
PREFERRED DENTAL CARE™

DENTAL EVIDENCE OF COVERAGE

**CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
d/b/a ERLANGER HEALTH SYSTEM**



**BlueCross BlueShield
of Tennessee**

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

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

TABLE OF CONTENTS

INTRODUCTION.....	1
INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION	1
HOW THE DENTAL PROGRAM WORKS	2
PARTICIPATING DENTISTS	2
PAYMENT FOR A NON-PARTICIPATING DENTIST	2
PREDETERMINATION OF BENEFITS	2
ELIGIBILITY	3
ENROLLMENT	3
EFFECTIVE DATE OF COVERAGE	5
TERMINATION OF COVERAGE	5
CONTINUATION OF COVERAGE (COBRA).....	6
GENERAL PROVISIONS	9
WHEN TO APPLY FOR BENEFITS	9
CLAIMS DECISIONS.....	9
SUBROGATION AND RIGHT OF RECOVERY	9
COORDINATION OF BENEFITS	10
APPEAL PROCEDURE.....	15
DEFINITIONS	17
ATTACHMENT A: Covered Services and Limitations on Covered Services	21
COVERAGE A - (Benefits for Preventive Dentistry).....	21
COVERAGE B - (Benefits For Restorative Dentistry)	21
COVERAGE C - (Crown and Prosthetic Care).....	21
COVERAGE D - (Orthodontic Care).....	22
ATTACHMENT B: EXCLUSIONS FROM COVERAGE	24
ATTACHMENT C: SCHEDULE OF BENEFITS	26
ATTACHMENT D: STATEMENT OF ERISA RIGHTS	27

Group Number: 89551

Benefits Effective: July 1, 2000

Benefits for Covered Services received from a Participating Dentist will be paid according to Attachment C, Schedule of Benefits.

Benefits for Covered Services received from a Non-Participating Dentist will be reduced.

Benefits are subject to exclusions, limitations, copayments, and deductible, if any.

INTRODUCTION

This Dental Evidence of Coverage (this “Dental EOC”) is included in the Summary Plan Description document (SPD) created by Your Employer as part of its employee welfare plan (the “Plan,”) and is subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA.) References in this Dental EOC to the “administrator” means BlueCross BlueShield of Tennessee, Inc., or BCBST. Your Employer has entered into an Administrative Services Agreement (ASA) with BCBST for it to administer the claims Payments under the terms of the SPD, and to provide other services. BCBST is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. Your Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator.

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

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

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

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

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

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

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

HOW THE DENTAL PROGRAM WORKS

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

PARTICIPATING DENTISTS

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

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

A listing of Participating Dentists is provided to Your Employer. There will be additions and deletions from time to time. Be sure to ask Your Dentist to confirm any change in his/her participation. You can go to the Dentist of Your choice, regardless of whether he/she is a Participating Dentist. However, greater benefits are usually paid when You use a Participating Dentist.

PAYMENT FOR A NON-PARTICIPATING DENTIST

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

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

PREDETERMINATION OF BENEFITS

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

To obtain a Predetermination of Benefits response, Your Dentist submits a form called the "Attending Dentist's Statement" after Your initial examination and before treatment begins. Your Dentist is then notified what benefits are available, and what payments, if any, You must make.

ACCEPTED BARRIER TECHNIQUES AND PRECAUTIONS TO PROTECT DENTISTS, THEIR STAFF, AND THE PUBLIC FROM CONTRACTING OR SPREADING DISEASE ARE RECOMMENDED; HOWEVER, NEITHER THE PLAN SPONSOR NOR BLUECROSS BLUESHIELD OF TENNESSEE CAN CONFIRM THE HEALTH STATUS OF ANY PARTICIPATING DENTIST.

ELIGIBILITY

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

1. Subscriber

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

- a. Be a full-time employee of the Employer, who is Actively at Work; and
- b. Satisfy all eligibility requirements of the Plan; and
- c. Enroll for Coverage by (a) submitting a completed and signed Enrollment Form to the administrator, or (b) submitting a completed Enrollment Form electronically to the administrator or the Plan.

