse and non-Incapacitated Dependent Child
If your spouse covered under this Policy is no longer eligible because of a legal divorce, or if a non-Incapacitated child covered under this Policy is no longer eligible because of reaching the age limit, then he or she qualifies for a Special Enrollment and may apply for a new Policy under the Special Enrollment rights.

Qualified Individual Redetermination

The Health Insurance Marketplace must periodically re-determine your eligibility for Advanced Premium Tax Credits during the benefit year if (1) updated information is reported to and verified by the Health Insurance Marketplace; or (2) the Health Insurance Marketplace identified updated information through its own data matching process. If a redetermination results in a change in eligibility, then the change will generally be effective for the first day of the month following the date of the eligibility redetermination notice. The Health Insurance Marketplace may establish a cut-off date for a redetermination notice (such as the 15th of the month). Any changes due to a redetermination received after this cut-off date will be effective the first day of the second month following the notice.

Covered Services

Subject to all provisions of this Policy benefits set forth below will be provided as shown in the Schedule of Benefits when a) the services or supplies are based on accepted standards of dental practice; b) the services or supplies are provided by a Dentist or dental hygienist acting within the scope of his or her license; and c) the services and supplies are billed by, or on behalf of, the Dentist.

Certain Covered Services provided to individuals under the age of 19 are considered Essential Health Benefits. When an individual under the age of 19 receives a Covered Service designated as an Essential Health Benefit, the specific Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations found in your Schedule of Benefits shall be controlling. In no event will the general frequency limitations set forth in this Policy apply to any of the Covered Services listed as Essential Health Benefits in your Schedule of Benefits. The remaining general exclusions and limitations found in this Policy shall only apply to Covered Services designated as Essential Health Benefits to the extent those general exclusions and limitations do not conflict with the specific Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations found in your Schedule of Benefits.

There are no annual or lifetime dollar limits on Essential Health Benefits.

Predetermination of Benefits
The Dentist should file a Predetermination of Benefits to BlueCross when the cost of the dental treatment is equal to or greater than the amount shown in the Schedule of Benefits. By doing this, the Member and the Dentist will know in advance how much will be paid for the recommended treatment.

If the Dentist does not ask for a Predetermination of Benefits, claims will be paid according to the information on the claim. Predetermination of Benefits is not needed for emergency care, routine oral examinations, x-rays, fluoride treatments, cleaning, scaling or polishing teeth.

Cleft Lip and Palate
We cover expenses for teeth capping, prosthodontics and orthodontics necessary for the care and treatment of congenital cleft lip and palate. The same Deductible and Coinsurance applies to these services as apply to other procedures the Policy covers. Benefits under this policy are primary to any benefits available for the patient under any individual or group accident and health insurance policy.

Class I — Preventive Care
We pay benefits for the following services:

1. Oral exams and periodontal exams (exams of the bones, tissues and gums around the teeth), twice per year;
2. Full mouth/Panoramic x-rays, with up to 4 additional bitewing x-rays taken on the same day, every three years;
3. Supplementary bitewing x-rays limited to 4 x-rays, twice per year, unless your Dentist feels they are Medically Necessary more often;
4. Cleaning, scaling and polishing teeth, twice per year;
5. Fluoride treatment, for Members or Dependents under age 19, limited to two times per year;
6. Emergency treatment for pain;
7. Space maintainers for prematurely lost baby teeth, for Members or Dependents under age 19;
8. Diagnostic casts (as long as it's not done with any type prosthodontics);
9. Pulp vitality tests;
10. Sealants on permanent teeth that have not had any fillings; covered on children from the ages of 6 through 15.

Class II — Restorative Care

There is a six month waiting period from the Effective Date of coverage for Restorative Care for those 19 years and older.

We pay benefits for the following services:

1. Fillings with amalgam and tooth-colored synthetic materials;
2. Simple extractions *or removal of impacted teeth;*
3. Pulp capping and root canal treatment*;*
4. General anesthesia or IV sedation when Medically Necessary and given with covered dental surgery;
5. Oral surgery (but not periodontal surgery) including the following:
   a. Surgical extractions;
   b. Alveoplasty;
   c. Surgical excision of lesions and tumors;
   d. Removal of cysts and neoplasms;
   e. Excision of bone tissue;
   f. Biopsies of oral tissue;
   g. Treatment of oral fistula;
   h. Excision of hyperplastic tissue; and,
   i. Frenulectomy;
6. Assistant at surgery when Medically Necessary;
7. Hemi-section;
8. Apicoectomy (removal of the apex of a tooth root);
9. Surgical periodontal exam (for gum disease);
10. Gingival curettage (removal of diseased gum tissue);
11. Gingivectomy and gingivoplasty (gum surgery);
12. Osseous surgery, including flap entry and closure (for gum tissue or bone);
13. *Mucogingivoplastic surgery;*
14. Management of acute infection and oral lesions;
15. Periodontal cleanings (payable only once every three months after the initial gum disease treatment);
16. Repair of removable dentures.

