Carolina ADVANTAGE

COMPREHENSIVE DENTAL

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Revised 7/05

BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA, INC.

AMENDMENT OF GROUP CONTRACT AND CERTIFICATE OF COVERAGE

This amendment is issued for attachment to and becomes part of Group Contract No. MGC SMGRP 0705 and Certificate of Coverage CA Combined certificate 0705 issued as stated in the BlueChoice HealthPlan Group Master Contract**.**

The Certificate of Coverage is amended to provide dental benefits as specified below, subject to all definitions, eligibility terms, limitations and exclusions included in the group contract and certificate of coverage referenced above.

BlueChoice Health Plan has arranged for Blue Cross and Blue Shield of South Carolina to serve as the Administrator for these dental benefits. The Administrator shall process claims, review Treatment Plans, respond to inquiries and process appeals.

SECTION 1 – DEFINITIONS

Administrator - Blue Cross and Blue Shield of South Carolina

Allowable Charge - The actual charge as submitted or the Maximum Payment, whichever is less.

The Maximum Payment is the total amount eligible for payment by the Corporation for the services, supplies or equipment the Member receives from a Provider. The Maximum Payment that the Administrator determines will not be less than the least of A, B, C, or D:

A. The actual charges made for similar services, supplies or equipment by Providers and filed with the Administrator 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 charge level at which any medical service, supply or equipment is generally available in the area, when in the judgment of the Administrator, a charge for such services, supplies or equipment generally should not vary significantly in quality from one Provider to another;
D. A set of allowances the Administrator establishes.

Review of the Maximum Payment will occur following each calendar year. If there are no actual or similar charges, as referred to above, the Administrator 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/or Copayment and Coinsurance as specified in the Schedule of Dental Benefits.

Dentist - A duly licensed person, excluding an intern or resident, legally entitled to practice dentistry within the scope of his license and who customarily bills patients for his services.

Medically Necessary - The services received are reasonable and necessary for the diagnosis or treatment of dental or oral disease or injury, or to improve the functioning of a malformed body member, according to accepted standards of good dental practice.

Predetermination of Benefits - The approval that must be obtained from the Administrator before the Member receives services, supplies or equipment the dentist or oral surgeon estimates will cost $100 or more.

Schedule of Dental Benefits - The pages so titled in this Amendment that specify the amount of coverage provided and the applicable Coinsurance, Deductibles and limitations.

Treatment Plan - A written report, including any necessary x-rays, showing the recommended treatment of any dental disease, defect or injury of a Member, prepared by a Dentist as a result of any examination made by such Dentist while coverage under this Contract is in effect for the Member.

SECTION 2 - DENTAL BENEFITS

Subject to all provisions of this Amendment, including but not limited to, *Section 3, EXCLUSIONS AND LIMITATIONS*, benefits set forth below will be provided as shown in the Schedule of Dental 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 license; and
C. the services and supplies are billed by, or on behalf of, the Dentist.

Predetermination of Benefits

If a Member needs dental treatment that a dentist or oral surgeon estimates will cost $100.00 or more, the dentist or oral surgeon should file a Predetermination of Benefits to the Administrator. By doing this, the Member and the dentist will know in advance how much will be paid for the recommended treatment.

If treatment costs $100.00 or more and the dentist does not ask for Predetermination of Benefits, claims will be paid according to the information on the claim.

Predetermination of Benefits is not needed for treatment costing less than $100.00, for emergency care, routine oral examinations, x-rays, fluoride treatments, cleaning, scaling or polishing teeth.

Cleft Lip and Palate

Benefits are available 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 covered by this Amendment. Benefits under this Amendment are primary to any benefits available for the patient under any individual or group health coverage contract.

If indicated on the Schedule of Dental Benefits, payment is provided for the following:

CLASS I – DIAGNOSTIC AND PREVENTIVE DENTAL BENEFITS

1. Oral and periodontal exams, limited to once every six (6) months;
2. Periapical, occlusal, extraoral x-rays, as required; bitewing x-rays limited to four x-rays, once every six (6) months, full mouth x-rays or panoramic film with up to four additional bitewing x-rays taken on the same day is limited to one in any 36 month period, unless a special need for these services at more frequent intervals is documented as Medically Necessary by the Dentist;
3. Topical fluoride applications of stannous fluoride or acid fluoride phosphate for an Employee and/or Dependent under age 19, limited to once every six (6) months;
4. Prophylaxis, including cleaning, scaling and polishing, limited to once every six (6) months;
5. Space maintainers for prematurely lost deciduous teeth, provided the Employee or Dependent has not attained age 19;
6. Emergency palliative treatment for the relief of pain;
7. Pulp vitality tests;
8. Diagnostic casts;
9. Sealants on permanent teeth that have not had any fillings; covered on children from the ages of 6 through 15.

