Evidence of Coverage

Dental benefit plan

DentalBlue™

Evidence of Coverage

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

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BCBST - Dental EOC
2008 (Rev. 7/22)

Please read this Evidence of Coverage carefully and keep it in a safe place for future reference. It explains Your Coverage from BlueCross BlueShield of Tennessee.

If You have questions about this Evidence of Coverage or any matter related to Your membership in the Plan, please write or call Us at:

BlueCross and BlueShield of Tennessee
Member Service
1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0002
1-(800) 565-9140

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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ 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).

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

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

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

ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 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 (TTY:1-800-848-0298) 1-800-565-9140 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'déé', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

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Get the Most from Your Benefits

1. **Create Your online account and download the BCBSTN mobile app.** Go to bcbst.com/activate and click register account so you can see and share Your Member ID card with a single tap, view claims, and access information about Your benefits anywhere, anytime. You can also download BCBSTN mobile app from the App Store® or Google Play® and log in using the same password[1].

2. **Please read Your Evidence of Coverage.** This Evidence of Coverage ("EOC") is part of the Group Agreement between BlueCross BlueShield of Tennessee, Inc. ("BlueCross®," "BlueCross BlueShield of Tennessee," "Our," "Plan," "Us" or "We") and Your Group. "Subscriber" means the individual to whom We have issued this EOC. "Member," "You" or "Your" means a Subscriber or a Covered Dependent. "Coverage" means the insurance benefits Members are entitled to under this EOC. This 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. This EOC replaces and supersedes any EOC that You may have previously received from Us.

   Please read this EOC carefully. It describes Your rights and duties as a Member. It is important to read the entire EOC. Certain services are not Covered by Us. Other Covered Services are limited.

   In order to make it easier to read and understand this EOC, defined words are capitalized. Those words are defined in the "Definitions" section of this EOC.

   The Group has delegated discretionary authority to the Plan to make any benefit determinations. It has also granted the authority to construe the terms of Your Coverage with 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. "ERISA" means the Employee Retirement Income Security Act. The Group retains the authority to determine whether You or Your Covered Dependents are eligible for Coverage.

   Any Grievance related to Coverage under this EOC must be resolved in accordance with the "Grievance Procedure" section of this EOC.

   Questions: Please contact Us at the Member Service number on the back of Your Member ID card, if You have any questions when reading this EOC. Our consumer advisors are also available to discuss any other matters related to Your Coverage under this EOC.

3. **How A PPO Plan Works**. You have a PPO plan. BlueCross has an agreement with a network of participating dentists. These Providers, called Network Dentists, agree to special pricing arrangements.

   Your PPO plan has two levels of benefits. By using Network Providers, You receive the highest level of benefits. However, You can choose to use Providers that are not Network Providers. These Providers are called Out-of-Network Providers. When You use Out-of-Network Providers, that Dentist can bill You for any amount not Covered by this EOC. You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for a Covered Service, if an Out-of-Network Dentist's Billed Charges are more than the Maximum Allowable Charge for such Services.

   Attachment C: "Schedule of Benefits", shows how Your benefits vary for services received from Network and Out-of-Network Providers. Attachment A details Covered Services, and Attachment B lists services excluded under the Plan. **By using Network Providers, You maximize Your benefits and avoid balance billing. Balance billing happens when You use an Out-of-Network Provider and You are billed for any unpaid Billed Charges. This amount can be substantial.**

4. **BlueCross BlueShield of Tennessee Identification Card**. Once Your Coverage becomes effective, You will receive a BlueCross BlueShield of Tennessee Member identification (ID) card. Providers nationwide recognize it. **The Member ID card is the key to receiving the benefits of the dental plan. Carry it at all times. Please be sure to show the Member ID card each time You receive dental services.**

   Our member service number is on the back of Your Member ID card. This is an important phone number. Call this number if You have any questions.

   If Your Member ID card is lost or stolen, or another card is needed for a Covered Dependent not living with You, please visit bcbst.com/myID or call the number listed on the front page of this EOC. You may want to record Your Member ID number for safekeeping.

5. **Always use Network Providers.** See "Attachment A: Covered Services" for an explanation of a Network Provider. Call Us to verify that a Provider is a Network Provider or visit bcbst.com/finddentalcare or use the BCBSTN mobile app.

6. **Ask Us** if the Provider is in the specific network shown on Your Member ID card. Since BlueCross has several networks, a Provider may be in one BlueCross network, but not in all of Our networks. Visit bcbst.com/finddentalcare or use the BCBSTN mobile app for more information on Providers in each network.

7. **Notify** Your Employer within thirty-one (31) days of a qualifying event if changes in the following occur for You or any of Your Covered Dependents:

   a. Name;
   b. Address;
   c. Telephone number;
   d. Employment (change companies or terminate employment);
   e. Status of any other health insurance You might have;
   f. Birth of additional dependents;
   g. Marriage or divorce;
   h. Death; or
   i. Adoption

[1] ***The App Store is a registered trademark of Apple, Inc.***

Google Play is a trademark of Google, Inc.

Enrolling in the Plan

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll if the Plan previously terminated his or her Coverage for any of the reasons listed under paragraph C. of the "When Coverage Ends" section of this EOC. Your Group chooses the classes of Employees who are eligible for Coverage under the Plan. Please refer to Attachment D: Eligibility for details.