Class III — Major Restorative Care

There is a twelve month waiting period from the Effective Date of coverage for Major Restorative Care for those 19 years and older.

We pay benefits for the following services:

1. Inlays that are not part of a bridge;
2. Permanent crowns that are not part of a bridge;
3. Onlays that are not part of a bridge;
4. Removable dentures (complete and partial) and bridges (fixed and removable) every five years. Benefits for replacement shall not be provided for (a) any denture replacement inlay, crown or onlays made less than five (5) years after a placement or replacement which was covered under this Plan of Benefits or (b) any replacement made necessary by reason of loss or theft;
5. Fixed bridge repairs;
6. Relining or rebasing of removable dentures payable once within six months after initial placement, then, once every three years thereafter.
7. Implants

Class IV — Orthodontics

We pay benefits for Members or Dependents age 18 and under for the following orthodontic services when Orthodontically Medically Necessary to correct a dysfunctional malocclusion:

1. Diagnosis, including exams, models and radiographs;
2. Active treatment, including necessary appliances; and
3. Retention treatment following active treatment, limited to 10 visits in an 18-month period.

Orthodontic benefits require a Preauthorization of Benefits under this policy.

Dental Exclusions and Limitations

No benefits will be provided under any article of this Plan of Benefits for the following:

1. Any services or charges for services not Medically Necessary;
2. Services covered under medical or drug plans
3. Dental services or supplies that are Investigational or Experimental;
4. Any charges for supplies or dental services rendered to the Member prior to the Member's Effective Date, or after the Member's coverage terminates;
5. Dental services received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trustee or similar person or group;
6. Dental services for which the Member incurs no charge;
7. Any service or charge for a service to the extent a Member is entitled to receive payment or benefits relating to such service under any state or federal program that provides health care or dental benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay;
8. Dental services or supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures;
9. Dental services for which the Member would have no legal obligation to pay in the absence of Dental Coverage;
10. Appliances or restorations necessary to increase vertical dimensions or restore the occlusion, including management of TMJ disorders;
11. Services rendered by a Provider beyond the scope of his or her license;
12. Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage hereunder;
13. Charges by a Provider for non-dental services such as broken appointments and completion of claim forms;
14. Charges for visits at home or in the hospital except in connection with emergency care;
15. Dental care or treatment not specifically listed under Dental Covered Services;
16. Any service or supply rendered by a member of the patient's immediate family or by the patient, including the dispensing of drugs. A member of the patient's family means the Spouse, parent, grandparent, brother, sister, child or Spouse's parent of the patient;
17. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service;
18. Services related to teeth missing prior to a Member's Effective Date of coverage under the Policy are not eligible for payment of benefits;
19. Any service for the treatment of dysfunctions or derangements of the TMJ, including orthognathic surgery for the treatment of dysfunctions or derangements of the TMJ;
20. Any service related to the treatment of malpositions or deformities of the jawbone(s), dysfunction of the muscles of mastication, or orthognathic deformities;
21. Consultations;
22. Non-IV sedation (nitrous oxide and non-conscious sedation);
23. Services for the excision or extraction of impacted teeth;
24. Replacement Prosthodontics made necessary by loss or theft;
25. Temporary crowns and partials;

26. Benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Member sought treatment for the injury or illness from a provider which is not authorized by the Member's employer. If BlueCross pays benefits for an injury or illness and BlueCross determines the Member also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, BlueCross shall have the right of recovery as outlined in the Policy;
27. Complications arising from a Member's receipt or use of either dental services or supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services;
28. Complications that occur because a Member did not follow the course of treatment prescribed by a Provider;
29. Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation;
30. Any dental service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent child age;
31. Any dental service, supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the BlueCross. If the Member refuses to provide these test results, no benefits will be provided;
32. Charges for a Member's appointment with a Provider that the Member did not attend;
33. Dental services or supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence;
34. Dental services or supplies or other items not specifically listed as a Benefit in the Policy;
35. Orthodontics

    If this Benefit is listed on the Schedule of Benefits as a Covered Service the following will apply:
    a. Benefits for these services will be limited to Members through the age set forth on the Schedule of Benefits, if any;
    b. The initial payment will be equal to no more than twenty-five percent (25%) of the total liability, with the following sequential payments payable no more frequently than once a month, and if for any reason the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Employer will cease with payment through the month of termination;
    c. The replacement of any appliances made necessary by reason of loss or theft is not covered by this Plan of Benefits; and
    d. Orthodontics performed primarily for cosmetic purposes.
36. Payment for dental services shall be limited as follows:
    a. In all cases involving covered services or supplies in which the Provider and Member selected a more expensive or personalized course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this agreement will be based on the charge allowed for the lesser procedure as determined by BlueCross;
    b. In the event a Member transfers from the care of one Provider to that of another Provider during the course of treatment, or if more than one Provider performs services for one dental procedure, BlueCross shall be liable not more than the amount it would have been liable for had but one Provider performed the service; or,
    c. Any additional treatment that is necessitated by lack of Member cooperation with the Provider or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member.