CLASS II – BASIC DENTAL, ORAL SURGERY AND PERIODONTIC BENEFITS

1. Repair of removable dentures;
2. Oral surgery including the following:
   - Surgical extractions,
   - Stomatoplasty,
   - Alveoplasty,
   - Removal of cysts and neoplasms,
   - Excision of bone tissue,
   - Biopsies of oral tissue,
   - Treatment of oral fistula,
   - Excision of hyperplasic tissue, and
   - Frenulectomy;
3. Fillings, consisting of amalgam and tooth-colored synthetic materials;
4. Simple extractions;
5. Endodontics, consisting of pulpotomy, pulp capping and root canal treatment;
6. General anesthesia or IV sedation if Medically Necessary and provided in connection with covered oral or dental surgery.
7. Hemi-section;
8. Apicoectomy (amputation of apex of a tooth root);
9. Assistant at surgery when Medically Necessary;
10. Periodontics, that being the diagnosis and treatment of diseases of the tooth-supporting tissues, as follows:
    - Surgical periodontic examination;
    - Gingival curettage;
    - Gingivectomy and gingivoplasty;
    - Osseous surgery, including flap entry and closure;
    - Mucogingivoplastic surgery; and
    - Management of acute infection and oral lesion;
11. Periodontal cleanings (payable only once every three months after the initial periodontal treatment is documented).

CLASS III – PROSTHODONTICS (There is a six-month waiting period from the Member's Effective Date for Prosthodontic services.)

1. Inlays (not part of a bridge);
2. Crowns (not part of a bridge);
3. Onlays (not part of a bridge);
4. Removable dentures, complete and partial, and bridges, fixed and removable except that benefits for replacement shall not be provided for any replacement made less than five years after a placement or replacement which was covered under this Contract, unless replacement is due to theft or loss;
5. Fixed bridge repairs; and
6. Relining or rebasing of removable dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any 36-month period.

CLASS IV – ORTHODONTICS (The Schedule of Dental Benefits will show if this Contract provides orthodontic coverage.)

1. The correction of dysfunctional malocclusion consisting of the following:
   - Diagnosis, including models and radiographs;
   - Active treatment, including necessary appliances; and
   - Retention treatment following active treatment, limited to 10 visits in an 18-month period.
2. Exclusions and Limitations:
   A. Benefits for these services will be limited to Employees or Dependents under the age of 19;
   B. Benefits payable per Employee or per each Dependent are limited to the lifetime maximum amount listed on the Schedule of Dental Benefits and to services rendered within a period not to exceed 36 consecutive months;
   C. The initial payment will be equal to no more than 25% of the total liability of the Corporation, with the following subsequential 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 Corporation will cease with payment through the month of termination; and
   D. The replacement of any appliances made necessary by reason of loss or theft is not covered by this Contract.

SECTION 3 – EXCLUSIONS AND LIMITATIONS

1. No benefits will be provided under any Section of this Amendment for the following:

A. Any services or charges for services not Medically Necessary;
B. Charges for services or supplies that are investigational/experimental in nature;
C. Dental services or supplies that are provided before the Contract Effective Date;
D. 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;
E. Dental services for which the Employee or Dependent incurs no charge;
F. Dental services paid by Workers’ Compensation (if a Workers’ Compensation claim is settled, it will be considered paid by Workers’ Compensation);
G. Dental services or supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures;
H. Dental services for which a Member is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) under the law (now existing or as may be amended) of the United States (including Medicare), or any state or political subdivision thereof, except for Medicaid;
I. Services or supplies related to chewing or bite problems, pain in the face, ears, jaws or neck resulting from problems of the jaw joint(s), also known as Temporomandibular Joint Disorder (TMJ). Benefits are limited to x-rays and exam only;
J. Services provided by a Dentist beyond the scope of his license;
K. Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage existed hereunder;
L. Charges by a Dentist for non-dental services such as broken appointments and completion of claim forms;
M. Charges for visits at home or in the hospital except in connection with emergency care;
N. Dental care or treatment not specifically listed under Section 2 and designated in the Schedule of Dental Benefits;
O. Any service or supply provided by a member of the patient's family or by the patient. A member of the patient's family means the spouse, parent, grandparent, brother, sister, child or spouses parent of the patient;

P. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service or units auxiliary thereto;

Q. Services related to teeth missing prior to the Member's Effective Date under this Amendment are not eligible for payment of benefits;

R. Services or supplies that do not meet accepted standards of dental practice;

S. Implants and/or bridges, crowns or dentures, including overlay dentures, involving implants;

T. Claims submitted after the time limit for filing claims has been exceeded;

U. Replacement of a denture that could have been repaired or extended;

V. Habitual appliances;

W. Sterilization fee charged by the Dentist;

X. Prosthodontic services received before the end of the six-month waiting period;

Y. Facility fees filed in conjunction with dental work being performed;

Z. Mechanical toothbrushes such as the sonic care varieties, rotary head types, or any variety of Water Pic, even if prescribed or recommended by a Dentist as Medically Necessary;

AA. Stainless steel crowns for patients age 19 and over;

BB. Non-covered forms of anesthesia, including but not limited to, Nitrous Oxide;

CC. Appliances or restoration necessary to increase vertical dimensions or to restore an occlusion;

DD. Services provided after the termination date of this Coverage, even though treatment began before coverage ended, except for dentures that were ordered and fitted while coverage was still in force, payment will be made if the dentures are delivered within 31 days after coverage ended. [Further, coverage may be extended for completion of dental services under a Treatment Plan approved by the Administrator, provided the dental services are completed within 30 days from the date of approval of the Treatment Plan];

EE. Orthodontic services, except when specified in the Schedule of Dental Benefits.

