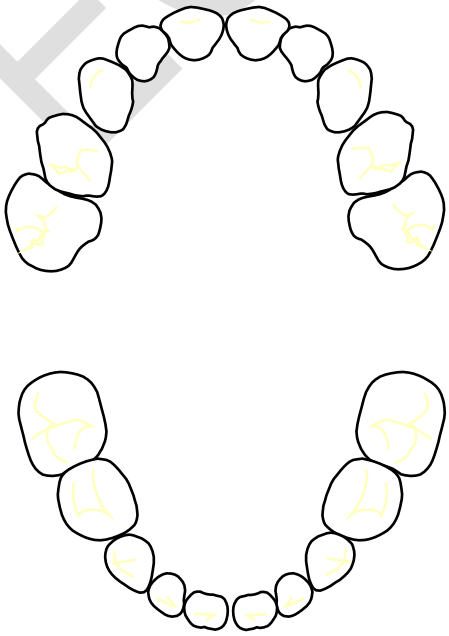
of Tennessee

bcbst.com

1 Cameron Hill Circle
Chattanooga, TN 37402

PERSONAL DENTAL COVERAGE

POLICY



BLUECROSS BLUESHIELD OF TENNESSEE, INC.

PERSONAL DENTAL COVERAGE

POLICY No.

NOTICE

PLEASE READ THIS POLICY CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR COVERAGE FROM BLUECROSS BLUESHIELD OF TENNESSEE, INC. IF YOU HAVE ANY QUESTIONS ABOUT THIS POLICY, PLEASE WRITE OR CALL US AT:

CUSTOMER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
1 Cameron Hill Circle
CHATTANOOGA, TN 37402-2555
(800) 565-9140

You may return this Policy within ten days after its delivery and receive a Premium refund if, after examination, you are not satisfied with it. Any benefits paid will be deducted from the Premium refund.

Henry Smith
Sr. Vice President, Operations and Chief Marketing Officer

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, ການບໍ່ ເສັຍຄ່າ ພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE OF CONTENTS

INTRODUCTION

This Policy describes the terms and conditions of Your Coverage. "We," "Us" and "Our" mean BlueCross BlueShield of Tennessee, Inc. “Member” means a Subscriber or a Covered Dependent. “Subscriber” means the individual to whom We have issued this Policy. “You” and “Your” mean a Subscriber. “Coverage” means the insurance benefits You are entitled to under this Policy.

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

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

To make it easier to read and understand this Policy, defined words are Capitalized. Those words are defined in the “DEFINITIONS” section of this Policy.

If You have any questions when reading this Policy, please contact one of Our customer service representatives, at the number listed on the dental ID card.

RIGHT TO RECEIVE AND RELEASE INFORMATION

You authorize and consent to Our receipt, use and release of personal information for Yourself and all Covered Dependents. This consent includes any and all dental records, obtained, used or released in connection with administration of the Policy, subject to applicable laws. Such consent is deemed given by Your signature on the Application. Additional consent may be required whenever You or Your Covered Dependents obtain Covered Services under this Policy. This authorization and consent remains in effect throughout the period You and Your Dependents are Covered under this Policy. This consent survives the termination of the Coverage to the extent that such information or records relate to services rendered while You and Your Dependents were insured under the Policy.

You may also be required to consent to the release of personally identifiable health information in connection with the administration of the Policy.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

You acknowledge this Policy is a contract solely between You and BCBST. BCBST is an independent corporation operating under a license from the BlueCross BlueShield Association, an association of independent BlueCross and BlueShield Plans, (the “Association”). The Association permits BCBST to use the Association’s Service Marks in Our service area. BCBST is not contracting as the agent of the Association. You further acknowledge and agree that:

1. You have not entered into this Policy based upon representations by any person other than BCBST; and

2. no person, entity, or organization other than BCBST shall be held accountable or liable to You for any of the obligations to You created under this Policy.

This paragraph shall not create any additional obligations on the part of BCBST other than those created under this Policy.

ELIGIBILITY

If You are eligible for Coverage, You can enroll under this Policy. If there is a question about eligibility, We will make the final decision.

A. Subscriber

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

1. Be enrolled as a Subscriber under Our Personal Health Coverage;
2. Be a resident of Tennessee, not residing outside the United States of America for more than 6 months out of the year, and not covered under any other individual or group dental policy or plan of benefits;
3. Maintain a student visa, work visa and/or a valid green card (if not a citizen of the United States of America);
4. Complete an Application for You and any dependent You want to cover; and
5. Submit the completed and signed Application to Us.

B. Dependents

You can apply for Coverage for Your dependents, at the same time You apply. Your dependents must be listed on Your Application, and be:

a. Your current spouse, as recognized under Tennessee law; or

b. Your or Your spouse's children. Children must be: (1) natural; (2) legally adopted (including children placed with You for the purposes of adoption); (3) step-child(ren); or (4) children for whom You or Your spouse are legal guardians or for whom you have a Qualified Medical Child Support Order. The child(ren) must also be 25 years old or less.

ENROLLMENT

Once You submit an Application, We will determine if You are eligible. We may tell You that some of Your dependents are not eligible to be Covered Dependents under Your Policy.

If You are eligible, You may apply to enroll for Individual Coverage. You must pay the required Premium when You enroll. If You want Family Coverage, You must apply to enroll all Your Eligible Dependents. You are not eligible to re-enroll, if We previously terminated Your Coverage for any reason other than non-payment of Premium.

A. Adding Dependents

After You are Covered, You may apply to add a dependent, who became eligible after You enrolled, as follows:

1. A newborn child is Covered from the moment of birth. A legally adopted child, or a child for whom You or Your spouse has been appointed legal guardian by a court of competent jurisdiction, will be Covered from the moment the child is placed in Your physical custody. You must enroll the child within thirty-one (31) days from when You acquire the child.

   If You fail to enroll the child, and an additional Premium is required to cover the child, Your Policy will not cover the child after thirty-one (31) days from when You acquire the child. If no additional Premium is required to provide Coverage to the child, Your failure to enroll the child does not make the child ineligible for Coverage. However, We cannot add Your child to Your Policy's Coverage, until notified of the child's birth. If the legally adopted (or placed) child has Coverage of his/her medical expenses from a public or private agency or entity, You may not add them to Your Policy until that Coverage ends.

