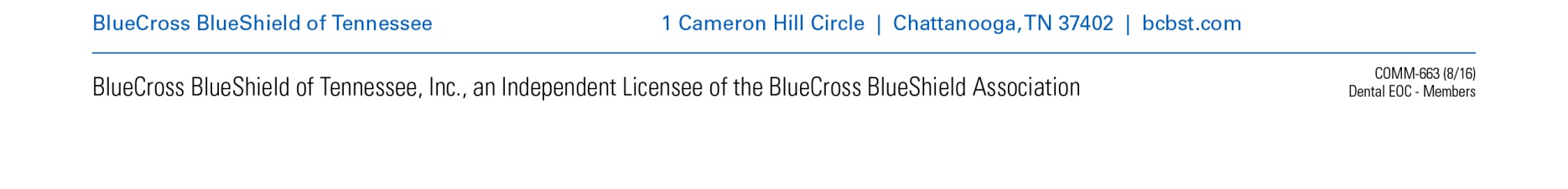


**** Evidence of Coverage

Dental Benefit Plan

[Group Name] - 2023

Evidence of Coverage

Dental Benefit Plan

Stepherson, Inc. dba Superlo Foods - 2023

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.

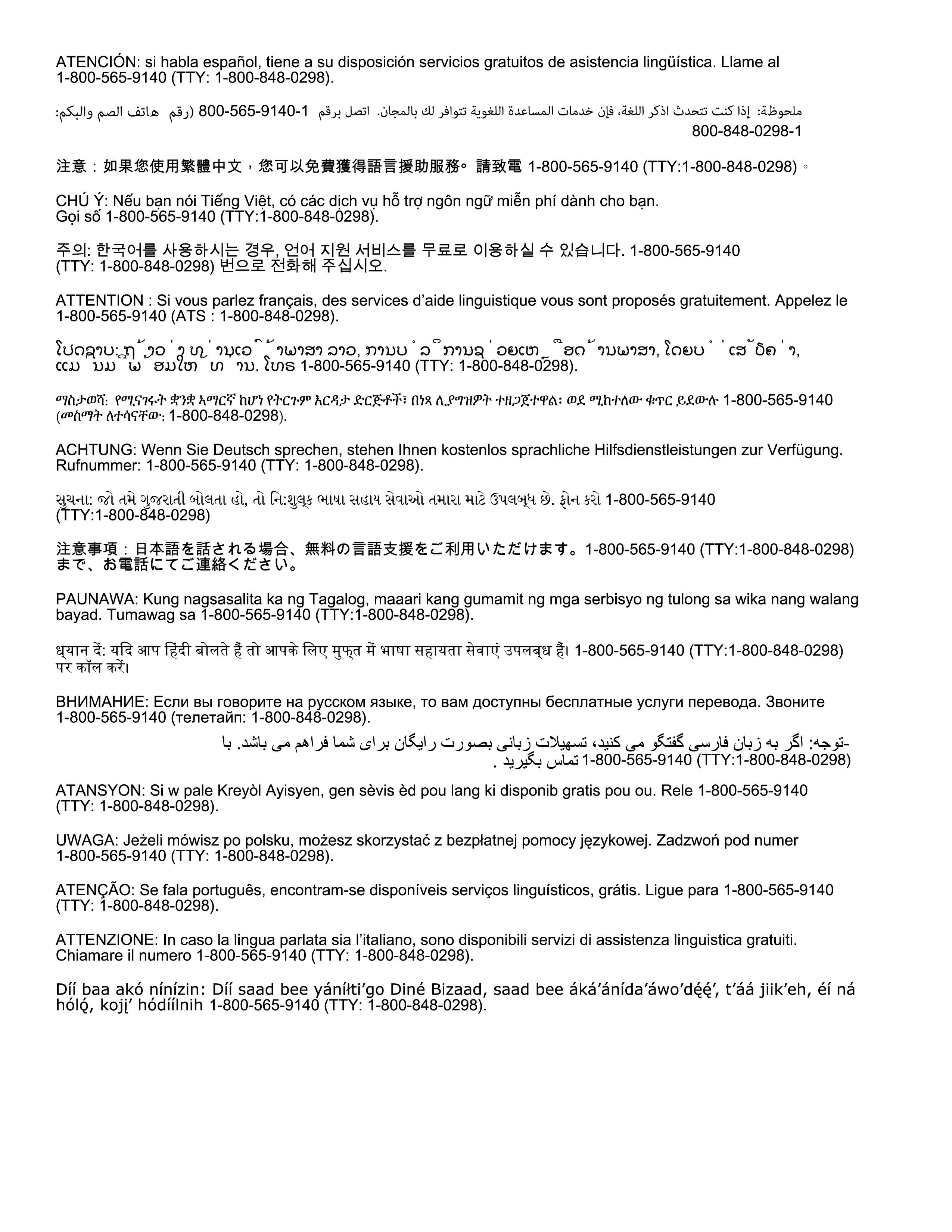
BlueCross:

* 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 ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance (“Nondiscrimination Grievance”). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of Your 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](mailto: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*](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*](http://www.hhs.gov/ocr/office/file/index.html).