How We Pay Benefits

We pay for covered dental services based on the Allowable Charge for that service. The Allowable Charge is the total amount eligible for payment by Blue Cross. The Allowable Charge may be subject to a Deductible and Coinsurance.

All covered services are subject to cost sharing, as shown on the schedule of benefits.

Deductible Amounts
Each Benefit Year, you must pay a dental Deductible. Your Schedule of Benefits shows this amount. We will begin to pay dental benefits once you meet the Deductible. This Deductible applies to the dental services as shown in the Schedule of Benefits.

Predetermination of Benefits
Except in an emergency, you should discuss fees with your Dentist before treatment begins. If the cost of recommended dental treatment is equal to or greater than the amount shown in the Schedule of Benefits, your Dentist should file a Predetermination of Benefits to Blue Cross. By doing this, both you and the Dentist will know up front how much we will pay for treatment recommended. Here's how it works.

Your Dentist should list, on a claim form, the treatment planned and its cost, and send the form to our Dental Claims Service Center. After we determine the amount eligible for payment, we will let you and your Dentist know.

If your Dentist does not ask for Predetermination of Benefits, we will pay benefits according to the information on the claim form. Predetermination of Benefits is not necessary for emergency care, routine oral examinations, X-rays, fluoride treatments, cleaning, scaling or polishing teeth.

Coordination of Benefits (COB)

Coordination of Benefits occurs when a person is covered by two or more dental insurance Plans. When you're covered under two or more types of insurance, one Plan will be considered "primary" and will pay your dental care claims first. The other Plan will be considered "secondary," and will process your claims only after the primary Plan has processed your claims. You must tell us of any other dental coverage you have for yourself or your Dependents. You must also confirm each year that you have no other insurance for you or your Dependents. All benefits provided under this Policy are subject to this section.

How We Pay Claims When We Are Primary
When we're the primary Plan, we'll pay benefits as we describe in this Certificate, just as if you had no other dental care coverage under any other Plan.

How We Pay Claims When We Are Secondary
We'll be secondary whenever the rules don't require us to be primary.

When we're the secondary Plan, we don't pay until after the primary Plan has paid its benefits. We'll then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a dental care expense covered by one of the Plans, including copayments, coinsurance and deductibles.

If your other dental coverage is responsible for making payments first, BlueCross can't pay until we know how much the other Plan has paid and the amount of your remaining liability.

Whether BlueCross is primary or secondary, we may need information about your other insurance. You may receive a notice stating a claim has been denied or that we need information to complete processing the claim. For us to update your files, return the notice with the requested information as quickly as possible. If you need more information, please contact a Customer Advocate.

As used in this Section, Plan means any of the following types of coverage that provide benefits or services for your care or treatment:

1. Dental Insurance Coverage;
2. Uninsured arrangements of group coverage;
3. Other type of prepayment coverage, including group practice and individual practice plans; and
4. Coverage in group and individual "no fault" contract and traditional automobile "fault" type contracts that includes dental coverage.

Effects on Benefits

1. If you're also covered for dental benefits or services under any other Plans, we'll coordinate benefits with each of your other Plans. If we're the secondary Plan, we'll determine our payment by subtracting the amount the primary Plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary Plan, the total benefits paid don't exceed the total Allowed Amount for your claim. We'll credit any amount we would have paid in the absence of your other dental care coverage toward our own Deductible.

2. We won't pay an amount the primary Plan didn't cover because you didn't follow its rules and procedures. For example, if your Plan has reduced its benefit because you didn't obtain Preauthorization, as required by that Plan, we won't pay the amount of the reduction, because it isn't an allowable expense.

3. The rules for Coordination of Benefits follow. If a rule applies to your situation, then you don't need to consider any rules that follow it. For example, if the first rule applies, you don't need to consider the second rule.

    a. If a Plan doesn't have a Coordination of Benefits provision, then that Plan is presumed to be primary.
    b. The Plan of the Employee is primary over one that covers the Employee as a dependent or inactive Employee.
    c. The Plan of the Employee is primary over one that covers the Employee as a laid off or otherwise inactive Employee.

