



Dental Benefit Plan
Evidence of Coverage



BlueCross BlueShield of Tennessee
1 Cameron Hill Circle | Chattanooga, TN 37402
bcbst.com

**Clarksville-Montgomery County
90045
January 1, 2013**

PREFERRED
DENTAL CARE[™]
DENTAL EVIDENCE OF COVERAGE



**BlueCross BlueShield
of Tennessee**

BlueCross BlueShield of Tennessee, Inc.,
an Independent Licensee of the
BlueCross BlueShield Association

® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

TABLE OF CONTENTS

INTRODUCTION	1
NOTIFICATION OF CHANGE IN STATUS	2
HOW THE DENTAL PROGRAM WORKS	3
NETWORK DENTISTS	3
PAYMENT FOR AN OUT-OF-NETWORK DENTIST	3
PREDETERMINATION OF BENEFITS	3
ELIGIBILITY	5
ENROLLMENT	5
EFFECTIVE DATE OF COVERAGE	7
TERMINATION OF COVERAGE	8
GENERAL PROVISIONS	10
CONTINUATION OF COVERAGE	12
COORDINATION OF BENEFITS	17
GRIEVANCE PROCEDURE	23
DEFINITIONS	27
ATTACHMENT A: COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES	30
ATTACHMENT B: EXCLUSIONS FROM COVERAGE	38
ATTACHMENT C: SCHEDULE OF BENEFITS	40
ATTACHMENT D: ELIGIBILITY	41
ATTACHMENT E: STATEMENT OF ERISA RIGHTS	43
ATTACHMENT F: NOTICE OF PRIVACY PRACTICES	45
GENERAL LEGAL PROVISIONS	49
INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION	49
SUBROGATION AND RIGHT OF RECOVERY	49
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994	49

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 or eligibility 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.

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 customer service representatives, at the number listed on Your membership ID card, if You have any questions when reading this Dental EOC. The customer service representatives 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;
- Termination of employment;

HOW THE DENTAL PROGRAM WORKS

DentalBlue™ 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.

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

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.

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

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 cause.

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.

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

After the Subscriber is Covered, he or she may apply to 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. The Subscriber must enroll that child within 31 days of the child's date of birth. A legally adopted child (including children placed with the Subscriber for the purposes of adoption) will be Covered as of the date of adoption or placement for adoption. 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 thirty-one (31) days from the date that the Subscriber 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 thirty-one (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. 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; and
 - 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; and
 - 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 be enrolled:

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, as outlined below, You may be eligible to change Your Coverage other than during the Open Enrollment Period. You must request the change within 31 days of the change in status. Any change in the Subscriber's elections must be consistent with the change in status.

Subscribers must submit a change form to the Group representative to notify the Plan of any changes in their status or the status of a Covered Dependent within thirty-one (31) days from the date of the event causing that change in status. Such events include, but are not limited to: (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.

EFFECTIVE DATE OF COVERAGE

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 You become 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 an Employee'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 Employee or the Employee's spouse - Coverage will be effective as of the date of birth.
3. Dependents adopted or placed for adoption with an Employee – 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. Eligibility For Extension of Benefits From a Prior Carrier

If the Plan replaces another group dental plan and a Member is Totally Disabled and eligible for an extension of Coverage from the prior group dental plan, Coverage shall not become effective under this Plan until the expiration of that extension of Coverage.

G. Actively at Work Rule

If an eligible Employee 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 Employee is Actively at Work. This is not applicable if the eligible Employee is an eligible retiree.

TERMINATION OF COVERAGE

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 of Coverage for Cause

The Plan may terminate Your Coverage for cause 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.

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 BCBST 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.

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.

A. Claims

There are 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.

B. 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.
 - a. If You are charged, or receive a bill, You must submit a claim to Us.
 - b. 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.
 - c. 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 customer service department. 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 customer service department. 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.
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.

C. 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 current industry standards, and based on Our information at the time We receive the claim form.
5. When a claim is paid or denied, in whole or in part, We will produce an Explanation of Benefits (EOB). This will describe 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 EOB available to you at www.bcbst.com, or by calling the customer service department, at the number listed on Your membership 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 healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.

D. Assignment

1. 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.

E. 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 customer service department at the number listed on Your membership ID card.

Mail all claim forms to:

**BCBST Claims Service Center
PO Box 180150
Chattanooga, Tennessee 37401-7150**

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 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. 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 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.

