



Evidence of Coverage

DENTAL BENEFIT PLAN

Clarksville-Montgomery County
90045
January 1, 2020

BCBST – PDC - EOC
2008
Revised 8/2019

Dental

EVIDENCE OF COVERAGE



**BlueCross BlueShield
of Tennessee**

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-565-9140-1 (رقم هاتف الصم والبكم: 800-848-0298-1)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

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ማስታዎሽ: የግንባር ጽንቁ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298)።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóíq, kojí' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

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INTRODUCTION

This Dental Evidence of Coverage (“Dental EOC”) is included in the Dental Group Agreement between BlueCross BlueShield of Tennessee, Inc. (“We”, “Us”, “Our” or the “Plan”) and Your Group. This Dental EOC describes the terms and conditions of Your Coverage from the Plan through the Group, and includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any Dental EOC that You have previously received from Your Group or the Plan.

PLEASE READ THIS DENTAL EOC CAREFULLY. IT DESCRIBES YOUR RIGHTS AND DUTIES AS A SUBSCRIBER. IT IS IMPORTANT TO READ THE ENTIRE DENTAL EOC. CERTAIN SERVICES ARE NOT COVERED BY THE PLAN. OTHER COVERED SERVICES ARE LIMITED. THE PLAN WILL NOT PAY FOR ANY SERVICE NOT SPECIFICALLY LISTED AS A COVERED SERVICE, EVEN IF A DENTAL CARE PROVIDER RECOMMENDS OR ORDERS THAT NON-COVERED SERVICE. (SEE ATTACHMENTS A-D.)

The Group has delegated discretionary authority to make any benefit determinations to the Plan. It has also granted the authority to construe the terms of Your Coverage to the Plan. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Group’s benefit plan is subject to ERISA. The Group retains the authority to determine whether You or Your dependents are eligible for coverage.

ANY GRIEVANCE RELATED TO YOUR COVERAGE UNDER THIS DENTAL EOC SHALL BE RESOLVED IN ACCORDANCE WITH THE “GRIEVANCE PROCEDURE” SECTION OF THIS DENTAL EOC.

In order to make it easier to read and understand this Dental EOC, defined words are capitalized. Those words are defined in the “DEFINITIONS” section of this Dental EOC.

Please contact one of the Plan’s consumer advisors, at the number listed on Your membership ID card, if You have any questions when reading this Dental EOC. The consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

BENEFIT ADMINISTRATION ERROR

If there is an error in administering the benefits under this Dental EOC, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this Dental EOC. The Plan complies with applicable laws governing the recovery of overpayments to providers.

NOTIFICATION OF CHANGE IN STATUS

Changes in Your status can affect the service under Your Plan. To make sure Your Plan works correctly, please notify the customer service department at the number listed on Your membership ID card when You or Your Covered Dependents change:

- Name;
- Address;
- Telephone number;
- Employment; or
- Status of any other dental or health coverage You may have.

Please notify the Plan of any eligibility or status changes for You or Your Covered Dependents, including:

- The marriage or death of a family member;
- Divorce;
- Adoption;
- Birth of additional dependents; or
- Termination of employment.

HOW THE DENTAL PROGRAM WORKS

Dental Coverage is designed to promote cost-effective care and provide a simple method for filing claims. Two important features include the network of participating dentists (Network Dentists) and the Predetermination of Benefits program.

NETWORK DENTISTS

To reduce Your out-of-pocket expense, You should receive services from a Network Dentist.

When You have dental work performed by a Network Dentist, You simply present Your membership ID card. The Network Dentist will file the necessary paperwork. We will make payment directly to the Network Dentist.

A listing of Network Dentists is provided to Your Group. There will be additions and deletions from time to time. Be sure to ask Your Dentist to confirm any change in his/her participation. You may also call Our customer service department, or You may check the most current directory information at Our website, www.bcbst.com. Click on Network Directories.

You can go to the Dentist of Your choice, regardless of whether he/she is a Network Dentist. However, Your out-of-pocket expense is less when You use a Network Dentist.

PAYMENT FOR AN OUT-OF-NETWORK DENTIST

If You select a Dentist who is not participating in the Preferred Dental Care Plan (an Out-of-Network Dentist), that Dentist can bill You for any amount not Covered by this Dental EOC. You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for a Covered Service, if an Out-of-Network Dentist's Billed Charges are more than the Maximum Allowable Charge for such Services.

In addition, if You select an Out-of-Network Dentist, You may have to file the claim Yourself.

PREDETERMINATION OF BENEFITS

The Predetermination of Benefits program allows You and Your Dentist to know exactly what kinds of treatment are Covered. If a course of treatment will exceed \$200.00, the treatment plan should be submitted for review before the work starts. In order to review the treatment plan, a description of each service and charge should be submitted along with all supporting aids such as pre-operative x-rays.

To obtain a Predetermination of Benefits response, Your Dentist submits a claim form and checks the box "Dentist's Pre-Treatment Estimate" after Your initial examination and before treatment begins. You and Your Dentist are then notified what benefits are available, and what payments, if any, You must make.

**ACCEPTED BARRIER TECHNIQUES AND PRECAUTIONS TO PROTECT DENTISTS, THEIR STAFF,
AND THE PUBLIC FROM CONTRACTING OR SPREADING DISEASE ARE RECOMMENDED.
HOWEVER, WE CANNOT CONFIRM THE HEALTH STATUS OF ANY DENTIST.**

ELIGIBILITY

Your Group chooses the classes of employees who are eligible for Coverage under the Plan. The eligibility requirements Your Group has selected are in Attachment D Eligibility to this Dental EOC. They are also on file in Your Group's human resource department.

ENROLLMENT IN THE PLAN

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll, if the Plan previously terminated his or her Coverage for any of the reasons listed under paragraph C. of the "When Coverage Ends" section of this EOC.

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that initial enrollment period, except as otherwise indicated in paragraph C. below.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during the Group's Open Enrollment Period. You must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period, may apply for Coverage for themselves and eligible dependents within 31 days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

C. Adding Dependents

A Subscriber may add a dependent, who becomes eligible after the Subscriber enrolled, as follows:

1. A newborn child of the Subscriber or the Subscriber's spouse is Covered from the moment of birth. A legally adopted child including children placed with You for the purposes of adoption will be Covered as of the date of adoption or placement for adoption, whichever is first. Children for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction will be Covered from the moment the child is placed in the Subscriber's physical custody. The Subscriber must enroll the child within 31 days from the date that the Subscriber or Subscriber's spouse acquires the child.

If the Subscriber fails to do so, and an additional premium is required to Cover the child, the Plan will not Cover the child after 31 days from the date the Subscriber acquired the child. If no additional premium is required to provide Coverage to the child, the Subscriber's failure to enroll the child does not make the child ineligible for Coverage.

However, the Plan cannot add the newborn or newly acquired child to the Subscriber's Coverage until notified. This may delay claims processing.