2. Any other new family dependent, (e.g., if You marry) may be added as a Covered Dependent. You must complete and submit a signed Application to Us within 31 days of the date that person first becomes eligible for Coverage. We will determine if that person is eligible for Coverage.

B. Notification of Change in Status

You must submit a Change Form to Us if any changes occur in Your status, or the status of a Covered Dependent, within 31 days from the date of the event causing that change. Such events include, but are not limited to: (1) marriage; (2) divorce; (3) death; (4) dependency status; (5) enrollment in Medicare; or (6) coverage by another Payor. These are also called "Qualifying Events."

EFFECTIVE DATE OF COVERAGE

If You are eligible, have applied, and have paid the Premium, We will notify You of Your Effective Date.

Adding 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 within 31 days of the Qualifying Event, and We receive any Premium required for Coverage.

PREMIUMS

You must pay the Premiums due for Your Policy to Us, in full on or before the due date. Payment must be received in Our office in Chattanooga, Tennessee.

A. Premium Due Date

The Premium due date is stated on Your Policy face page. The term of Your Policy is the same as Your Premium payment period.

For example, if You pay Your Premiums monthly, Your Policy term is for one month. If You pay Your Premium quarterly, Your Policy term is for one quarter. Your Policy automatically renews for Your Policy Term when You pay Your Premium.

B. Our Right to Change Premium

We have the right to change Your Premium, or rate basis, on:

1. Any Premium due date. We must notify You at least 30 days before We make the change; or
2. Any date the terms of the Policy are changed.

C. Other Premium Changes

Your Premium may change automatically in the following circumstances, on the next date Your Premium is due:

1. If (a) Your benefits increase or decrease; or (b) You add or delete Covered Dependents, or their Coverage increases or decreases.
2. As Your Covered Dependents age, Your Premium rate can change at certain ages.

D. Returned Check Fee

You will be charged a fee for any check or draft not honored by Your financial institution.

TERMINATION OF COVERAGE

A. Termination of Policy

Your Policy is renewable, until the first of the following occurs:

1. We do not receive the required Premium for Your Coverage when it is due; or
2. You request to terminate the policy and give Us advance written notice. Unless requested otherwise, termination will take place the first day of the month following Our receipt of such notice; or
3. You fail to cooperate with Us as required by this Policy; or
4. You move outside of Tennessee; or
5. You have made a material misrepresentation or committed fraud against Us. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of Your dental ID card; or
6. We decide to terminate the type of Coverage You have, for all persons within a specified class; or
7. We cease to offer this Coverage in the individual market.

B. Termination of Covered Dependent Coverage

Your Covered Dependent's Coverage will automatically terminate on the earliest of the following dates:

1. The date that Your Coverage terminates; or
2. The last day of the month for which You paid Your Covered Dependent's Premium; or
3. The date a Covered Dependent is no longer eligible, (e.g., the day the Covered Dependent turns 26); or
4. The date a Covered Dependent enters active duty with the armed forces of any country.

C. Exceptions to Covered Dependent Termination of Coverage

Coverage for a mentally retarded or physically handicapped Covered Dependent will not stop due to age, if he or she is incapable of self-support and mainly dependent upon You at that time. Coverage will continue as long as:

1. You continue to pay the required Premium for the Covered Dependent's Coverage; and
2. Your own Coverage under the Policy remains in effect; and
3. You provide Us with required proof of the Covered Dependent's incapacity and dependency. Initial proof of the Covered Dependent's incapacity and dependency must be furnished to Us within 31 days of the Covered Dependent's mental retardation or physical handicap. We may require this proof again, but not more than once a year.

D. Grace Period

You have a 31-day Grace Period in which to pay your Premium. A Grace Period is a specific time after Your Premium is due, during which You can pay Your Premium, without a lapse in Coverage.

If You pay the Premium during the Grace Period, Your Coverage will continue and claims for Covered Services incurred during the Grace Period will be honored.

If You do not pay the Premium due, in full, during the Grace Period, Your Coverage will terminate retroactive to the Premium due date. We may suspend payments to Providers rendering services to You during the Grace Period. You will be liable for Providers' charges for services rendered during the Grace Period.

E. Payment For Services Rendered After Termination of Coverage

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

F. Reinstatement

If Your Policy terminates, You may request that We reinstate Your Policy. Your request must be in writing. To reinstate, You must request reinstatement within 60 days of the last day for which Your Policy was paid. We will notify You within 45 days of Your request if we will reinstate. If Your policy is reinstated, You will not have a gap in Coverage. You will be charged a reinstatement fee. You must pay the reinstatement fee and required Premium for the entire period Your Coverage had lapsed.

If you request reinstatement after 60 days from the last day for which Your Policy was paid, We will require a new Application. We will notify You within 45 days of Your Application if We will issue a new Policy. You will have a gap in Coverage and a new Effective Date.

G. Right To Request A Hearing

You may request that We conduct a Grievance Hearing to appeal the termination of Your Coverage for cause, as explained in the "Grievance Procedure" section of this Policy. The fact that You have requested a hearing does not postpone or prevent Us 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 Us for consideration, in accordance with the "Claims Procedure" section of this Policy.

CLAIMS AND PAYMENT

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

A. Claims

There are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

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

B. Claims Billing

1. You or Your Covered Dependents may be charged or billed by a Provider for Covered Services rendered by that Provider. You or Your Covered Dependents are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You or Your Covered Dependents are also responsible for complying with any of Our policies or procedures (including, obtaining Prior Authorization of such Services, when necessary.)
   a. The Provider, You or Your Covered Dependents must submit a claim to Us to be reimbursed.
   b. To be reimbursed, the claim must be submitted within 1 year and 90 days from the date a Covered Service was received. If the claim is not submitted within the 1 year and 90 day time period, it will not be paid.
   c. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced.
2. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. Proof of payment acceptable to Us must be submitted with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
3. A Provider may refuse to render, or reduce or terminate a service that has been rendered; or require You or Your Covered Dependents 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) to determine whether the Policy will cover that service.

b. You may request a claim form from Our customer service department. We will send a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

C. Payment

1. If You or Your Covered Dependents received Covered Services, You or the Provider must submit, in a timely manner, a completed claim form for Covered Services. We will reimburse You or pay the Provider according to the Maximum Allowable Charges in Attachment C. Our payment fully discharges Our obligation related to that claim.
2. If this Policy is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to Us within 1 year and 90 days from the date the Covered Services were received.
3. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry practices, and based on Our information at the time We receive the claim form. We are not responsible for over or under payment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted. Payment for Covered Services is more fully described in Attachment C.