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 human resources department 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 prior to the termination of Your Coverage under the Dental Group Agreement, for any reason, except for termination of the Dental Group Agreement.

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.

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 for health care, 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 each service rendered will be considered both an Allowable Expense, and a benefit paid.

- (2) The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private hospital room is Medically Necessary, either in terms of generally accepted medical practice, or as specifically defined in the Plan.

- (3) 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 of the Group 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;

exceed 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

I. 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. Please contact the customer service department at the number listed on Your membership ID card: (1) to file a Claim; (2) if You have any questions about this Dental EOC or other documents related to Your Coverage (e.g. an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this Dental EOC. Any decision to award damages must be based upon the terms of this Dental EOC.
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 Dentist was negligent. Network Dentists 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 Dentists.
4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), which are in the *Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure* (the “Claims Regulation”).
5. An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.
 - a. If a Dentist does not render, 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.
 - b. Dentists 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 Dentist 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.
6. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
7. 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.
8. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Dental Group Agreement and this Dental EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. 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.

B. 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.

Contact the customer service department at the number listed on Your membership 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.

1. 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 Dental Group Agreement. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Dental Group Agreement is not otherwise governed by ERISA.

2. Written Decision

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

- (a) For a pre-service claim, within 30 days of receipt of Your request for review;
- (b) For a post-service claim, within 60 days of receipt of Your request for review; and
- (c) 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:

- (a) A statement of the committee's understanding of Your Grievance;
- (b) The basis of the committee's decision; and

- (c) 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 Dental 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

- (1) 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 promptly contact You to explain the hearing process and schedule the time, date and place for that hearing.
- (2) 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 and You will be permitted to question each other and any witnesses during the hearing. You will also be permitted to 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 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 Dental EOC and the Dental 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 Dental 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 Limitations on Covered Services 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.

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 mental retardation or physical handicap, or is mentally handicapped and has qualified for Social Security Insurance disability benefits; 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, and have less than a 63 day break in coverage from the prior plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment.

We may ask 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 sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Dentist for Covered Services rendered by that Dentist or the amount payable based on the Plan's fee schedule for the Covered Services for 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 Limitations on Covered Services;

- (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; and
- (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 Class C or Class D.

ATTACHMENT A: COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

The Preferred Dental Care program provides a wide range of benefits to Cover most services associated with dental care.

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, limitations, 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
 - a. Standard exams including comprehensive, periodic, detailed/extensive and periodontal oral evaluations (exams).
 - b. Emergency exams, including limited oral evaluations (exams).
2. Limitations
 - a. No more than one standard exam in any 6 month period.
 - b. No more than one emergency exam in any 12 month period.
 - c. No more than one comprehensive, detailed/extensive, or periodontal exam in any 36- month period.
3. Exclusions
 - a. Re-evaluations and consultations.

B. X-rays

1. Covered
 - a. Full mouth series, intraoral and bitewing radiographs (x-rays).
2. Limitations
 - a. No more than 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.
 - b. No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date of service.
3. Exclusions
 - a. Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey x-ray films, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be Covered as orthodontic benefits under Coverage D.

II. Preventive Services

A. Prophylaxis (Cleanings)

1. Covered
 - a. Adult and child prophylaxis (cleaning).
2. Limitations
 - a. No more than four of any prophylaxis or periodontal maintenance procedure in any 12-month period.
 - b. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics in Section VI, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.

B. Fluoride Treatment

1. Covered
 - a. Topical fluoride treatments, performed with or without a prophylaxis.
2. Limitations
 - a. No more than two fluoride treatments in any 12-month period.
 - b. Fluoride must be applied separately from prophylaxis paste.
 - c. Covered only for Covered Dependents under age 19.

C. Other Preventive Services

1. Covered
 - a. Sealants, preventive resin restorations, space maintainers.
 - b. Oral cancer screenings

2. Limitations
 - a. No more than 1 sealant or preventive resin restoration per first or second molar tooth per lifetime, for Dependents under age 16.
 - b. Space maintainers for Dependents under age 14, no more than one recementation in any 12 month period.
3. Exclusions
 - a. Nutritional and tobacco counseling, oral hygiene instructions.

III. Basic Restorative Services

A. Fillings and Stainless Steel Crowns

1. Covered
 - a. Amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), stainless steel crowns.
2. Limitations
 - a. No more than 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. Replacement of stainless steel crowns Covered only after 36 months from the date of initial restoration.
3. Exclusions
 - a. Gold foil restorations.