2. A Subscriber may add a dependent who became eligible after the Subscriber enrolled. Any other new dependent (e.g., if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Plan within 31 days of the date that person first becomes eligible for Coverage.
3. The Subscriber or the Subscriber's eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:
 - a. the Subscriber or the Subscriber's eligible dependent had other health care coverage at the time Coverage under this Plan was previously offered;
 - b. the Subscriber stated, in writing, when Coverage under this Plan was previously offered, that such other coverage was the reason for declining Coverage under this Plan;
 - c. such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because the Subscriber or the Subscriber's eligible dependent ceased to be eligible due to involuntary termination or Group contributions for such coverage ended; and
 - d. the Subscriber or the Subscriber's eligible dependent applies for Coverage under this Plan and the Plan receives the change form within 31 days after the loss of the other coverage.

D. Late Enrollment

Employees or their dependents who do not enroll when first becoming eligible for Coverage under (A), (B) or (C), above, may enroll:

1. During a subsequent Open Enrollment Period; or
2. If the Employee acquires a new dependent, and he or she applies for Coverage within 31 days.

E. Enrollment upon Change in Status

If You qualify for a change in status, You may be eligible to change Your Coverage other than during the Open Enrollment Period. Any change in the Subscriber's elections must be consistent with the change in status.

Subscriber must request the change within 31 days of the change in status for the following events: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) change in dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse.

WHEN COVERAGE BEGINS

If You are eligible, have enrolled and have paid or had the premium for Coverage paid on Your behalf, Coverage under this Dental EOC shall become effective on the earliest of the following dates, subject to the Actively at Work Rule set out below:

A. Effective Date of Dental Group Agreement

Coverage shall be effective on the effective date of the Dental Group Agreement, if all eligibility requirements are met as of that date.

B. Enrollment During an Open Enrollment Period

Coverage shall be effective on the first day of the month following the Open Enrollment Period, unless otherwise agreed to by the Group and the Plan.

C. Enrollment During an Initial Enrollment Period

Coverage shall be effective on the first day of the month following the Plan's receipt of the eligible Employee's Enrollment Form, unless otherwise agreed to by the Group and the Plan.

D. Newly Eligible Employees

Coverage will become effective after Subscriber becomes eligible, having met all the eligibility requirements as specified in the Dental Group Agreement; or

E. Newly Eligible Dependents

1. Dependents acquired as the result of Subscriber's marriage – Coverage will be effective on the first day of the marriage, unless otherwise agreed to by the Group or Plan.
2. Newborn children of the Subscriber or the Subscriber's spouse - Coverage will be effective as of the date of birth.
3. Dependents adopted or placed for adoption with Subscriber – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

For Coverage to be effective, the dependent must be enrolled, and the Plan must receive any required premium for the Coverage, as set out in the "Enrollment" section.

F. Actively at Work Rule

If an eligible Employee, other than a retiree who is otherwise eligible, is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all of his or her Covered Dependents will be deferred until the date the Employee is Actively at Work. An Employee who is not at work on the date Coverage would otherwise become effective due to a health-related factor shall be treated as Actively at Work for the purposes of determining eligibility.

WHEN COVERAGE ENDS

A. Termination or Modification of Coverage by the Plan or the Group

The Plan or the Group may modify or terminate the Dental Group Agreement. Notice to the Group of the termination or modification of the Dental Group Agreement is deemed to be notice to all Members. The Group is responsible for notifying You of such a termination or modification of Your Coverage.

All Members' Coverage through the Dental Group Agreement will change or terminate at 12:00 midnight on the date of such modification or termination. The Group's failure to notify You of the modification or termination of Your Coverage does not continue or extend Your Coverage beyond the date that the Dental Group Agreement is modified or terminated. You have no vested right to Coverage under this Dental EOC following the date of the termination of the Dental Group Agreement.

B. Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Group and the Plan during the term of the Dental Group Agreement. See Attachment D: Eligibility for details regarding Loss of Eligibility. A Covered Dependent loses eligibility when You lose eligibility.

C. Termination or Rescission of Coverage

The Plan may terminate Your Coverage if:

1. The Plan does not receive the required premium for Your Coverage when it is due. The fact that You have made a premium contribution to the Group will not prevent the Plan from terminating Your Coverage if the Group fails to submit the full premium for Your Coverage to the Plan when due; or
2. You fail to make a required Member Payment; or
3. You fail to cooperate with the Plan as required by this Dental EOC; or
4. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

At its discretion, the Plan may terminate or Rescind Coverage if You have made an intentional misrepresentation of material fact or committed fraud in connection with Coverage. If applicable, the Plan will return all Premiums paid after the termination date less claims paid after the date. If claims paid after the termination date are more than Premiums paid after the date, the Plan has the right to collect the amount from You or Your terminated dependents to the extent allowed by law. You will be notified thirty (30) days in advance of any Rescission.

D. Right To Request A Hearing

You may appeal the termination of Your Coverage for cause, as explained in the "Grievance Procedure" section of this Dental EOC. The fact that You have appealed shall not postpone

or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated as part of the Grievance Procedure, You may submit any claims for services rendered after Your Coverage was terminated to the Plan for consideration in accordance with the Claims Procedure section of this Dental EOC.

E. Payment For Services Rendered After Termination of Coverage

Services received after Coverage terminates are not Covered, even if BlueCross has pre-determined benefits for the dental services. However, if You are incurring expenses for Covered Services and this Coverage ends, benefits will be available as follows:

1. Charges for dentures will be paid if:
 - a. the impression was made prior to the date Coverage ends;
 - b. the denture was ordered prior to the date Coverage ends;
 - c. the denture is placed in the mouth within 30 days from the date Coverage ends; and
 - d. the Employer's new Dental insurer is not responsible for paying these charges.
2. Charges for fixed bridgework, crowns and inlays will be paid if:
 - a. the tooth or teeth were prepared prior to the date Coverage ends;
 - b. the impression was taken prior to the date Coverage ends;
 - c. the bridgework, crown or inlay was ordered prior to the date Coverage ends;
 - d. the work is seated in the mouth within 30 days from the date Coverage ends; and
 - e. the Employer's new Dental insurer is not responsible for paying these charges.
3. Charges for endodontic treatment, including root canal therapy, will be paid if:
 - a. the tooth was opened prior to the date Coverage ends;
 - b. the procedure is completed within 30 days from the date Coverage ends; and
 - c. the Employer's new Dental insurer is not responsible for paying these charges.

CONTINUATION OF COVERAGE

Federal Law

If the Dental Group Agreement remains in effect, but Your Coverage under this Dental EOC would otherwise terminate, the Group may offer You the right to continue Coverage. This right is referred to as “COBRA Continuation Coverage” and may occur for a limited time subject to the terms of this Section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA.)

A. Eligibility

If You have been Covered by the Plan on the day before a qualifying event, You may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

1. Subscribers. Loss of Coverage because of:
 - The termination of employment except for gross misconduct.
 - A reduction in the number of hours worked by the Subscriber.
2. Covered Dependents. Loss of Coverage because of:
 - The termination of the Subscriber’s Coverage as explained in subsection (a) above.
 - The death of the Subscriber.
 - Divorce or legal separation from the Subscriber.
 - The Subscriber becomes entitled to Medicare.
 - A Covered Dependent reaches the Limiting Age.

B. Enrolling for COBRA Continuation Coverage

The Group shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

1. The Subscriber’s termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or
2. The Subscriber or Covered Dependent notifies the Group, in writing, within 60 days after any other qualifying event set out above.