2. Covered Dependents

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

- a. The Subscriber's current spouse as recognized by the state where the Subscriber lives; or
- b. The unmarried, natural, legally adopted, foster or step-child(ren) of the Subscriber or the Subscriber's spouse who is (a) 24 years old or less, or up to 25 years old if a Full-Time Student; and (b) is dependent upon Subscriber or Subscriber's spouse for at least 50% of his or her support; or
- c. Children placed with the Subscriber or the Subscriber's spouse pending adoption, and children for whom the Subscriber or Subscriber's spouse is court-appointed legal guardian; or

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

ENROLLMENT

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

1. Initial Enrollment Period

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

2. Open Enrollment Period

Eligible employees shall be entitled to apply for Coverage for themselves and eligible family members during their Employer's Open Enrollment Period. The Subscriber must include all requested information, sign and submit an Enrollment Form to the administrator during that Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period may apply for Coverage for themselves and eligible

family dependents within 31 days of becoming eligible for Coverage or during a subsequent Open Enrollment Period.

3. Enrollment of Newly Eligible Family Dependents

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

- a. A legally adopted child, or a child for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction, will be treated as a Covered Dependent from the moment that child is placed in the Subscriber's physical custody, provided:
 - Coverage of the child's medical expenses is not provided by a public or private agency or entity; and
 - The child is enrolled for Coverage within 31 days from the date of such placement. If the Subscriber fails to do so, and an additional Payment is required to cover that child, the Plan will not provide Coverage for that child after 31 days from the child's date of placement. The Plan shall not provide Coverage for any Services or expenses incurred prior to the date the child is physically placed in the Subscriber's custody.
- b. Any other new family dependent, (e.g., if the Subscriber becomes married) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the administrator within 31 days of the date that new family dependent first becomes eligible for Coverage.
- c. An employee or eligible family dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:

- he or she had other dental care coverage at the time Coverage under this Plan was previously offered; and
- he or she stated, in writing, at that time that such other coverage was the reason for declining Coverage under this Plan; and
- such other coverage is exhausted (if the previous coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible or Employer contributions for such coverage ended; and
- he or she applies for Coverage and the administrator receives the change form within 31 days after the loss of the other coverage.

4. Late Enrollment

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

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

5. Notification of Change in Status

Subscribers must submit a Change Form to the Employer of any changes in their status or the status of a Covered Dependent within 31 days from the date of the event causing that change of status. Such events include, but are not limited to: changes in address, marriage, divorce, death, dependency status, or coverage by another Payor. Subscribers should submit all Change Forms to the Employer's Benefits Department.

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

EFFECTIVE DATE OF COVERAGE

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

1. Effective Date of ASA

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

2. Enrollment During an Open Enrollment Period

Coverage shall be effective on the first day of the month following the Open Enrollment Period, unless otherwise agreed to by Employer; or

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

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

4. Newly Eligible Dependents

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

5. Eligibility For Extension of Benefits From a Prior Carrier

If the Plan replaces another group dental plan and You are Totally Disabled and eligible for an extension of Coverage from the prior group dental plan, Coverage shall not become effective until the expiration of that extension of Coverage; or

6. Actively at Work Rule

If an Eligible Employee, other than a retiree, is not Actively at Work on the

date Coverage would otherwise become effective, Coverage for the Employee and all of his/her Covered Dependents will be deferred until the date the Employee is Actively at Work.

TERMINATION OF COVERAGE

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

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

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

2. Loss of Eligibility

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

3. Termination of Your Coverage

The Plan may terminate Your Coverage, if:

- a. You fail to make a required Member payment (The fact that You have made a Payment contribution to the Employer will not prevent the administrator from terminating Your Coverage if the Employer fails to submit the full Payment for Your Coverage to the administrator when due); or

- b. You act in such a disruptive manner as to prevent or adversely affect the ordinary operations of the Plan; or
- c. You fail to cooperate with the Plan as required by this Dental EOC; or
- d. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of Your Membership card.