B. Other Basic Restorative Services

1. Covered
 - a. Palliative (emergency) treatment for the relief of pain.
 - b. Repair of full and partial dentures.
2. Limitations
 - a. No more than one repair per denture per 24 months.

IV. Major Restorative & Prosthodontic Services

A. Single Tooth Restorations

1. Covered
 - a. Crowns (resin, porcelain, $\frac{3}{4}$ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.
2. Limitations
 - a. 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).

- b. For permanent teeth only.
 - c. For Dependents under age 12, benefits will not be provided for cast crowns or laminate veneers.
 - d. Replacement of single tooth restorations or fixed partial dentures. Covered only after 60 months from the date of initial placement.
3. Exclusions
- a. Temporary and provisional crowns.

B. Multiple Tooth Restorations – Bridges

1. Covered
- a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ³/₄ and full cast).
2. Limitations
- a. Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture.
 - b. For permanent teeth only, no benefits for Dependents under age 16.
 - c. Replacement of fixed partial dentures or single tooth restorations. Covered only after 60 months from the date of initial placement.
3. Exclusions
- a. Interim pontic and retainer crowns.

C. Removable Prosthodontics (Dentures)

1. Covered
- a. Complete, immediate and partial dentures.
2. Limitations
- a. If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan).
 - b. Benefits are not provided for Dependents under age 16.
 - c. Replacement of removable dentures Covered only after 60 months from the date of initial placement.
3. Exclusions
- a. Interim (temporary) dentures.

D. Other Major Restorative & Prosthodontic Services

1. Covered
- a. Crown and bridge services including core buildups, post and core, recementation, and repair.
 - b. Denture services including adjustment, relining, rebasing and tissue conditioning.

2. Limitations

- a. The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation.
- b. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible.
- c. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge.
- d. Crown and bridge repair and re-cementation are Covered separately only after 12 months from the date of initial placement.
- e. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement.
- f. No more than one denture reline or rebase in any 36 month period.

3. Exclusions

- a. Other major restorative services including protective restoration and coping.
- b. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.

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

A. Basic Endodontics

1. Covered

- a. Pulpotomy, pulpal therapy.

2. Limitations

- a. For primary teeth only.
- b. Not Covered when performed in conjunction with major endodontic treatment.
- c. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality tests, and protective restoration provided in conjunction with basic endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

3. Exclusions

- a. Pulpal debridement.

B. Major Endodontics

1. Covered Services

- a. Root canal treatment and re-treatment, apexification, pulpal regeneration, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.

2. Limitations
 - a. No more than 1 root canal treatment, re-treatment, pulpal regeneration, or apexification per tooth in 60 month period.
 - b. No more than one apicoectomy per root per lifetime.
 - c. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and protective restoration and temporary filling material provided in conjunction with major endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.
3. Exclusions
 - a. Implantation, canal preparation, and incomplete endodontic therapy.

VI. Periodontics

A. Basic Periodontics

1. Covered
 - a. Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.
2. Limitations
 - a. No more that one periodontal scaling and root planing per quadrant in any 24-month period.
 - b. No more than four of any prophylaxis (cleanings) or periodontal maintenance procedure in any 12-month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
 - c. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment.
 - d. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.
3. Exclusions
 - a. Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

B. Major Periodontics

1. Covered
 - a. Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.
2. Limitations
 - a. No more than one major periodontal surgical procedure in any 36 month period.

3. Exclusions
 - a. Tissue regeneration and apically positioned flap procedure.

VII. Oral Surgery

A. Basic Oral Surgery

1. Covered
 - a. Non-surgical or simple extractions.
2. Limitations
 - a. Benefits provided for basic oral surgery include benefits for suturing and postoperative care.
3. Exclusions
 - a. Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.

B. Major Oral Surgery

1. Covered
 - a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.
 - b. Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care.
2. Limitations
 - a. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.
3. Exclusion
 - a. Implants and any related 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
 - 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. Limitations

- a. The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan.
- b. The Plan reserves the right to review the Member's dental records, including necessary x-rays, photographs, and models to determine whether orthodontic treatment is Covered.
- c. Orthodontic services may be limited to Dependents under a specified age limit, as defined on Attachment C: Schedule of Benefits.
- d. Orthodontic services may be limited by a Maximum Allowable Charge, Annual Benefit Period Deductible and lifetime maximum as defined on Attachment C: Schedule of Benefits. Multiple occurrences of orthodontic treatment may be allowed subject to the lifetime maximum.
- e. All orthodontic services shall be deemed to have been concluded on the last date treatment performed during Member's Coverage, even if a prior approved Treatment Plan has not been completed.