You have 60 days from the later of the date of the qualifying event or the date that You receive notice of the right to COBRA Continuation Coverage to enroll for such Coverage. The Group or the Plan will send You the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Group within that 60-day period, You will lose the right to COBRA Continuation Coverage under this section. If You are qualified for COBRA Continuation Coverage and receive services that would be Covered Services before enrolling and submitting the Payment for such Coverage, You will be required to pay for those services. The Plan will reimburse You for Covered Services, less required Member payments, after You enroll and pay the premium for Coverage, and submit a claim for those Covered Services as set forth in the Claim Procedure section of this Dental EOC.

C. Premium Payment

You must pay any premium required for COBRA Continuation Coverage to the Plan at the address indicated on the premium notice. If You do not enroll when first becoming eligible, the premium due for the period between the date You first become eligible and the date You enroll for COBRA Continuation Coverage must be paid to the Group within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all premiums are due and payable on a monthly basis as required by the Group. If the premium is not received by the Plan on or before the due date, whether or not the premium was paid to the Group, Coverage will be terminated, for cause, effective as of the last day for which premium was received as explained in the Termination of Coverage Section, above. The Plan may use a third party vendor to collect the COBRA premium payment.

D. Coverage Provided

If You enroll for COBRA Continuation Coverage, You will continue to be Covered under the Dental Group Agreement and this Dental EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this Dental EOC and the Dental Group Agreement. The Plan and the Group may agree to change the Dental Group Agreement and/or this Dental EOC. The Group may also decide to change insurers. If this happens after You enroll for COBRA Continuation Coverage, Your Coverage will be subject to such changes.

E. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

1. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
2. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary must:
 - a. Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability and before the close of the initial 18-month Coverage period; and
 - b. Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or
3. 36 months of Coverage if the loss of Coverage is caused by:
 - a. the death of the Subscriber;
 - b. loss of dependent child status under the Plan;

- c. the Subscriber becomes entitled to Medicare; or
 - d. divorce or legal separation from the Subscriber; or
4. 36 months for other qualifying events. If, a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g. divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

F. Termination of COBRA Continuation Coverage

After You have elected COBRA Continuation Coverage, that Coverage will terminate either at the end of the applicable 18, 29 or 36 month eligibility period or, before the end of that period, upon the date that:

1. The premium for such Coverage is not submitted when due; or
2. You become Covered as either a Subscriber or dependent by another group dental care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or
3. The Dental Group Agreement is terminated; or
4. You become entitled to Medicare Coverage; or
5. The date that You, are otherwise eligible for 29 months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA Law.

G. Continued Coverage During a Family and Medical Leave Act (FMLA) Leave of Absence

Under the Family and Medical Leave Act, Subscribers may be able to take:

- up to 12 weeks of unpaid leave from employment due to certain family or medical circumstances, or
- in some instances, up to 26 weeks of unpaid leave if related to certain family members' military service related hardships.

Contact the Employer to find out if this provision applies. If it does, Members may continue health coverage during the leave, but must continue to pay the Employee portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time. If the Subscriber takes a leave and Coverage is cancelled for any reason during that leave, Members may resume Coverage when the Subscriber returns to work without waiting for an Open Enrollment Period.

H. Continued Coverage During a Military Leave of Absence

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies. If it does, Members may continue health coverage during the leave, but must continue to pay the Employee portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time.

I. Continued Coverage During Other Leaves of Absence

Your Employer may allow Subscribers to continue their Coverage during other leaves of absence. Continuous coverage during such leave of absence is permitted for up to 6-months. Please check with Your Employer to find out how long a Subscriber may take a leave of absence.

A Subscriber will also have to meet these criteria to have continuous Coverage during a leave of absence:

1. Your Employer continues to consider the Subscriber an Employee, and all other Employee benefits are continued;
2. The leave is for a specific period of time established in advance; and
3. The purpose of the leave is documented.

You may apply for Federal or State Continuation or Conversion, if the Subscriber's leave lasts longer than the permitted amount of time.

Members may continue health coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time.

J. The Trade Adjustment Assistance Reform Act of 2002

The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added to Your COBRA rights. If You lost Your job because of import competition or shifts of production to other countries, You may have a second COBRA Continuation election period. If You think this may apply to You, check with Your Employer or the Department of Labor.

CONTINUATION OF COVERAGE

State Law

A. State Continuation Coverage

If the Dental Group Agreement remains in effect, but Your Coverage under this Dental EOC would otherwise terminate, the Group may offer the Subscriber the right to continue Coverage for a limited period of time according to State law ("State Continuation Coverage").

1. Eligibility

You are eligible for State Continuation Coverage if You have been continuously Covered under the Group's dental plan or a plan that it replaced for at least three 3 months prior to the date Your Coverage terminates under the Dental Group Agreement for any reason, except the termination of the Dental Group Agreement entirely or for an insured class.

2. Enrolling for State Continuation Coverage

The Group will notify Members eligible for State Continuation Coverage about how to enroll for such Coverage on or before the date their Coverage would otherwise terminate under the Dental Group Agreement. You must request State Continuation Coverage in writing and pay the amount required in advance.

3. Premium Payment

You must pay the quarterly premium for State Continuation Coverage to the Group at the time and place specified by the Group.

4. Coverage Provided

Members enrolled for State Continuation Coverage will continue to be Covered under the Dental Group Agreement and this Dental EOC for the remainder of the month that Coverage would otherwise end and the greater of:

- a. Three (3) months; or
- b. Six (6) months after Your pregnancy ends, if You are pregnant at the time Your Coverage would otherwise terminate; or
- c. Fifteen (15) months for Your Covered Dependents if Coverage ends because of divorce or Your death.

5. Termination of State Continuation Coverage

State Continuation Coverage will terminate upon the earliest of the following:

- a. The end of the applicable period in subsection 4, above; or
- b. The end of the period for which You paid for Coverage; or
- c. The termination date of the Dental Group Agreement; or
- d. The date You become eligible for Coverage under another group dental plan.

REMINDER: Check with the Employer to determine if You are eligible for any continuation of Coverage.

GENERAL PROVISIONS

CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Dentist must submit a claim form to Us. We will review the claim and let You or the Dentist know if We need more information, before We pay or deny the claim.

Claims

Federal regulations use several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining dental care as a condition of receipt of a Covered Service, in whole or in part.
2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the dental care has already been provided to You. Only post-service claims can be billed to the Plan, or You.
3. Urgent Care is dental care or treatment that, if delayed or denied, could seriously jeopardize: (1) Your life or health; or (2) Your ability to regain maximum function. Urgent Care is also dental care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of Your dental condition, would subject You to severe pain that cannot be adequately managed without the dental care or treatment. A claim for denied Urgent Care is always a pre-service claim.

Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Dentists, except for required Member payments. The Network Dentist will submit the claim directly to Us.
2. You will be billed all charges for Non-covered Services rendered by Network Dentists. Network discounts do not apply to these Non-covered Services.
3. You may be charged or billed by an Out-of-Network Dentist for Covered Services rendered by that Dentist. If You use an Out-of-Network Dentist, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service.
If You are charged, or receive a bill, You must submit a claim to Us.
 - a. To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim, within the 1 year and 90 day time period, it will not be paid.
 - b. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced. We may require verification of the reason for such delay.
4. You may request a claim form from Our consumer advisors. We will send You a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim

form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

5. A Network Dentist or an Out-of-Network Dentist may refuse to render services, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:
 - a. You may submit a claim to Us to obtain a Coverage decision (Predetermination of Benefits) concerning whether the Plan will Cover that service.
 - b. You may request a claim form from Our consumer advisors. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
6. Dentists may bill or charge for Covered Services differently. Network Dentists are reimbursed based on Our agreement with them. Different Network Dentists have different reimbursement rates for different services. Your out-of-pocket expenses can be different from Dentist to Dentist.