4. Payment For Services Rendered After Termination of Coverage

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

5. Extended Benefits

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

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

- **Subscribers.** Loss of Coverage because of:
 - The termination of employment except for gross misconduct.
 - A reduction in the number of hours worked by the Subscriber.
- **Covered Dependents.** Loss of Coverage because of:
 - The termination of the Subscriber's Coverage as explained in subsection (a) above.
 - The death of the Subscriber.
 - Divorce or legal separation from the Subscriber.
 - The Subscriber is participating in COBRA, and becomes entitled to Medicare.
 - A Covered Dependent reaches the limiting age or becomes married.

b. Enrolling for COBRA Coverage

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

- The Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or

CONTINUATION OF COVERAGE –

Federal Law

If the ASA remains in effect, but Your Coverage under this Dental EOC would otherwise terminate, the Employer 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 42 U.S.C. 300bb-1 et. seq. (the "COBRA Law.")

a. Eligibility

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

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

c. Payment

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

d.

Coverage Provided

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

e. Duration of Eligibility for COBRA Coverage

COBRA Coverage is available for a maximum of:

- 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
- 36 months for other qualifying events. If, as a Covered Dependent who is eligible for 18 months of COBRA Coverage under subsection a, You have a second qualifying event (e.g., divorce), You may be eligible for 36 months of COBRA Coverage from the date of the first qualifying event. As a limited exception to subsection a, above, if You, as the Subscriber, were disabled, as defined by the COBRA Law, at the time of that qualifying event, and You notify the administrator or the Employer of that fact during the 18 month COBRA Coverage period, You will be eligible for an additional 11 months of COBRA Coverage (i.e., a total of 29 months of Coverage.)

f. Termination of COBRA Coverage

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

- The Payment for such Coverage is not submitted when due; or
- You become Covered by another group dental care plan as either a Subscriber or dependent, and that coverage is as good as or better than the COBRA Coverage for all of Your conditions; or

- The ASA is terminated; or
- You become entitled to Medicare coverage; or
- The date that a disabled Member, who is otherwise eligible for 29 months of COBRA Coverage, is determined to no longer be disabled for purposes of the COBRA Law.

RIGHT TO RECEIVE AND RELEASE INFORMATION

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

GENERAL PROVISIONS

WHEN TO APPLY FOR BENEFITS

You or Your Dentist should file claims as soon as possible after You receive care. If care is received on a continuing basis, Your claims should be submitted at least every 30 days.

All claims must be submitted by the end of the calendar year following the year in which services were performed. If coverage is terminated, claims for services performed before termination must be received by us within one year of the termination date.

Whenever You need to file a claim yourself, we can process it for You more efficiently if You complete a BlueCross claim form. This will ensure that You provide all the information needed. Most providers will have BlueCross claim forms, or You can request them from us by calling Your nearest BlueCross BlueShield of Tennessee office:

Chattanooga, TN 423-755-5917	Jackson, TN 901-664-4100
Nashville, TN 615-386-8500	Middle TN 615-386-8500
Johnson City, TN 423-854-6000	Knoxville, TN 423-588-4600

Mail all claim forms to:

BCBST Claims Service Center
P.O. Box 180150
Chattanooga, TN 37401-7150

CLAIMS DECISIONS

A claims decision is normally made within 45 days after a claim has been filed. If there are special circumstances which require more time to make a decision, You will be sent a notice within that period, explaining why more time is needed. A claims decision will, however, be made no later than 90 days from the date the claim was originally filed.

If You want to appeal the claims decision, follow the Appeal Procedure in this Dental EOC.

SUBROGATION AND RIGHT OF RECOVERY

The Plan is subrogated to and/or has 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 Participating Providers.

