DENTAL
PLAN OF BENEFITS

South Carolina

BlueCross BlueShield of South Carolina
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Blue Cross and Blue Shield Association

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ARTICLE I - DENTAL DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

Actively at Work: a permanent, full-time Employee who works at least the minimum number of hours per week and the minimum number of weeks per year (each as set forth on the Schedule of Benefits) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary layoff.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including a denial, reduction or termination of, or failure to provide or make payment (in whole or in part), for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Investigational or Experimental or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit), except to the extent attributable to a failure to pay any required Premiums or Employee contributions.

Allowable Charge: the charge payable by the Corporation. The payment will not exceed the Maximum Payment.

Alternate Recipient: any Child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

Authorized Representative: an individual (including a Provider) whom the Member designates in writing to act on his or her behalf.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Corporation will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated.

Benefit(s): services or supplies that are:

1. Medically Necessary;
2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);
3. Included in Article III of this Plan of Benefits; and,
4. Not limited or excluded under the terms of this Plan of Benefits.

Benefits Checklist: the document (in electronic or hardcopy form) maintained by the Corporation which reflects the benefits selected by the Employer and submitted to the Corporation which outlines the Benefits to be offered under the Group Health Plan. The Corporation shall administer the Group Health Plan in accordance with the terms of the Benefits Checklist.

Child: an Employee's child, whether a natural child, adopted child, foster child, stepchild or child for whom an Employee has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent and a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. The term "Child" does not include the Spouse of an eligible child.

COBRA: those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain Employers to offer continuation of healthcare coverage to Employees and Dependents of Employees who would otherwise lose coverage.

COBRA Administrator: the Corporation or its designated subcontractor that provides administrative services related to COBRA.

Coinsurance: the sharing of the Allowable Charge between the Member and the Corporation. After the Member's Benefit Year Deductible requirement is met, the Corporation will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

Concurrent Care: an ongoing course of treatment to be provided over a period of time or number of treatments.

Contract: the Master Group Contract between the Corporation and the Employer including the Employer Application, Benefits Checklist, Plan of Benefits and all endorsements, amendments, riders or addenda.

Copayment: the amount, if any, specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

Corporation: Blue Cross and Blue Shield of South Carolina.

Covered Expenses: the amount payable by the Corporation for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Dental Coverage: coverage under a Group Health Plan that includes Benefits for treatment of the mouth, including limited-scope dental Benefits.

Dependent(s): an individual who is:

1. An Employee's Spouse;

2. A Child under the age set forth on the Schedule of Benefits; or,

3. An Incapacitated Dependent.

Discount Services: from time to time Benefits in the form of discounts for certain Provider Services or products will be provided to Members by networks of complementary healthcare Providers with which the administrator has an agreement for various programs. This discount applies to services the Group Health Plan does not cover. The Corporation will not be responsible for any costs associated with these programs.

Employee: any employee of the Employer who is eligible for coverage, as provided in Article II of this Plan of Benefits, and who is so designated to the Corporation by the Employer.

Employer: the entity identified as the Employer in the Contract.

Employer's Effective Date: the date the Corporation begins to provide Services under the Contract.

ERISA: the Employee Retirement Income Security Act of 1974, as amended.

Grace Period: the thirty-one (31) day period for the payment of any Premium due, except the first Premium, during which time the Covered Expenses are paid by the Corporation, unless the Employer gives the Corporation written notice of intent to discontinue the Contract or this Plan of Benefits prior to the date the next Premium is due in accordance with the terms of the Contract. There is no Grace Period for the payment of the first Premium.

Group Health Plan: this Employee welfare Benefit Plan established and/or sponsored by the Employer to provide benefits to Employees and/or their Dependentsdirectly or through insurance, reimbursement or otherwise.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Identification Card: the card issued by the Corporation to a Member that contains the Member's identification number.