D. Assignment

If You assign payment for a claim to a Provider, We must honor that assignment. If You have paid the Provider, and also assigned payment for the claim to the Provider, We must still pay that Provider.

E. Complete Information

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

Mail all claim forms to: the address on Your dental ID card.

SUBROGATION OR RIGHT OF RECOVERY

You agree that We shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You and Your Covered Dependents for dental illnesses or injuries caused by third parties, including the right to recover the reasonable value of services rendered by Providers.

We shall have first lien against any payment, judgment or settlement of any kind that You receive from or on behalf of such third parties for dental expenses, for the costs of Covered Services and any costs of recovering such amounts from those third parties. We may notify those parties of its lien without notice to or consent from You.

Without limitation, We may enforce Our rights of subrogation and recovery against 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.

To enable Us to protect Our rights under this section, You are required to notify Us promptly if a dental illness or injury is caused by a third party. You are also required to cooperate with Us and to execute any documents that We deem necessary to protect Our rights under this section. If You settle any claim or action against any third party, You shall be deemed to have been made whole by the settlement, and We shall be entitled to immediately collect the present value of Our rights as a first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by You for Our benefit. We shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You in such circumstances.

GRIEVANCE PROCEDURE

I. INTRODUCTION

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

1. The Procedure can only resolve Disputes that are subject to Our control.
2. 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 Us; however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
3. 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. In addition, an Adverse Benefit Determination includes any recision of Coverage or a denial of Coverage in an initial eligibility determination.
    a. If a Provider does not render, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to Us to obtain a determination concerning whether the Policy will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to Us to obtain a determination about whether it is Covered by the Policy. 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 Our Provider dispute resolution procedure.
    c. Our 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 We have rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
4. You may request a form from Us to authorize another person to act on Your behalf concerning a Dispute.
5. You and We may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.
6. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, and this Policy.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

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

B. Grievance

You must submit a written request asking Us 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 or from the date of the event that is otherwise causing You to be dissatisfied with Us. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute.

Contact the customer service department at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

1. Grievance Hearing

After We have received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, We will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Policy.

2. Written Decision

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

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

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

c) For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

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

a. A statement of the committee's understanding of Your Grievance;

b. The basis of the committee's decision; and

c. Reference to the documentation or information upon which the committee based its decision. We will send You a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance Procedure

You may file a written request for reconsideration within ninety (90) days after We issue the first level Grievance committee's decision. This is called a second level Grievance.

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Policy. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

1. Second Level 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 will also be permitted to make a closing statement to the committee at the end of the hearing.

2. Second Level Written Decision

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

a) A statement of the second level committee's understanding of Your Grievance;

b) The basis of the second level committee's decision; and

c) Reference to the documentation or information upon which the second level committee based its decision. Upon written request, We will send You a copy of any such documentation or information, without charge.

D. Independent Review of Medical Necessity Determinations or Coverage Recissions

If Your Grievance involves a Medical Necessity or a Coverage rescission determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance

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

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Policy

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

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

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

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of the Policy; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of the Policy. If You chose to pursue Independent Review following the first level grievance process, Your grievance rights would be exhausted following the Independent Review.

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.

GENERAL PROVISIONS

A. Entire Policy: Changes

The Entire Policy consists of: (1) this Policy; (2) Your Application; (3) any Riders; (4) the Attachments; and (5) any other attached papers. The terms of this Policy can be changed only if: (1) We agree in writing; and (2) one of Our authorized officers agrees to the change.

No agent or employee may change this Policy, or waive any of its provisions.

We may change the terms of the Policy when Your Policy renews. We will notify You in writing at least 30 days before the effective date of any change. Your continued payment of Premiums indicates acceptance of a change. Any notice of change will be mailed to You at the address shown in Our records.

B. Applicable Law

The laws of Tennessee govern this Policy.

C. Notices

All notices required by this Policy must be in writing. Notices to Us should be addressed to:

BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402-2555

We will send notices to You at the most recent address in Our files.

You are responsible for notifying Us of Your and Your Covered Dependents' address changes.

D. Conflicts with State Laws

If any provision of the Policy conflicts with any state law governing insurance, that provision will be administered as required by the law.

E. Legal Action

You cannot bring legal action under this policy until 60 days after proof of loss has been furnished. You cannot bring legal action after 3 years after the time proof of loss is required.

F. Right to Request Information

We have the right to request any additional necessary information or records with respect to any Member Covered or claiming benefits under the Policy.

G. Coordination of Benefits

This is an Individual Policy; it does not coordinate with other insurance coverage. If You or Your Covered Dependents have group dental Coverage, this Policy will always pay secondary to a Group Plan.

H. Administrative Errors

If an error is made in administering the benefits under this Policy, We may provide additional benefits or recover any overpayments from any person, insurance company, or plan. Any recovery must begin by the end of the calendar year following the year in which the claim was paid. This time limit does not apply if the Member did not provide complete information or if material misstatements or fraud have occurred.

No such error may be used to demand more benefits than those otherwise due under this Policy.

I. Overinsurance Termination Provision

We have the right to request information, in advance of premium payment, about whether or not You are eligible for benefits under another group or individual contract, including:

- Another dental expense insurance policy;
- Any BlueCross and BlueShield Plan; or
- Any dental practice or other prepayment plan.

We also have the right to terminate this Policy if You fail to give correct information about other coverage.