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement 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 and right to reimbursement without notice to or consent from those Members.

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

Members are required to promptly notify the administrator if they are involved in an incident that gives rise to such rights for subrogation and recovery, to enable the administrator to protect the Plan's rights under this section. Members are also required to cooperate with the administrator and to execute any documents that the administrator, acting on behalf of the Employer, deems necessary to protect the Plan's rights under this section. If a Member settles any claim or action 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. The Member shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the Member in such circumstances.

COORDINATION OF BENEFITS

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

a. Definitions

The following terms apply to this provision:

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

Each Contract or other arrangement for coverage is a

separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

- "This Plan" refers to the part of the employee welfare benefit plan under which benefits for health care expenses are provided.

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

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

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

When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

When there are two or more Plans, a Member's benefits will not exceed the total charges for any covered service.

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

provides benefits in the form of services.

- The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private Hospital room is Medically Necessary, either in terms of generally accepted medical practice, or as specifically defined in the Plan.
- We will determine only the benefits available under This Plan. You or the Member is responsible for supplying Us with information about Other Plans so We can act on this provision.
- When benefits are reduced under a Primary Plan because a covered person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and Participating Provider arrangements.
- "Claim Determination Period" means a Calendar Year. It does not, however, include any part of a year during which a person has no coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

b. Effect on Benefits

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined after the Other Plan(s).

- Benefits of This Plan will be reduced when the sum of:
 - the benefits that would be payable for the Allowable

Expenses under This Plan, in the absence of this COB provision; and

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

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

- When the benefits of This Plan are reduced as described in subparagraph 2(a) above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.
- We will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:
- the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
 - the order of benefit determination rules require Us to determine benefits before those of the Other Plan.

c. Order of Benefit Determination Rules

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

- Non-Dependent/Dependent

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

except that:

- if the person is also a Medicare beneficiary and,
- if the rule established by the Social Security Act of 1965 as amended makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then
- the order of benefit determination shall be:
 - benefits of the Plan of an active Employee covering the person as a Dependent;
 - Medicare;
 - benefits of the Plan covering the person as an Employee, Member, or Subscriber.
- Dependent Child/Parents Not Separated or Divorced

Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called “parents”:

- The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
- If both parents have the same birthday, the benefits of the Plan that has covered one parent longer are determined before those of the Plan that has covered the other parent for a shorter period of time.

However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

- Dependent Child/Separated or Divorced Parents

If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the Plan of the parent with custody of the child;
- Then, the Plan of the spouse of the parent with the custody of the child; and
- Finally, the Plan of the parent not having custody of the child.
- However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 3(b), Dependent Child/Parents Not Separated or Divorced.
- Active/Inactive Employee

The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as

a laid off or retired Employee. The same would hold true if a person were a Dependent of a person covered as a retiree and an Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

- Continuation Coverage

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

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

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

- Longer/Shorter Length of Coverage

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

- To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.
- The start of the new Plan does not include:
 - A change in the amount or scope of a Plan's benefits;

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

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

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

- Plans with Excess and Other Non-conforming COB Provisions

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

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

- If This Plan is the Primary Plan, it will provide its benefits on a primary basis.
- If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.
- If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will

assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly.

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

APPEAL PROCEDURE

1. INTRODUCTION

This appeal procedure (the "Procedure") is intended to provide a fair, simple and expeditious method of resolving any and all matters causing You to be dissatisfied with any aspect of Your relationship with the administrator or the Plan (a "Dispute.") You should contact Customer Service at the number listed on Your identification card or other documents You receive from the Plan (e.g., a claim denial notice) to discuss any questions or initiate an appeal under this Procedure.