Incapacitated Dependent: a Child who is:

1. Incapable of financial self-sufficiency by reason of total disability; and,

2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

Investigational or Experimental: surgical, dental or medical procedures, supplies, devices or drugs which, at the time provided or sought to be provided, are, in the judgment of the Corporation, not recognized as conforming to generally accepted medical or dental practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;

2. Is one about which the peer-reviewed dental literature in the United States does not permit conclusions concerning its effect on health outcomes;

3. Is not demonstrated in the United States to be superior to established alternatives;

4. Has not been demonstrated in the United States to improve net health outcomes; or,

5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Legally Intoxicated: the Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Member was under the influence of alcohol when measured by law enforcement or medical personnel.

Lifetime Maximum: the total Benefits (under this Group Health Plan) to which a Member is entitled during such Member's lifetime.

Maximum Payment: the total amount the Corporation will pay for a particular Benefit. The Maximum Payment will not be affected by any credit. The Maximum Payment will not be less than:

1. The actual charges made for similar services, supplies or equipment by Providers and filed with the Corporation during the preceding calendar year;

2. The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices;

3. The lowest rate at which any service, supply or equipment is generally available in the local service area when, in the judgment of the Corporation, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Members upon written request;

4. An amount that has been agreed upon by a Provider and the Corporation; or,

5. An amount established by the Corporation in its discretion. In determining the Maximum Payment under this paragraph 5, the Corporation may, through its staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides Child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law) and relates to this Plan of Benefits; or,

2. Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

1. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;

3. The period to which such order applies; and,

4. Each Group Health Plan to which such order applies.

If the Medical Child Support Order is a national medical support notice, the order must also include:

1. The name of the issuing agency;

2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,

3. The identification of the underlying medical Child support order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medically Necessary/Medical Necessity: using United States standards, services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of dental practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;

3. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,

4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

All requirements of the above-referenced definition must be met in order for a service to be deemed Medically Necessary. The failure of a service to meet any one of the above referenced requirements means, in the discretion of the Corporation, the service does not meet the definition of Medically Necessary.

For the purposes of determining Medical Necessity:

1. The Corporation has the discretion to utilize and rely upon any dental standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which, in their discretion, are determined to be generally accepted by the dental community;

2. "Generally accepted standards of dental practice" means United States standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant United States dental community, dental society recommendations, and/or any other factors deemed relevant in the discretion of the Corporation; and,

3. The Corporation may use the following materials, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC or affiliated companies which reflect clinically appropriate services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC and/or its affiliated companies are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies.

Member: an Employee or Dependent who has enrolled under this Group Health Plan.

Member Effective Date: the date on which an Employee or Dependent is covered for Benefits under the terms of Article II of this Plan of Benefits.

Membership Application: any mechanism agreed upon by the Corporation and the Employer for transmitting necessary Member enrollment information from the Employer to the Corporation.

Non-Participating Provider: any Provider who does not have a current, valid Participating Provider Agreement.

Participating Provider: a Provider who has a current, valid Participating Provider Agreement.

Plan: any program that provides benefits or services for medical or dental care or treatment, including:

1. Group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and,

2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Article V apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of this Plan of Benefits. The Employer is the Plan Administrator of this Plan of Benefits.

Plan of Benefits: this benefit booklet which reflects the Benefits offered under the Group Health Plan based on the Benefits Checklist. The Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.

Plan of Benefits Effective Date: 12:01 a.m. EST on the date listed on the Schedule of Benefits.

Plan Sponsor: the party sponsoring this Group Health Plan. The Employer is the Plan Sponsor of the Group Health Plan.

Post-Service Claim: any claim for a Benefit that is not a Pre-Service Claim.

Preauthorized/Preauthorization: the Corporation's approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member.

Premium: the amount paid to the Corporation by the Employer for coverage under this Plan of Benefits. Payment of Premiums by the Employer constitutes acceptance by the Employer of the terms of this Plan of Benefits and the Contract.

Pre-Service Claim: any request for a Benefit where Preauthorization must be obtained before receiving the care, service or supply.

Primary Plan: a Plan whose Benefits must be determined without taking into consideration the existence of another Plan.

Probationary Period: the period of continuous employment (if included on the Schedule of Benefits) with the Employer that an Employee must complete before becoming eligible to enroll in this Plan of Benefits. The Employer may require an additional orientation period.

Protected Health Information (PHI) : has the same meaning as the term is defined under HIPAA.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of either of the following:

1. Dentistry; or,

2. Oral surgery.

Provider Agreement: an agreement between the Corporation or a designated agent of the Corporation and a Provider under which the Provider has agreed to accept the Corporation's allowance as payment in full for Benefits (subject to the Member liability amounts).

Qualified Medical Child Support Order: a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,

2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes under Article VII, a Qualifying Event is any one (1) of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under this Plan of Benefits;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from his or her Spouse;

4. A Child ceasing to qualify as a Dependent under this Plan of Benefits;

5. Entitlement to Medicare by an Employee or by a parent of a Child; or,

6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Schedule of Benefits: the pages of this Plan of Benefits, so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Secondary Plan: a Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

Spouse: any individual who is legally married under any state law.

Treatment Plan: a written report, including any necessary x-rays, showing the recommended treatment of any dental disease, defect or injury of a Member, prepared by a Provider as a result of any examination made by such Provider while coverage under this Plan of Benefits is in effect for the Member.

Urgent Care Claim: any claim for care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function, or, in the opinion of a licensed medical doctor or oral surgeon with knowledge of the Member's condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE II - ELIGIBILITY FOR COVERAGE

A. ELIGIBILITY

1. Every Employee who is Actively at Work and who has completed the Probationary Period on or after the Employer's Effective Date is eligible to enroll (and to enroll his or her Dependents) for coverage under this Plan of Benefits.

2. If an Employee is not Actively at Work or has not completed the Probationary Period such Employee is eligible to enroll (and to enroll his or her Dependents) beginning on the next day that the Employee:

    a. Is Actively at Work; and,

    b. Has completed the Probationary Period.

3. Dependents are not eligible to enroll for coverage under this Plan of Benefits without the sponsorship of an Employee who is enrolled under this Plan of Benefits.

4. The Employee must furnish written proof of the requirements for an Incapacitated Dependent, as outlined in Article I, to the Employer no later than thirty-one (31) days after the Child's attainment of the maximum age listed on the Schedule of Benefits. The Employee will provide proof upon request.

B. ELECTION OF COVERAGE

Any Employee may enroll for coverage under this Plan of Benefits for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Employer. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents.

The Employee is required to submit a marriage license and file it with the Employer. The Corporation reserves the right to request documentation of such marriage.

C. COMMENCEMENT OF COVERAGE

Coverage under this Plan of Benefits will commence as follows, provided that coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application:

1. Employees and Dependents Eligible on the Employer's Effective Date.

   For Employees (and such Employee's Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer's Effective Date, coverage will generally commence on this Plan of Benefits Effective Date.

   If the Corporation receives an Employee's Membership Application dated after the Employer's Effective Date, coverage will commence on the date chosen by the Employer.

2. Employees and Dependents Eligible After this Plan of Benefits Effective Date.

   Employees and Dependents who become eligible for coverage after this Plan of Benefits Effective Date and have elected coverage will have coverage after they have completed the Probationary Period.

3. Dependents Resulting from Marriage.

   Dependents resulting from the marriage of an Employee will have coverage upon enrollment provided they have been enrolled for coverage within thirty-one (31) days after marriage and appropriate Premiums must be paid to the Corporation for such Dependents to have coverage from the date of the marriage.

4. Newborn Children.

   A newborn Child will have coverage upon the date of the Child's birth provided he or she has been enrolled for coverage (and the coverage has been paid for) within thirty-one (31) days after the Child's birth.

5. Adopted Children.

   For an adopted Child of an Employee, coverage shall commence as follows:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth;

   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth and if the Employee has obtained temporary custody of the Child; or,

   c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered, in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.

   If an adopted Child is not enrolled within the time frame set forth in (a)-(c) above, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium.