        If the other Plan doesn't contain this rule, and, as a result, the Plans don't agree on the order of benefits determination, the order of liability will be determined according to rule d.

    d. When the prior rules don't establish an order of benefit determination, the Plan under which you have been covered the longest is primary.
    e. A Plan sometimes states that it is always secondary or is always the excess coverage. When a Plan makes that statement, this Certificate will coordinate benefits as follows:
        1. If we determine this Certificate is primary, it will pay or provide benefits on a primary basis;
        2. If we determine this Certificate is secondary, we'll provide benefits, but the amount of benefits payable will be determined as if this Certificate were the secondary Plan;
        3. If the other Plan fails to furnish the information needed for us to determine Benefits within a reasonable time after we request the information, we'll assume the benefits of the other Plan are the same as those provided under this Certificate and will pay benefits accordingly. If the other Plan makes information available about the actual benefits of the other Plan, any benefit payment we've made under this Certificate will be adjusted accordingly;
        4. If the other Plan refuses to pay as the primary Plan, we'll advance you an amount equal to what the other Plan should have paid; however we won't advance more than what we would have paid if we had been the primary Plan and we'll be subrogated to all your rights against the other Plan.

            In no event will this Certificate advance more than it would have paid as the primary Plan less any amount it previously paid. In consideration of such advance, this Certificate will be subrogated to all your rights against the other Plan. Such advance under this Certificate will also be without prejudice to any claim it may have against the other Plan in the absence of such subrogation.

f. If your Dependent children have coverage under this Certificate and as Dependents under other dental coverage, the following order of liability will be used:
   1. The Plan covering the parent whose birthday falls earlier in the year (month and day in a calendar year) are determined before those of the Plan of the parent whose birthday falls later in the year;
   2. If both parents have the same birthday, the benefits of the Plan that covered the parent for a longer period of time are determined first;
   3. If the other Plan always considers the father's coverage as primary (gender rule), and as a result, the Plans don't agree on the order of benefits, the gender rule will apply.

g. In the case of divorce or legal separation, we look first to any court order. If a court order requires one of the parents to be financially responsible for the health and/or dental care of the child, and the Plan for that parent has actual knowledge of the court order, that Plan becomes primary. If a court says that the parents will share joint custody, without stating that one of the parents is financially responsible for the health and/or dental care of the child, we follow the rules above as if the parents aren't separated or divorced.
   When no court order exists, we determine the primary Plan for a Dependent child as follows:
   1. The Plan of the custodial parent;
   2. The Plan of the spouse of the custodial parent;
   3. The Plan of the non-custodial parent.
   4. The Plan of the spouse of the non-custodial parent.

Facility of Payment
If another Plan mistakenly pays as the primary Plan, we have the right to reimburse that Plan directly for its overpayment; any amount paid to reimburse the other Plan will be considered paid Benefits under this Certificate.

Right of Recovery
If we pay more than we should have paid under this COB provision, we're entitled to receive the overpayment from the person or company that received the overpayment.

Right to Receive and Release Necessary Information
BlueCross may need to release information to, or obtain information from, another Plan, other organization or person for the purpose of determining whether COB applies or processing benefits using the COB provision. No authorization or prior notice is required to release or obtain this information. Any person claiming benefits under this Plan will furnish information upon request. If another Plan or Provider requires an authorization to release information, the Member (or personal representative if the Member is a minor) will provide this upon request.

Continuation of Care

If benefits under this Policy are no longer covered due to a change in a Provider's terms of participation in the Network, such as a Network Provider's contract is modified, ends, or is not renewed for any reason other than fraud or failure to meet specified quality standards, including suspension or revocation of the Provider's license, and you are a Continuing Care Patient of the Provider at the time, you may be eligible to continue to receive Network benefits for that Provider's services for a limited period of time. We will attempt to notify you if and when these situations arise with your providers, and explain your right to elect continued Network coverage, but such continued Network coverage is not automatic; please contact us or have your provider contact us in order to receive this continued Network coverage.

Your treating Provider should include a statement confirming that you have a Serious Medical Condition. Upon receipt of your request, we will confirm the last date the Provider is part of our Network and a summary of continuation of care requirements. If additional information is necessary, we may contact you or the Provider.

If you qualify for continued Network status, we will provide in-Network benefits for you from that Provider, for the course of treatment relating to your status as a continuing care patient, for 90 days or until the date you are no longer a Continuing Care Patient with respect to the Provider, whichever occurs earlier. During this time, the Provider will accept the Network Provider allowance as payment in full. Such continued Network status is subject to all other terms and conditions of this Policy, including regular benefit limits.