- a. This Procedure is the exclusive method of resolving any Disputes, including any claim, controversy or potential cause of action You may have against the Plan, or the claims administrator. Its procedures are binding on all the parties, and the final decision cannot be appealed to a state or federal court, except for enforcement.
- b. The Procedure shall only apply to resolve Disputes that are subject to the Plan's control.
- c. This Procedure shall not be used to consider matters related to claims of Provider negligence. Participating Providers are independent contractors who are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan to complain about any matter related to the quality or availability of services or any other aspect of Your relationship with Providers, but such matters may not be subject to resolution under this Procedure.
- d. Any Dispute must be initiated not more than 3 years after the date on which the matter forming the basis of that Dispute first arises (e.g., the date You receive notice of a claim denial.) Failure to make an inquiry within that time period will result in Your giving up the right to take any action based on the Dispute.
- e. Either the Plan or You (a "Party") may request an extension of the

response periods (e.g., for responding to an inquiry) or the time periods for taking actions (e.g., scheduling an appeal hearing), if it is not reasonably possible to meet those deadlines. The Party requesting such extension must act in good faith to respond or take the required action as soon as is reasonably possible.

- f. The Parties may agree to skip one or more of the steps of this Procedure if they agree that it will not help to resolve their Dispute.
- g. Any Dispute shall be resolved in accordance with ERISA to the fullest extent permitted by law, even if Your benefit plan is not otherwise subject to ERISA.

2. DESCRIPTION OF THE APPEAL PROCEDURE.

a. Inquiry

You should contact a Customer Service Representative to discuss and attempt to resolve any issues that may lead to a Dispute. If the Representative is unable to immediately respond to that inquiry, he or she will investigate and respond to You within 30 working days.

b. Request for Expedited Reconsideration

Participating Providers may request that the Plan reconsider its denial of Coverage or Authorizations to render services (a "Denial") on an expedited basis, if that Denial can reasonably be expected to prevent You from obtaining urgently needed Covered Services (e.g., because You can not afford to pay for such services.) If the treating Participating Provider fails to request such reconsideration and decides to not provide services that You believe are urgently needed, You (or someone acting on Your behalf) may request that the Plan reconsider the Denial on an expedited basis. If the Plan agrees that it is appropriate to conduct an expedited reconsideration of a Denial, it will conduct such reconsideration and inform You of its decision as quickly

as possible based upon the circumstances of that case, including the Plan's ability to obtain information concerning that case from Participating Providers.

c. Complaints

If You are not satisfied with the response to Your inquiry or request for expedited reconsideration, You may submit a written request that the administrator reconsider its decision within 60 days after receiving a response. The administrator shall inform You of the name, address and phone number of the Customer Services Coordinator who will coordinate the review of Your complaint and assist You in submitting necessary information concerning Your complaint. The coordinator shall not be involved in making the decision concerning the Your inquiry or request for expedited reconsideration.

The administrator's Appeal Committee will consider Your appeal within 10 working days after the Plan receives the written request for such reconsideration and any additional information submitted by or requested from You or others that the Appeal Committee deems to be reasonably necessary to consider the issues raised by that appeal. Individuals involved in making the decision concerning Your inquiry or request for expedited reconsideration will not be eligible to be members of the Appeal Committee.

The Appeal Committee will consider that information and issue a written decision concerning Your complaint within 5 working days after the end of the committee meeting at which Your complaint was considered. That decision will contain a statement of the committee's understanding of Your complaint, the basis of the Appeal Committee's decision and reference to the documentation or information upon which the decision was based. The chairperson of the committee will send You a letter with that decision.

d. Employer/Plan Sponsor Resolution

If You are not satisfied with the Committee's decision, You will need to contact Your Employer/Plan Sponsor for further help in resolving Your complaint. Your Employer/Plan Sponsor will make the final determination concerning Your complaint.

e. Mediation or Arbitration

You can request the dispute be submitted to a neutral third party for resolution if You are not satisfied with the hearing decision. The written request should be submitted to the Plan Administrator within 30 working days after You receive the appeal committee's decision.