3. Exclusions

- a. Replacement or repair of any lost, stolen and damaged appliance furnished under the Treatment Plan.
- b. Surgical procedures to aid in orthodontic treatment.

ATTACHMENT B: EXCLUSIONS FROM COVERAGE

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. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
19. 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.
20. Diagnostic dental services such as diagnostic tests and oral pathology services.
21. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
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.

ATTACHMENT C: SCHEDULE OF BENEFITS

Product Name: DentalBlue Traditional Plan
 Group Name: Clarksville-Montgomery County
 Group Number: 90045
 Benefits Effective: January 1, 2013

Deductible		<u>Individual</u>	<u>Family</u>
Annual Benefit Period		\$50	None
Applies to Coverages B and C only			
Maximums			
Applies to Coverage A, B and C		\$1,500 per Annual Benefit Period	
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	50%	None	
Coverage D			
Orthodontics All Members, no age limit	50%	None	
Annual Benefit Period	January 1 - December 31		

In addition to the Coinsurance percentage, You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of an Out-of-Network Dentist are more than the Maximum Allowable Charge for such Services.

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 Attachment will be eligible for Coverage 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 Plan shall make final eligibility determinations.

A. Subscriber

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

1. Be a full-time or part-time Employee of the Group who is Actively at Work; and
2. Be a permanent part-time Employee who works at least 15 hours per week, and
3. Satisfy all eligibility requirements of the Dental Group Agreement; and
4. Enroll for Coverage by (a) submitting a completed and signed Enrollment Form to the Plan, or (b) submitting a completed Enrollment Form electronically to the Plan.
5. Satisfy any new Employee eligibility period required by the Employer.

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 recognized by Tennessee law; or the law of California; or
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 this EOC.

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

The Plan'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 either: (1) the last day of the month during which that loss of eligibility occurred; or (2) the day that loss of eligibility occurred. Check with the Group to see which termination date will apply to You.

ATTACHMENT E: STATEMENT OF ERISA RIGHTS

For the purposes of this Attachment E, the term, “Plan” means the employee welfare benefit plan sponsored by the Plan Sponsor (usually, the Employer.) The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the group under this Plan, to:

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually the Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator (plan sponsor, i.e., the Employer.) The administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan’s annual financial report. The plan administrator (plan sponsor, usually the Employer) is required by law to furnish each participant with a copy of this summary annual report.
4. Obtain a statement telling You whether You have a right to receive a pension at normal retirement age and if so, what Your benefits would be at normal retirement age if You stop working under the Plan now. If You do not have a right to a pension, the statement will tell You how many more years You have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.
5. Continue Your health care Coverage if there is a loss of Coverage under the Plan as a result of a qualifying event. You may have to pay for such Coverage. Review the Continuation of Coverage section of this EOC for the rules governing Your COBRA Continuation Coverage rights.

If You have Creditable Coverage from a prior employer’s Plan, that Creditable Coverage may reduce or eliminate any Pre-existing Condition Waiting Period under this Plan. You should be given a Certificate of Creditable Coverage, free of charge, when: (1) You lose Coverage under the Plan; (2) You become entitled to elect COBRA Continuation Coverage; and (3) Your COBRA Continuation Coverage ceases if You request the Certificate of Creditable Coverage before losing Coverage, or within 24 months after losing Coverage.

Without evidence of Creditable Coverage, You may be subject to a Pre-existing Condition exclusion for 12 months (18 months for late enrollees) after You enroll for Coverage under this Plan.

In addition to creating rights for the Subscribers and other Employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan are called “fiduciaries” of the plan. They must handle the plan prudently and in the interest of Subscriber’s and other plan participants and beneficiaries. No one, including the Employer, the union, or any other person, may fire the Subscriber or otherwise discriminate against the Subscriber in any way to prevent the Subscriber from obtaining a welfare benefit or exercising rights under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive an

explanation of the reason for the denial. You have the right to have the plan review Your claim and reconsider it.

Under ERISA, there are steps You can take to enforce the above rights.