Claims Filing

How to File Claims

1. When a Participating Provider renders services, generally, the Participating Provider should either file the claim on the Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.
2. Written notice of receipt of services on which a claim is based must be furnished to BlueCross, at its address on the Identification Card, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, BlueCross will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after BlueCross receives the notice, the Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Member must submit written proof covering the character and extent of the services within the time fixed for filing proof of loss.
3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with BlueCross. When filing the claims, the Member will need the following:

    a. A claim form for each Member. Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via BlueCross's website, www.SouthCarolinaBlues.com.
    b. Itemized bills from the Provider(s). These bills should contain all the following:
        i. Provider's name and address;
        ii. Member's name and date of birth;
        iii. Member's Identification Card number;
        iv. Description and cost of each service;
        v. Date that each service took place; and,
        vi. Description of the illness or injury and diagnosis.

c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's explanation of benefits notice.
d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to BlueCross's address listed on the claim form.

4. BlueCross must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.

5. Receipt of a claim by BlueCross will be deemed written proof of loss and will serve as written authorization from the Member to BlueCross to obtain any dental, medical or financial records and documents useful to BlueCross (as determined by BlueCross). BlueCross, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits dental, medical or financial reports and documents to BlueCross in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an authorized representative in connection with such Member's claims, the Member should contact BlueCross for an authorized representative form.

6. If a member requires emergency treatment and receives covered services from an Out-of-Network Provider, covered services for the emergency care rendered during the course of the emergency will be treated as if they had been provided by an In-Network Provider.

Claims Determination

There are four types of claims. They are Pre-service Claims, Urgent Care Claims (a type of Pre-service Claim), Post-service Claims, and Concurrent Claims. The time frames allowed for us to provide a determination for each of these claims are listed below:

1. Pre-service Claim – We must give you our decision in writing or electronic form within 15 calendar days.

   An extension of 15 calendar days may be provided if we determine that, for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 15-day time period that an extension is necessary.

   If we receive incomplete information from you and need more information to make a decision, we will let you know within five calendar days. You have 60 calendar days to send us the required information. If we do not receive it within the 60-day time period, we may deny the claim.

   When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination once we get that additional information from you or your provider.

2. Urgent Care Claim – We will make our decision, based on Medical Necessity, and let you know in writing or in electronic form within 72 hours of the original Urgent Care Claim.

   Within 24 hours of getting the original Urgent Care Claim, we will let you or your authorized representative know if we lack information needed to make a decision. An extension of 48 hours may be required if we do not have complete information to make a Medical Necessity decision. If we do not get that information from you within 48 hours after notifying you, we may deny the claim.

3. Post-service Claim – We will give you our decision in writing or in electronic form within 30 calendar days if the decision goes against you. An adverse decision includes any amount due that you may be held responsible for other than amounts already paid to the provider.

An extension of 15 calendar days may be provided if we determine, that for reasons beyond our control, an extension is necessary. If an extension is required, we will let you know within the initial 30-day time period.

If we receive incomplete information from you and need more information to make a decision, we will let you know within 30 calendar days. You have 60 calendar days to send us the required information. If we do not receive it within the 60-day time period, we may deny the claim.

When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to make a decision once we get the additional information from you or your provider.

4. Concurrent Care Decision – If we make a decision to reduce or stop benefits for Concurrent Care that had previously been approved, you must be notified sufficiently in advance of the reduction or termination of benefits to allow you time to appeal the decision before the benefits are reduced or terminated.

   If you ask us to extend benefits beyond the time or number of treatments we initially approved and the request involves urgent care, the request to extend must be made at least 24 hours prior to the end of the initially approved period. We must make a decision within 24 hours.

5. Notice of Determination.

   a. If the Member's claim is filed properly and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination that will:
      i. State the specific reason(s) for the Adverse Benefit Determination;
      ii. Reference the specific Plan of Benefits provisions on which the determination is based;
      iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
      iv. Describe the claims review procedures and this Plan of Benefits and the time limits applicable to such procedures;
      v. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,
      vi. If the reason for denial is based on a lack of Medical Necessity, Investigational or Experimental exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
   b. The Member will also receive a notice if the claim is approved.

Appeal Procedures

1. The Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing;
   b. An appeal must be sent (via U.S. mail) to BlueCross BlueShield of South Carolina at the address on the Member's Identification Card;
   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
   d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.

2. The Member may submit written comments, documents or other information in support of the appeal and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of dental or medical judgment, the Corporation will consult with an appropriately qualified healthcare practitioner with training and experience in the relevant field of medicine. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on the appeal.