The dispute will be submitted to arbitration in accordance with applicable rules of the American Arbitration Association, or a similar organization. The arbitrator will be required to issue a written decision explaining the basis of his or her decision and the manner of calculating any award. The arbitrator may not award punitive or exemplary damages and must base the decision on the terms of Your benefit plan and applicable laws.

The arbitrator's decision will be binding on all the parties. It cannot be appealed to a state or federal court, except to enforce its terms and conditions, or if it is determined to be (1) in violation of law, or (2) arbitrary and capricious.

DEFINITIONS

Actively At Work - An employee is performing all of his or her regular duties for the Employer on a regularly scheduled work day at the location where such duties are normally performed. An employee will be considered to be Actively At Work on a non-scheduled work day only if he or she was Actively At Work on the last regularly scheduled work day.

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

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

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

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

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

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

Dentist - a duly licensed medical professional who is legally entitled to

practice dentistry at the time and place Covered Services are performed.

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

Experimental or Investigational Services - a drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:

- cannot be lawfully marketed without the Approval of the Food and Drug Administration ("FDA") when such Approval has not been granted at that time of its use or proposed use, or
- is the subject of a current Investigational new drug or new device application on file with the FDA, or
- is being provided according to Phase I or Phase II clinical trial or the Experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial,) or
- is being provided according to a written protocol which describes among its objectives, the determining of the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with convention alternatives, or
- is being delivered or should be delivered subject to the Approval and supervision of an Institutional Review Board ("IRB") as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS,") or
- The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is either Experimental or Investigational or that there is insufficient data to determine if it is clinically acceptable, or
- in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
- in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in

order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives, or

- the service or supply is required to treat a complication of an Experimental or Investigational Service.

The Medical Director shall have discretionary authority, in accordance with applicable ERISA standards, to make a determination concerning whether a service or supply is an Experimental or Investigational Service. If the Medical Director does not Authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

- Your medical records, or
- the protocol(s) under which proposed service or supply is to be delivered, or
- any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or
- the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or
- regulations and other official publications issued by the FDA and HHS, or
- the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Experimental or Investigational Services, or
- the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

The Medical Director's decision may be appealed to the Employer, which has final authority on any decision affecting the Plan.

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

Family Deductible - The maximum dollar amount, specified in Attachment C, Schedule

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

Full-time Student - A Dependent who is a student, is enrolled in and attending an accredited or licensed high school, vocational or technical school, college or university. The number of hours required for full-time status is dependent on that school's internal requirements. Ceasing full-time attendance terminates qualification as a Full-time Student, except if cessation is due to:

- school vacation (Full-time Student status will terminate when the school reconvenes if the Dependent does not resume attendance,) or
- disability of the Full-time Student which prevents full-time attendance (Full-time Student status will terminate on the first day of the school's next regular session which follows the date established by a physician's written statement to the Plan or its delegate that the Dependent is capable of full-time attendance, if attendance does not resume at that time.)

Limiting Age (or Dependent Child

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

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

Maximum Lifetime Amount - the total dollar amount of benefits available for Coverage D - Orthodontic Services during the Member's lifetime under the Preferred Dental Care Contract between Employer and

BCBST, as stated in the Schedule of Benefits.

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

Medically Appropriate – services which have been determined by the Medical Director of the administrator to be of value in the care of a specific Member. To be Medically Appropriate a service must:

- be Medically Necessary.
- be used to diagnose or treat a Member’s condition caused by disease, injury or congenital malformation.
- be consistent with current standards of good medical practice for the Member’s medical condition.
- be provided in the most appropriate site and at the most appropriate level of service for the Member’s medical condition.
- on an ongoing basis, have a reasonable probability of:
 - correcting a significant congenital malformation or disfigurement caused by disease or injury.
 - preventing significant malformation or disease.
 - substantially improving a life sustaining bodily function impaired by disease or injury.
- not be provided solely to improve a Member’s condition beyond normal variations in individual development and aging including:
 - comfort measures in the absence of disease or injury.
 - improving physical appearance that is within normal individual variation.
- not be for the sole convenience of the Provider, Member or Member’s family.