Payment

1. If You received Covered Services from a Network Dentist, We will pay the Network Dentist directly. These payments are made according to the Plan's agreement with that Network Dentist. You authorize assignment of benefits to that Network Dentist.
2. If You received Covered Services from an Out-of-Network Dentist, You must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, We will reimburse You. If You have not paid the Dentist, We may make payment for Covered Services to either the Dentist or to You, at Our discretion. Our payment fully discharges Our obligation related to that claim.
3. If the Dental Group Agreement is terminated, all claims for Covered Services rendered prior to the termination date must be submitted to the Plan within 1 year and 90 days from the date the Covered Services was received.
4. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with Our internal administration procedures, and based on Our information at the time We receive the claim form. We are not responsible for overpayment or underpayment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted. Payment for Covered Services is more fully described in "Attachment C: Schedule of Benefits."
5. At least monthly, You will receive a Claims Summary. The Claim Summary, sometimes referred to as the Explanation of Benefits (EOB), shows how a claim paid, denied, how much was paid to the Dentist, and also let You know if You owe an additional amount to that Dentist. The Plan will make the Claim Summary available to you at bcbst.com, or you can obtain it at no cost by calling Our customer advisors at the number on the back of Your ID card.

6. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Dentist. If We pay such amounts to a Dentist on Your behalf, We may collect those cost-sharing amounts directly from You.
7. You are also responsible for the providers' charges for Non-covered Services as defined in this Dental EOC. Network discounts do not apply to these Non-covered Services.

Assignment

If You assign payment for a claim to a Dentist, We must honor that assignment, in most circumstances. If You have paid the Dentist, and also assigned payment for the claim to the Dentist, You must request repayment from that Dentist.

Complete Information

Whenever You need to file a claim Yourself, We can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most Dentists will have claim forms, or You can request them from Us by calling Our consumer advisors at the number on the back of Your ID card.

Mail all claim forms to:

**BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002**

COORDINATION OF BENEFITS

This Dental EOC includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group dental care "Plan." A COB provision is one that is intended to avoid claims payment delays, to aid in prompt payment, and avoid duplication of benefits.

Rules of this Section determine whether the benefits available under this Dental EOC are determined before or after those of another Plan. In no event, however, will benefits under this Dental EOC, or the Group Agreement, be increased because of this provision. The benefits under this Dental EOC may be reduced when another Plan determines its benefits first.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another Plan.

1. Definitions

The following terms apply to this provision:

- a. "Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:
 - (1) Group, blanket, or franchise insurance;
 - (2) A group BlueCross Plan, BlueShield Plan;
 - (3) Group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;
 - (4) Coverage under labor management trust Plans or employee benefit organization Plans;
 - (5) Coverage under government programs to which an employer contributes or makes payroll deductions;
 - (6) Coverage under a governmental Plan or coverage required or provided by law;
 - (7) Medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
 - (8) Coverage under Medicare and other governmental benefits; and
 - (9) Any other arrangement of health coverage for individuals in a group.
- b. "Plan" does not include individual or the individual's family:
 - (1) Insurance contracts;
 - (2) Subscriber contracts;
 - (3) Coverage through Health Maintenance (HMO) organizations;
 - (4) Coverage under other prepayment, group practice and individual practice plans;

- (5) Public medical assistance programs (such as TennCare);
- (6) Group or group-type hospital indemnity benefits of \$100 per day or less;
- (7) School accident-type coverages.

Each Contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

- c. "This Plan" refers to the part of the Dental Group Agreement under which benefits for health care expenses are provided.

The term "Other Plan" applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other Contracts when benefits are determined.

- d. Primary Plan/Secondary Plan.

- (1) The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering You.
- (2) When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.
- (3) When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.
- (4) When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

- e. "Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one or more Plans covering the Member for whom the claim is made.

- (1) When a Plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense, and a benefit paid.
- (2) We will determine only the benefits available under This Plan. You are responsible for supplying Us with information about Other Plans so We can act on this provision.

- f. "Claim Determination Period" means an Annual Benefit Period. However, it does not include any part of a year during which You have no coverage under This Plan, or any part of a year prior to the date this COB provision or a similar provision takes effect.

2. Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- a. Non-Dependent/Dependent

The benefits of the Plan which covers the person as an Employee, Member, or Subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent, except that:

- (1) if the person is also a Medicare beneficiary and,
 - (2) if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a dependent of an active Employee, then the order of benefit determination shall be:
 - benefits of the Plan of an active Employee covering the person as a dependent;
 - Medicare;
 - benefits of the Plan covering the person as an Employee, Member, or Subscriber.
- b. Dependent Child/Parents Not Separated or Divorced
- Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents:"
- (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - (2) If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.
 - (3) However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.
- c. Dependent Child/Separated or Divorced Parents
- If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
- (1) First, the Plan of the parent with custody of the child;
 - (2) Then, the Plan of the spouse of the parent with the custody of the child; and
 - (3) Finally, the Plan of the parent not having custody of the child.
 - (4) However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
 - (5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above, Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee

The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent), are determined before those of a Plan that covers that person as a laid off or retired Employee (or as that Employee's dependent). If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored, and other applicable rules control the order of benefit determination.

e. Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan which has covered an Employee, Member, or Subscriber longer are determined before those of the Plan which has covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

(2) The start of the new Plan does not include:

- A change in the amount or scope of a Plan's benefits;
- A change in the entity which pays, provides, or administers the Plan's benefits;
- or
- A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan).

(3) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a Member shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

f. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These Plans are called "Non-complying Plans."

This Plan coordinates its benefits with a Non-complying Plan as follows:

- (1) If This Plan is the Primary Plan, it will provide its benefits on a primary basis.
- (2) If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.
- (3) If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

(4) If:

- (a) The Non-complying Plan reduces its benefits so that the Employee, Subscriber or Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

- (b) Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to You, or on Your behalf, an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

3. Effect on the Benefits of this Plan

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

a. Benefits of This Plan will be reduced when the sum of:

- (1) The benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and
- (2) The benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;

exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

b. When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately, and is then charged against any applicable benefit limit of This Plan.

4. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

5. Facility of Payment

A payment under Another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term "Payment Made" includes providing benefits in

the form of services; in which case, Payment Made means reasonable cash value of the benefits provided in the form of services.

6. Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- (a) The persons it has paid or for whom it has paid;
- (b) Insurance companies; or
- (c) Other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

7. Are You Also Covered by Medicare?

If You are also Covered by Medicare, We follow the Medicare Secondary Payor (MSP) rules to determine Your benefits. If Your Employer has 20 or fewer employees, the MSP rules might not apply. Please contact customer service at the toll free number on Your membership ID card if You have any questions.

GRIEVANCE PROCEDURE

A. Introduction

Our Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan.