NOTICE

PLEASE READ THIS EVIDENCE OF COVERAGE CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR BENEFITS AS ADMINISTERED BY BLUECROSS BLUESHIELD OF TENNESSEE, INC. IF YOU HAVE ANY QUESTIONS ABOUT THIS EVIDENCE OF COVERAGE OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:

**CUSTOMER SERVICE DEPARTMENT**

**BLUECROSS BLUESHIELD OF TENNESSEE, INC.**

**ADMINISTRATOR**

**1 CAMERON HILL CIRCLE**

**CHATTANOOGA, TENNESSEE 37402**

**(800) 565-9140**

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INTRODUCTION

This Dental Evidence of Coverage (“Dental EOC”) was created for the Employer (listed on the cover of this EOC) as part of its Employee welfare benefit plan (the “Plan”), and is subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). References in this EOC to “Administrator,” “We,” “Us,” “Our,” or “BlueCross” mean BlueCross BlueShield of Tennessee, Inc. The Employer has entered into an Administrative Services Agreement (ASA) with BlueCross for it to administer the claims Payments under the terms of the EOC, and to provide other services. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

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

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

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

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

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

Please contact one of the Administrator’s consumer advisors, at the number on the back of Your ID card, if You have any questions when reading this Dental EOC. Our consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

BENEFIT ADMINISTRATION ERROR

If the Administrator makes an error in administering the benefits under this Dental EOC, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this Dental EOC.

NOTIFICATION OF CHANGE IN STATUS

Changes in Your status can affect the service under the Plan. To make sure the Plan works correctly, please notify the Employer when You change:

* name;
* address;
* telephone number;
* employment; or
* status of any other health Coverage You have.

Subscribers must notify the Employer of any eligibility or status changes for themselves or Covered Dependents, including:

* the marriage or death of a family member;
* divorce;
* adoption;
* birth of additional dependents; or
* termination of employment.

HOW THE DENTAL PROGRAM WORKS

DentalBlue™ Coverage is designed to promote cost-effective care and provide a simple method for filing claims. Two important features are Network Dentists and the Predetermination of Benefits program.

NETWORK DENTISTS

To reduce Your out-of-pocket expense, You should receive services from a Network Dentist.

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

A listing of Network Dentists is provided to Your 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 may also call Our customer service department, [or You may check the most current directory information at Our website, [bcbst.com](http://www.bcbst.com). Click on Network Directories. You can go to the Dentist of Your choice, regardless of whether he/she is a Network Dentist. However, Your out-of-pocket expense is less when You use a Network Dentist.

PAYMENT FOR AN OUT-OF-NETWORK DENTIST

If You select an Out-of-Network Dentist, that Dentist can bill You for any amount not Covered by this Dental EOC. You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for a Covered Service, if an Out-of-Network Dentist’s Billed Charges are more than the Maximum Allowable Charge for such Covered Services.

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

PREDETERMINATION OF BENEFITS

The Predetermination of Benefits program allows You and Your Dentist to know exactly what kinds of treatment are Covered. If a course of treatment will exceed $200.00, the treatment plan should be submitted for review before the work starts. In order to review the treatment plan, a description of each service and charge should be submitted along with all supporting aids such as pre-operative x-rays.

To obtain a Predetermination of Benefits response, Your Dentist submits a claim form and checks the box "Dentist’s Pre-Treatment Estimate after Your initial examination and before treatment begins. You and Your Dentist are then notified what benefits are available, and what payments, if any, You must make.

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

ELIGIBILITY

Any Employee of the Employer and his or 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 shall make final eligibility determinations in accordance with the requirements of this EOC.

# Subscriber

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

## Be an Employee of the Employer, who is Actively At Work; and

## Satisfy all eligibility requirements of the Plan; and

## Enroll for Coverage from the Plan as outlined by the Employer.

# Covered Dependents

To be eligible to enroll as a 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:

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

## The Subscriber’s or the Subscriber’s spouse’s: (1) natural child; (2) legally adopted child (including children placed for the purpose of adoption); (3) step-child(ren); or (4) children for whom the Subscriber or Subscriber’s spouse is the legal guardian who are less than 26 years old (or to age 26, if a full-time student); or

## A child of the Subscriber or the Subscriber’s spouse for whom a Qualified Medical Child Support Order has been issued; or

## An Incapacitated Child of the Subscriber or Subscriber’s spouse.

The Plan’s determination of eligibility under the terms of this provision shall be conclusive.

The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order.

# Waiting Period

The Plan has a Waiting Period. Each Employee must wait 30 days after he or she is hired before he or she is eligible for Coverage.

# Lay-off/Rehire Provision

If a Subscriber’s Coverage is reinstated within 13 weeks of the last date of employment, the Subscriber will be considered as having continuous Coverage under this EOC. However, expenses incurred while Coverage was not in effect will not be considered eligible expenses.



ENROLLMENT IN THE PLAN

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll if the Plan previously terminated his or her Coverage for any of the reasons listed under paragraph C. of the “When Coverage Ends” section of this EOC.

# Initial Enrollment Period

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

# Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during their Employer’s Open Enrollment Period. The eligible Employee must: (1) include all requested information; (2) sign; and (3) 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 dependents within 31 days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

# Adding Dependents

A Subscriber may add a dependent who became eligible after the Subscriber enrolled as follows:

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

If the Subscriber fails to do so, and an additional Premium is required to cover a newborn or newly acquired child, the Plan will not provide Coverage for that child after 31 days from the date the Subscriber or the Subscriber’s spouse acquired the child if the Premium was not furnished to the Plan within that time period. If no additional Premium is required to provide Coverage to the child, the Subscriber’s failure to enroll the child does not make the child ineligible for Coverage.

However, the Plan cannot add the newborn or newly acquired child to the Subscriber’s Coverage until notified. This may delay claims processing.

## A Subscriber may add a dependent who became eligible after the Subscriber enrolled. If the legally adopted (or placed) child has Coverage of his or her medical expenses from a public or private agency or entity, the Subscriber may not add the child until that coverage ends. Any other new dependent, (e.g., if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Administrator within 31 days of the date that person first becomes eligible for Coverage.