Medically Necessary or Medical Necessity

– services which have been determined by the administrator to be of proven value for use in the general population. To be Medically Necessary a service must:

- have final approval from the appropriate government regulatory bodies.
- have scientific evidence permitting conclusions concerning the effect of the service on health outcomes.
- improve the net health outcome.
- be as beneficial as any established alternative.
- demonstrate the improvement outside the investigational setting.
- not be an Experimental or Investigational service.

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT A

COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

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

COVERAGE A - (Benefits for Preventive Dentistry)

- Two routine periodic examinations in any calendar year;
- Set of two bitewing X-rays per 12-month period;
- Full mouth X-rays once in any 36-month period;
- Topical fluoride application for Dependent children under age 19, twice in any calendar year;
- Prophylaxis (adult prophylaxis, for Members age 14 years and older) and periodontal maintenance, not to exceed two such procedures in any calendar year;
- Any combination of exams — initial, periodic, emergency or periodontal — limited to 3 times in a 12-month period.

COVERAGE B - (Benefits For Restorative Dentistry)

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

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

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

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

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

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

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

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

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

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

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

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

- Repair of full and partial dentures;
- Space maintainers for Dependents up to age 19;
- Temporary stainless steel crowns; and

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

- Sealants, only for occlusal (biting) surface of first and second permanent molar teeth on Dependents up to age 16.

Only one sealant benefit will be allowed on each tooth every two years.

COVERAGE C - (Crown and Prosthetic Care)

- Full and partial dentures;

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

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

ATTACHMENT A

COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

- Bridges and bridge repair 12 months after initial placement;

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

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

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

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

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

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

- Cast onlays for treatment of severe carious lesions and severe fracture when the tooth cannot be restored with

amalgam, synthetic porcelain or plastic restorations;

- Laminate veneers for severe carious lesions and severely fractured teeth; and
- Relining and rebasing of full and partial dentures (up to one in any three-year period.)

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

COVERAGE D - (Orthodontic Care)

- Straightening and alignment of teeth for Dependents under the age limit as stated in the Schedule of Benefits, if prescribed by a treatment plan approved by us.

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

- The need for orthodontic services must be diagnosed and Treatment Plan submitted to the administrator. The diagnosis must indicate that the orthodontic condition consists of handicapping malocclusion which is both abnormal and correctable.
- The Plan reserves the right to review the Member's dental records, including necessary x-rays, photographs, and models, to determine whether orthodontic needs and treatment are covered.
- For the purpose of determining benefits when a Member's coverage under the ASA is terminated or canceled, all orthodontic services shall be deemed to have been rendered on the date performed. Benefits will cease when the Member's coverage terminates, even if an approved orthodontic treatment

ATTACHMENT A

COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

treatment has not been completed.

- For orthodontic services rendered by a Dentist, benefits will be provided as specified in Attachment C, Schedule of Benefits (billed charges or MAC, whichever is less.)
- The maximum amount of benefits for orthodontic services on behalf of a Member will be stated in Attachment C, Schedule of Benefits.
- After completion of orthodontic services as set forth in the Treatment Plan, additional benefits will be provided for orthodontic services (if previous benefits have not exceeded the Lifetime Maximum.)
- Benefits will not be provided for expenses in connection with the replacement and/or repair of any appliance furnished under the Treatment Plan.
- Orthodontic benefits will not be provided for surgical procedures.

ATTACHMENT B

EXCLUSIONS FROM COVERAGE

GENERAL EXCLUSIONS

Your Coverage does not provide benefits for:

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
2. Dental services for which You are not required or legally obligated to pay.
3. Any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements.)
4. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.