Nondiscrimination Notice

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

BlueCross:

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

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

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance (“Nondiscrimination Grievance”). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-

800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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

DEFINITIONS

Defined terms are Capitalized. When such defined words are used in this Policy, they will have the meaning set forth in this section.

1. **ADA Code** – The American Dental Association Code assigned to a particular dental procedure.

2. **Application** – A form that must be completed in full before You or Your dependents will be considered for Coverage under the Policy.

3. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that We determine to be the Maximum Allowable Charge for services.

4. **Calendar Year** – The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on the following December 31st.

5. **Calendar Year Maximum** – The maximum amount payable for all Covered Services in any calendar year. This will apply to each Member under this Policy.

6. **Covered Dependent** – A Subscriber's family member who: (1) meets the eligibility requirements of this Policy; (2) has been enrolled for Coverage; and for whom We have received the applicable Premium for Coverage.

7. **Covered Services, Coverage or Covered** – Those services and procedures performed by a duly licensed practitioner, deemed Necessary Dental Care and listed as a Covered Service. Covered Services are subject to all the terms, conditions, exclusions and limitations of this Policy.

8. **Deductible** – The dollar amount, specified in Attachment C, that the Member must incur and pay for Covered Services during a Calendar Year before We provide benefits for services. Any balance of charges (between Billed Charges and the Maximum Allowable Charge) is not considered when determining if You have satisfied a Deductible.

9. **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.

10. **Family Coverage** – Coverage for the Subscriber and one or more Covered Dependents.

11. **Family Deductible** – The maximum dollar amount, specified in Attachment C, that a Subscriber and Covered Dependents must incur and pay for Covered Services during a Calendar Year before We provide benefits for such Services. Once the Family Deductible amount has been satisfied by 3 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. Any balance of charges (between Billed Charges and the Maximum Allowable Charge) will not be considered when determining if the Family Deductible has been satisfied. "Covered Family Members" means a Subscriber and his or her Covered Dependents.

12. **Individual Coverage** – Coverage just for the Subscriber. It does not include any Dependents.

13. **Lifetime Maximum** – The maximum amount of benefits for Covered Services rendered to the Member during the Member's lifetime while Covered under this Policy.

14. **Maximum Allowable Charge** –– The amount that We, at Our sole discretion, have determined to be the maximum amount payable for a Covered Service. That determination will be based upon the amount payable based on Our fee schedule for Covered Services.

15. **Member** – Any person enrolled as a Subscriber or Covered Dependent under this Policy.

16. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C, including Deductibles and amounts over the Maximum Allowable Charge.

17. **Necessary Dental Care** – Any treatment or service prescribed by a dental Practitioner that We determine to be necessary and appropriate.

18. **Payor(s)** – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for the Member's dental care benefits.

19. **Practitioner** – A Dentist acting within the scope of his or her license or a physician performing dental services within the scope or his or her license. Also including a person licensed by the State to provide dental services, including but not limited to a licensed dental hygienist acting under the supervision and direction of a licensed Dentist.

20. **Premium** – The total payment for Coverage under the Policy.

21. **Prior Authorization** – A review conducted by Us, prior to the delivery of certain services, to determine if such services will be considered Covered Services.

22. **Probationary Period** – The amount of time a Member must be continuously covered under this Policy before eligible for certain benefits. The Probationary Period for each class of benefits is shown in Attachment C.

23. **Provider** – A person or entity that is engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable State or Federal laws.

24. **Rider** – An attachment or endorsement to this Policy providing limited benefits under this Policy. A rider shall be in effect throughout the term of the Policy, unless otherwise specified.

25. **Subscriber, You, Your** – An individual who meets all applicable eligibility requirements, has applied for Coverage, for whom We have received the applicable Premium for Coverage and to whom we have issued the Policy.

ATTACHMENT A:
COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

We pay the Maximum Allowable Charge for Covered dental services rendered to You and Your Covered Dependents. Expenses for the services must be incurred while the Policy is in force and the Member Covered by the Policy.

I. ELIGIBLE EXPENSES

A. Practitioners

The services provided by a Practitioner must be within his or her specialty or degree. To be an eligible expense the service must be performed by a Practitioner.

B. Expenses Incurred

An eligible expense is considered incurred on the following dates:

1. For full and partial dentures – on the date of delivery.
2. For fixed bridges, crowns, inlays and onlays – on the date the teeth are seated.
3. For root canal therapy – on the date the pulp chamber is opened.
4. For periodontal surgery – on the date the surgery is performed.
5. For all other services – on the date the service is performed.

II. ELIGIBLE SERVICES:

A. Covered Services

Personal Dental Coverage provides a wide range of benefits to cover most services associated with dental care. **Only the services listed in Attachment C will be Covered.** Services include:

1. Diagnostic and preventive services;
2. Restorative services;
3. Major restorative services;
4. Endodontic services;
5. Periodontic services;
6. Removable prosthetic services;
7. Fixed prosthetic services;
8. Oral surgical services; and

Listed miscellaneous services.

Orthodontics are not Covered under this Policy.

B. Limitations on Services

1. **Limitation on Diagnostic and Preventive Benefits**: A Member will be eligible for diagnostic and preventive services subject to the following limitations:

   Exams – limited to 2 in a 12 month period.

   X-rays, intraoral (complete series) – limited to 1 in a 36 month period.

   X-rays, bitewings – limited to 4 films in a 12 month period.

   X-Ray, panoramic – limited to 1 in a 36 month period.

   Prophylaxis (cleaning) – limited to 2 in a 12 month period.

   Fluoride treatment – limited to 1 in a 12 month period for Members up to age 18.

   Sealants – limited to 1st and 2nd permanent molars for Members up to age 19.

   Periodontal maintenance – limited to 2 in a 12 month period and only when following active therapy.

2. **Limitation on Prosthetic Benefits:** A Member will be eligible for the replacement of a prosthetic appliance (including but not limited to onlays, crowns, jackets, partials, dentures and bridges) only after the probationary period shown in Attachment C and 5 years have elapsed since the existing appliance was supplied. Services necessary to make an appliance satisfactory will be provided in accordance with the terms of the policy.
3. **Limitation on Crowns and Cast Restorations:** A crown or cast restoration is a Covered Service only when required for restorative reasons (decay or fracture) and only when the tooth cannot be restored with amalgam, silicate or composite filling. A Member will be eligible for the replacement of a crown only after the probationary period shown in Attachment C and 5 years have elapsed since the prior installation.
4. **Limitation on Partial Dentures and Bridges:** Personalized restorations or specialized techniques will be paid at the level payable for standard procedures and materials. A Member will be eligible for the replacement of a partial denture or bridge only after the probationary period shown in Attachment C and 5 years have elapsed since the prior installation.
5. **Limitation on Mouth Rehabilitation:** In a course of mouth rehabilitation, We will make payment on those procedures necessary for eliminating oral disease and replacing missing teeth. Any balance of treatment costs, including costs related to appliances or restorations intended to increase vertical dimension or restore the occlusion will remain the Member's responsibility.
6. **Limitation on Optional Treatment Plans:** When more than one 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 Member's condition, We reserve the right to provide payment for the least expensive Covered Service alternative. Any balance of treatment costs will remain the Member's responsibility.

ATTACHMENT B:
EXCLUSIONS FROM COVERAGE

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

1. Any procedure not listed in the Schedule of Benefits under Attachment C.
2. Services or supplies that are determined to be not Necessary Dental Care or have not been authorized by Us.
3. Any portion of a charge for any service in excess of the Maximum Allowable Charge.
4. Overdentures and associated procedures.
5. Cosmetic procedures.
6. The replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
7. Dental implants.
8. Replacement of lost or stolen appliances or orthodontic retainers.
9. Athletic mouth guards.
10. Precision or semi-precision attachments.
11. Denture duplication.
12. Oral hygiene instructions.
13. Plaque control.
14. Completion of a claim form.
15. Broken appointments.
16. Prescription or take home fluoride.
17. Diagnostic photographs.
18. Services not completed by the end of the month in which Coverage terminates.
19. Procedures that are begun, but not completed.
20. Services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge.
21. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
22. Care or treatment of a condition for which the Member is entitled to or eligible for benefits under any Worker's Compensation Act or similar law.
23. Amounts applied toward the satisfaction of a Deductible, if any.

24. Services or supplies that are experimental or investigational in nature including, but not limited to: (1) drugs, (2) biologicals; (3) medications; (4) devices; and (5) treatments.
25. Services required because of illness or injury related to Your commission of, or attempt to commit, a felony.
26. 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 resulting from self-employment.
27. Services or supplies received before the Member's effective date for Coverage under this Policy.
28. Telephone or email consultations, or charges for failure to keep a scheduled appointment or charges to complete a claim form or to provide medical records.
29. Services for providing requested medical information or completing forms. We will not charge for statutorily authorized copying charges.
30. Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum.
31. Any service stated in Attachment A as a non-Covered Service or limitation.
32. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
33. Any charges for handling fees.
34. Pharmaceuticals, drugs and drug compounds except as otherwise specified.

ATTACHMENT C:
Schedule of Benefits

ADA Code*	Description	Maximum Allowable Charge
Diagnostic and Preventive Services		
D0120(1)	Periodic Oral Evaluation	$30
D0140	Limited Oral Evaluation-Problem Focused	$41
D0150(1)	Comprehensive Oral Evaluation	$46
D0160(1)	Detailed Extensive Oral Evaluation-Problem Focused	$116
D0180(1)	Comprehensive Perio Evaluation	$38
D0210(1)	Intraoral-Complete Series Including Bitewings	$74
D0220	Intraoral-Periapical-First Film	$15
D0230	Intraoral-Periapical-Each Additional Film	$12
D0240	Intraoral-Occlusal Film	$22
D0270(1)	Bitewings-Single Film	$18
D0272(1)	Bitewings-Two Films	$29
D0274(1)	Bitewings-Four Films	$41
D0277(1)	Vertical Bitewings-7 To 8 Films	$54
D0330(1)	Panoramic Film	$65
D1110(1)	Prophylaxis-Adult	$56
D1120(1)	Prophylaxis-Child	$43
D1206	Topical Application Of Fluoride varnish (for Members under 18)	$26
D1208	Topical Application Fluoride (for Members under 18)	$26
D1351(1)	Sealant-Per Tooth	$29
D1510	Space Maintainer-Fixed-Unilateral primary teeth only	$95
D1516	Space Maintainer-Fixed-Bilateral primary teeth only Maxillary	$125
D1517	Space Maintainer-Fixed-Bilateral primary teeth only Mandibular	$125
D1520	Space Maintainer-Removable-Unilateral, primary teeth only	$118
D1526	Space Maintainer-Removable-Bilateral, primary teeth only Maxillary	$161
D1527	Space Maintainer-Removable-Bilateral, primary teeth only Mandibular	$161
D1550	Recementation Of Space Maintainer	$20
Restorative Services		
D2140	Amalgam-One Surface	$38
D2150	Amalgam-Two Surfaces	$46
D2160	Amalgam-Three Surfaces	$53
D2161	Amalgam-Four Or More Surfaces	$65