4. The Corporation will make a final decision on the appeal within the time periods specified below:
   a. Pre-Service Claim.
      The Corporation will decide the appeal within a reasonable period of time, taking into account the circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Member disagrees with the Corporation's decision, the Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Corporation will decide the second appeal within a reasonable period of time, taking into account the circumstances, but no later than fifteen (15) days after receipt of the second appeal.
   b. Urgent Care Claim.
      The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Corporation will communicate with the Member by telephone or facsimile. The Corporation will decide the appeal within a reasonable period of time, taking into account the circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
   c. Post-Service Claim.
      The Corporation will decide the appeal within a reasonable period of time but no later than thirty (30) days after receipt of the appeal. If the Member disagrees with the Corporation's decision, the Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Corporation will decide the second appeal within a reasonable period of time but no later than thirty (30) days after receipt of the second appeal.
   d. Concurrent Care Claim.
      The Corporation will decide the appeal of Concurrent Care claims within the time frames set forth in Article XI (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.

   a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination that will:
      i. State specific reason(s) for the Adverse Benefit Determination;
      ii. Reference specific provision(s) of this Plan of Benefits on which the benefit determination is based;
      iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
      iv. Describe any voluntary appeal procedures offered by the Corporation and the Member's right to obtain such information;
      v. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request); and,
      vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
   b. The Member will also receive a notice if the claim on appeal is approved.

General Provisions

1. **Authorized Representatives**
   A provider may be considered an authorized representative without a specific designation by the Member when the Approval request is for Urgent Care Claims. A provider may be an authorized representative with regard to non-Urgent Care Claims only when the Member gives BlueCross or the provider a specific designation to act as an authorized representative. If the Member has designated an authorized representative, all information and notifications should be directed to that representative unless the Member gives contrary directions.

2. **Clerical Errors**
   Clerical errors in keeping records for this Policy by BlueCross will not cause a denial of insurance that should otherwise have been granted nor will clerical errors extend coverage that should otherwise have ended. Clerical errors may require an adjustment of premiums.

3. **Confidentiality**
   Information from the Member's medical records and information about the Member's doctor-patient and Hospital-patient relationships will be kept confidential. Such information will not be revealed without the Member's authorization, except: a) use in medical research according to government regulations; b) use in administering this Policy; or c) disclosure required or permitted by law.

4. **Conformity with State Statutes**
   Any provision of this Policy which, at any relevant time, is in conflict with the laws of the state in which it is delivered or in conflict with Federal law on that date is amended to conform to the minimum requirements of such laws. Notwithstanding anything herein to the contrary, no provision of this Policy shall be interpreted as prohibiting any provision, access, use, or disclosure of information to the extent required by applicable law.

5. **Disclosure**
   The Member must provide information regarding all other dental coverage to which the Member or Dependent is entitled.

6. **Entire Policy; Changes**
   This Policy, together with the Application and any attached papers, is the entire Policy between you and BlueCross. No agent can change it in any way. Only an officer of ours can approve a change. That change must be shown on your Policy.

7. **Governing Law**
   This Policy will be administered according to applicable federal and state laws and regulations; any provision in conflict with applicable laws and regulations will be amended to conform to the minimum requirements.

8. **Identification Cards**
   BlueCross will issue an ID card for each covered Member.

   ID cards are for identification only. To be entitled to Covered Services, the cardholder must be a Member whose premium has been paid. Any person receiving services or benefits to which the person is not entitled will be responsible for the charges. Loss or theft of an ID card must be reported as soon as possible after the theft is discovered.

9. **Information and Records**
   BlueCross is entitled to obtain such authorization for medical and hospital records as it may reasonably require from any provider of services incident to the treatment, payment and dental care operations for the administration of the benefits hereunder and the attending Dentist's certification as to the Medical Necessity for care or treatment. BlueCross will in every case hold such records as confidential except as authorized in writing by a Member or provided by law.

10. **Legal Action**
No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after six years from the time written proof of loss is required to be given.

11. **Notices**
Except as otherwise provided in this Policy, any notice under this Policy may be given by United States mail, postage paid and addressed to Blue Cross and Blue Shield of South Carolina, Post Office Box 100300, Columbia, South Carolina 29202.

12. **Payment of Claims**
BlueCross will pay all benefits directly to the Member upon receipt of due proof of loss, and the right to assign any benefits due and payable hereunder is expressly prohibited unless otherwise determined by BlueCross. BlueCross will pay benefits of this Policy directly to a provider if BlueCross has a written agreement with the provider that provides for direct payment of benefits. Any payment of benefits or refund due after death will be paid to the Member's estate.

13. **Physical Examination**
BlueCross, at its own expense, has the right to have a Member, for whom a claim is made, examined as often as reasonably required while a claim is pending.

14. **Proofs of Loss**
Written proof of loss must be furnished to us at our office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time the proof is otherwise required.