A. Initial Enrollment Period

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

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during the Group's Open Enrollment Period. The Employee 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 thirty-one (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 became eligible after the Subscriber enrolled as follows:

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

   If the Subscriber fails to do so, and an additional Premium is required to Cover the child, the Plan will not Cover the child after thirty-one (31) days from the date the Subscriber or the Subscriber's spouse 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 newly acquired child to the Subscriber's Coverage until notified of the child's birth. 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 Group representative within thirty-one (31) days of the date that person first becomes eligible for Coverage.

D. 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:

1. During a subsequent Open Enrollment Period; or

2. If the Employee acquires a new dependent, and the Employee applies for Coverage within thirty-one (31) days.

E. Enrollment Upon Change in Status

If You have a change in status, You may be eligible to change Your Coverage other than during the Open Enrollment Period. The Subscriber must, within the timeframe set forth below, submit a change form to the Group representative to notify the Plan of any changes in status for Yourself or for Your Covered Dependent. Any change in Coverage elections must be consistent with the change in status.

1. The Subscriber must request the change within thirty-one (31) days of the change in status for the following events:
   a. Marriage or divorce;
   b. Death of the Employee's spouse or dependent;
   c. Change in dependency status;
   d. Medicare eligibility;
   e. Coverage by another Payor;
   f. Birth or adoption of a child of the Employee;
   g. Termination of employment, or commencement of employment, of the Employee's spouse; or
   h. Switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse.
2. The Subscriber must request the change within sixty (60) days of the change in status for the following events:
   a. Loss of eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
   b. Becoming eligible to receive a subsidy for Medicaid or CHIP coverage.
3. An Employee or eligible dependent who did not apply for Coverage within thirty-one (31) days of first becoming eligible for Coverage under this Plan may enroll if:
   a. He or she had other dental coverage at the time Coverage under this Plan was previously offered; and
   b. He or she stated, in writing, that such other coverage was the reason for de clining Coverage under this Plan at the time Coverage under this Plan was previously offered; and
   c. Such other coverage is:
      i. COBRA and the COBRA coverage is exhausted; or
      ii. Non-COBRA and
         1. You lose eligibility under the other coverage (other than for a failure to pay Premiums); or
         2. Employer contributions for the other coverage ended; and
   d. He or she applies for Coverage under this Plan and the administrator receives the change form within thirty-one (31) days after the loss of the other coverage.

When Coverage Begins

If You are eligible, have enrolled and have paid or had the Premium for Coverage paid on Your behalf, Coverage under this 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 Group Agreement

Initial Coverage through the Plan shall be effective on the effective date of the Group Agreement, if all eligibility requirements are met as of that date; or

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; or

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; or

D. Newly Eligible Employees

Coverage will become effective after You become eligible having met all of the eligibility requirements as specified in the Group Agreement; or

E. Newly Eligible Dependents

(1) Dependents acquired as the result of a marriage – Coverage will be effective on the day of the marriage unless otherwise agreed to by Group and the Plan;

(2) Newborn children of the Subscriber or the Subscriber's spouse – Coverage will be effective as of the date of birth;

(3) Dependents adopted or placed for adoption – 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 "Enrolling in the Plan" section.

F. Actively at Work Rule

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

When Coverage Ends

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

The Plan or the Group may modify or terminate the Group Agreement. Notice to the Group of the termination or modification of the Group Agreement is deemed to be notice to all Members of the Group. The Group 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 Group's failure to notify You of the modification or termination of Your Coverage shall not be deemed to continue or extend Your Coverage beyond the date that the Group Agreement is modified or terminated. You have no vested right to Coverage under this EOC following the date of the termination of the Group Agreement.

B. Termination of Coverage Due to 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 Group Agreement. See Attachment D: Eligibility for details regarding "Loss of Eligibility."

C. Termination of Coverage

The Plan may terminate Your Coverage, if:

1. The Plan does not receive the required Premium for Your Coverage when it is due. The fact that You have paid 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 EOC; or
4. You or Your Covered Dependent(s) have made a misrepresentation of fact or committed fraud in connection with the Coverage. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the Member ID card.

D. Right To Request A Hearing

You may request that We conduct a grievance hearing to appeal the termination of Your membership or Rescission of Your Coverage, as explained in the "Grievance Procedure" section. The fact that You have requested a hearing does not postpone or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated following that hearing, You may submit any claims for Covered Services rendered after Your Coverage was terminated to the Plan for consideration, in accordance with the "Claims and Payment" section.

E. Payment For Services Rendered After Termination of Coverage

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

1. Charges for dentures will be paid if:

   a. The impression was made prior to the date Coverage ends;

b. The denture was ordered prior to the date Coverage ends;

c. The denture is placed in the mouth within thirty (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 thirty (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 thirty (30) days from the date Coverage ends; and

c. The Employer's new dental insurer is not responsible for paying these charges.

Continuation of Coverage

A. Continuation of Coverage - Federal Law

If the Group Agreement remains in effect, but Your Coverage under this EOC would otherwise terminate, the Group may be required to offer You the right to continue Coverage. This right is referred to as "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).