ADA Code*	Description	Maximum Allowable Charge
D2330	Resin-One Surface, Anterior	$39
D2331	Resin-Two Surfaces, Anterior	$50
D2332	Resin-Three Surfaces, Anterior	$60
D2335	Resin-Four+ Surfaces Or Indv Incisal Angle(Anterior)	$71
D2390	Composite Resin Crown, Anterior-Permanent	$85
D2391	Resin-One Surface, Posterior	$45
D2392	Resin-Two Surfaces, Posterior	$58
D2393	Resin-Three Surfaces, Posterior	$74
D2394	Resin-Four Or More Surfaces, Posterior	$89
	Major Restorative Services	
D2510	Inlay-Metallic-One Surface	$219
D2520	Inlay-Metallic-Two Surfaces	$248
D2530	Inlay-Metallic-Three Or More Surfaces	$286
D2542	Onlay-Metallic-Two Surfaces	$281
D2543	Onlay-Metallic-Three Surfaces	$294
D2544	Onlay-Metallic-Four Or More Surfaces	$305
D2610	Inlay-Porcelain/Ceramic-One Surface	$258
D2620	Inlay-Porcelain/Ceramic-Two Surfaces	$272
D2630	Inlay-Porcelain/Ceramic-Three Or More Surfaces	$290
D2642	Onlay Porcelain/Ceramic-Two Surfaces	$281
D2643	Onlay Porcelain/Ceramic-Three Surfaces	$304
D2644	Onlay Porcelain/Ceramic-Four Or More Surfaces	$322
D2650	Inlay-Comp/Resin-One Surface (Lab Processed)	$169
D2651	Inlay-Comp/Resin-Two Surfaces (Lab Processed)	$202
D2652	Inlay-Comp/Resin-Three/More Surf (Lab Processed)	$212
D2662	Onlay-Comp/Resin-Two Surfaces (Lab Processed)	$184
D2663	Onlay-Comp/Resin-Three Surfaces (Lab Processed)	$216
D2664	Onlay-Comp/Resin-Four/More Surf (Lab Processed)	$232
D2710	Crown-Resin (Indirect)	$131
D2712	Crown-3/4 Resin-based Composite (indirect)	$131
D2720	Crown-Resin W/High Noble Metal	$322
D2721	Crown-Resin W/Predominately Base Metal	$302
D2722	Crown-Resin W/Noble Metal	$308
D2740	Crown-Porcelain/Ceramic Substrate	$387
D2750	Crown-Porcelain Fused To High Noble Metal	$326
D2751	Crown-Porcelain Fused To Predominantly Base Metal	$304

ADA Code*	Description	Maximum Allowable Charge
D2752	Crown-Porcelain Fused To Noble Metal	$311
D2780	Crown-3/4 Cast W/High Noble Metal	$313
D2781	Crown-3/4 Cast W/Predominately Base Metal	$294
D2782	Crown-3/4 Cast W/Noble Metal	$304
D2783	Crown-3/4 Cast Porcelain/Ceramic	$322
D2790	Crown-Full Cast High Noble Metal	$315
D2791	Crown-Full Cast Predominantly Base Metal	$298
D2792	Crown-Full Cast Noble Metal	$304
D2794	Crown-titanium	$315
D2910	Recement Inlay	$25
D2915	Recement Cast or Prefab Post and Core	$25
D2920	Recement Crown	$27
D2930	Prefabricated Stainless Steel Crown-Primary	$72
D2931	Prefab Stainless Steel Crown-Primary	$82
D2932	Prefab Resin Crown	$89
D2933	Prefab Stainless Steel Crown W/Resin Window	$100
D2934	Prefab Esthetic Coated Stainless Steel Crown – Primary	$100
D2940	Sedative Filling	$28
D2950	Core Build-Up, Including Any Pins	$69
D2951	Pin Retention/Tooth, In Addition To Restoration	$15
D2952	Cast Post And Core In Addition To Crown	$105
D2953	Each Additional Cast Post-Same Tooth	$53
D2954	Prefabricated Post And Core In Addition To Crown	$87
D2957	Each Additional Prefabricated Post-Same Tooth	$44
D2980	Crown Repair	$64
D2981	Inlay Repair	$64
D2982	Onlay Repair	$64
Endodontic Services		
D3110	Pulp Cap-Direct (Excluding Final Restoration)	$22
D3120	Pulp Cap-Indirect (Excluding Final Restoration)	$17
D3220	Therapeutic Pulpotomy (Excluding Final Rest)	$51
D3221	Pulpal Debridement	$56
D3230	Pulpal Therapy (Resorbable Fill)-Ant Prim Tooth	$54
D3240	Pulpal Therapy (Resorbable Fill)-Post Prim Tooth	$58
D3310	Root Canal-Anterior(Excluding Final Restoration)	$216
D3320	Root Canal-Bicuspid(Excluding Final Restoration)	$264

ADA Code*	Description	Maximum Allowable Charge
D3330	Root Canal-Molar (Excluding Final Restoration)	$340
D3346	Retreatment Previous Root Canal Therapy-Anterior	$291
D3347	Retreatment Previous Root Canal Therapy-Bicuspid	$343
D3348	Retreatment Previous Root Canal Therapy-Molar	$412
D3351	Apex./Recal.-Initial Visit(Ap.Clos./Cal.Rep.Etc)	$122
D3352	Apex./Recal.-Interim Medication Replacement	$54
D3353	Apexification/Recalcification-Final Visit	$181
D3410	Apicoectomy/Periradicular Surgery- Anterior	$247
D3421	Apicoectomy/Periradicular Surg-Bicusp (First Rt)	$270
D3425	Apicoectomy/Periradicular Surg-Molar(First Root)	$305
D3426	Apicoectomy/Periradicular Surg (Ea. Additional Root)	$102
D3430	Retrograde Filling-Per Root	$75
D3450	Root Amputation-Per Root	$152
D3920	Hemisection (Inc Root Removal) Not Inc Endo	$118
Periodontic Services		
D4210	Gingivectomy/Gingivoplasty-4+ Cont Teeth,Per Quadrant	$164
D4211	Gingivectomy/Gingivoplasty-1 to 3 Teeth, Per Quadrant	$44
D4240	Gingival Flap w/Root Planing - 4+ Cont Teeth,Per Quadrant	$194
D4241	Gingival Flap w/Root Planing – 1 to 3 Teeth,Per Quadrant	$97
D4249	Clinical Crown Lengthening-Hard Tissue	$221
D4260	Osseous Surgery w/Flap Entry/Closure, 4+ Cont Teeth,Per Quadrant	$312
D4261	Osseous Surgery w/Flap Entry/Closure, 1 to 3 Cont Teeth, Per Quadrant	$156
D4263	Bone Replacement Graft-First Site In Quadrant	$94
D4264	Bone Replacement Graft-Each Add'l Site In Quadrant	$47
D4270	Pedicle Soft Tissue Graft Procedure	$231
D4273	Subepithelial Connective Tiss Gft (Incl Donor)	$254
D4274	Distal/Proximal Wedge Proc (Not W/Proc In Same Area)	$72
D4275	Soft Tissue Allograft	$144
D4276	Combo Connect Tissue and Dbl Ped Graft	$254
D4277	Free Soft Tissue Graft 1st tooth	$178
D4278	Free Soft Tissue Graft each additional	$60
D4283	Autogenous Connective Tissue Graft (Including Donor)	$254
D4285	Non-Autogenous Connective Tissue Graft (Including Donor)	$144
D4341	Periodontal Scaling And Root Planing, 4+ Cont Teeth,Per Quadrant	$68