15. **Right of Recovery**
Whenever payments have been made by BlueCross with respect to Allowable Charges in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time, BlueCross will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as BlueCross will determine: 1) any person to or for whom such payments were made; 2) as an offset against future benefits payable under this Policy; and 3) any other insurance companies or any other organizations.

16. **Right to Amend**
BlueCross may modify the Dental Insurance Policy so long as the modification is consistent with applicable law and is effective on a uniform basis among all members with that product.

17. **Time Limit On Certain Defenses**
After two years from the issue date only fraudulent misstatements in the Application may be used to void the Policy or deny any claim for loss incurred or disability that starts after the two year period.

18. **Time of Payment of Claim**
We will pay completed claims received via paper within forty business days and completed electronic claims within twenty business days following the later of 1) date the claim is received; or 2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a "clean" claim as defined in the South Carolina Health Care Financial Recovery and Protection Act.

19. **Waiver of BlueCross's Rights**
On occasion, BlueCross may, at its option, choose not to enforce all of the terms and conditions of this Policy. Such a decision does not mean BlueCross waives or gives up any rights under this Policy in the future.

Subrogation

If you receive benefits under this coverage for an injury caused by the act or omissions of a liable third party and receive a settlement, judgment, or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, you agree to reimburse us for benefits that we've paid relating to the injury. This agreement is a condition to receiving benefits under this coverage. Our right to subrogation or reimbursement applies to any judgment and/or settlement proceeds, whether or not liability is admitted.

Our interest in subrogation or reimbursement extends to all benefits relating to your injury even if claims for those benefits haven't been submitted to us for payment at the time you receive the settlement, judgment or payment.

You have the right to petition the Director of Insurance, or his designee, to determine if our subrogation action is inequitable or unjust. If the Director makes the determination that allowing subrogation is inequitable or unjust, then it isn't allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by law.

We'll pay attorney's fees and costs from the amount recovered.

If you choose not to pursue an action to recover damages, you agree to transfer all rights to recover damages in full for such benefits to us. At our expense, we lawfully stand in your place to recover the amount of money we've paid for your medical benefits from any third party who's liable, responsible, or otherwise makes a payment for your injury. We may seek recovery for our payment of claims from the liable third party, any liability or other insurance covering the liable third party or from your own uninsured motorist insurance and/or underinsured motorist insurance.

In all situations involving subrogation, you shall not do anything to hinder or slow our right to seek reimbursement. You shall cooperate with us, sign any documents, and do all things necessary to protect and secure our subrogation right.
Each time a claim is filed with a diagnosis that could be related to an accident or injury, you may receive either a notice stating that we need information to complete processing the claim along with a questionnaire regarding the claim. For your files to be updated, you must return the questionnaire with the requested information.

Definitions

Allowable Charge: The charge payable by BlueCross. The payment will not be more than the Maximum Payment.

Application: The electronic or paper form to transmit the necessary information from the Member to us when applying for this Policy. The Application is a part of this Policy.

Benefit Year or **Plan Year:** It begins on January 1 of each year or on the date you elect coverage and ends on December 31.

Coinsurance: The percentage of Allowable Charges you pay as your share of covered services. The percentage you pay will be applied to the negotiated rate or lesser charge for that provider.

Concurrent Care: An ongoing course of treatment to be provided over a period of time or number of treatments.

Copayment: The amount, if any, specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member received Benefits.

Covered Expenses: Charges for Medically Necessary services, supplies or equipment that a Dentist or oral surgeon performs or prescribes that aren't otherwise excluded by any term, condition, limitation or exclusion of the Policy.

Dental Deductible: The amount of Covered Expenses you must pay each Benefit Year for your dental care before we pay benefits on a claim.

Dentist: A dental practitioner who specializes in the care and treatment of teeth and gums.

Dependent: Your spouse and any children under age 26 who are covered under this Dental Policy. Dependent child(ren) include a natural or adopted child, stepchild, foster child or a child who is under your legal guardianship. A spouse of a Dependent is not eligible for this coverage.

Effective Date: The date (beginning at 12:01 a.m.) on which the Member becomes covered under the terms of the Policy.

Enrollment Date: The date of enrollment in this plan.

Incapacitated Dependent: An unmarried Dependent child who is: 1) incapable of self-sustaining employment because of a mental or physical handicap; and 2) mainly dependent upon you or your spouse for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. You must give us a written report of such dependency and incapacity from a Physician within 31 days of the Dependent's 26th birthday. Our Medical Director will determine if the child meets the criteria of an Incapacitated Dependent. For the child to remain covered, we must receive a Physician's written report every two years within 31 days of the child's birthday. Coverage must also remain in effect for the Member.