This does not exclude those services provided under Orthodontic benefits (if applicable.)
5. Services or supplies furnished without cost under the laws of any government except Medicaid or TennCare coverage provided by the State of Tennessee.
6. Diagnosis for, or fabrication of appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
7. Replacement of tooth structure lost from wear or attrition.
8. Services rendered by a Dentist beyond the scope of his or her license.
9. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no coverage existed hereunder.
10. Dental care or treatment not specifically listed in the Schedule of Benefits.
11. Dental services covered by any basic group insurance coverage for which any Employer pays any portion of the cost or makes payroll deduction or for which a group collector remits premiums, or expenses covered by any other contract or certificate issued by BlueCross BlueShield of Tennessee or another BlueCross and BlueShield Plan.
12. Dental services resulting from loss or theft of a denture, crown, or bridge.
13. Provisional splinting, or double (multiple) abutments for fixed bridges.
14. Courses of treatment undertaken before You become covered under this program.
15. Services of anesthetists or anesthesiologists, or general anesthesia or intravenous sedation for restorative dentistry.
16. Any services performed after You cease to be eligible for Coverage.
17. Services rendered for oral hygiene, dietary instructions, or for prescribed drugs or other medications.
18. Treatment for desensitizing teeth.
19. Services or supplies which are not Medically Necessary.
20. A drug, device, medical or dental treatment or procedure which is an Experimental or Investigational Service.
21. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
22. Implants (or any synthetic material implanted into or on bone or gums) or their removal.

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

ATTACHMENT B
EXCLUSIONS FROM COVERAGE

26. Any court-ordered treatment of a Member unless benefits are otherwise payable.
27. Crowns and prosthetics including bridges, full and partial dentures, and relining and duplication of full and partial dentures (except as specified in Attachment C, Schedule of Benefits); and/or Orthodontics (except as specified in Attachment C, Schedule of Benefits.)

**CARE RENDERED BY MORE
THAN ONE DENTIST**

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

**ALTERNATE COURSE OF
TREATMENT**

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

ATTACHMENT C
SCHEDULE OF BENEFITS

Group Name: Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System

Group Number: 89551

Benefits Effective: July 1, 2000

Deductible applies to Coverages B and C only	<u>Individual</u> \$25	<u>Family</u> 3 Deductibles
---	----------------------------------	---------------------------------------

Covered Services	Benefit Percentages
Diagnostic and Preventive Services (Coverage A)	100%
Restorative Services (Coverage B)	90%
Prosthetic and Complex Restorative Services (Coverage C)	70%
Orthodontic Services for Dependents under age 24, or to age 25 if a full-time student (Coverage D)	50%

Maximums	
Coverages A, B and C	\$1,000 per Calendar Year
Coverage D	\$1,500 Lifetime

ATTACHMENT D
STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a member of the group under this Plan, to:

1. Examine, without charge, at the office of the plan administrator (plan sponsor, usually Your Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator (plan sponsor, i.e., Your Employer.) The administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan's annual financial report. The plan administrator (plan sponsor, usually Your Employer) is required by law to furnish each participant with a copy of this summary annual report.

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

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

For instance, if You request materials from the plan and do not receive them within 30 days, You may file suit in a

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

The court will decide who should pay court costs and legal fees. It may order You to pay these expenses, for example, if it finds Your claim is frivolous. If You have any questions about Your plan, You should contact the plan administrator (plan sponsor, i.e., Your Employer.) If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the U. S. Labor Management Services Administration, Department of Labor.

Use this space for information You'll need when asking about Your coverage.

The company office or person to contact about coverage is:

Name:

Address:

Phone:

The BlueCross BlueShield Plan to contact is:

Address: BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
Chattanooga, TN 37402-2555

The Subscriber Number shown on my identification card is:

The "Effective Date" when my coverage begins is:



801 Pine Street
Chattanooga, Tennessee
37402-2555

www.bcbst.com

BENEFIT QUESTIONS?

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

Revised 12/00
B/ASODEN.1200
Printed 08/01

*An Independent Licensee of the BlueCross BlueShield Association
© Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans