of Tennessee

Evidence of Coverage

DENTAL BENEFIT PLAN

Sumner County Employees
2019

COMM-663 (8/16)
Dental EOC - Members

Nondiscrimination Notice

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

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

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

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

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

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ ນມ ໄ ຂມໃຫ ທ ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

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

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

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

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

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

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

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

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

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

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

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

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

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INTRODUCTION

This Dental Evidence of Coverage (this "Dental EOC") was created for Your Employer as part of its employee welfare plan (the "Plan,"). References in this Dental EOC to the "administrator" means BlueCross BlueShield of Tennessee, Inc., or BlueCross. Your Employer has entered into an Administrative Services Agreement (ASA) with BlueCross for it to administer the claims Payments under the terms of the EOC, and to provide other services. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary. Your Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator.

This Dental EOC describes the terms and conditions of Your Coverage through the Plan. It replaces and supersedes any Certificate or other description of benefits You have previously received from the Plan.

PLEASE READ THIS DENTAL EOC CAREFULLY. IT DESCRIBES YOUR RIGHTS AND DUTIES AS A MEMBER. IT IS IMPORTANT TO READ THE ENTIRE DENTAL EOC. CERTAIN SERVICES ARE NOT COVERED BY THE PLAN. OTHER COVERED SERVICES ARE OR MAY BE 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 BENEFIT. (SEE ATTACHMENTS A-C.)

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

ANY APPEAL RELATED TO YOUR COVERAGE UNDER THIS DENTAL EOC SHALL BE RESOLVED IN ACCORDANCE WITH THE "APPEAL 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 administrator's Customer Service Representatives, at the number listed on Your 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.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BlueCross is an independent corporation operating under a license from the BlueCross BlueShield Association (the "Association.") That license permits BlueCross to use the Association's service marks within its assigned geographical location. BlueCross is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

HOW THE DENTAL PROGRAM WORKS

Preferred Dental Care coverage is designed to promote cost-effective care and provide a simple method for filing claims. Two important features include the Participating Dentist Program and the Predetermination of Benefits program.

PARTICIPATING DENTISTS

To obtain the highest level of benefits, You should receive services from a Participating Dentist.

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

A listing of Participating Dentists is provided to Your Employer. 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 can go to the Dentist of Your choice, regardless of whether he/she is a Participating Dentist. However, greater benefits are usually paid when You use a Participating Dentist.

PAYMENT FOR A NON-PARTICIPATING DENTIST

If You select a Dentist who is not participating in the Preferred Dental Care Plan, that Dentist can bill You for any amount not Covered by this Dental EOC.

In addition, if You select a Non-Participating Dentist, You must file the claim yourself. “Attending Dentist’s Statements” for a Non-Participating Dentist are available through the Employer.

PREDETERMINATION OF BENEFITS

The Predetermination of Benefits program allows You and Your Dentist to know exactly what kinds of treatment are covered.

To obtain a Predetermination of Benefits response, Your Dentist submits a form called the "Attending Dentist’s Statement" after Your initial examination and before treatment begins. Your Dentist is 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, NEITHER THE PLAN SPONSOR NOR BLUECROSS BLUESHIELD OF TENNESSEE CAN CONFIRM THE HEALTH STATUS OF ANY PARTICIPATING DENTIST.

ELIGIBILITY

Any employee of the Employer and his/her family dependents, who meet the eligibility requirements of this Section, will be eligible for Coverage if properly enrolled for Coverage, and upon payment of the required Payment for such Coverage. If there is any question about whether a person is eligible for Coverage, the Plan Administrator shall make final eligibility determinations.

1. Subscriber

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

a. Be a full-time employee of the Employer, who is Actively at Work; and

b. Satisfy all eligibility requirements of the Plan; and

c. Enroll for Coverage by (a) submitting a completed and signed Enrollment Form to the administrator, or (b) submitting a completed Enrollment Form electronically to the administrator or the Plan.

2. Covered Dependents

To be eligible to enroll as Covered Dependent, a Member must be listed on the Enrollment Form completed by the Subscriber, meet all dependent eligibility criteria established by the Employer, and be:

a. The Subscriber's current spouse as defined by the Employer, which may include a Domestic Partner; or

b. The unmarried, natural, legally adopted, foster or step-child(ren) of the Subscriber or the Subscriber's spouse who is (a) 19 years old or less, or up to 25 years old if a Full-Time Student; and (b) is dependent upon Subscriber or Subscriber's spouse for at least 50% of his or her support; or

c. Children placed with the Subscriber or the Subscriber's spouse pending adoption, and children for whom the Subscriber or Subscriber's spouse is court-appointed legal guardian; or

d. A child of Subscriber or Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or

e. An unmarried child of Subscriber or Subscriber's spouse, as defined above, who is, and continues to be, both (1) incapable of self-sustaining employment by reason of mental or physical handicap, and (2) chiefly dependent upon the Subscriber for economic support and maintenance, provided proof of such incapacity and dependency is furnished within 31 days of the child's attainment of the applicable limiting age and subsequently as may be required by BlueCross, but not more frequently than annually. In addition, such unmarried child must be a dependent enrolled in the Plan prior to attaining the applicable limiting age.

ENROLLMENT

Eligible employees may enroll for Coverage for themselves and their eligible family members as set forth in this section. No person is eligible to re-enroll, if the Plan previously terminated his or her Coverage for cause.

1. Initial Enrollment Period

Eligible employees may enroll for Coverage for themselves and their eligible family dependents within the first 31 days after becoming eligible for Coverage under the Plan. The Subscriber must include all requested information, sign and submit an Enrollment Form to the administrator during that initial enrollment period.

Employees and Eligible Dependents that choose not to enroll when first eligible may not enter the Plan unless there is a Life Changing Event except during the Open Enrollment Period of each year.

2. Open Enrollment Period

Eligible employees shall be entitled to apply for Coverage for themselves and eligible family members during their Employer's Open Enrollment Period. The Subscriber must include all requested information, sign and submit an Enrollment Form to the administrator 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 family dependents within 31 days of becoming eligible for Coverage or during a subsequent Open Enrollment Period.

3. Enrollment of Newly Eligible Family Dependents

A Subscriber may enroll a dependent, who becomes an eligible family dependent after the Subscriber has enrolled for Coverage under 1., above, as follows:

a. A newborn child of the Subscriber or Subscriber's spouse is a Covered Dependent from the moment of birth. The Subscriber must enroll that child within 31 days of the date of birth. If the Subscriber fails to do so, and an additional payment is required to cover that child, the Plan will not provide Coverage for that child after 31 days from the child's date of birth.

b. A legally adopted child, or a child for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction, will be treated as a Covered Dependent from the moment that child is placed in the Subscriber's physical custody, provided:

- Coverage of the child's medical expenses is not provided by a public or private agency or entity; and
- The child is enrolled for Coverage within 31 days from the date of such placement. If the Subscriber fails to do so, and an additional Payment is required to cover that child, the Plan will not provide Coverage for that child after 31 days from the child's date of placement. The Plan shall not provide Coverage for any Services or expenses incurred prior to the date the child is physically placed in the Subscriber's custody.

c. Any other new family dependent, (e.g., if the Subscriber becomes married) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the administrator within 31 days of the date that new family dependent first becomes eligible for Coverage.

d. An employee or eligible family dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:

- he or she had other dental care coverage at the time Coverage under this Plan was previously offered; and
- he or she stated, in writing, at that time that such other coverage was the reason for declining Coverage under this Plan; and
- such other coverage is:

  (1) COBRA and the COBRA coverage is exhausted; or

  (2) Non-COBRA and

    (a) You lose eligibility under the other coverage (other than for a failure to pay premiums); or

    (b) Employer contributions for the other coverage ended; and

- he or she applies for Coverage and the administrator receives the change form within 31 days after the loss of the other coverage.

4. Late Enrollment

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

a. During a subsequent Open Enrollment Period; or

b. If the Employee acquires a new dependent, and he or she applies for Coverage within 31 days.

5. Notification of Change in Status

Subscribers must submit a Change Form to the Employer of any changes in their status or the status of a Covered Dependent within 31 days from the date of the event causing that change of

status. Such events include, but are not limited to: changes in address, marriage, divorce, death, dependency status, Medicare eligibility or coverage by another Payor. Subscribers should submit all Change Forms to the Employer's Benefits Department.

If You submit a Change Form within 31 days of the change, You may be entitled to a refund of any overpayment of Your charge for Coverage; however, any refund will be limited to a one month charge for Coverage.

EFFECTIVE DATE OF COVERAGE

If You are eligible, have enrolled and have paid or had the Payment 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:

1. Effective Date of ASA

Coverage shall be effective on the effective date of the ASA, if all eligibility requirements are met as of that date; or

2. Enrollment During an Open Enrollment Period

Coverage shall be effective on July 1st, unless otherwise agreed to by Employer; or

3. Enrollment During an Initial Enrollment Period, including Newly Eligible Employees

Coverage shall be effective on the day of the month indicated on the eligible employee's Enrollment Form, following the administrator's receipt of the eligible employee's Enrollment Form; or

4. Newly Eligible Dependents

Coverage will be effective as of the date of the qualifying event (i.e., marriage, birth, adoption or guardianship) if the dependent is enrolled and the administrator receives any payment required for such Coverage as set out in the "Enrollment" section.