For instance, if You request materials from the plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the plan administrator (plan sponsor, i.e., Your Employer) to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees; for example, it may order You to pay these expenses if it finds Your claim is frivolous.

If You have any questions about Your Plan, You should contact the Plan Administrator (Plan Sponsor, usually, Your Employer). If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Sponsor, You should contact the nearest Office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ATTACHMENT F: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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. is required to maintain the privacy of all medical information as required by applicable laws and regulations (hereafter referred to as our “legal obligations”); provide this notice of privacy practices to You; inform You of Our legal obligations; and advise You of additional rights concerning Your medical information. We must follow the privacy practices contained in this notice from its effective date of April 14, 2003, until this notice is changed or replaced. Medical information includes dental information.

We reserve the right to change privacy practices and the terms of this notice at any time, as permitted by Our legal obligations. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes are made. All Subscribers will be notified of any changes by receiving a new notice of Our privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross BlueShield of Tennessee, Inc., Privacy Office, 1 Cameron Hill Circle, Chattanooga, TN 37402.

A. 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.

B. Uses And Disclosures Of Medical Information

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

TREATMENT: Your medical information may be disclosed to a doctor or hospital that asks for it to provide treatment to You.

PAYMENT: Your medical information may be used or disclosed to pay claims for services, which are Covered under Your health insurance policy.

HEALTH CARE OPERATIONS: Your medical 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, 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. We cannot use or disclose Your medical information for any reason except those described in this notice without Your written authorization.

PERSONAL REPRESENTATIVE: Your medical 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 We may do so, as described in the Individual Rights section of this notice below.

UNDERWRITING: Your medical 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 We do not issue that contract, Your medical information will not be used or further disclosed for any other purpose, except as required by law.

MARKETING: Your medical information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your medical 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.

RESEARCH: Our legal obligations permit Your medical information to be used or disclosed for research purposes. If You die, Your medical information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

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

COURT OR ADMINISTRATIVE ORDER: Medical 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, medical 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. Medical 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: Medical information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Medical information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

C. Individual Rights

You have the right to look at or get copies of Your medical information, with limited exceptions. **You must make a written request, using a form available from the Privacy Office, to obtain access to Your medical information. If You request copies of Your medical information, We will charge \$0.25 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 Our cost of providing Your medical information in that format. If You prefer, We will prepare a summary or explanation of Your medical information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. We will require advance payment before copying Your medical information.**

You have the right to receive an accounting of any disclosures of Your medical information made by Us or a business associate for any reason, other than treatment, payment, health care operations purposes after April 14, 2003. 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 medical information disclosing 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.

You have the right to request restrictions on Our use or disclosure of Your medical information We are not required to agree to such requests. **We will only restrict the use or disclosure of Your medical information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of BlueCross BlueShield of Tennessee, Inc.**

If You reasonably believe that sending confidential medical information to You in the normal manner will endanger You, You have the right to make a written request, We 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 consumer advisor or The Privacy Officer at 1-888-455-3824 and follow up with a written request when feasible.** We must accommodate Your request if it is reasonable, specifies how and where to communicate with You, and continues to permit us to collect premium and pay claims under Your health plan.

You have the right to make a written request that We amend Your medical information. **Your request must explain why the information should be amended.** We may deny Your request if the medical information You seek to amend was not created by Us or for other reasons permitted by Our legal obligations. If Your request is denied, We will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your medical information. If We accept Your request, We will make reasonable efforts to inform the people that You designate about that amendment and will amend any future disclosures of that information.

If you receive this notice on Our web site or by electronic mail (e-mail), You may request a written copy of this notice by contacting the Privacy Office.

D. 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:

1. You are concerned that We have violated Your privacy rights; or
2. You disagree with a decision made about access to Your medical information or in response to a request You made to amend or restrict the use or disclosure of Your medical information; or
3. You wish to request We 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. We will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

We support Your right to protect the privacy of Your medical information. There will be no retaliation in any way if You choose to file a complaint with Us or with the U.S. Department of Health and Human Services.

**The Privacy Office
BlueCross BlueShield of Tennessee, Inc.
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 (the "Association.") That license permits BlueCross BlueShield of Tennessee, Inc. to use the Association's service marks within its assigned geographical location. BlueCross BlueShield of Tennessee, Inc. is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

SUBROGATION AND RIGHT OF RECOVERY

The Group has agreed that the Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to Group 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. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the Member in such circumstances.

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.



BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association
© Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans
This document has been classified as public information