## The Subscriber or the Subscriber’s eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:

### The Subscriber or the Subscriber’s eligible dependent had other health care Coverage at the time Coverage under this Plan was previously offered;

### The Subscriber stated, in writing, at the time Coverage under this Plan was previously offered, that such other Coverage was the reason for declining Coverage under this Plan;

### such other Coverage is exhausted (if the other Coverage was continuation Coverage under COBRA) or the other Coverage was terminated because the Subscriber or the Subscriber’s eligible dependent ceased to be eligible due to involuntary termination or Employer contributions for such Coverage ended; and

### The Subscriber or the Subscriber’s eligible dependent applies for Coverage under this Plan and the Administrator receives the change form within 31 days after the loss of the other Coverage.

# Late Enrollment

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

## During a subsequent Open Enrollment Period; or

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

# Enrollment upon Change in Status

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

## You must request the change within 31 days of the change in status for the following events: (1) Marriage or divorce; (2) Death of the Employee’s spouse or dependent; (3) Change in dependency status; (4) Medicare eligibility; (5) Coverage by another Payor; (6) Birth or adoption of a child of the Employee; (7) Termination of employment, or commencement of employment, of the Employee’s spouse; (8) Switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee’s spouse; (9) Taking an unpaid leave of absence by the Employee or the Employee’s spouse, or returning from unpaid leave of absence; (10) Significant change in the health Coverage of the Employee or the Employee’s spouse attributable to the spouse’s employment.

## You must request the change within 60 days of the change in status for the following events: (1) Loss of eligibility for Medicaid or Children’s Health Insurance Program (CHIP) Coverage, or (2) Becoming eligible to receive a subsidy for Medicaid or CHIP Coverage.

WHEN COVERAGE BEGINS

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

# 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

# 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

# Enrollment During an Initial Enrollment Period

Coverage shall be effective on the day of the month indicated on the Employee’s Enrollment Form, following the Administrator’s receipt of the Employee’s Enrollment Form; or

# Newly Eligible Employees

Coverage shall be effective on the date of eligibility as specified in the ASA; or

# Newly Eligible Dependents

## Dependents acquired as the result of Employee’s marriage – Coverage will be effective on the day of the marriage, unless otherwise agreed to by Employer and the Administrator;

## Newborn children of the Employee or Employee’s spouse- Coverage will be effective as of the date of birth;

## Dependents adopted or placed for adoption with Employee – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

For Coverage to be effective, the dependent must be enrolled, and the Administrator must receive any required Payment for the Coverage, as set out in the “Enrollment” section; or

# Actively At Work Rule

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

WHEN COVERAGE ENDS

# Termination or Modification of Coverage by BlueCross or the Employer

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

All Members’ Coverage through the ASA 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 EOC following the date of the termination of the ASA.

# Termination of Coverage Due to Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements of the Employer. Coverage for a Member who has lost his or her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.

# Termination or Rescission of Coverage

The Plan may terminate Your Coverage if:

## You fail to make a required Member Payment when it is due. (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

## You fail to cooperate with the Plan or Employer as required; or

## You have made a misrepresentation of fact or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the ID card.

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

# Right to Request a Hearing

You may appeal the termination of Your Coverage or Rescission of Your Coverage, as explained in the “Grievance Procedure” section of this EOC. The fact that You have appealed shall not postpone or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated as part of the Grievance Procedure, You may submit any claims for services rendered after Your Coverage was terminated to the Plan for consideration in accordance with the Claims Procedure section of this EOC.

# Payment For Services Rendered After Termination of Coverage

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

1. Charges for dentures will be paid if:
2. the impression was made prior to the date Coverage ends;
3. the denture was ordered prior to the date Coverage ends;
4. the denture is placed in the mouth within 30 days from the date Coverage ends; and
5. the Employer’s new Dental insurer is not responsible for paying these charges.
6. Charges for fixed bridgework, crowns and inlays will be paid if:
7. the tooth or teeth were prepared prior to the date Coverage ends;
8. the impression was taken prior to the date Coverage ends;
9. the bridgework, crown or inlay was ordered prior to the date Coverage ends;
10. the work is seated in the mouth within 30 days from the date Coverage ends; and
11. the Employer’s new Dental insurer is not responsible for paying these charges.
12. Charges for endodontic treatment, including root canal therapy, will be paid if:
13. the tooth was opened prior to the date Coverage ends;
14. the procedure is completed within 30 days from the date Coverage ends; and
15. the Employer’s new Dental insurer is not responsible for paying these charges.

CONTINUATION OF COVERAGE

Federal Law

If Your Coverage under this EOC terminates, You may be offered the right to continue Coverage. This right is referred to as “COBRA Continuation Coverage” and may occur for a limited time subject to the terms of this section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

# Eligibility

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

1. Subscribers. Loss of Coverage because of:
2. The termination of employment except for gross misconduct.
3. A reduction in the number of hours worked by the Subscriber.
4. Covered Dependents. Loss of Coverage because of:
5. The termination of the Subscriber’s Coverage as explained in subsection (a), above.
6. The death of the Subscriber.
7. Divorce or legal separation from the Subscriber.
8. The Subscriber becomes entitled to Medicare.
9. A Covered Dependent reaches the Limiting Age.

# Enrolling for COBRA Continuation Coverage

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

1. The Subscriber’s termination of employment, reduction in hours worked, death or entitlement to Medicare Coverage; or
2. The Subscriber or Covered Dependent notifies the Employer, in writing, within 60 days after any other qualifying event set out above.

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

# Payment

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

# Coverage Provided

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

# Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

1. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
2. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. “Disabled” means Disabled as determined under Title II or XVI of the Social Security Act. In addition, the Disabled qualified beneficiary or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must.
3. Notify the Employer or the Administrator of the disability determination within 60 days after the determination of disability, and before the close of the initial 18-month Coverage period; and
4. Notify the Employer or the Administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or
5. 36 months of Coverage if the loss of Coverage is caused by:
6. the death of the Subscriber;
7. loss of dependent child status under the Plan;
8. the Subscriber becomes entitled to Medicare; or
9. divorce or legal separation from the Subscriber; or
10. 36 months for other qualifying events. If a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g., divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

# Termination of COBRA Continuation Coverage

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

1. The Payment for such Coverage is not submitted when due; or
2. You become Covered as either a Subscriber or dependent by another group health care plan, and that Coverage is as good as or better than the COBRA Continuation Coverage; or
3. The Plan is terminated; or
4. You become entitled to Medicare Coverage; or
5. The date that You, otherwise eligible for 29 months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA law.