5. Actively at Work Rule

If an Eligible Employee, other than a retiree, is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all of his/her Covered Dependents will be deferred until the date the Employee is Actively at Work.

TERMINATION OF COVERAGE

1. Termination or Modification of Coverage by BlueCross or the Employer

BlueCross or the Employer may modify or terminate the ASA. Notice to the Employer of the termination or modification of the ASA is deemed to be notice to all Members. The Employer is responsible for notifying You of such a termination or modification of Your Coverage.

All Members' Coverage through the Agreement will change or terminate at 12:00 midnight on the date of such modification or termination. The Employer'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 ASA is modified or terminated. You have no vested right to Coverage under this Dental EOC following the date of the termination of the ASA.

2. Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Employer and the administrator during the term of the ASA. Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on the last day of the month during which he or she loses eligibility.

3. Termination or Rescission of Your Coverage

The Plan may terminate Your Coverage, if:

a. You fail to make a required Member payment (The fact that You have made a Payment contribution to the Employer will not prevent the administrator from terminating Your

Coverage if the Employer fails to submit the full Payment for Your Coverage to the administrator when due); or

b. You act in such a disruptive manner as to prevent or adversely affect the ordinary operations of the Plan; or

c. You fail to cooperate with the Plan as required by this Dental EOC; or

d. You have made a misrepresentation of fact 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 Your Membership card.

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

4. Payment For Services Rendered After Termination of Coverage

If You receive Covered Services after the termination of Your Coverage, the Plan may recover the Maximum Allowable Charge for such Services from You, plus any costs of recovering such Charges, including its attorneys' fees.

5. Extended Benefits

Benefits for Hospital Services will be provided where a Member is hospitalized on the date the ASA is terminated, in which case benefits for Hospital Services will be provided for 60 days or until the Member is discharged, whichever occurs first. The provisions of this paragraph will not apply to a newborn child of a Subscriber if an application for Coverage for that child has not been made within 31 days following the child's birth.

CONTINUATION OF COVERAGE –

Federal Law

If the ASA remains in effect, but Your Coverage under this Dental EOC would otherwise terminate, the Employer 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:

- 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.
- 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 or becomes married.

b. Enrolling for COBRA Continuation Coverage

The administrator, acting on behalf of the Employer, shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

- The Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or
- The Subscriber or Covered Dependent notifies the Employer, 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 Employer or the administrator 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 Employer within that 60 day period, You will lose Your 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 submit the Payment for Coverage, and submit a claim for those Covered Services as set forth in the Claim Procedure section of this Dental EOC.

c. Payment

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

d. Coverage Provided

If You enroll for COBRA Continuation Coverage You will continue to be Covered under the Plan and this Dental EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this Dental EOC and the Plan. The Plan and the Employer may agree to change the ASA and/or this Dental EOC. The Employer may also decide to change administrators. 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:

- 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
- 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 or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must.

- 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
- 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

- 36 months of Coverage if the loss of Coverage is caused by:

  the death of the Subscriber;

  - loss of dependent child status under the Plan;
  - the Subscriber becomes entitled to Medicare; or
  - divorce or legal separation from the Subscriber; or

- 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:

- The Payment for such Coverage is not submitted when due; or
- 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
- The ASA is terminated; or
- You become entitled to Medicare Coverage; or
- The date that You, 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

The Employer may allow Subscribers to continue their Coverage during other leaves of absence. Please check with the Employer to find out how long Subscribers may take a leave of absence.

Subscribers also have to meet these criteria to have continuous Coverage during a leave of absence:

1. The 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.

A Subscriber may apply for COBRA Continuation if the leave lasts longer than allowed by the Employer.

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 the Employer or the Department of Labor.

RIGHT TO RECEIVE AND RELEASE INFORMATION

By signing the Enrollment Form, the Subscriber authorizes and consents to the Plan's receipt, use and release of personal information for the Subscriber and all Covered Dependents. This consent includes any and all medical records, in connection with administration of the Plan's benefit plans in accordance with applicable laws. Additional consent may be required whenever You obtain Covered Services under this Dental EOC. This authorization and consent shall be and remain in effect throughout the period You are Covered by the Plan. This consent shall survive the termination of such Coverage to the extent that such information or records relate to services rendered while You were a Member.

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. We follow our internal administration procedures when We adjudicate claims.

A. Claims

Due to federal regulations, there are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

a. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.

b. 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 the Member. Only post-service claims can be billed to the Plan, or You.

c. Urgent Care is dental care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the Member; or (2) the Member's 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 the Member's dental condition, would subject the Member 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 may be charged or billed by an Out-of-Network Dentist for Covered Services rendered by that Dentist. If You use an Out-of-Network Dentist, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service.
   - If You are charged, or receive a bill, You must submit a claim to Us.
   - 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.
   - 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.
1. 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.
2. A Network Dentist or an Out-of-Network Dentist may refuse to render, 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:
   - You may submit a claim to Us to obtain a Coverage decision (Predetermination of Benefits) concerning whether the Plan will Cover that service.
   - 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.

C. Payment

1. If You received Covered Services from a Network Dentist, the Plan will pay the Network Dentist directly. You authorize assignment of benefits to that Network Dentist. If You have paid that Dentist for the same claim, You must request repayment from that 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. The Plan may make payment for Covered Services to either the Dentist or to You, at its discretion. The Plan's payment fully discharges its obligation related to that claim.
3. If the ASA 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. Benefits will be paid according to the Plan 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. Neither the Plan nor We are responsible for over or under payment of claims if Our information is not complete or inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.
5. When a claim is paid or denied, in whole or part, We will produce an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The administrator 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 Provider. 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. 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 the membership ID card.

Mail all claim forms to:

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

SUBROGATION AND RIGHT OF RECOVERY

The Plan assumes and is subrogated to Your legal rights to recover any payments the Plan makes for Covered Services, when Your illness or injury resulted from the action or fault of a third party. The Plan's subrogation rights include the right to recover the reasonable value of prepaid services rendered by Network Providers.

The Plan has the right to recover any and all amounts equal to the Plan's payments from:

- the insurance of the injured party;
- the person, company (or combination thereof) that caused the illness or injury, or their insurance company; or
- any other source, including uninsured motorist coverage, medical payment coverage, or similar medical reimbursement policies.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The Plan's recovery will not be reduced by Your negligence, nor by attorney fees and costs You incur.

A. Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. The Plan's first lien supercedes any right that You may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery You might procure regardless of whether You have received compensation for any of Your damages or expenses, including Your attorneys' fees or costs. This priority right of reimbursement supersedes Your right to be made whole from any recovery, whether full or partial. In addition, You agree to do nothing to prejudice or oppose the Plan's right to subrogation and reimbursement and You acknowledge that the Plan precludes operation of the "made-whole", "attorney-fund", and "common-fund" doctrines. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

- Any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from Your own insurance and/or from the third party (or their insurance);
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured motorist coverage;
- Business and homeowner medical liability insurance coverage or payments.

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from those Members.

This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether the Member is a minor.

This priority right of reimbursement will not be reduced by attorney fees and costs You incur.

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.

<u>Notice and Cooperation</u>

Members are required to notify the administrator promptly if they are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable the administrator to protect the Plan's rights under this section. Members are also

required to cooperate with the administrator and to execute any documents that the administrator, acting on behalf of the Employer, deems necessary to protect the Plan's rights under this section.

The Member shall not do anything to hinder, delay, impede or jeopardize the Plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the Plan to withhold any and all benefits due the Member under the Plan. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan's subrogation rights and/or priority right of reimbursement.

If the Plan has to file suit, or otherwise litigate to enforce its priority right of reimbursement, You are responsible for paying any and all costs, including attorneys' fees, the Plan incurs in addition to the amounts recovered through the priority right of reimbursement.

Legal Action and Costs

If You settle any claim or action against any third party, You shall be deemed to have been made whole by the settlement and the Plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. You shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You in such circumstances.

Additionally, the Plan has the right to sue on Your behalf, against any person or entity considered responsible for any condition resulting in medical expenses, to recover benefits paid or to be paid by the Plan.

Settlement or Other Compromise

You must notify the administrator prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the Plan's rights so that the Plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The Plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against You.

The right of subrogation and the right of reimbursement are based on the Plan language in effect at the time of judgment, payment or settlement.

The Plan, or its representative, may enforce the subrogation and priority right of reimbursement.

The Covered Person agrees that the proceeds subject to the Plan's lien are Plan assets and the Covered Person will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, the Covered Person agrees to direct such counsel to hold the proceeds subject to the Plan's lien in trust and to remit such funds to the Plan, or its representative, upon request. Should the Covered Person violate any portion of this section, the Plan shall have a right to offset future benefits otherwise payable under this plan to the extent of the value of the benefits advanced under this section to the extent not recovered by the Plan.

COORDINATION OF BENEFITS

This EOC includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care "Plan." Rules of this Section determine whether the benefits available under this EOC are determined before or after those of another Plan. In no event, however, will benefits under this EOC be increased because of this provision.

a. Definitions

The following terms apply to this provision:

- "Plan" means any arrangement which provides benefits or services for, or because of, medical or dental care or treatment through:
  - group, blanket, or franchise insurance (whether insured or uninsured) other than school accident-type coverage;
  - BlueCross Plan, BlueShield Plan, group practice, individual practice, or other pre-paid insurance;
  - coverage under labor management trust Plans or employee benefit organization Plans;
  - coverage under government programs to which an employer contributes or makes payroll deductions;
  - coverage under a governmental Plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); and
  - any other arrangement of health coverage for individuals in a group.

  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.
- "This Plan" refers to the part of the employee welfare benefit plan 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.
- The order of benefit determination rules state whether This Plan is a "Primary Plan" or "Secondary Plan" as to another plan covering the person.

  When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan and without considering the Other Plan's benefits.

  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.

  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.
- "Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered in whole or in part by one or more Plans covering the Member for whom the claim is made.
  - The reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid when a Plan provides benefits in the form of services.

- 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.
- We will determine only the benefits available under This Plan. You or the Member is responsible for supplying Us with information about Other Plans so We can act on this provision.
- When benefits are reduced under a Primary Plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and Participating Provider arrangements.

- "Claim Determination Period" means a Calendar Year. It does not, however, include any part of a year during which a person has no coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

b. Effect on Benefits

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 after the Other Plan(s).

- Benefits of This Plan will be reduced when the sum of:
  - the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and
  - 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.
- When the benefits of This Plan are reduced as described in subparagraph 2(a) above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.
- We will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:

- the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
  - the order of benefit determination rules require Us to determine benefits before those of the Other Plan.

c. Order of Benefit Determination Rules

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

- 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:
  - if the person is also a Medicare beneficiary and,
  - 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.

- 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":

  - 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
  - If both parents have the same birthday, the benefits of the Plan that has covered one parent longer are determined before those of the Plan that has covered the other parent for a shorter period of time.

    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.

- 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:

  - First, the Plan of the parent with custody of the child;
  - Then, the Plan of the spouse of the parent with the custody of the child; and
  - Finally, the Plan of the parent not having custody of the child.
  - However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense 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.
  - 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 in Paragraph 3(b), Dependent Child/Parents Not Separated or Divorced.

- Active/Inactive Employee

  The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. The same would hold true if a person were a Dependent of a person covered as a retiree and an Employee. 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.

- Continuation Coverage

  If a person whose Coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

  - First, the benefits of a Plan covering the person as an Employee, Member, or Subscriber (or as that person's Dependent);
  - Second, the benefits under the continuation coverage.

  If the Other Plan does not have the Rule described above, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

- 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.

  - 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.
  - 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).
  - 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 covered under the plan 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.

  If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first.

- 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."

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

  - If This Plan is the Primary Plan, it will provide its benefits on a primary basis.
  - 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.
  - 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.
  - If the Non-complying Plan reduces its benefits so that benefits received by the Member are less than those he or she would have received if the Non-complying Plan provided its benefits as the Primary Plan and This Plan

provided its benefits as the Secondary Plan, then This Plan may advance the difference to or on behalf of the Member. The benefits advanced shall not exceed the benefits This Plan would have provided if it had been the Primary Plan, less any benefits already provided as the Secondary Plan. In consideration of such advance, This Plan shall be subrogated to all rights of the Member against the Non-complying Plan. Such advance shall also be without prejudice to any independent claims This Plan may have against the Non-complying Plan in the absence of such subrogation.

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 the 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. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
5. We, 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.
6. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA 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 the customer service department 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. First Level 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, We may raise Your failure to initiate a Grievance in a timely manner as a defense if You file a lawsuit against the Administrator later.

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. BlueCross is a limited fiduciary for the first level Grievance.

1. Grievance Process

   After We have 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, We 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. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Plan is not otherwise governed by ERISA.

2. Written Decision

   The committee or reviewers will consider the information presented, and You will receive 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. You may receive a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance

You may file a written request for reconsideration with Us within ninety (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 the Plan 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, the Plan agrees 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 Process

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.

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

a. Any new, relevant information that You submit for consideration; and

b. Information presented during the hearing. Second level Grievance committee members may ask You questions during the hearing. You may make a closing statement to the committee at the end of the hearing.

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

If Your Grievance involves a Medical Necessity determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance followed by completion of the second level Grievance,, You may request that the Dispute be submitted to a neutral third party, selected by Us, 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 oral testimony during the Grievance Process. Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of

the 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 Employer or Employer's Plan, until the independent reviewer makes its decision.

The Employer or Employer's 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.

We will submit the necessary information to the independent review entity within five (5) business days after receiving Your request for review. We 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 five (5) business days after receiving that request from the reviewer.

The reviewer must submit a written determination to Us and We will submit the determination to 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 five (5) business days to issue a determination to consider additional information submitted by Us or You.

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

No legal action shall be brought to recover under this EOC until 60 days after the claim has been filed. No such legal action shall be brought more than 3 years after the time the claim is required to be filed.

DEFINITIONS

Actively At Work - An employee is performing all of his or her regular duties for the Employer on a regularly scheduled work day 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 only if he or she was Actively At Work on the last regularly scheduled work day.

Administrative Services Agreement or ASA – The arrangements between the administrator and the Employer, including any amendments, and any attachments to the ASA or this Dental EOC.

Benefit Maximum - the total amount of benefits available for services under Your contract during the Benefit Year. (See Attachment C, Schedule of Benefits.)

Calendar Year - The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st of the year in which Coverage is effective.

Covered Dependent - A Subscriber's family member who meets the eligibility requirements of this Dental EOC, has been enrolled for Coverage and for whom the Plan has received the applicable Payment for Coverage.

Covered Services, Coverage or Covered - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this Dental EOC, (which is incorporated by reference.) Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this Dental EOC.

Deductible - the dollar amount, specified in Attachment C, Schedule of Benefits, which a Member must incur and pay for Covered Services during a Calendar Year before the Plan provides benefits for such services. The Deductible will apply to the Out-of-Pocket. Neither Copayments nor any balance of charges (between Billed Charges and the Maximum Allowable Charge) required for Covered Services rendered by a Non-Participating Provider will be considered when determining if the Member has satisfied a Deductible.

Dentist - a duly licensed medical professional who is legally entitled to practice dentistry at the time and place Covered Services are performed.

Effective Date - the date on which a Member's coverage begins.

Employee – A person who fulfills all eligibility requirements established by the Employer and the administrator.

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

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. The form or application may be in paper form, or electronic, as determined by the Plan Sponsor.

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

Family Coverage - coverage of a Member and one or more eligible Dependents as defined in Section II.

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 a Calendar Year before the Plan provides benefits for such Services. Once the Family Deductible amount has been satisfied by 2 or more Covered Family Members during a Calendar Year, the Deductible will be considered satisfied for all Covered Family Members for the remainder of that Calendar Year.

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

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.

Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

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

Maximum Allowable Charge - The amount that the administrator, acting through the authority of the Plan Administrator, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the administrator's contract with a Participating Provider or the amount payable based on the administrator's fee schedule for the Covered Services rendered by Non-Participating Providers.

Maximum Lifetime Amount - the total dollar amount of benefits available for Coverage D - Orthodontic Services during the Member's lifetime under the Preferred Dental Care Contract between Employer and BlueCross, as stated in the Schedule of Benefits.

Benefits available during any contract year will be subject to such maximum—reduced by benefits provided for services during contract years preceding the Effective Date of the Preferred Dental Care Contract, provided the Member has had continuous coverage under contract(s) to provide group dental coverage between BlueCross and Employer during such years.

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

Non-Participating Dentist - a Dentist who has not signed a Participating Dental Agreement with BlueCross BlueShield of Tennessee.

Participating Dentist - a Dentist who has signed a Participating Dental Agreement with BlueCross BlueShield of Tennessee.

Payment Schedule For Non-Participating Dentists - the maximum benefits provided under Your coverage for covered dental procedures received from a Non-Participating Dentist.

The Plan reserves the right to amend such allowances without notice and determine the payment for services not listed.

Physician - a duly licensed medical professional who is legally entitled to practice medicine and perform surgery at the time and place Covered Services are performed.

All Physicians must be licensed in Tennessee or in the state in which Covered Services are rendered.

Rescind or Rescission – A retroactive termination of Coverage because You committed fraud or made an intentional misrepresentation of a material fact in connection with Coverage. Actions that are fraudulent or an intentional misrepresentation of a material fact include, but are not limited to, knowingly enrolling or attempting to enroll an ineligible individual in Coverage, permitting the improper use of Your Member ID card, or claim fraud. A Rescission does not include a situation in which the Plan retroactively terminates Coverage in the ordinary course of business for a period for which You did not pay the Premium. An example would be if You left Your job on January 31, but Coverage was not terminated until March 15. In that situation, the Plan may retroactively terminate Your Coverage effective February 1 if You did not pay any Premium after You left Your job (subject to any right You may have to elect continuation coverage). This is not a Rescission.

Service Area - those areas in which Covered Services are available from Participating Dentists.

Subscriber - an employee who has satisfied the eligibility requirements and is enrolled for coverage.

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

Two Person Coverage - coverage for the Subscriber and one Covered Dependent.

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.