1. 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 if, under the terms of this EOC, the event causes You to lose coverage:

a. Subscribers

Loss of Coverage because of:

i. The termination of employment except for gross misconduct; or

ii. A reduction in the number of hours worked by the Subscriber.

b. Covered Dependents

Loss of Coverage because of:

i. The termination of the Subscriber's Coverage as explained in subsection (a), above;

ii. The death of the Subscriber;

iii. Divorce or legal separation from the Subscriber;

iv. The Subscriber becomes entitled to Medicare; or

v. A Covered Dependent reaches the limiting age.

2. Enrolling for COBRA Continuation Coverage

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

a. The Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare Coverage; or

b. The Subscriber or Covered Dependent notifies the Group, in writing, within 60 days after any other qualifying event set out above.

You have sixty (60) days from the later of the date of the qualifying event or the date that You receive notice of Your right to COBRA Continuation Coverage to enroll for such Coverage. The Group 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 sixty (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 paying the Premium 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 this EOC.

3. Premium Payment

You must pay any Premium required for COBRA Continuation Coverage to the Group, which will send that Premium to the Plan. The Group may also direct You to send Your Premium directly to the Plan, or a third party. 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 forty-five (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.

4. Coverage Provided

If You enroll for COBRA Continuation Coverage You will continue to be Covered under the Group Agreement and this EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this EOC and the Group Agreement. The Plan and the Group may agree to change the Group Agreement, and/or this EOC, and 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.

5. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

a. Eighteen (18) months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or

b. Twenty-nine (29) months of Coverage. If, as a qualified beneficiary who has elected eighteen (18) months of COBRA Continuation Coverage, You are determined to be disabled within the first sixty (60) days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional eleven (11) months, up to twenty-nine (29) months. Also, the twenty-nine (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 Employer or the administrator must be notified:

   1. Of the disability determination within sixty (60) days after the determination of disability and before the close of the initial eighteen (18) month Coverage period; and

   2. Within thirty (30) days of the date of a final determination that the qualified beneficiary is no longer Disabled; or

c. Thirty-six (36) months of Coverage if the loss of Coverage is caused by:

   i. The death of the Subscriber;

   ii. Loss of dependent child status under the Plan;

   iii. The Subscriber becomes entitled to Medicare; or

   iv. Divorce or legal separation from the Subscriber; or

d. Thirty-six (36) months for other qualifying events. If, a Covered Dependent is eligible for eighteen (18) months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g. divorce), You may be eligible for thirty-six (36) months of COBRA Continuation Coverage from the date of the first qualifying event.

6. Termination of COBRA Continuation Coverage

After You have elected COBRA Coverage, Your COBRA Coverage will terminate either at the end of the applicable eighteen (18), twenty-nine (29) or thirty-six (36) month eligibility period or, before the end of that period, upon the date that:

a. The Premium for such Coverage is not paid when due; or

b. You become covered as either a Subscriber or dependent by another group health care plan; or

c. The Group Agreement is terminated; or

d. You become entitled to Medicare coverage; or

e. The date that a Disabled Member, who is otherwise eligible for twenty-nine (29) months of COBRA Continuation Coverage, is determined to no longer be Disabled for purposes of the COBRA law.

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.

B. Conversion Options

If Your Coverage under this EOC terminates, You may be eligible for other insurance coverage. You and Your family may be able to buy individual insurance directly from Us. Please contact Your Broker, call 1-(800)-845-2738 or visit bcbst.com for more information.

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

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

- up to twelve (12) weeks of unpaid leave from employment due to certain family or medical circumstances; or
- in some instances, up to twenty-six (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.

D. Continued Coverage During a Military Leave of Absence

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

E. Continued Coverage During Other Leaves of Absence

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

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

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

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

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

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

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

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

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 one (1) year and ninety (90) days from the date a Covered Service was received. If You do not submit a claim, within the one (1) year and ninety (90) day time period, it will not be paid.
    c. If it is not reasonably possible to submit the claim within the one (1) year and ninety (90) days time period, the claim will not be invalidated or reduced. We may require verification of the reason for such delay.
4. The dental claim form can be found at bcbst.com/dentalclaimform. You may also request a claim form from Our consumer advisors. We will send You a claim form within fifteen (15) days. You must submit proof of payment acceptable to Us with the claim form to the address below. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

Mail dental claim forms to:
BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

5. A Network Dentist or an Out-of-Network Dentist may refuse to render services or reduce or terminate a service that has been rendered or require You to pay for what You believe should be a Covered Service. If this occurs:
    a. You may submit a claim to Us to obtain a Coverage decision (Predetermination of Benefits) concerning whether the Plan will Cover that service.
    b. You may request a claim form from Our consumer advisors. We will send You a claim form within fifteen (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. Predetermination of Benefits 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.

C. Payment

1. If You received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to the Plan's agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.
2. If You received Covered Services from an Out-of-Network Provider, 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 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 were received.

4. We will pay benefits within thirty (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. We are not responsible for overpayment or underpayment of claims if Our information is not complete or accurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted. Payment for Covered Services is more fully described in "Attachment C: Schedule of Benefits."

5. At least monthly, You will receive a Claims Summary. The Claim Summary, sometimes referred to as the Explanation of Benefits (EOB), shows how a claim paid, denied, how much was paid to the Dentist, and also let You know if You owe an additional amount to that Dentist. The Plan will make the Claim Summary available to You at bcbst.com/claims, or You can obtain it at no cost by calling Our customer advisors at the Member Service number on the back of Your ID card.

6. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Dentist. If We pay such amounts to a Dentist on Your behalf, We may collect those cost-sharing amounts directly from You.

7. You are also responsible for the providers' charges for Non-covered Services as defined in this EOC. Network discounts do not apply to these Non-covered Services.

D. Assignment

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

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 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 EOC are determined before or after those of another Plan. In no event, however, will benefits under this EOC, or the Group Agreement, be increased because of this provision. The benefits under this 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.

A. Definitions

The following terms apply to this provision:

1. "Plan" means any form of medical or dental coverage with which coordination is allowed. “Plan” includes:
    a. Group, blanket, or franchise insurance;
    b. A group BlueCross Plan, BlueShield Plan;
    c. Group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;
    d. Coverage under labor management trust Plans or employee benefit organization Plans;
    e. Coverage under government programs to which an employer contributes or makes payroll deductions;
    f. Coverage under a governmental Plan or coverage required or provided by law;
    g. Medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
    h. Coverage under Medicare and other governmental benefits; and
    i. Any other arrangement of health coverage for individuals in a group.

2. “Plan” does not include individual or the individual’s family:
    a. Insurance contracts;
    b. Subscriber contracts;
    c. Coverage through Health Maintenance (HMO) Organizations;
    d. Coverage under other prepayment, group practice and individual practice plans;
    e. Public medical assistance programs (such as TennCare[SM]);
    f. Group or group-type hospital indemnity benefits of $100 per day or less;
    g. 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.

3. "This Plan" refers to the part of the 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.

4. Primary Plan/Secondary Plan.

   a. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering You.

   b. 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.

   c. 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.

   d. 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.

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

   a. When a Plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense, and a benefit paid.

   b. 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.

6. “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.

B. Order of Benefit Determination Rules

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

1. 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:

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

   b. 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:

      (1) benefits of the Plan of an active Employee covering the person as a dependent;

      (2) Medicare;

      (3) benefits of the Plan covering the person as an Employee, Member, or Subscriber.

2. 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:"

   a. 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

b. 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.

c. 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.

3. 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:

a. First, the Plan of the parent with custody of the child;

b. Then, the Plan of the spouse of the parent with the custody of the child; and

c. Finally, the Plan of the parent not having custody of the child.

d. 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.

e. 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.

4. 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.

5. 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.

a. 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.

b. The start of the new Plan does not include:

(1) A change in the amount of scope of a Plan's benefits;

(2) A change in the entity which pays, provides, or administers the Plan's benefits; or

(3) A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan).

c. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first

became a Member shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

6. 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:

   a. If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

   b. 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.

   c. 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.

   d. If:

      (1) 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

      (2) 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.

C. 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.

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;

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

D. 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.

E. 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.

F. 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.

G. 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 Our consumer advisors at the Member Service number on Your membership ID card if You have any questions.

Grievance Procedure

A. INTRODUCTION

Our grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with the Plan. Such disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact Us at the number listed on Your Member ID card: (1) to ask questions about a Claim; (2) if You have any questions about this EOC or other documents that You receive from Us (e.g. an explanation of benefits); or (3) to initiate a grievance concerning a dispute.

1. This grievance procedure must be exhausted as required by ERISA. However, nothing in this EOC shall prevent You from filing a complaint with the Tennessee Department of Commerce and Insurance, but such complaint is outside of, separate from and in addition to this grievance procedure.
2. The Procedure can only resolve disputes that are subject to Our control.
3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims ("Claims"), that are in the Employee Retirement Income Security Act of 1974 ("ERISA"), Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation").

   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 Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. Providers may be required to hold You harmless for the cost of services in some circumstances.
   b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
   c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
5. You may authorize another person to act on Your behalf concerning a dispute.
6. Any dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Group Agreement and this EOC.

B. DESCRIPTION OF THE REVIEW PROCEDURES

1. **Inquiry**

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

2. **Grievance**

   You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of dispute (Your "grievance"). You must begin the dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that dispute other than filing a legal proceeding in court with appropriate jurisdiction.

   Contact the Customer Care Center 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.

   a. **Grievance Hearing**

      After the Plan has received and reviewed Your grievance, the Plan will review the 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 reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Group Agreement. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Group Agreement is not otherwise governed by ERISA.

   b. **Written Decision**

      The reviewers will consider the information presented, and You will receive a written decision concerning Your grievance within 30 days of Your request for review.

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

      1) A statement of the Plan's understanding of Your grievance;
      2) The basis of the decision; and
      3) Reference to the documentation or information upon which the Plan based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

   c. **Second Level Grievance**

      You may file a written request for reconsideration 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 Evidence of Coverage 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.

Your decision concerning whether to file a second level grievance has no effect on Your rights to any other benefits under this EOC. 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 grievance (e.g. first level committee members) will not be a voting member of the second level grievance committee.

1) Grievance Hearing

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

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

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

b. Information presented during the hearing. Second level grievance committee members and You will be permitted to question each other and any witnesses during the hearing. You may be able to make a closing statement to the committee.

c. If You wish to appoint a personal representative, You must notify Us at least five (5) days in advance, provide the name, address and telephone number of Your personal representative, and provide a personal authorization form.