ADA Code*	Description	Maximum Allowable Charge
D4342	Periodontal Scaling And Root Planing, 1 to 3 Cont Teeth,Per Quadrant	$34
D4355	Full Mouth Debride-Enable Periodontal Eval & Dx	$46
D4910(1)	Periodontal Maintenance	$42
Removable Prosthetic Services		
D5110	Complete Denture-Maxillary	$360
D5120	Complete Denture-Mandibular	$360
D5130	Immediate Denture-Maxillary	$393
D5140	Immediate Denture-Mandibular	$393
D5211	Maxillary Partial Denture-Resin Base(Clasp/Rests)	$304
D5212	Mandibular Partial Denture-Resin Base(Clasp/Rests)	$353
D5213	Maxillary Partial Denture-Metal Frame W/Resin Base	$398
D5214	Mandibular Partial Denture-Metal Frame W/Resin Base	$398
D5221	Immediate Maxillary Partial Denture-Resin Base(Clasp/Rests)	$304
D5222	Immediate Mandibular Partial Denture-Resin Base(Clasp/Rests)	$353
D5223	Immediate Maxillary Partial Denture-Metal Frame W/Resin Base	$398
D5224	Immediate Mandibular Partial Denture-Metal Frame W/Resin Base	$398
D5225	Maxillary partial Denture-Flex Base (Incl Clasps, Rests, tth)	$304
D5226	Mandibular partial Denture-Flex Base (Incl Clasps, Rests, tth)	$353
D5282	Remov Unilat Partial Denture-1 Piece Metal(W/Teeth) - Maxillary	$232
D5283	Remov Unilat Partial Denture-1 Piece Metal(W/Teeth) - Mandibular	$232
D5410	Adjust Complete Denture-Maxillary	$20
D5411	Adjust Complete Denture-Mandibular	$20
D5421	Adjust Partial Denture-Maxillary	$20
D5422	Adjust Partial Denture-Mandibular	$20
D5511	Repair Broken Complete Denture Base - Mandibular	$39
D5512	Repair Broken Complete Denture Base - Maxillary	$39
D5520	Replace Miss/Brkn Teeth-Complete Denture/Tooth	$33
D5611	Repair Resin partial Denture Base - Mandibular	$43
D5612	Repair Resin partial Denture Base - Maxillary	$43
D5621	Repair Cast Framework, Partial Denture - Mandibular	$46
D5622	Repair Cast Framework, Partial Denture - Maxillary	$46
D5630	Repair Or Replace Broken Clasp, Partial Denture	$56
D5640	Replace Broken Teeth-Per Tooth, Partial Denture	$36

ADA Code*	Description	Maximum Allowable Charge
D5650	Add Tooth To Existing Partial Denture	$49
D5660	Add Clasp To Existing Partial Denture	$59
D5670	All Teeth/Acryllic on Cast Frame – Maxillary	$138
D5671	All Teeth/Acryllic on Cast Frame – Mandibular	$138
D5710	Rebase Complete Maxillary Denture	$146
D5711	Rebase Complete Mandibular Denture	$140
D5720	Rebase Maxillary Partial Denture	$138
D5721	Rebase Mandibular Partial Denture	$138
D5730	Reline Complete Maxillary Denture (Chairside)	$83
D5731	Reline Complete Mandibular Denture (Chairside)	$83
D5740	Reline Maxillary Partial Denture (Chairside)	$76
D5741	Reline Mandibular Partial Denture (Chairside)	$76
D5750	Reline Complete Maxillary Denture (Laboratory)	$110
D5751	Reline Complete Mandibular Denture (Laboratory)	$110
D5760	Reline Maxillary Partial Denture (Laboratory)	$108
D5761	Reline Mandibular Partial Denture (Laboratory)	$108
D5863	Overdenture – complete maxillary	$360
D5864	Overdenture – Partial maxillary	$304
D5865	Overdenture – Complete mandibular	$360
D5866	Overdenture – Partial mandibular	$304
Fixed Prosthetic Services		
D6205	Pontic-Indirect Resin Based Composite	$118
D6210	Pontic-Cast High Noble Metal	$296
D6211	Pontic-Cast Predominantly Base Metal	$277
D6212	Pontic-Cast Noble Metal	$289
D6214	Pontic-Titanium	$296
D6240	Pontic-Porcelain Fused To High Noble Metal	$292
D6241	Pontic-Porcelain Fused To Predom. Base Metal	$270
D6242	Pontic-Porcelain Fused To Noble Metal	$285
D6245	Pontic-Prcelain/Ceramic	$302
D6250	Pontic-Resin W/High Noble Metal	$289
D6251	Pontic-Resin W/Predominately Base Metal	$266
D6252	Pontic-Resin W/Noble Metal	$275
D6545	Retainer-Cast Metal-Resin Bonded Fixed Prosthes	$123
D6548	Retainer-Porc/Ceram For Resin Bonded Fx Prosth	$135
D6600	Inlay-Porc/Ceramic, 2 Surfaces	$274