COVERAGE A - (Benefits for Preventive Dentistry)

- Two routine periodic examinations in any 12-month period;
- Set of two bitewing X-rays per 12-month period;
- Full mouth X-rays once in any 36-month period;
- Topical fluoride application for Dependent children under age 19, once in any 12-month interval;
- Prophylaxis (adult prophylaxis, for Members age 14 years and older) and periodontal maintenance, not to exceed two such procedures in any 12-month period;
- Any combination of exams — initial, periodic, emergency or periodontal — limited to 3 times in a 12-month period.
- Space maintainers for Dependents up to age 14;
- Sealants, only for occlusal (biting) surface of first and second permanent molar teeth on Dependents up to age 16.

  Only one sealant benefit will be allowed on each tooth per lifetime of coverage.

COVERAGE B - (Benefits For Restorative Dentistry)

- Emergency treatment for relief of pain;
- Restorative services: filling material such as amalgam, synthetic porcelain and plastic restorations—limited to one restoration on any surface of a tooth;

  Benefits will not be provided for replacement within 12 months of a restoration.

- Oral surgery: provides for extractions and other oral surgery, including pre- and post-operative care;

  General anesthesia or intravenous sedation is covered only in connection with covered oral surgical procedures when administered by a Dentist licensed to administer such agents.

- Endodontics (treatment of the dental pulp including root canal treatment);

  Benefits will be provided for one standard root canal treatment for an individual tooth in a single five-year period.

  Benefits will not be provided for X-rays and sedative filling which is part of a root canal treatment or a temporary when a casting is being prepared.

- Periodontics (treatment for diseases of the gums and bones supporting teeth);

  Benefits will be provided for root planing once in a single two-year-period, but will not be provided when performed on the same day as a prophylaxis or periodontal maintenance procedure.

  Benefits for periodontal surgical procedures shall be provided for up to three months post-operative care and any surgical re-entry for a three-year-period.

  Benefits for periodontal maintenance will not be provided unless performed 91 days or more after completion of active periodontal treatment.

  Benefits for scaling in the presence of gingival inflammation will be limited to one such procedure for Members age 19 years or older.

- Repair of full and partial dentures;
- Temporary stainless steel crowns; and

  Benefits will not be provided for replacement of a stainless steel crown within 36 months following initial placement of such crown.

COVERAGE C - (Crown and Prosthetic Care)

- Full and partial dentures;

  Benefits will be provided for any necessary adjustments for a six-month period.

  Benefits will not be provided for cast partial dentures for eligible Dependents under age 16.

- Bridges and bridge repair 12 months after initial placement;

  Benefits will not be provided for cast or partial dentures or fixed bridges for eligible Dependents under age 16.

  If, in the construction of a denture, the Member and the Dentist decide on personalized restoration or to employ special techniques rather than standard procedures, benefits provided shall be limited to those which would otherwise be provided for the standard procedures for prosthetic services (as determined by the administrator, acting on behalf of the Plan Administrator.)

  Benefits will not be provided for recementation of a bridge if performed within 6 months of its placement where both procedures are performed by the same Dentist.

- Cast crowns for treatment of severe carious lesions or severe fracture when the teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations;

  Benefits will not be provided for porcelain, gold or veneer crowns for eligible Dependents under age 12. Benefits provided for cast restorations include preparation of the tooth and gingiva, crown build-up, impressions, temporary restorations, and recementation in a 12-month period.

  Benefits will not be provided for a core build-up separate from those provided for crown construction—except in those circumstances where severe carious lesions or fracture are so extensive that retention of the crown would not be possible. Benefits will not be provided for reseating of a crown within 12 months of its initial placement or for prefabricated crowns when used as a permanent restoration on an adult tooth. (Charges for a prefabricated crown should be included as part of those for the permanent restoration.)

- Cast onlays for treatment of severe carious lesions and severe fracture when the tooth cannot be restored with amalgam, synthetic porcelain or plastic restorations;

- Laminate veneers for severe carious lesions and severely fractured teeth; and

- Relining and rebasing of full and partial dentures (up to one in any three-year period.)

  Benefits will be provided on behalf of an individual Member for cast onlays, crowns, labial veneer (laminate), fixed bridges and prosthetic appliances once in any single five-year period. Benefits for post and core, and core buildup, will be limited to five-year replacement.

COVERAGE D - (Orthodontic Care)

- Straightening and alignment of teeth for all eligible Members, if prescribed by a treatment plan approved by us.

  Benefits include initial and subsequent installation of orthodontic appliances and all orthodontic treatments, intended to reduce or eliminate an existing malocclusion and its attendant sequelae through the correction of malposed teeth, subject to the following conditions:

  - The need for orthodontic services must be diagnosed and Treatment Plan submitted to the administrator. The diagnosis must indicate that the orthodontic condition consists of handicapping malocclusion which is both abnormal and correctable.