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

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

* up to 12 weeks of unpaid leave from employment due to certain family or medical circumstances, or
* in some instances, up to 26 weeks of unpaid leave if related to certain family members’ military service related hardships.

Contact the Employer to find out if this provision applies. If it does, Members may continue health Coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time. If the Subscriber takes a leave and Coverage is cancelled for any reason during that leave, Members may resume Coverage when the Subscriber returns to work without waiting for an Open Enrollment Period.

# Continued Coverage During a Military Leave of Absence

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

# The Trade Adjustment Assistance Reform Act of 2002

The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added to Your COBRA rights. If You lost Your job because of import competition or shifts of production to other countries, You may have a second COBRA Continuation election period. If You think this may apply to You, check with the Employer or the Department of Labor.

GENERAL PROVISIONS

CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Dentist must submit a claim form to Us. We will review the claim, and let You or the Dentist know if We need more information before We pay or deny the claim. We follow Our internal administration procedures when We adjudicate claims. If these procedures differ from those required by the ERISA claims regulations, the ERISA claims regulations shall control.

# Claims.

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

## 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.

## A post-service claim is a claim for a Covered Service that is not a pre-service claim – the dental care has already been provided to You. Only post-service claims can be billed to the Plan, or You.

## Urgent care is dental care or treatment that, if delayed or denied, could seriously jeopardize (a) the life or health of the claimant; or (b) the claimant’s ability to regain maximum function. Urgent care is also dental care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant’s dental condition, would subject the claimant 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

# Claims Billing.

## You should not be billed or charged for Covered Services rendered by Network Dentists, except for required Member Payments. The Network Dentist will submit the claim directly to Us.

## You will be billed all charges for Non-covered Services rendered by Network Dentists. Network discounts do not apply to these Non-covered Services.

## You may be charged or billed by an Out-of-Network Dentist for Covered Services rendered by that Dentist. If You use an Out-of-Network Dentist, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service.

## If You are charged, or receive a bill, You must submit a claim to Us.

### To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim, within the 1 year and 90 day time period, it will not be paid.

### If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced. We may require verification of the reason for such delay.

## You may request a claim form from Our consumer advisors. We will send You a claim form within 15 days. You must submit proof of Payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

## A Network Dentist or an Out-of-Network Dentist may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:

### You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service.

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

## Dentists may bill or charge for Covered Services differently. Network Dentists are reimbursed based on Our agreement with them. Different Network Dentists have different reimbursement rates for different services. Your expenses can be different from Dentist to Dentist.

# Payment.

## If You received Covered Services from a Network Dentist, the Plan will pay the Network Dentist directly. These Payments are made according to Our agreement with that Network Dentist. You authorize assignment of benefits to that Network Dentist.

## Out-of-Network Dentist, may or may not file Your claims for You. A completed claim form for Covered Services must be submitted in a timely manner. Payment for Covered Services may be made to either the Out-of-Network Provider or to You, at the Plan’s discretion. You will be responsible for any unpaid Billed Charges. The Plan’s Payment fully discharges its obligation related to that claim.

## We will pay benefits according to the Plan within 30 days after We receive a claim form that is complete. Claims are processed in accordance with Our internal administration procedures, and based on Our information at the time We receive the claim form. Neither the Plan nor We are responsible for over or under Payment of claims if Our information is not complete or is inaccurate.

## At least monthly, You will receive an Explanation of Benefits (EOB) that describes how a claim was treated. For example, the EOB shows how a claim paid, denied, how much was paid to the Dentist, and will also let You know if You owe an additional amount to that Dentist. The Administrator will make the EOB available to You at bcbst.com, or by calling Our consumer advisors at the number on the back of Your ID card.

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

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

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

# Assignment

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

# Complete Information.

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

Mail all claim forms to:

BlueCross BlueShield of Tennessee

Claims Service Center

1 Cameron Hill Circle, Suite 0002

Chattanooga, Tennessee 37402-0002

COORDINATION OF BENEFITS

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

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the Plan’s benefits are determined before or after those of another plan.

# Definitions

The following terms apply to this provision:

## "Plan" means any form of medical or dental Coverage with which coordination is allowed. “Plan” includes:

### group, blanket, or franchise insurance;

### a group BlueCross Plan, BlueShield Plan;

### group or group-type Coverage through HMOs or other prepayment, group practice and individual practice plans;

### 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;

### medical benefits Coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type Coverages;

### Coverage under Medicare and other governmental benefits; and

### any other arrangement of health Coverage for individuals in a group.

## “Plan” does not include individual or family:

### Insurance contracts;

### Subscriber contracts;

### Coverage through Health Maintenance Organizations (HMO);

### Coverage under other prepayment, group practice and individual practice plans;

### Public medical assistance programs (such as TennCaresm);

### Group or group-type hospital indemnity benefits of $100 per day or less;

### School accident-type Coverages.

Each Contract or other arrangement for Coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

## "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.

## Primary Plan/Secondary Plan.

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

### When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

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

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

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

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

### We will determine only the benefits available under this Plan. You are responsible for supplying Us with information about other plans so We can act on this provision.

## "Claim Determination Period" means an Annual Benefit Period. However, it does not include any part of a year during which You have no Coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

# Order of Benefit Determination Rules

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

## Non-Dependent/Dependent

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

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

### if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

* benefits of the Plan of an active Employee covering the person as a Dependent;
* Medicare;
* benefits of the Plan covering the person as an Employee, Member, or Subscriber.