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.

C. Independent Review of Medical Necessity Determinations or Rescissions

If Your Grievance involves a Medical Necessity, Investigational or Rescission 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 voluntary second level grievance, You may request that the grievance be submitted to a neutral third party, selected by the Plan, to independently review and resolve such grievances. 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 one-hundred and eighty (180) days after the date You receive notice of the committee's decision. Receipt shall be deemed to have occurred no more than two (2) days after

the date of issuance of the committee's decision. Any person involved in making a decision concerning Your grievance 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 this EOC. 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 grievance to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorneys' fees.

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

The reviewer must make a decision within forty (40) calendar days after receipt of the independent review request. The reviewer must then notify Us within two (2) calendar days of its decision. We will then notify You within three (3) calendar days after receiving the reviewer's decision. In the case of a life-threatening condition, the decision must be issued within seventy-two (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 You or Us.

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

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

Definitions

Defined terms are capitalized. When defined words are used in this EOC, they have the meaning set forth in this section. Words that are defined in the Plan's Medical Policies and Procedures have the same meaning if used in this EOC.

1. **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 workday (which would include a scheduled vacation day) only if he or she was Actively at Work on the last regularly scheduled workday. 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.
2. **Annual Benefit Period** – The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.
3. **Benefit Maximum** – The total amount of benefits available for services under this EOC during the Benefit Year, or during the Member's lifetime. (See Attachment C: Schedule of Benefits.)
4. **Billed Charges** – The amount that a Dentist charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the Maximum Allowable Charge for services.
5. **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.
6. **Covered Dependent** – A Subscriber's family members who: (1) meet the eligibility requirements of this EOC; (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable Premium for Coverage.
7. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
8. **Covered Services, Coverage or Covered** – Those necessary and appropriate services and supplies that are set forth in Attachment A of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Group Agreement and this EOC.
9. **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.
10. **Dentist** – A doctor of dentistry, duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed; Dentist is defined to include any dental professional that is duly licensed and qualified to perform Covered Services at the time and place Covered Services are performed.
11. **Effective Date** – The date Your Coverage under this EOC begins.
12. **Employee** – A person who fulfills all eligibility requirements established by the Group and the Plan.
13. **Enrollment Form** – A form or application which must be completed in full by the eligible Employee before he/she will be considered for Coverage under the Plan. Your Group may have You use an electronic form to enroll, rather than a paper form.
14. **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.

15. **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.
    a. 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.
16. **Full-time Student** – A student who is enrolled in and attending an accredited or licensed high school, vocational or technical school, college or university, on a full time basis. The number of hours required for full-time status is dependent on that school's published requirements.
17. **Group Agreement or Agreement** – The arrangements between the Plan and the Group, including this EOC, the Employer Group Application, any riders, any amendments, and any attachments to the Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.
18. **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.
19. **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; and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.
    a. If the child reaches this Plan's Limiting Age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the Limiting Age.
    b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment, and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.
20. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage: (1) within 31 days after such person first became eligible for Coverage under this EOC; or (2) within a subsequent Open Enrollment Period.
21. **Limiting Age or Dependent Child Limiting Age** – The age at which a child will no longer be considered an eligible dependent.
22. **Maximum Allowable Charge** – The amount that the Plan, at its discretion, has determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Network Dentists, that determination will be based upon the Plan's contract with a Network Dentist for Covered Services rendered by that Dentist. For Covered Services provided by Out-of-Network Dentists, the amount payable will be based upon the Plan's fee schedule for the Covered Services rendered by Out-of-Network Dentists.
23. **Member, You, Your** – Any person enrolled as a Subscriber or Covered Dependent, under a Group Agreement.
24. **Necessary Dental Care** – Any treatment or service prescribed by a Dentist that the Plan determines to be necessary and appropriate.
25. **Network Dentist** – A Dentist who has signed a Preferred Dental Agreement with the Plan.
26. **Non-covered Services** – Services that:

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

27. **Out-of-Network Dentist** – A Dentist who has not signed a Preferred Dental Agreement with the Plan.
28. **Premium** – The total payment for Coverage under the Group Agreement, including amounts paid by You and the Group for such Coverage.
29. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received applicable Premium for Coverage from the Group.
30. **Treatment Plan** – A written report by a Dentist showing the recommended treatment of any dental disease, defect or injury for a Member.
31. **Waiting Period** – The time that must pass before a Member is eligible to be Covered for benefits under the Plan or under Coverage C or Coverage D.

Evidence of Coverage
Attachment A: Covered Services and Exclusions

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

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

If more than one procedure or course of treatment:

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

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

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

I. Diagnostic Services

A. Exams

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

B. X-rays

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

2. Exclusions

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

II. Preventive Services

A. Prophylaxis (Cleanings)

1. Covered Services

    a. Three prophylaxis in any 12 month period, except when replaced as described below in Basic Periodontics.

B. Fluoride Treatment

1. Covered Services

    a. One fluoride treatment in any 12 month period for Members age 18 and under.

C. Other Preventive Services

1. Covered Services

    a. One sealant or preventive resin restoration per lifetime on first and second permanent molars for Members age 15 and under.

    b. Space maintainers for Members age 13 and under.

    c. One recementation per space maintainer in any 12 month period.