  - The Plan reserves the right to review the Member's dental records, including necessary x-rays, photographs, and models, to determine whether orthodontic needs and treatment are covered.

- For the purpose of determining benefits when a Member's coverage under the ASA is terminated or canceled, all orthodontic services shall be deemed to have been rendered on the date performed. Benefits will cease when the Member's coverage terminates, even if an approved orthodontic treatment has not been completed.
- For orthodontic services rendered by a Dentist, benefits will be provided as specified in Attachment C, Schedule of Benefits (billed charges or MAC, whichever is less.)
- The maximum amount of benefits for orthodontic services on behalf of a Member will be stated in Attachment C, Schedule of Benefits.
- After completion of orthodontic services as set forth in the Treatment Plan, additional benefits will be provided for orthodontic services (if previous benefits have not exceeded the Lifetime Maximum.)
- Benefits will not be provided for expenses in connection with the replacement and/or repair of any appliance furnished under the Treatment Plan.
- Orthodontic benefits will not be provided for surgical procedures.

ATTACHMENT B

EXCLUSIONS FROM COVERAGE

GENERAL EXCLUSIONS

Your Coverage does not provide benefits for:

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. Dental services for which You are not required or legally obligated to pay.
3. Any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements.)
4. 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.)
5. Services or supplies furnished without cost under the laws of any government except Medicaid or TennCare coverage provided by the State of Tennessee.
6. Diagnosis for, or fabrication of appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
7. Replacement of tooth structure lost from wear or attrition.
8. Services rendered by a Dentist beyond the scope of his or her license.
9. 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.
10. Dental care or treatment not specifically listed in the Schedule of Benefits.
11. Dental services covered by any basic group insurance coverage for which any Employer pays any portion of the cost or makes payroll deduction or for which a group collector remits premiums, or expenses covered by any other contract or certificate issued by BlueCross BlueShield of Tennessee or another BlueCross and BlueShield Plan.
12. Dental services resulting from loss or theft of a denture, crown, or bridge.
13. Provisional splinting, or double (multiple) abutments for fixed bridges.
14. Courses of treatment undertaken before You become covered under this program.
15. Services of anesthetists or anesthesiologists, or general anesthesia or intravenous sedation for restorative dentistry.
16. Any services performed after You cease to be eligible for Coverage.
17. Services rendered for oral hygiene, dietary instructions, or for prescribed drugs or other medications.
18. Treatment for desensitizing teeth.
19. Services or supplies which are not Medically Necessary.
20. A drug, device, medical or dental treatment or procedure which is an Experimental or Investigational Service.
21. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
22. Implants (or any synthetic material implanted into or on bone or gums) or their removal.

    (Alternative benefits may be provided for a full or partial denture in connection with the restoration of fixed prosthesis to implanted artificial teeth.)
23. A posterior bridge in conjunction with an allowance for a partial denture in the same arch.
24. Temporary partial dentures, excepting those immediately following extraction of anterior teeth.
25. Gold foil restorations.
26. Any court-ordered treatment of a Member unless benefits are otherwise payable.

27. Crowns and prosthetics including bridges, full and partial dentures, and relining and duplication of full and partial dentures (except as specified in Attachment C, Schedule of Benefits); and/or Orthodontics (except as specified in Attachment C, Schedule of Benefits.)

CARE RENDERED BY MORE THAN ONE DENTIST

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 which would have been provided had one Dentist rendered the service.

ALTERNATE COURSE OF TREATMENT

If there are alternative procedures (courses of treatment) that meet generally accepted standards of professional dental care for the patient's condition, benefits will be based on the lowest cost alternative.

ATTACHMENT C: SCHEDULE OF BENEFITS

Group Name: Sumner County Employees

Group Number: 93120

Benefits Effective: July 1, 2019

Deductible applies to Coverages B, C and D only	**Individual**	**Family**
	$50	3 Deductibles

Covered Services	**Benefit Percentages**
Diagnostic and Preventive Services (Coverage A)	100%
Restorative Services (Coverage B)	80%
Prosthetic and Complex Restorative Services (Coverage C)	50%
Orthodontic Services (Coverage D)	50%

Maximums	
Coverages A, B and/or C if applicable	$1,500 per Calendar Year
Coverage D	$1,500 per Lifetime

BlueCross BlueShield of Tennessee*

1 Cameron Hill Circle
Chattanooga, Tennessee
37402

www.bcbst.com

BENEFIT QUESTIONS?

Call the Customer Service Number on your I.D. Card

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