Adverse Benefit Determination means:

1. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
2. The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a covered person's eligibility to participate in the health carrier's health benefit plan; or
3. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.

Please contact Our consumer advisors at the number on the back of Your Member ID card: (1) to file a Claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g. a Claim Summary, sometimes referred to as an explanation of benefits **(EOB)** or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. This Grievance Procedure must be exhausted as required by ERISA. However, nothing in this EOC shall prevent You from filing a complaint with the Tennessee Department of Commerce and Insurance, but such complaint is outside of, separate from, and in addition to this Grievance Procedure.
2. The Procedure can only resolve Disputes that are subject to Our control.
3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. Under this Procedure:
 - a. If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to the Plan to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.
 - b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.

- c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
5. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
6. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.
7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Group Agreement and this EOC.

B. Description of the Review Procedures

1. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a consumer advisor if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

2. Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute. The Grievance process that was in effect on the date(s) of service for which you received an Adverse Benefit Determination will apply.

Contact Our consumer advisors at the number on the back of Your Member ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

a. Grievance Hearing

After the Plan has received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Group Agreement. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Group Agreement is not otherwise governed by ERISA.

b. Written Decision

The committee or reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance as follows:

- i. For a pre-service claim, within 30 days of receipt of Your request for review;

- ii. For a post-service claim, within 60 days of receipt of Your request for review; and
- iii. For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

The decision of the Committee will be sent to You in writing and will contain:

- i. A statement of the committee's understanding of Your Grievance;
- ii. The basis of the committee's decision; and
- iii. Reference to the documentation or information upon which the committee based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance Procedure

You may file a written request for reconsideration within 90 days after We issue the first level Grievance committee's decision. This is called a second level Grievance. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review.

If Your Group Agreement is governed by ERISA, You also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA ("ERISA Actions") after completing the mandatory first level Grievance process.

The Plan may require You to exhaust each step of this Procedure in any Dispute that is not an ERISA Action.

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. If You file a second level Grievance concerning an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

1. Grievance Hearing

You may request an in-person or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if You do not want to participate in a hearing concerning Your Grievance. If You wish to participate, Our representatives will contact You to explain the hearing process and schedule the time, date and place for that hearing.

In either case, the second level committee will meet and consider all relevant information presented about Your Grievance, including:

- a. Any new, relevant information that You submit for consideration; and
- b. Information presented during the hearing. Second level Grievance committee members may ask You questions during the hearing. You may make a closing statement to the committee at the end of the hearing.
- c. If You wish to bring a personal representative with You to the hearing, You must notify Us at least 5 days in advance and provide the name, address and telephone number of Your personal representative.

2. Written Decision

After the hearing, the second level committee will meet in closed session to make a decision concerning Your Grievance. That decision will be sent to You in writing. The written decision will contain:

- a. A statement of the second level committee's understanding of Your Grievance;
- b. The basis of the second level committee's decision; and
- c. Reference to the documentation or information upon which the second level committee based its decision. Upon written request, We will send You a copy of any such documentation or information, without charge.

D. Independent Review of Medical Necessity Determinations or Coverage Rescissions

If Your Grievance involves a Medical Necessity determination or a Coverage rescission determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance immediately followed by completion of the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by the Plan, to independently review and resolve such Dispute(s). If You request an independent review following the mandatory first level Grievance, You waive Your right to a second level Grievance and Your right to present testimony during the Grievance Procedure. Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the committee's decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the committee's decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. If You request independent review of an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan, until the independent reviewer makes its decision.

The Plan will pay the fee charged by the independent review organization and its reviewers if You request that the Plan submit a Dispute to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorney's fees.

The Plan will submit the necessary information to the independent review entity within 5 business days after receiving Your request for review. The Plan will provide copies of Your file, excluding any proprietary information to You, upon written request. The reviewer may also request additional medical information from You. You must submit any requested information, or explain why that information is not being submitted, within 5 business days after receiving that request from the reviewer.

The reviewer must submit a written determination to the Plan and You within 45 days after receipt of the independent review request. In the case of a life threatening condition, the decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by the Plan or You.

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this EOC and the Group Agreement; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of the Group Agreement.

No action at law or in equity shall be brought to recover on this EOC until 60 days after written proof of loss has been furnished as required by this EOC. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.

DEFINITIONS

Defined terms are capitalized. When defined words are used in this Dental EOC, they have the meaning set forth in this section.

Actively at Work – The performance of all an Employees regular duties for the Group on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively at Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee is Actively at Work on the last regularly scheduled work day. An Employee who is not at work due to a health-related factor shall be treated as Actively at Work for purposes of determining Eligibility.

Annual Benefit Period - The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.

Benefit Maximum - The total amount of benefits available for services under this Dental EOC during the Benefit Year, or during the Member's lifetime. (See Attachment C: Schedule of Benefits.)

Billed Charges – The amount that a Dentist charges for services rendered. Billed Charges may be different from the amount that the Plan determines to be the Maximum Allowable Charge for services.

Coinsurance – The amount stated as a percentage of the Maximum Allowable Charge for a Covered Service, that is Your responsibility during the Annual Benefit Period after any Deductible is satisfied. The Coinsurance percentage is calculated as 100%, minus the percentage Payment of the Maximum Allowable Charge as specified in Attachment C: Schedule of Benefits.

Covered Dependent - A Subscriber's family members who: (1) meet the eligibility requirements of this Dental EOC; (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable premium for Coverage.

Covered Family Members – A Subscriber and his or her Covered Dependents.

Covered Services, Coverage or Covered - Those necessary and appropriate services and supplies that are set forth in Attachment A: Covered Services and Exclusions of this Dental EOC, (which is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Dental Group Agreement and this Dental EOC.

Deductible - The dollar amount, specified in Attachment C: Schedule of Benefits, which You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for such services.

Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) is not considered when determining if You have satisfied a Deductible.

Dental Group Agreement or Agreement – The arrangements between the Plan and the Group, including this Dental EOC, the Employer Group Application, any riders, any amendments, and any attachments to the Agreement or this Dental EOC. If there is any conflict between the Dental Group Agreement and this Dental EOC, the Dental Group Agreement shall be controlling.

Dentist - A doctor of dentistry, duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed; Dentist is defined to include

any dental professional that is duly licensed and qualified to perform Covered Services at the time and place Covered Services are performed.

Dispute or Grievance – Any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Benefit Determination concerning a claim; or any other claim controversy, or potential cause of action You may have against Us.

Effective Date - The date Your Coverage under this EOC begins.

Employee – A person who fulfills all eligibility requirements established by the Group and the Plan.

Enrollment Form – A form or application which must be completed in full by the eligible Employee before he or she will be considered for Coverage under the Plan.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Family Deductible – The maximum dollar amount, specified in Attachment C: Schedule of Benefits that a Subscriber and Covered Dependents must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for such Services. Once the Family Deductible amount has been satisfied by 3 or more Covered Family Members during an Annual Benefit Period, the Deductible will be considered satisfied for all Covered Family Members for the remainder of that Annual Benefit Period.

Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) is not considered when determining if the Family Deductible has been satisfied.