Investigational or Experimental Services: Surgical procedures, dental procedures or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgment of BlueCross not recognized as conforming to generally accepted medical or dental practice, or the procedure, drug or device:

a. Has not received required final approval to market from appropriate government bodies;
b. Is one about which the peer-reviewed literature does not permit conclusions concerning its effect on health outcomes;
c. Is not demonstrated to be as beneficial as established alternatives;
d. Has not been demonstrated to improve net health outcomes; or,
e. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Maximum Payment: The total amount eligible for payment by BlueCross for the services, supplies or equipment the Member receives from a provider. The Maximum Payment will be the lowest of the following:

a. The actual charges made for similar services, supplies or equipment by providers and filed with Blue Cross during the last calendar year;
b. The Maximum Payment for the last year increased by an index based on national or local economic factors or indices;
c. The lowest rate at which any medical services, supplies or equipment are generally available in the area, when in the judgment of Blue Cross, a charge for such services, supplies or equipment generally should not vary significantly in quality from one provider to another;
d. An amount that has been agreed upon by a Provider and BlueCross; or
e. An amount established by BlueCross in its discretion.

If there are no actual or similar charges, as referred to above, Blue Cross may determine the Maximum Payment based on comparable or similar services or procedures, through its medical staff and/or consultants. Allowable Charges may be subject to a Deductible and Coinsurance as specified in the Schedule of Benefits.

Medically Necessary: Services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of dental practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,

3. Not primarily for the convenience of the patient or Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community, appropriate dental society recommendations, and the views of Providers practicing in relevant clinical areas and any other relevant factors.

Member: An enrolled Individual or covered Dependent.

Minimum Essential Coverage: Any of the following: 1) coverage under certain government-sponsored plans; 2) employer-sponsored plans, with respect to any employee; 3) plans in the individual market; 4) grandfathered health plans; and 5) any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Health and Human Services Secretary.

Network Provider: A Provider who has a current Provider Agreement (with BlueCross).

Orthodontically Medically Necessary: Medically Necessary services that are related to the treatment of severe craniofacial deformity that results in a Physically Handicapping Malocclusion, including but not limited to the following conditions:

a. Cleft Lip and/or Cleft Palate;
b. Crouzon Syndrome/Craniofacial Dysostosis;
c. Hemifacial Hypertrophy/Congenital Hemifacial Hyperplasia;
d. Parry-Romberg Syndrome/Progressive Hemifacial Atrophy;
e. Pierre-Robin Sequence/Complex; or
f. Treacher-Collins Syndrome/Mandibulofacial Dysostosis.

Orthodontic treatment is not considered Medically Necessary for dental conditions that are primarily cosmetic in nature.

Physically Handicapping Malocclusion: A deviation in intramaxillary and/or intermaxillary relations of teeth from normal occlusion which severely interferes with the ability of a person to speak or chew food. It is often associated with other dentofacial deformities.

Post-service Claim: Any claim that is not a Pre-service Claim or any claim that you submit to us after you received the dental care, service or supply.

Preauthorization: BlueCross's approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. Preauthorization means only that BlueCross has determined that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed.

Pre-service Claim: Any claim or request for a benefit where Predetermination of Benefits must be obtained from Blue Cross before receiving the dental care, service, or supply. An approval means only that a service is Medically Necessary to treat your condition. It does not guarantee that we will pay benefits. Payment is subject to your eligibility and all other Policy limitations and exclusions. We will make our final benefit determination when we process your claim.

Predetermination of Benefits: The approval that you or your Dependents should get from us before you or your Dependents receive services, supplies or equipment the Dentist estimates will cost $250 or more.

Provider: Any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of dentistry or oral surgery.

Resident/South Carolina Resident: Person who resides primarily within the State of South Carolina, typically at least six months of the calendar year. Residency may be shown by possession of a current government identification (such as a South Carolina driver's license, South Carolina voters registration card, etc.), the most recent year's tax return document, or a current utility bill showing the state of South Carolina as residence. For children, residency may be shown by the existence of the above documents for a custodial parent.

Schedule of Benefits: The pages of within the Outline of Coverage that specify the amount of coverage you have along with any Coinsurance, Copayments, Deductibles and limitations.

Serious Medical Condition: a health condition or illness that requires medical attention, and where failure to provide the current course of treatment through the current Dentist would place the person's health in serious jeopardy.

Urgent Care Claim: Any claim made by you or by a provider or Dentist (with knowledge of your current dental condition), where, if the normal Pre-service Claim review time frames of the Policy were used:

1. Your life, health, or ability to regain maximum function could be seriously jeopardized; or
2. You, in the opinion of the Dentist, would be subject to severe pain that cannot be adequately managed without the recommended care or treatment.