III. Basic Restorative Services

A. Fillings and Stainless Steel Crowns

1. Covered Services

    a. One amalgam or resin restoration per tooth surface in any 12 month period.

    b. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration.

    c. Stainless steel crowns.

    d. Replacement of stainless steel crowns Covered after 36 months from the date of initial restoration.

    e. One sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per lifetime for Members age 15 and under. Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.

2. Exclusions

    a. Gold foil restorations.

B. Other Basic Restorative Services

1. Covered Services

    a. Palliative (emergency) treatment for the relief of pain.

    b. One repair per denture in any 24 month period.

c. General anesthesia or intravenous (IV) sedation in connection with major oral surgery procedures and implants when provided by a Dentist licensed to administer such agents.

IV. Major Restorative & Prosthodontic Services

A. Single Tooth Restorations

1. Covered Services

   a. Crowns, inlays and onlays only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). Replacement of single tooth restorations or fixed partial dentures (bridges) after 60 months from the date of initial placement.

   b. Veneers for anterior permanent teeth.

2. Exclusions

   a. Provisional restorations and crowns.

   b. Crowns, inlays, onlays or laminate veneers for Members age 11 and under.

B. Multiple Tooth Restorations – Bridges

1. Covered Services

   a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast) for permanent teeth only.

   b. Replacement of fixed partial dentures or single tooth restorations after 60 months from the date of initial placement.

2. Exclusions

   a. Provisional or interim restorations.

   b. Bridges for Members age 15 and under.

C. Removable Prosthodontics (Dentures)

1. Covered Services

   a. Complete, immediate and partial dentures utilizing standard techniques and materials as determined by the Plan.

   b. Personalized restorations, special techniques or materials shall be covered up to the amount allowed for standard techniques and materials.

   c. Replacement of removable dentures after 60 months from the date of initial placement.

2. Exclusions

   a. Interim (temporary) dentures.

   b. Dentures for Members age 15 and under.

D. Other Major Restorative & Prosthodontic Services

1. Covered Services

   a. Core build-up covered separately from restoration only in those circumstances where benefits are provided because severe carious lesions or fractures are so extensive that retention of the restoration would not be possible.

b. Crown inlay, onlay, veneer and bridge repair and re-cementation after 12 months from the date of initial placement.

c. One denture adjustment in any six month period and only after 6 months from the date of initial placement.

d. One denture reline, rebase, or tissue conditioning in any 36 month period.

e. One implant per tooth per lifetime.

f. One bone graft for implant per tooth per lifetime.

g. One implant debridement per tooth per lifetime.

h. Initial placement or replacement of implant supported prosthesis after 60 months from the date of any corresponding major restoration.

2. Exclusions

a. Provisional and interim restorations.

b. Other major restorative services including protective restoration and coping.

c. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.

d. Crown preparation, temporary or prefabricated crowns, impressions and cementation.

e. Post and core services not performed in conjunction with a Covered crown or bridge.

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

A. Basic Endodontics

1. Covered Services

a. Pulpotomy, pulpal therapy for primary teeth but not when performed in conjunction with major endodontic treatment.

2. Exclusions

a. Pulpal debridement.

b. Pulp vitality tests.

c. Protective restorations.

B. Major Endodontics

1. Covered Services

a. One root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, hemisection, pulp cap or root amputation) per tooth in any 60 month period.

b. One apicoectomy per root per lifetime.

c. Retrograde filling if done on same date of service as apicoectomy.

2. Exclusions

a. Guided tissue regeneration.

b. Intentional re-implantation (including necessary splinting).

c. Canal preparation.

d. Incomplete endodontic therapy.

e. Pulp vitality test.

f. Protective restorations.

VI. Periodontics

A. Basic Periodontics

1. Covered Services

a. One periodontal scaling and root planing per quadrant in any 24 month period.

b. One full mouth debridement per lifetime.

c. Periodontal maintenance no sooner than 90 days after completion of any one of the Basic Periodontic Covered Services above. Periodontal maintenance will replace a prophylaxis or scaling.

d. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a prophylaxis or periodontal maintenance procedure.

2. Exclusions

a. Provisional splinting, and antimicrobial medication and dressing changes.

b. Periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.

B. Major Periodontics

1. Covered Services

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

b. One crown lengthening procedure per tooth in any 36 month period.

c. One bone and tissue grafting procedure per site in any 36 month period.

2. Exclusions

a. Tissue regeneration and apically positioned flap procedure.

VII. Oral Surgery

A. Basic Oral Surgery

1. Covered Services

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

B. Major Oral Surgery

1. Covered Services

a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.

2. Exclusions

a. Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures.

b. Orthognathic surgery and treatment for congenital malformations.

c. Harvesting of bone for use in autogenous grafting.

VIII. Orthodontics

A. Orthodontic Services (straightening and alignment of teeth)

1. Covered Services

   a. Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

2. Exclusions

   a. Replacement or repair of any lost, stolen and damaged appliance.

   b. Surgical procedures to aid in orthodontic treatment.

Evidence of Coverage
Attachment B: Other Exclusions

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

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

ATTACHMENT C: SCHEDULE OF BENEFITS

Product Name: Dental Traditional Plan
Group Name: Montgomery County Government
Group Number: 127578 - Option 2
Benefits Effective: September 1, 2024

Deductible Annual Benefit Period Applies to Coverage B and C only	**Individual** $50	**Family** 3 x Individual
Maximums Applies to Coverage B and C	$1,500 per Annual Benefit Period	

Covered Services	Benefit Percentages	Waiting Period
Coverage A Diagnostic and Preventive Services Exams X-rays Preventive	100%	None
Coverage B Basic and Restorative Services Basic Restorative Endodontics Oral Surgery Periodontics	80%	None
Coverage C Major Restorative and Prosthodontic Services Major Restorative Implants	10%	None
Coverage D Orthodontics	Your Plan does not Cover these services.	None
Annual Benefit Period	January 1 - December 31	

Network discounts do not apply to Non-covered Services.

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.

Evidence of Coverage
Attachment D: Eligibility

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

A. Subscriber

To be eligible to enroll as a Subscriber, You must:

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

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 Group Agreement, and be either:

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

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

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

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

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

C. Loss of Eligibility

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

EVIDENCE OF COVERAGE

ATTACHMENT E: PRIVACY PRACTICES

Important Privacy Information

Effective Date 05/01/2021

This notice describes how information we have about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Legal Obligations

The law requires BlueCross BlueShield of Tennessee, Inc. and certain subsidiaries and affiliates ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

The law requires us to keep private all of the information we have about you, including your name, address, claims information and other information that can identify you. The law requires us to follow all the privacy practices in this notice from the date on the cover until we change or replace it.

We have the right to make changes to our privacy practices and this notice at any time, but we will send you a new notice any time we do. Any changes we make to this notice will apply to all information we keep including information created or received before we made changes.

Please review this notice carefully and keep it on file for reference. You may ask us for a copy of this notice at any time. To get one, please contact us at:

Privacy Office
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle Chattanooga, TN 37402
Phone: **(888) 455-3824**
Fax: **(423) 535-1976**
E-mail: privacy_office@bcbst.com

You may reach out to us at this address or phone number to ask questions or make a complaint about this notice or how we've handled your privacy rights. You may also submit a written complaint to the U.S. Department of Health and Human Services (HHS). Just ask us for their address, and we will give it to you.

We support your right to protect the privacy of the information we have about you. We won't retaliate against you if you file a complaint with HHS or us.

Organizations This Notice Covers

This notice applies to BlueCross BlueShield of Tennessee, Inc. We may share our members' information with certain subsidiaries and affiliates of BlueCross BlueShield of Tennessee, Inc. as outlined in this notice. If we buy or create new subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

For additional information, including TTY/TDD users, please call the Privacy Office at **1-888-455-3824**. Para obtener ayuda en español, llame al 1-888-455-3824.

How We May Use and Share Your Information

We typically use your information for treatment, payment or health care operations. Sometimes we are allowed, and sometimes we are required, to use or disclose your information in other ways. This is usually to contribute to the public good, such as public health and research.

Some states may have more stringent laws. When those laws apply to your information, we follow the more stringent law. Specifically, Tennessee law and other state and federal laws require us to obtain your consent for most uses and disclosures of behavioral health information, alcohol and other substance use disorder information, and genetic information.

Ways We May Use and Share Your Information

The following are examples of how we may use or disclose your information in accordance with federal and state laws.

For your treatment: We may use or share your information with health care professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional care for you from other health care providers.

To make payments: We may use or share your information to pay claims for your care or to coordinate benefits covered under your health care coverage. For example, we may share your information with your dental provider to coordinate payment for dental services.

For health care operations: We may use or share your information to run our organization. For example, we may use or share it to measure quality, provide you with care management or wellness programs, and to conduct audit and other oversight activities.

To work with plan sponsors: We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. Please see your plan documents for all ways a plan sponsor may use this information.

For underwriting: We may use or share your health plan information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health plan contract. We're not allowed to use or disclose genetic information for underwriting purposes.

Research: We may use or share your information in connection with lawful research purposes.

In the event of your death: If You die, we may share your health plan information with a coroner, medical examiner, funeral director or organ procurement organization.

To help with public health and safety issues: We can share information about you in certain situations, such as:

- Preventing disease
- Assisting public health authorities in controlling the spread of disease such as during pandemics
- Helping with product recalls
- Reporting negative reactions to medications
- Reporting suspected abuse, neglect or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

As required by law: We may use or share your information as required by state or federal law.

To comply with a court or administrative order: Under certain circumstances, we may share your information in response to a court or administrative order, subpoena, discovery request, or other lawful process.

To address workers' compensation, law enforcement and other government requests: We can use or share information about you:

- For workers' compensation claims
- For law enforcement purposes, or with a law enforcement official
- With health oversight agencies for legal activities
- To comply with requests from the military or other authorized federal officials

With your permission: Some uses and disclosures of information require your written authorization, including certain instances if you want us to share your information with anyone. You may cancel your authorization in writing at any time, but doing so won't affect use or disclosure that happened while your authorization was valid.

For example, we would need your written authorization for:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of your health plan information for marketing
- Sale of your health plan information
- Other uses and disclosures not described in this notice

We will let you know if any of these circumstances arise.

Your Individual Rights

To access records: You have the right to view and get copies of your information that we maintain, with some exceptions. You must make a written request, using a form available from the Privacy Office, to get access to your information.