Group or Employer – A corporation, partnership, union or other entity that is eligible for group coverage under State and Federal laws; and the Plan's Underwriting Guidelines; and that enters into an Agreement with the Plan to provide Coverage to its Employees and their eligible dependents.

Incapacitated Child – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual or physical disability (what used to be called mental retardation or physical handicap); and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.

- a. If the child reaches this Plan's Limiting Age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the Limiting Age.
- b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment, and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

Limiting Age (or Dependent Child Limiting Age) - The age at which a child will no longer be considered an eligible dependent.

Maximum Allowable Charge - The amount that the Plan, at its discretion, has determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Network Dentists, that determination will be based upon the Plan's contract with a Network
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Dentist for Covered Services rendered by that Dentist. For Covered Services provided by Out-of-Network Dentists, the amount payable will be based upon the Plan's fee schedule for the Covered Services rendered by Out-of-Network Dentists.

Member, You, Your - Any person enrolled as a Subscriber or Covered Dependent, according to the terms of the Group's Plan.

Necessary Dental Care – Any treatment or service prescribed by a Dentist that the Plan determines to be necessary and appropriate.

Network Dentist - A Dentist who has signed a Preferred Dental Agreement with the Plan.

Non-covered Services - Services that:

- (a) exceed the benefit period and/or age limitations of the Plan as listed in Attachment A: Covered Services and Exclusions;
- (b) are listed in Attachment B: Other Exclusions;
- (c) are beyond the limitations set forth in Attachment C: Schedule of Benefits, including Deductibles, Coinsurance and amounts above the Benefit Maximums; or
- (d) are not Necessary Dental Care.

Out-of-Network Dentist - A Dentist who has not signed a Preferred Dental Agreement with the Plan.

Subscriber - An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received applicable premium for Coverage.

Treatment Plan - A written report by a Dentist showing the recommended treatment of any dental disease, defect or injury for a Member.

Waiting Period – The time that must pass before a Member is eligible to be Covered for benefits under the Plan or under Coverage C or Coverage D.

ATTACHMENT A: COVERED SERVICES AND EXCLUSIONS

Plan benefits are based on the Maximum Allowable Charge for Necessary Dental Care as described in this Attachment A and provided in accordance with the benefit schedule set forth in this Dental EOC's Attachment C: Schedule of Benefits.

This Attachment sets forth Covered Services and exclusions (services not Covered), and is arranged according to type of services. Some groups of services such as orthodontia, although listed in this section, may not be covered under all plans. There are also certain circumstances when services are not covered. Please also refer to Attachment B: Other Exclusions and Attachment C: Schedule of Benefits to determine Your benefits under this Plan.

If more than one procedure or course of treatment:

- can be used to accomplish the same treatment goal; and
- meets generally accepted standards of professional dental care; and
- offers a favorable prognosis for the patient's condition;
- benefits may be based on the lowest cost procedure or treatment. This will be at Our sole discretion.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service.

The Group chooses the classes of Employees who are eligible for Coverage under the Plan. The Group also determines the Waiting Periods for the classes of benefits under the Plan. The eligibility requirements the Group has selected are in Attachment D: Eligibility to this Dental EOC. They are also on file in the Group's human resource department.

I. Diagnostic Services

A. Exams

1. Covered Services
 - a. One periodic exam in any 6-month period.
 - b. One limited oral evaluation in any 12-month period.
 - c. One comprehensive, detailed/extensive, or periodontal exam in any 36-month period.

B. X-rays

1. Covered Services
 - a. Up to four bitewing films in any 12-month period. All bitewing films must be taken on the same date of service.
 - b. One full mouth set of x-rays in any 36-month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.

2. Exclusions
 - a. Extraoral, skull and bone survey, sialography, temporomandibular joint dysfunction (TMJ), and tomographic survey x-ray films, cephalometric films and diagnostic photographs, unless otherwise stated in this Dental EOC.

II. Preventive Services

A. Prophylaxis (Cleanings)

1. Covered Services
 - a. Four prophylaxis in any 12-month period, except when replaced as described below in Basic Periodontics.

B. Fluoride Treatment

1. Covered Services
 - a. Two fluoride treatment in any 12-month period for Members age 18 and under.

C. Other Preventive Services

1. Covered Services
 - a. One sealant or preventive resin restoration per lifetime on first and second permanent molars for Members age 16 and under.
 - b. Space maintainers for Members age 14 and under.
 - c. One recementation per space maintainer in any 12 month period.
 - d. One oral cancer screening in any 36 month period for Members age 40 and older

III. Basic Restorative Services

A. Fillings and Stainless Steel Crowns

1. Covered Services
 - a. One amalgam or resin restoration per tooth surface in any 12 month period.
 - b. Replacement of existing amalgam and resin composite restorations Covered only after 12-months from the date of initial restoration.
 - c. Stainless steel crowns.
 - d. Replacement of stainless steel crowns Covered after 36 months from the date of initial restoration.
 - e. One sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per lifetime, for Members age 16 and under. Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
2. Exclusions
 - a. Gold foil restorations.

B. Other Basic Restorative Services

1. Covered Services
 - a. Palliative (emergency) treatment for the relief of pain.
 - b. One repair per denture in any 24 month period.
 - c. General anesthesia

IV. Major Restorative & Prosthodontic Services

A. Single Tooth Restorations

1. Covered Services
 - a. Crowns, inlays and onlays only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). Replacement of single tooth restorations or fixed partial dentures (bridges) after 60 months from the date of initial placement.
 - b. Veneers for anterior permanent teeth.
2. Exclusions
 - a. Provisional restorations and crowns.
 - b. Cast crowns or laminate veneers for Members age 11 and under.

B. Multiple Tooth Restorations – Bridges

1. Covered Services
 - a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, $\frac{3}{4}$ and full cast) for permanent teeth only.
 - b. Replacement of fixed partial dentures or single tooth restorations after 60 months from the date of initial placement.
2. Exclusions
 - a. Provisional or interim restorations.
 - b. Bridges for Members age 16 and under.

C. Removable Prosthodontics (Dentures)

1. Covered Services
 - a. Complete, immediate and partial dentures utilizing standard techniques and materials as determined by the Plan.
 - b. Personalized restorations, special techniques or materials shall be covered up to the amount allowed for standard techniques and materials.
 - c. Replacement of removable dentures after 60 months from the date of initial placement.

- 2 Exclusions
 - a. Interim (temporary) dentures.
 - b. Dentures for Members age 16 and under.

D. Other Major Restorative & Prosthodontic Services

1. Covered Services
 - a. Core build-up covered separately from restoration only in those circumstances where benefits are provided because severe carious lesions or fractures are so extensive that retention of the restoration would not be possible.
 - b. Crown inlay, onlay, veneer and bridge repair and re-cementation after 12 months from the date of initial placement.
 - c. One denture adjustment in any six month period and only after 6 months from the date of initial placement.
 - d. One denture reline, rebase, or tissue conditioning in any 36 month period.
 - e. One implant per tooth per lifetime
 - f. One bone graft for implant per tooth per lifetime.
 - g. One implant debridement per tooth per lifetime.
 - h. Initial placement or replacement of implant supported prosthesis after 60 months from the date of any corresponding major restoration.
2. Exclusions
 - a. Provisional and interim restorations.
 - b. Other major restorative services including protective restoration and coping.
 - c. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
 - d. Crown preparation, temporary or prefabricated crowns, impressions and cementation.
 - e. Post and core services not performed in conjunction with a Covered crown or bridge.