## Dependent Child/Parents Not Separated or Divorced

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

### The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

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

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

## Dependent Child/Separated or Divorced Parents

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

### First, the Plan of the parent with custody of the child;

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

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

### However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

### 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 2(b), Dependent Child/Parents Not Separated or Divorced.

## Active/Inactive Employee

The benefits of a Plan that 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. 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.

## Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan that has Covered an Employee, Member, or Subscriber longer are determined before those of the Plan that 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 24 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 that 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 of the Group shall be used as the date from which to determine the length of time the claimant's Coverage under the present Plan has been in force.

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."

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. However, this Plan must adjust any Payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

### If:

#### The Non-complying Plan reduces its benefits so that the Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

#### Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to You or on Your behalf an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

# Effect on the Benefits of this Plan

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

## Benefits of This Plan will be reduced when the sum of:

### 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;

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

## When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.

## The Administrator 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 requires Us to determine benefits before those of the Other Plan.

# Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

# Facility of Payment

A Payment under Another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that Payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term “Payment Made” includes providing benefits in the form of services; in which case, Payment Made means reasonable cash value of the benefits provided in the form of services.

# Right of Recovery

If the amount of the Payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

## The persons it has paid or for whom it has paid;

## Insurance companies; or

## Other organizations.

The “amount of the Payments made” includes the reasonable cash value of any benefits provided in the form of services.

# Are You Also Covered by Medicare?

If You are also Covered by Medicare, We follow the Medicare Secondary Payor (MSP) rules to determine Your benefits. If Your Employer has 20 or fewer Employees, the MSP rules might not apply. Please contact Our consumer advisors at the toll free number on the back of Your ID card if You have any questions.

GRIEVANCE PROCEDURE

**I.** **INTRODUCTION**

Our Grievance Procedure (the “Procedure”) is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact Our consumer advisors at the number on the back of Your ID card: (1) to file a claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g., an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

## This Grievance Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this Dental EOC. Any decision to award damages must be based upon the terms of this Dental EOC.

## The Grievance Procedure can only resolve Disputes that are subject to Our control.

## You cannot use this Grievance Procedure to resolve a claim that a Dentist was negligent. Network Dentists are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Dentists.

## This Grievance Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) Urgent Care; and (3) pre-service and post-service claims (“Claims”), that are in the Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).

Adverse Benefit Determination means:

1. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or Payment is not provided or made, in whole or in part, for the benefit;
2. The denial, reduction, termination or failure to provide or make Payment, in whole or in part, for a benefit based on a determination by a health carrier of a Member’s eligibility to participate in the health carrier's health benefit plan; or
3. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make Payment for, in whole or in part, a benefit.

## You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.

## The Plan and You may agree to skip one or more of the steps of this Grievance Procedure if it will not help to resolve the Dispute.

## Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA and this Dental EOC.

**II. DESCRIPTION OF THE REVIEW PROCEDURES**

# Inquiry

An inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact Our consumer advisors 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.

# First Level Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination. We may raise Your failure to initiate a Grievance in a timely manner as a defense if You file a lawsuit against the Administrator later.

Contact Our consumer advisors at the number on the back of Your ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance Procedure and is mandatory. BlueCross is a limited fiduciary for the first level Grievance.

## **Grievance Process**

After We have received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning Urgent Care or pre-service claims, We will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Plan is not otherwise governed by ERISA.

## **Written Decision**

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

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

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

##### 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 statement of the committee’s understanding of Your Grievance;

##### The basis of the committee’s decision; and

##### Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

# Second Level Grievance

You may file a written request for reconsideration with Us within ninety (90) days after We issue the first level Grievance committee’s decision. This is called a second level Grievance. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review.

If the Plan is governed by ERISA, You also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA (“ERISA Actions”) after completing the mandatory first level Grievance process.

The Plan may require You to exhaust each step of this Grievance procedure in any Dispute that is not an ERISA Action:

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. If You file a second level Grievance concerning an ERISA Action, the Plan agrees to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

## **Grievance Process**

You may request an in-person or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if You do not want to participate in a hearing concerning Your Grievance. If You wish to participate, Our representatives will 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:

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

##### 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.

## **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 statement of the second level committee’s understanding of Your Grievance;

##### The basis of the second level committee’s decision; and

##### 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.

# Independent Review of Medical Necessity Determinations

If Your Grievance involves a Medical Necessity determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance followed by completion of the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by Us, to independently review and resolve such Dispute(s). If You request an independent review following the mandatory first level Grievance, You waive Your right to a second level Grievance and Your right to present oral testimony during the Grievance Process. Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. If You request independent review of an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Employer or Employer’s Plan, until the independent reviewer makes its decision.

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

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

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

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

DEFINITIONS

Defined terms are capitalized. When defined words are used in this Dental EOC, they have the meaning set forth in this section.

## **Actively At Work** – The performance of all an Employees regular duties for the Group on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee is Actively At Work on the last regularly scheduled work day. An Employee who is not at work due to a health-related factor shall be treated as Actively At Work for purposes of determining Eligibility.

## **Annual Benefit Period** - The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.

## **Benefit Maximum** - The total amount of benefits available for services under this Dental EOC during the Benefit Year, or during the Member’s lifetime. (See Attachment C: Schedule of Benefits.)

## **Billed Charges** – The amount that a Dentist charges for services rendered. Billed Charges may be different from the amount that the Plan determines to be the Maximum Allowable Charge for services.

## **Coinsurance** – The amount stated as a percentage of the Maximum Allowable Charge for a Covered Service, that is Your responsibility during the Annual Benefit Period after any Deductible is satisfied. The Coinsurance percentage is calculated as 100%, minus the percentage Payment of the Maximum Allowable Charge as specified in Attachment C: Schedule of Benefits.

## **Covered Dependent** - A Subscriber’s family members who: (1) meet the eligibility requirements of this Dental EOC; (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable premium for Coverage.

## **Covered Family Members –** A Subscriber and his or her Covered Dependents.

## **Covered Services, Coverage or Covered** - Those necessary and appropriate services and supplies that are set forth in Attachment A: Covered Services and Exclusions of this Dental EOC, (which is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Dental Group Agreement and this Dental EOC.

## **Deductible** - The dollar amount, specified in Attachment C: Schedule of Benefits, which You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for such services.

Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) is not considered when determining if You have satisfied a Deductible.

## **Dental Group Agreement or Agreement –** The arrangements between the Plan and the Group, including this Dental EOC, the Employer Group Application, any riders, any amendments, and any attachments to the Agreement or this Dental EOC. If there is any conflict between the Dental Group Agreement and this Dental EOC, the Dental Group Agreement shall be controlling.

## **Dentist** - A doctor of dentistry, duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed; 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.

## **Effective Date** - The date Your Coverage under this EOC begins.

## **Employee** – A person who fulfills all eligibility requirements established by the Group and the Plan.

## **Enrollment Form** – A form or application which must be completed in full by the eligible Employee before he or she will be considered for Coverage under the Plan.

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

## **Family Deductible** – The maximum dollar amount, specified in Attachment C: Schedule of Benefits that a Subscriber and Covered Dependents must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for such Services. Once the Family Deductible amount has been satisfied by 3 or more Covered Family Members during an Annual Benefit Period, the Deductible will be considered satisfied for all Covered Family Members for the remainder of that Annual Benefit Period.

Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) is not considered when determining if the Family Deductible has been satisfied.

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

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

1. If the child reaches this Plan’s limiting age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the Limiting Age.
2. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber’s or the Subscriber’s spouse’s previous health benefit plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment, and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

## **Limiting Age (or Dependent Child Limiting Age)** - The age at which a child will no longer be considered an eligible Dependent.

## **Maximum Allowable Charge** - The amount that the Plan, at its discretion, has determined to be the maximum amount payable for a Covered Service.  For Covered Services provided by Network Dentists, that determination will be based upon the Plan’s contract with a Network Dentist for Covered Services rendered by that Dentist. For Covered Services provided by Out-of-Network Dentists,  the amount payable will be based upon the Plan’s fee schedule for the Covered Services rendered by Out-of-Network Dentists.

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

## **Necessary Dental Care –** Any treatment or service prescribed by a Dentist that the Plan determines to be necessary and appropriate.

## **Network Dentist** - A Dentist who has signed a Preferred Dental Agreement with the Plan.

## **Non-covered Services** - Services that:

1. exceed the benefit period and/or age limitations of the Plan as listed in Attachment A: Covered Services and Exclusions ;
2. are listed in Attachment B: Other Exclusions;
3. are beyond the limitations set forth in Attachment C: Schedule of Benefits, including Deductibles, Coinsurance and amounts above the Benefit Maximums; and
4. are not Necessary Dental Care.

## **Out-of-Network Dentist** - A Dentist who has not signed a Preferred Dental Agreement with the Plan.

## **Subscriber** - An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received applicable premium for Coverage.

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

## **Waiting Period** – The time that must pass before a Member is eligible to be Covered for benefits under the Plan or under Class C or Class D.

ATTACHMENT A: COVERED SERVICES AND EXCLUSIONS

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

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

If more than one procedure or course of treatment:

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

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

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

1. Diagnostic Services
   1. Exams
      1. Covered Services
         1. One periodic exam in any 6 month period.
         2. One limited oral evaluation in any 12 month period.
         3. One comprehensive, detailed/extensive, or periodontal exam in any 36- month period.
   2. X-rays
      1. Covered Services
         1. One full mouth set of x-rays in any 36- month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.
         2. Up to four bitewing films in any 12-month period. All bitewing films must be taken on the same date of service.
      2. Exclusions
         1. Extraoral, skull and bone survey, sialography, temporomandibular joint dysfunction (TMJ), and tomographic survey x-ray films, cephalometric films and diagnostic photographs, unless otherwise stated in this Dental EOC.
2. Preventive Services
   1. Prophylaxis (Cleanings)
      1. Covered Services
         1. One prophylaxis in any 6-month period, except when replaced as described below in Basic Periodontics.
   2. Fluoride Treatment
      1. Covered Services
         1. One fluoride treatment in any 12-month period for Members age 18 and under.
   3. Other Preventive Services
      1. Covered Services
         1. One sealant or preventive resin restoration per lifetime on first and second permanent molars for Members age 15 and under.
         2. Space maintainers for Members age 13 and under.
         3. One recementation per space maintainer in any 12 month period.
3. Basic Restorative Services
   1. Fillings and Stainless Steel Crowns
      1. Covered Services
         1. One amalgam or resin restoration per tooth surface in any 12 month period.
         2. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration.
         3. Stainless steel crowns.
         4. Replacement of stainless steel crowns Covered after 36 months from the date of initial restoration.
         5. One sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per lifetime, for Members age 15 and under. Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
      2. Exclusions
         1. Gold foil restorations.
   2. Other Basic Restorative Services
      1. Covered Services
         1. Palliative (emergency) treatment for the relief of pain.
         2. One repair per denture in any 24 month period
         3. General anesthesia or intravenous (IV) sedation in connection with major oral surgery procedures when provided by a Dentist licensed to administer such agents.
4. Major Restorative & Prosthodontic Services
   1. Single Tooth Restorations
      1. Covered Services
         1. Crowns, inlays and onlays only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling).Replacement of single tooth restorations or fixed partial dentures (bridges) after 60 months from the date of initial placement.
         2. Veneers for anterior permanent teeth.
      2. Exclusions
         1. Provisional restorations and crowns.
         2. Cast crowns or laminate veneers for Members age 11 and under.
   2. Multiple Tooth Restorations – Bridges
      1. Covered Services
         1. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast) for permanent teeth only.
         2. Replacement of fixed partial dentures or single tooth restorations after 60 months from the date of initial placement.
      2. Exclusions
         1. Provisional or interim restorations.
         2. Bridges for Members age 15 and under.
   3. Removable Prosthodontics (Dentures)
      1. Covered Services
         1. Complete, immediate and partial dentures utilizing standard techniques and materials as determined by the Plan.
         2. Personalized restorations, special techniques or materials shall be covered up to the amount allowed for standard techniques and materials.
         3. Replacement of removable dentures after 60 months from the date of initial placement.
      2. Exclusions
         1. Interim (temporary) dentures.
   4. Dentures for Members age 15 and under. Other Major Restorative & Prosthodontic Services
      1. Covered Services
         1. Core build-up covered separately from restoration only in those circumstances where benefits are provided because severe carious lesions or fractures are so extensive that retention of the restoration would not be possible.
         2. Crown inlay, onlay, veneer and bridge repair and re-cementation after 12 months from the date of initial placement.
         3. One denture adjustment in any six month period and only after 6 months from the date of initial placement.
         4. One denture reline, rebase, or tissue conditioning in any 36 month period.
      2. Exclusions
         1. Provisional and interim restorations.
         2. Other major restorative services including protective restoration and coping.
         3. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
         4. Crown preparation, temporary or prefabricated crowns, impressions and cementation.
         5. Post and core services not performed in conjunction with a Covered crown or bridge.
         6. One implant per tooth per lifetime.
         7. One bone graft for implant per tooth per lifetime.
         8. One implant debridement per tooth per lifetime.
         9. Initial placement or replacement of implant supported prosthesis after 60 months from the date of any corresponding major restoration.
5. Endodontics (treatment of the dental pulp or root canal)
   1. Basic Endodontics
      1. Covered Services
         1. Pulpotomy, pulpal therapy for primary teeth but not when performed in conjunction with major endodontic treatment.
      2. Exclusions
         1. Pulpal debridement.
         2. Pulp vitality tests.
         3. Protective restorations.
   2. Major Endodontics
      1. Covered Services
         1. One root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, hemisection, pulp cap or root amputation) per tooth in any 60-month period.
         2. One apicoectomy per root per lifetime.
         3. Retrograde filling if done on same date of service as apicoectomy.
      2. Exclusions
         1. Guided tissue regeneration.
         2. Intentional re-implantation (including necessary splinting).
         3. Canal preparation.
         4. Incomplete endodontic therapy.
         5. Pulp vitality test.
         6. Protective restorations.
6. Periodontics
   1. Basic Periodontics
      1. Covered Services
         1. One periodontal scaling and root planing per quadrant in any 24- month period.
         2. One full mouth debridement per lifetime.
         3. Periodontal maintenance no sooner than 90 days after completion of any one of the Basic Periodontic Covered Services above. Periodontal maintenance will replace a prohylaxis or scaling.
         4. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a prohylaxis or periodontal maintenance procedure.
      2. Exclusions
         1. Provisional splinting, and antimicrobial medication and dressing changes.
         2. Periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.
   2. Major Periodontics
      1. Covered Services
         1. One major surgical periodontal procedure, including gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, per quadrant in any 36 month period.
         2. One crown lengthening per tooth in any 36 month period.
         3. One bone and tissue grafting per site in any 36 month period.

### Exclusions

* + - 1. Tissue regeneration and apically positioned flap procedure.

1. Oral Surgery
   1. Basic Oral Surgery
      1. Covered Services
         1. Non-surgical or simple extractions (pulling teeth).
   2. Major Oral Surgery
      1. Covered Services
         1. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.
      2. Exclusion
         1. Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures.
         2. Orthognathic surgery and treatment for congenital malformations.
         3. Harvesting of bone for use in autogenous grafting.

ATTACHMENT B: OTHER EXCLUSIONS

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

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
2. Services or supplies not listed as Covered Services under Attachment A, Covered Services and Limitations on Covered Services.
3. Charges for services performed by You or Your spouse, or Your or Your spouse’s parent, sister, brother or child.
4. Services rendered by a Dentist beyond the scope of his or her license.
5. Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental Coverage.
6. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.
7. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
8. Any court-ordered treatment of a Member unless benefits are otherwise payable.
9. Courses of treatment undertaken before You become Covered under this program.
10. Any services performed after You cease to be eligible for Coverage, except as shown under the Payment For Services Rendered After Termination of Coverage section.
11. Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
12. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
13. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers’ compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers’ Compensation with the appropriate government department.
14. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
15. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)
16. Replacement of tooth structure lost from wear or attrition.
17. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
18. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
19. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
20. Diagnostic dental services such as diagnostic tests and oral pathology services.
21. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as stated elsewhere in this EOC).
22. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
23. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.
24. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.
25. Dental consultations including but not limited to re-evaluations, teledentistry, nutritional and tobacco counseling and oral hygiene instruction.
26. Implants.