2. Payment for services will be limited as follows:

A. In all cases involving covered services or supplies in which the Dentist 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 the Administrator;

B. In the event a Member transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist performs services for one dental procedure, the Corporation will be liable for not more than the amount it would have been liable for had but one Dentist performed the service;

C. Any additional treatment that is necessitated by lack of Member cooperation with the Dentist or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member.

SECTION 4 – GENERAL PROVISIONS

HOW TO GET HELP

If you have any questions about your dental claims, please contact the Dental Service Center. Telephone numbers and the mailing address are listed below.

Telephone Numbers:

788-2571	from the Columbia area
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

HOW TO FILE CLAIMS

Most of the time a dentist will fill out a dental claim form for you. However, if your dentist will not do this, ask him to complete the bottom half of the form. If he refuses to do this or does not have a dental claim form, ask for an itemized receipt that must contain the following information:

A. The patient's name,
B. The date or dates of service,
C. The type of service, and
D. The charge(s).

If you fill out your own dental claim form, complete the top half of the form, attach the itemized receipt to it and mail it to the Dental Service Center. If the patient has other insurance that has already paid on claims, be sure to attach a copy of the other plan's explanation of benefits (EOB) notice. This will help prevent a delay in claims processing. Before you submit your claims, we suggest you make a copy of all claim forms and itemized bills for your records since we don't return them to you.

TIME LIMITS FOR CLAIMS

Except in the absence of legal capacity, claims must be filed no later than 12 months from the end of the benefit period in which services were incurred in which you or your dependents receive dental services or supplies.

You have 180 days from the date you receive an Explanation of Benefits regarding a claim to request a review of all or part of the claim.

Any questions you have concerning a claim must be made to the Administrator within 18 months of the date services or supplies are received.

DENIAL OF CLAIMS

If all or part of a claim is denied, you will receive an Explanation of Benefits (EOB) explaining the reason(s). If the information Blue Cross received with your claim was incomplete, the EOB notice will tell you what additional facts or materials are needed and why. You can then resubmit your claim.

If you don't understand why your claim was denied, you can do the following:

- Read the information in this amendment. It outlines the terms and conditions of your dental coverage.
- Contact the Dental Service Center for help.

APPEALS

If you disagree with the disposition of this claim, you may request a review or appeal within 180 days from the date of this notice. Your request for review or appeal must be in writing unless it involves an urgent claim. You may submit written comments, documents, or other information in support of your appeal or review, and you will have access to all documents that are relevant to your claim. If your plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), you may have the right to bring a civil action under ERISA § 502(a) following your appeal or review. Please check your health plan and booklet for more specific information regarding your appeal or review.

PAYMENT OF CLAIMS

All benefits provided in this Amendment will be paid promptly upon receipt of due proof of loss. Payments shall, at the option of the Administrator, be made either directly to the Employee or to the Dentist.

WRITTEN PROOF OF LOSS

Submission of a claim will be deemed written proof of loss and will serve as written authorization from the Member to the Administrator to obtain any medical, dental or financial records and documents useful to the Administrator. The Administrator, 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 to it at the time the claim was processed. Any party who submits medical, dental or financial reports and documents to the Administrator in support of a Member's claim will be deemed to be acting as the agent of the Member.

NOTICES

Except as otherwise provided in this Contract, any notice under this Contract may be given by United States mail, postage paid and addressed:

A. To the Administrator: Blue Cross and Blue Shield of South Carolina, Dental Claims Service Center, Post Office Box 100300, Columbia, South Carolina 29202.
B. To an Employee: To the last known name and address listed for the Employee on the Membership Application delivered to the Corporation. The Employee is responsible for notifying the Corporation of any name or address changes within 31 days of the change.
C. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation of any name or address changes within 31 days of the change.

SCHEDULE OF DENTAL BENEFITS

Employer:	as stated in the BlueChoice HealthPlan Master Group Contract
Group Number:	as stated in the BlueChoice HealthPlan Master Group Contract
Original Effective Date:	as stated in the BlueChoice HealthPlan Master Group Contract
Anniversary Date:	as stated in the BlueChoice HealthPlan Master Group Contract

Class I

Diagnostic and Preventive Dental Benefits	100% of the Allowable Charge

Class II

Basic Dental, Oral Surgery and Periodontic Benefits	80% of the Allowable Charge

Class III

Prosthodontic Benefits	50% of the Allowable Charge
Maximum Payment per Member per Benefit Year for Class I, Class II, and Class III Benefits	$1,000

Class IV

Orthodontic Benefits	Not covered
Maximum Deductible Amount Per Benefit Year	$50 per Member 3 per Family
This Deductible applies to:	Class II Class III

BlueChoice HealthPlan
Post Office Box 6170
Columbia, South Carolina 29260
(803) 786-8476
1-800-868-2528
www.BlueChoiceSC.com