V. Endodontics (treatment of the dental pulp or root canal)

A. Basic Endodontics

1. Covered Services
 - a. Pulpotomy, pulpal therapy for primary teeth but not when performed in conjunction with major endodontic treatment.
2. Exclusions
 - a. Pulpal debridement.
 - b. Pulp vitality tests.

- c. Protective restorations.

B. Major Endodontics

1. Covered Services
 - a. One root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, hemisection, pulp cap or root amputation) per tooth in any 60-month period.
 - b. One apicoectomy per root per lifetime.
 - c. Retrograde filling if done on same date of service as apicoectomy.
2. Exclusions
 - a. Guided tissue regeneration.
 - b. Intentional re-implantation (including necessary splinting).
 - c. Canal preparation.
 - d. Incomplete endodontic therapy.
 - e. Pulp vitality test.
 - f. Protective restorations.

VI. Periodontics

A. Basic Periodontics

1. Covered Services
 - a. One periodontal scaling and root planing per quadrant in any 24- month period.
 - b. One full mouth debridement per lifetime.
 - c. Periodontal maintenance no sooner than 90 days after completion of any one of the Basic Periodontic Covered Services above. Periodontal maintenance will replace a prophylaxis or scaling.
 - d. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a prophylaxis or periodontal maintenance procedure.
2. Exclusions
 - a. Provisional splinting, and antimicrobial medication and dressing changes.
 - b. Periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.

B. Major Periodontics

1. Covered Services
 - a. One major surgical periodontal procedure, including gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, per quadrant in any 36 month period.

- b. One crown lengthening per tooth in any 36 month period.
- c. One bone and tissue grafting per site in any 36 month period.
- 2. Exclusions
 - a. Tissue regeneration and apically positioned flap procedure.

VII. Oral Surgery

A. Basic Oral Surgery

- 1. Covered Services
 - a. Non-surgical or simple extractions (pulling teeth).

B. Major Oral Surgery

- 1. Covered Services
 - a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.
- 2. Exclusions
 - a. Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures.
 - b. Orthognathic surgery and treatment for congenital malformations.
 - c. Harvesting of bone for use in autogenous grafting.

VIII. Orthodontics

A. Orthodontic Services (straightening and alignment of teeth)

- 1. Covered Services
 - a. Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.
- 2. Exclusions
 - a. Replacement or repair of any lost, stolen and damaged appliance.
 - b. Surgical procedures to aid in orthodontic treatment.

ATTACHMENT B: OTHER EXCLUSIONS

This Dental EOC does not provide benefits for the following services, supplies or charges:

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
2. Services or supplies not listed as Covered Services under Attachment A, Covered Services and Limitations on Covered Services.
3. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
4. Services rendered by a Dentist beyond the scope of his or her license.
5. Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental Coverage.
6. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.
7. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
8. Any court-ordered treatment of a Member unless benefits are otherwise payable.
9. Courses of treatment undertaken before You become Covered under this program.
10. Any services performed after You cease to be eligible for Coverage, except as shown under the Payment For Services Rendered After Termination of Coverage section.
11. Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
12. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
13. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
14. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
15. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)

16. Replacement of tooth structure lost from wear or attrition.
17. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
18. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
19. Diagnostic dental services such as diagnostic tests and oral pathology services.
20. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as stated elsewhere in this EOC).
21. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching (except as stated elsewhere in this EOC).
22. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.
23. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.
24. Dental consultations including but not limited to re-evaluations, teledentistry, nutritional and tobacco counseling and oral hygiene instruction.

ATTACHMENT C: SCHEDULE OF BENEFITS

Product Name: DentalBlue Traditional Plan
 Group Name: Clarksville-Montgomery County
 Group Number: 90045
 Benefits Effective: January 1, 2020

Deductible		<u>Individual</u>	<u>Family</u>
Annual Benefit Period Applies to Coverage B and C only		\$50	None
Maximums		\$2,000 per Annual Benefit Period	
Applies to Coverage A, B and C			
Coverage D		\$1,500 per lifetime	
Covered Services	Benefit Percentages	Waiting Period	
Coverage A Exams X-rays Preventive	100%	None	
Coverage B Basic Restorative Endodontics Oral Surgery Periodontics	80%	None	
Coverage C Major Restorative Implants	50%	None	
Coverage D Orthodontics All Members, no age limit	50%	None	
Annual Benefit Period		January 1 - December 31	

Network discounts do not apply to Non-covered Services.

EVIDENCE OF COVERAGE

ATTACHMENT D: ELIGIBILITY

Any Employee of the Group and his/her family dependents, who meet the eligibility requirements of this Section, will be eligible for Coverage under the Group Agreement if properly enrolled for Coverage and upon payment of the required Premium for such Coverage. If there is any question about whether a person is eligible for Coverage, the Employer shall make final eligibility determinations in accordance with the requirements of this EOC and the Group Agreement. At the Group or Employer's request, this Plan may not cover Spouses or dependent children. If You qualify as a retiree, You may still be an eligible Employee under this Dental EOC after You leave employment. Check with Your benefits representative for full details.

A. Subscriber

To be eligible to enroll as a Subscriber, an Employee must:

1. Be a full-time Employee of the Group who is Actively at Work; and
2. Satisfy all eligibility requirements of the Employer and Group Agreement; and
3. Enroll for Coverage by (a) submitting a completed and signed Enrollment Form or other required documentation to the Plan, or (b) submitting a completed Enrollment Form or other required documentation electronically to the Plan.

For leaves of absence, please refer to the Continuation of Coverage section of this EOC.

B. Covered Dependents

You can apply for Coverage for Your dependents. You must list Your dependents on the Enrollment Form. To qualify as a Covered Dependent, each dependent must meet all dependent eligibility criteria established by the Employer, satisfy all eligibility requirements of the Dental Group Agreement and be either:

1. The Subscriber's current spouse as defined by the Employer, which may include a Domestic Partner;
2. The Subscriber's or the Subscriber's spouse's: (1) natural child; (2) legally adopted child (including children placed with the Subscriber for the purpose of adoption); (3) step-child(ren); or (4) children for whom the Subscriber or the Subscriber's spouse are legal guardians; who are less than 26 years old; or
3. A child of the Subscriber or the Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued.
4. An Incapacitated Child of the Subscriber or Subscriber's spouse.

Dependents who permanently reside outside the United States are not eligible for Coverage under the EOC.

Subscribers who are not U.S. citizens, do not reside in the United States, and work at an Employer's location not located in the United States, are not eligible for Coverage under the EOC.

The Employer's determination of eligibility under the terms of this provision shall be conclusive.

The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order or certification of Full-Time Student status.

C. Loss of Eligibility

Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.

ATTACHMENT E:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH PLAN INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

LEGAL OBLIGATIONS

BlueCross BlueShield of Tennessee, Inc. and some subsidiaries and affiliates (BlueCross) are required to maintain the privacy of all health plan information, which may include Your: name, address, diagnosis codes, etc. as required by applicable laws and regulations (hereafter referred to as "legal obligations"); provide this notice of privacy practices to all members, inform members of the company's legal obligations; and advise members of additional rights concerning their health plan information. BlueCross must follow the privacy practices contained in this notice from its effective date, until this notice is changed or replaced.