ATTACHMENT C:   
SCHEDULE OF BENEFITS

Product Name: Dental

Group Name: Stepherson, Inc. dba Superlo Foods

Group Number: 143186

Benefits Effective: December 1, 2023

|  |  |  |
| --- | --- | --- |
| **Deductible**  Annual Benefit Period  Applies to Coverages B and C only | **Individual**  $50 | **Family**  3 x Individual ($150) |
| **Maximums**  Applies to Coverage A, B and C | $1,000 per Annual Benefit Period | |

| **Covered Services** | **Benefit Percentages** | **Waiting Period** |
| --- | --- | --- |
| Coverage A Diagnostic and Preventive Services  Exams X-rays | 100% | None |
| Coverage B Basic Restorative Basic/Major Endodontics Basic/Major Oral Surgery Basic/Major Periodontics | 80% | None |
| Coverage C Major Restorative and Prosthodontics | 50% | 12 months |
| Coverage D | Not Covered | Not Covered |
| **Annual Benefit Period** | January 1 – December 31 | |

## Network discounts do not apply to Non-covered Services.

ATTACHMENT D:   
STATEMENT OF ERISA RIGHTS

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

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually the Employer) and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for these copies;
3. Receive a summary of the Plan’s annual financial report. The Plan Administrator (Plan Sponsor, usually the Employer) is required by law to furnish each participant with a copy of this summary annual report; and
4. Continue Your health care Coverage if there is a loss of Coverage under the Plan as a result of a qualifying event. You may have to pay for such Coverage. Review the “Continuation of Coverage” section of this EOC for the rules governing Your COBRA Continuation Coverage rights.

In addition to creating rights for You and other Employees, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan are called “fiduciaries” of the Plan. They must handle the Plan prudently and in the interest of You and other Plan participants and beneficiaries. No one, including the Employer, a 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 rights under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You have a right to know why this was done and to obtain copies of documents relating to the decision without charge. You have the right to have the Plan review Your claim and reconsider it, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report 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., the 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 Plan 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. Also, if You disagree with the Plan’s decision (or lack thereof) concerning the qualified status of a Medical Child Support Order, You may file suit in federal court. If Plan fiduciaries misuse the Plan’s money or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or may file suit in a federal court.

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

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

GENERAL LEGAL PROVISIONS

INDEPENDENT LICENSEE OF THE BLUE CROSS BLUE SHIELD ASSOCIATION

BlueCross is an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent BlueCross and BlueShield Plans (the “Association”). The Association permits BlueCross to use the Association’s service marks within its service area. BlueCross is not contracting as an agent of the Association.

REWARDS OR INCENTIVES

Any reward or incentive You receive under a health or wellness program may be taxable. Talk to Your tax advisor for guidance. Rewards or incentives may include cash or cash equivalents, merchandise, gift cards, debit cards, Premium discounts or rebates, contributions toward Your health savings account (if applicable), or modifications to a Copayment, Coinsurance, or Deductible amount.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

You may continue Your Coverage and Coverage for eligible Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies.

SUBROGATION AND RIGHT OF REIMBURSEMENT

1. **Subrogation Rights**

The Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You for illnesses or injuries caused, insured or reimbursed by any parties, including the right to recover the reasonable value of services rendered by Network Providers.

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

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

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

1. **Priority Right of Reimbursement**

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

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

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

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

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

Notice and Cooperation

Members are required to notify the Administrator if they are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable the Administrator to protect the Plan’s rights under this section. Members are also required to cooperate with the Administrator and to execute any documents that the Administrator, acting on behalf of the Employer, deems necessary to protect the Plan’s rights under this section.

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

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

Legal Action and Costs

The Plan may enforce its rights of subrogation and reimbursement against, without limitation, any tortfeasors, any responsible 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.

If You settle any claim or action against any party, You 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 subrogation and recovery rights from the settlement fund. You shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys’ fees incurred in collecting proceeds held by You in such circumstances.

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

Settlement or Other Compromise

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

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

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

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

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

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 THIS NOTICE CAREFULLY. THEN, KEEP IT ON FILE FOR REFERENCE.**

LEGAL OBLIGATIONS

Employer is 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 Employer’s Legal Obligations; and advise Members of additional rights concerning their health plan information. Employer must follow the privacy practices contained in this notice from its Effective Date until this notice is changed or replaced.

Employer reserves the right to change its 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 Employer’s privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting the Employer at the address at the end of this notice.

**ORGANIZATIONS COVERED BY THIS NOTICE**

This notice applies to the privacy practices of the Employer. Health plan information about Members may be shared among these organizations as needed for treatment, Payment or healthcare operations. As the Employer procures or creates new business lines, they may be required to follow the terms defined in this notice of privacy practices.

Subsidiaries or affiliates that do not receive or have access to Your health plan information and are to be excluded from this notice of privacy practices include: The non-healthcare components of the Employer.

**USES AND DISCLOSURES OF YOUR 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 healthcare 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 that 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 health plan 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. Employer cannot use or disclose Your health plan information except as described in this notice, without Your written Authorization.** Examples of where an Authorization would be required include: 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 protected health information (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 Employer 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 Employer 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 law.

**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 Employer 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. Employer 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 Employer 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 Employer’s use or disclosure of Your health plan information. Employer is not required to agree to such requests. Employer 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 Employer.

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 Employer 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 the Employer. Follow up with a written request is required as soon as possible. Employer 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 Employer amend Your health plan information. Your request must explain why the information should be amended. Employer may deny Your request if the health plan information You seek to amend was not created by the Employer or for other reasons permitted by its Legal Obligations. If Your request is denied, the Employer 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 Employer 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 Employer’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 Employer’s privacy practices or have questions or concerns, please contact the Privacy Office.

If You: (1) are concerned that the Employer has violated Your privacy rights; (2) 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 of Your health plan information; or (3) request that the Employer 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. Employer will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

Employer 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 the Employer or subsidiaries and affiliates, or with the U.S. Department of Health and Human Services.

Stepherson, Inc. dba Superlo Foods

2155 Covington Pike

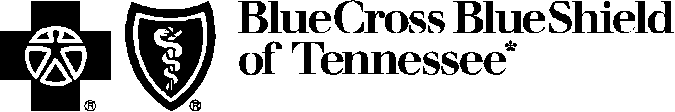
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