ADA Code*	Description	Maximum Allowable Charge
D6601	Inlay-Porc/Ceramic, 3+ Surfaces	$274
D6602	Inlay-Cast Hi Noble, 2 Surfaces	$255
D6603	Inlay-Cast Hi Noble, 3+ Surfaces	$292
D6604	Inlay-Cast Predom Base Metal, 2 Surfaces	$255
D6605	Inlay-Cast Predom Base Metal, 3+ Surfaces	$292
D6606	Inlay-Cast Noble, 2 Surfaces	$255
D6607	Inlay-Cast Noble, 3+ Surfaces	$292
D6608	Onlay-Porc/Ceramic, 2 Surfaces	$274
D6609	Onlay-Porc/Ceramic, 3+ Surfaces	$274
D6610	Onlay-Cast Hi Noble, 2 Surfaces	$300
D6611	Onlay-Cast Hi Noble, 3+ Surfaces	$313
D6612	Onlay-Cast Predom Base Metal, 2 Surfaces	$300
D6613	Onlay-Cast Predom Base Metal, 3+ Surfaces	$313
D6614	Onlay-Cast Noble, 2 Surfaces	$300
D6615	Onlay-Cast Noble, 3+ Surfaces	$313
D6624	Inlay-Titanium	$292
D6634	Onlay-Titanium	$313
D6710	Crown-Indirect Resin Based Composite	$131
D6720	Crown-Resin W/High Noble Metal	$326
D6721	Crown-Resin W/Predominately Base Metal	$309
D6722	Crown-Resin W/Noble Metal	$315
D6740	Crown-Porcelain/Ceramic	$343
D6750	Crown-Retainer-Porcelain Fused High Noble Metal	$334
D6751	Crown-Retainer-Porcelain Fused Pred. Base Metal	$311
D6752	Crown-Retainer-Porcelain Fused To Noble Metal	$319
D6780	Crown-3/4 Cast High Noble Metal	$315
D6781	Crown-3/4 Cast Predominately Base Metal	$315
D6782	Crown-3/4 Cast Noble Metal	$292
D6783	Crown-3/4 Cast Porcelain/Ceramic	$324
D6790	Crown-Retainer-Full Cast High Noble Metal	$322
D6791	Crown-Retainer-Full Cast Predom. Base Metal	$305
D6792	Crown-Retainer-Full Cast Noble Metal	$317
D6794	Crown-Titanium	$322
D6930	Recement Fixed Partial Denture	$39
D6970	Cast Post And Core/Addition To Bridge Retainer	$108
D6971	Cast Post As Part Of Bridge Retainer	$95

ADA Code*	Description	Maximum Allowable Charge
D6972	Prefab Post And Core In Addition To Bridge Ret	$88
D6973	Core Build-Up For Retainer Incl Any Pins	$71
D6976	Each Addl Cast Post-Same Tooth	$46
D6977	Each Addl Prefabricated Post-Same Tooth	$44
D6980	Fixed Partial Denture Repair	$64
D6985	Pediatric Partial Denture – Fixed	$304
Oral Surgical Services		
D7111	Coronal Remnants – Deciduous Tooth	$36
D7140	Extraction, Erupted Tooth or Exposed Root	$47
D7210	Surg Rem Erup Tooth Req Flap/Bone Rem/Sec Tooth	$88
D7250	Surg Rem Of Residual Tooth Roots (Cutting Proc)	$74
D7310	Alveoloplasty In Conjunction With Exts-Per Quad	$82
D7311	Alveoplasty w/extract – 1 to 3 Teeth or Spaces, Per Quad	$41
D7320	Alveoloplasty Not In Conjunction With Exts-Per Quad	$365
D7321	Alveoplasty w/o Eextract – 1 to 3 Teeth or Spaces, Per Quad	$183
D7450	Removal Benign Odontogenic Cyst/Tumor<1.25 Cm	$260
D7451	Removal Benign Odontogenic Cyst/Tumor>1.25 Cm	$409
D7510	I & D Abscess Intraoral-Soft Tissue	$78
D7511	Incision and Drainage of Abscess-Intraoral Soft Tissue	$98
D7960	Frenulectomy (Frenectomy/Frenotomy) Sep. Proc.	$172
D7963	Frenuloplasty	$215
D7970	Excision Of Hyperplastic Tissue/ Per Arch	$177
D7971	Excision Pericoronal Gingiva	$56
D7972	Surgical Reduction of Fibrous Tuberosity	$56
Miscellaneous Services		
D9110	Palliative (Er) Tx-Dental Pain-Minor Procedure	$22

Maximums		
Deductible[2]	Individual	Family
	$50	$150
Annual Maximum[3]	$1,000	
Probationary Period[4]	12 Months	

* Current Dental Terminology © American Dental Association.

1. This service is limited. See “Limitations on Services” under Attachment A.
2. Deductible does not apply to Diagnostic and Preventive Services.

3. Calendar Year maximum per Subscriber and each Covered Dependent.
4. The Probationary Period applies to: Major Restorative Services, Periodontic Services, Removable Prosthetic Services and Fixed Prosthetic Services.

ATTACHMENT F

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY

LEGAL OBLIGATIONS

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

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

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

ORGANIZATIONS COVERED BY THIS NOTICE

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

USES AND DISCLOSURES OF MEDICAL INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET**: You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged $.25 per page, $10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the cost of providing Your health plan information in the requested format. If You prefer, the company will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. The company requires advance payment before copying Your health plan information.

2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of Your health plan information made by the company or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.

3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the company's use or disclosure of Your health plan information. The company is not required to agree to such requests. The company will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the company.

4. **BREACH NOTICE:** You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.

5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the company communicate that information to You by a different method or to a different address. If there is an immediate threat, You may make that request by calling a BlueCross BlueShield of Tennessee Customer Service Representative or the Privacy Officer at 1-888-455-3824. Follow up with a written request is required as soon as possible. The company must accommodate Your request if it is reasonable, specifies how and where to

communicate with You, and continues to permit collection of Premium and payment of claims under Your health plan.

6. **AMENDMENT REQUESTS:** You have the right to make a written request that the company amend Your health plan information. Your request must explain why the information should be amended. The company may deny Your request if the health plan information You seek to amend was not created by the company or for other reasons permitted by its legal obligations. If Your request is denied, the company will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your health plan information. If the company accepts Your request, reasonable efforts will be made to inform the people that You designate about that amendment. Any future disclosures of that information will be amended.

7. **RIGHT TO REQUEST WRITTEN NOTICE:** If You receive this notice on the company's web site or by electronic mail (e-mail), You may request a written copy of this notice, by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

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

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

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

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

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

bcbst.com

1 Cameron Hill Circle
Chattanooga, TN 37402