BlueCross reserves the right to change privacy practices and the terms of this notice at any time, as permitted by the legal obligations. Any changes made in these privacy practices will be effective for all health plan information that is maintained, including health plan information created or received before the changes are made. All members will be notified of any changes by receiving a new notice of the company's privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross at the address on the back of this notice.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee, Inc. and its subsidiaries or affiliated covered entities. Medical information about Our subscribers and members may be shared with each other as needed for treatment, payment or health care operations.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your health plan information may be used and disclosed for treatment, payment, and health care operations, for example:

TREATMENT: Your health plan information may be disclosed to a health care provider that asks for it to provide treatment.

PAYMENT: Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits, which are covered under Your health insurance policy.

HEALTH CARE OPERATIONS: Your health plan information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, accreditation, conducting and arranging legal services, fraud prevention and investigation, wellness, disease management, and for other similar administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. BlueCross cannot use or disclose Your health plan information except those described in this notice, without Your written authorization. Examples of where an authorization would be required: Most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of PHI, other uses and disclosures not described in this notice.

PERSONAL REPRESENTATIVE: Your health plan information may be disclosed to a family member, friend or other person as necessary to help with Your health care or with payment for Your health care. You must agree that the company may do so, as described in the Individual Rights section of this notice.

PLAN SPONSORS: Your health plan information, and the health plan information of others enrolled in Your group health plan, may be disclosed to Your Plan sponsor in order to perform Plan administration functions. Please see Your Plan documents for a full description of the uses and disclosures the Plan sponsor may make of Your health plan information in such circumstances.

UNDERWRITING: Your health plan information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the company does not issue that contract, Your health plan information will not be used or further disclosed for any other purpose, except as required by law; Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA).

MARKETING: Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your health plan information may be disclosed to a business associate assisting Us in providing that information to You. We will not market products or services other than health-related products or services to You unless You affirmatively opt-in to receive information about non-health products or services We may be offering. You have the right to opt out of fundraising communications.

RESEARCH: Your health plan information may be used or disclosed for research purposes, as allowed by law.

YOUR DEATH: If You die, Your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

AS REQUIRED BY LAW: Your health plan information may be used or disclosed as required by state or federal laws.

COURT OR ADMINISTRATIVE ORDER: Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan information may be released to the extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Health plan information may be disclosed, when necessary, to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: Health plan information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Health plan information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET:** You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged \$.25 per page, \$10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the cost of providing Your health plan information in the requested format. If You prefer, the company will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. The company requires advance payment before copying Your health plan information.
2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of Your health plan information made by the company or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.
3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the company's use or disclosure of Your health plan information. The company is not required to agree to such requests. The company will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the company.
4. **BREACH NOTICE:** You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.
5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the company communicate that information to You by a different method or to a different address. If there is an immediate threat, You may make that request by calling a BlueCross BlueShield of Tennessee Customer Service Representative or the Privacy Officer at 1-888-455-3824. Follow up with a written request is required as soon

as possible. The company must accommodate Your request if it is reasonable, specifies how and where to communicate with You, and continues to permit collection of Premium and payment of claims under Your health plan.

6. **AMENDMENT REQUESTS:** You have the right to make a written request that the company amend Your health plan information. Your request must explain why the information should be amended. The company may deny Your request if the health plan information You seek to amend was not created by the company or for other reasons permitted by its legal obligations. If Your request is denied, the company will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your health plan information. If the company accepts Your request, reasonable efforts will be made to inform the people that You designate about that amendment. Any future disclosures of that information will be amended.
7. **RIGHT TO REQUEST WRITTEN NOTICE:** If You receive this notice on the company's web site or by electronic mail (e-mail), You may request a written copy of this notice, by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

If You want more information concerning the company's privacy practices or have questions or concerns, please contact the Privacy Office.

If You are concerned that: (1) the company has violated Your privacy rights; (2) You disagree with a decision made about access to Your health plan information or in response to a request You made to amend or restrict the use or disclosure of Your health plan information; (3) to request that the company communicate with You by alternative means or at alternative locations; please contact the privacy office.

You may also submit a written complaint to the U.S. Department of Health and Human Services. The company will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

The company supports Your right to protect the privacy of Your health plan information. There will be no retaliation in any way if You choose to file a complaint with BlueCross BlueShield of Tennessee or subsidiaries or affiliates, or with the U.S. Department of Health and Human Services.

BlueCross BlueShield of Tennessee, Inc.
The Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402
(888) 455-3824
(423) 535-1976 FAX
privacy_office@bcbst.com

GENERAL LEGAL PROVISIONS

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BlueCross BlueShield of Tennessee, Inc. is an independent corporation operating under a license from the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association.") The Association permits BlueCross BlueShield of Tennessee, Inc. to use the Association's service marks within its service area. BlueCross BlueShield of Tennessee, Inc. is not contracting as an agent of the Association. .

SUBROGATION AND RIGHT OF RECOVERY

The Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to Members for illnesses or injuries caused by third parties, including the right to recover the reasonable value of prepaid services rendered by Network Dentists.

When this Plan is primary, the Plan shall have first lien against any payment, judgment or settlement of any kind that a Member receives from or on behalf of such third parties for medical expenses, for the costs of Covered Services and any costs of recovering such amounts from those third parties. The Plan may notify those parties of its lien without notice to or consent from those Members.

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available insurance coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

The Group has agreed that Members shall be required to promptly notify the Plan if they are involved in an incident that gives rise to such rights for subrogation and recovery to enable the Plan to protect its rights under this section. Members are also required to cooperate with the Plan and to execute any documents that the Plan deems necessary to protect its rights under this section.

If a Member settles any claim or action without Our consent against any third party, that Member shall be deemed to have been made whole by the settlement and the Plan shall be entitled to immediately collect the present value of its rights as the first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of the Plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave. Check with the Employer to see if this provision applies.

Nondiscrimination Notice

BlueCross complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

1. Provides free aids and services to people with disabilities to communicate effectively with Us, such as:
 - a. Qualified sign language interpreters; and
 - b. Written information in other formats, such as large print, audio and accessible electronic formats.
2. Provides free language services to people whose primary language is not English, such as:
 - a. Qualified interpreters; and
 - b. Written information in other languages.

If You need these services, contact Our consumer advisors at the number on the back of Your Member ID card or call 1-(800) 565-9140, or for hearing impaired, TTY 1-(800) 848-0298 or 711.

If You believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, You can file a grievance (“Nondiscrimination Grievance”). For help with preparing and submitting Your Nondiscrimination Grievance, contact Our consumer advisors at the number on the back of Your Member ID card or call 1-(800) 565-9140, or for hearing impaired, TTY 1-(800) 848-0298 or 711. We can provide You with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address Your Nondiscrimination Grievance to:

Nondiscrimination Compliance Coordinator
c/o Manager, Operations, Member Benefits Administration
1 Cameron Hill Circle, Suite 0019
Chattanooga, TN 37402-0019
Fax: 1-(423) 591-9208
Email: Nondiscrimination_OfficeGM@bcbst.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building

Washington, DC 20201

Phone: 1-(800) 368-1019

TTY: 1-(800) 537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