If you ask for copies of your information, we may charge you a reasonable, cost-based fee for staff time, and postage if you want us to mail the copies to you. If you ask for this information in another format, this charge will reflect the cost of giving you the information in that format. If you prefer, you may request a summary or explanation of your information, which may also result in a fee. For details about fees we may charge, please contact the Privacy Office.

To see who we've disclosed your information to: You have the right to receive a list of most disclosures we (or a business associate on our behalf) made of your information, other than for the purpose of treatment, payment or health care operations, within the past six (6) years. This list will include the date of the disclosure, what information was disclosed, the name of the person or entity it was disclosed to, the reason for the disclosure and some other information.

If you ask for this list of disclosures more than once in a twelve (12) month period, we may charge you based on the cost of responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of these charges.

To ask for restrictions: You have the right to ask for restrictions on how we use or disclose your health plan information. We're not required to agree to these requests except in limited circumstances. If we agree to a restriction, you and we will agree to the restriction in writing. Please contact the Privacy Office for more information.

To get notified of a breach: The law requires us to notify you after the unauthorized acquisition, access, use, or disclosure of your unsecured information that compromises the security or privacy of the information. This notice must include various data points, such as:

- The date of the breach
- The type of data disclosed
- Who accessed, used or disclosed the information without permission
- Who received your information, if known
- What we did or will do to prevent future breaches

To ask for confidential communications: You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your Premiums. If there is an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

To ask for changes to your personal information: You have the right to request in writing that we revise your information. Your request must be in writing and explain why the information should be revised. We may deny your request, for example, if we received (but didn't create) the information you want to amend. If we deny your request, we will write to let you know why. If you disagree with our denial, you may send us a written statement that we will include with your information.

If we grant your request, we will make reasonable efforts to notify people you name about this change. Any future disclosures of that information will be revised.

To request another copy of this notice: You can ask for a paper copy of this notice at any time, even if you got this notice by email or from our website. Please contact the Privacy Office at the address above.

To choose a personal representative: You may choose someone to exercise your rights on your behalf, such as a power of attorney. You may also have a legal guardian exercise your rights. We will work with you if you'd like to make this effective.

GENERAL LEGAL PROVISIONS

The Plan is an Independent Licensee of the Blue Cross Blue Shield Association

You acknowledge this EOC is a contract solely between You and Us. We are an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent BlueCross and BlueShield Plans (the "Association"). The Association permits Us to use the Association's service marks in Our service area. We are not contracting as an agent of the Association. You further acknowledge and agree that:

1. You have not entered into this EOC based upon representation by any person other than Us; and
2. No person, entity or organization other than Us shall be held accountable or liable to You for any of the obligations to You created under this EOC.

   This paragraph shall not create any additional obligations on Our part other than those created under this EOC.

RELATIONSHIP WITH NETWORK PROVIDERS

Network Providers are Independent Contractors and are not employees, agents or representatives of the Plan. Such Providers contract with the Plan, which has agreed to pay them for rendering Covered Services to You. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Plan does not make medical treatment decisions under any circumstances.

The Plan has the discretionary authority to make benefit or eligibility determinations and interpret the terms of Your Coverage to the Plan ("Coverage Decisions"). It makes those Coverage Decisions based on the terms of this EOC, the Group Agreement, its participation agreements with Network Providers and applicable State or Federal laws.

The Plan's participation agreements permit Network Providers to dispute the Plan's Coverage decisions if they disagree with those decisions. If Your Network Provider does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the grievance procedure section of this EOC. The participation agreement requires Network Providers to fully and fairly explain the Plan's Coverage decisions to You, upon request, if You decide to request that the Plan reconsider a Coverage decision.

The Plan or a Network Provider may end their relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients during the term of this Agreement. The Plan does not promise that any specific Network Provider will be available to render services while You are Covered by the Plan.

SUBROGATION AND RIGHT OF RECOVERY

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

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

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tort feasors, other responsible third parties or against available insurance coverages, including underinsured or

uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

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

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

You may continue Your Coverage and Coverage for eligible 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.

GOVERNING LAWS

To the extent not governed by federal law, the laws of the State of Tennessee govern Your benefits.

NONDISCRIMINATION NOTICE

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

BlueCross:

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

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

If You believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, You can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting Your nondiscrimination grievance, contact Our consumer advisors at the Member Service number on the back of Your Member ID card or call 1-(800)

565-9140, or for hearing impaired, TTY 1-(800) 848-0298 or 711. We can provide You with the appropriate form to use in submitting a nondiscrimination grievance. You can file a nondiscrimination grievance in person or by mail, fax or email. Address Your nondiscrimination grievance to:

Nondiscrimination Compliance Coordinator

c/o Manager, Operations, Member Benefits Administration

1 Cameron Hill Circle, Suite 0019

Chattanooga, TN 37402-0019

Fax: 1-(423) 591-9208

Email: Nondiscrimination_OfficeGM@bcbst.com

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

U.S. Department of Health and Human Services

200 Independence Avenue SW, Room 509F, HHH Building

Washington, DC 20201

Phone: 1-(800) 368-1019

TTY: 1-(800) 537-7697

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

1 Cameron Hill Circle
Chattanooga, TN 37402

bcbst.com

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