D. DEPENDENT CHILD'S ENROLLMENT

1. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits. For a Dependent to be covered under this Plan of Benefits, the required Premium must be paid.

2. Absent the sponsorship of an Employee, Dependents are not eligible to enroll for coverage under this Plan of Benefits.

E. MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Employer on behalf of each Employee. The Corporation will not accept a Membership Application directly from an Employee or Dependent.

F. MEMBER CONTRIBUTIONS

The Member is solely responsible for making all payments for any Premium.

G. DISCLOSURE OF INFORMATION

The Member agrees that the Corporation may obtain claims information, records and other information necessary for the Corporation to consider a request for Preauthorization or to process a claim for Benefits.

ARTICLE III - DENTAL COVERED EXPENSES

Subject to all provisions of this Plan of Benefits, including but not limited to ARTICLE IV – DENTAL EXCLUSIONS, Benefits set forth shall be provided as specified on the Schedule of Benefits when:

1. The services are based on accepted standards of dental practice;

2. The services are rendered or the supplies furnished by a Provider or dental hygienist acting within the scope of his or her license; and,

3. The services and supplies are billed by or on behalf of the Provider. The Benefit must not have a "Non-Covered" notation associated with it on the Schedule of Benefits. Please refer to the Schedule of Benefits for limitations on specific Benefits.

Payment is provided for the following:

A. DIAGNOSTIC AND PREVENTIVE DENTAL BENEFITS

1. Oral examination, including Treatment Plan, if necessary;

2. Periapical, occlusal, extra oral x-rays, as required, and bitewing x-rays;

3. Full mouth x-rays or panoramic films;

4. Topical fluoride applications of stannous fluoride or acid fluoride phosphate;

5. Prophylaxis, including cleaning, scaling and polishing;

6. Space maintainers for prematurely lost deciduous teeth;

7. Emergency palliative treatment for the relief of pain;

8. Pulp vitality tests;

9. Diagnostic casts; and,

10. Sealants on permanent teeth that have not had any fillings.

B. BASIC DENTAL BENEFITS

1. Oral surgery (but not periodontal surgery), including the following:

    a. Surgical extractions;

    b. Alveoplasty;

    c. Surgical excision of lesions and tumors;

    d. Removal of cysts and neoplasms;

    e. Excision of bone tissue;

    f. Biopsies of oral tissue;

    g. Treatment of oral fistula;

    h. Excision of hyperplastic tissue; and,

    i. Frenulectomy;

2. Fillings, consisting of amalgam and tooth-colored synthetic materials;

3. Simple extractions;

4. Endodontics, consisting of pulpotomy, pulp capping and root canal treatment;

5. Thirty (30) minutes of IV sedation and general anesthesia if Medically Necessary and rendered in connection with covered oral or dental surgery, except as specified on the Schedule of Benefits;

6. Assistant at surgery when Medically Necessary;

7. Hemi-section;

8. Apicoectomy (amputation of apex of a tooth root);

9. Periodontics, that being the diagnosis and treatment of diseases of the tooth-supporting tissues, as follows:

    a. Surgical periodontic examination;

    b. Gingival curettage;

c. Gingivectomy and gingivoplasty;

d. Osseous surgery, including flap entry and closure; and,

e. Management of acute infection and oral lesions;

10. Periodontal cleanings; and,

11. Repair of removable dentures.

C. MAJOR DENTAL BENEFITS

The restoration and maintenance of oral function by the replacement of missing teeth and structures by artificial appliances, as follows:

1. Inlays (not part of a bridge);

2. Permanent crowns (not part of a bridge);

3. Onlays (not part of a bridge);

4. Removable dentures, complete and partial, and bridges, fixed and removable. Benefits for replacement shall not be provided for:

   a. Any denture replacement inlay, crown or onlays made less than the timeframe, if any, set forth on the Schedule of Benefits after a placement or replacement which was covered under this Plan of Benefits; or,

   b. Any replacement made necessary by reason of loss or theft;

5. Fixed bridge repairs; and,

6. Relining or rebasing of removable dentures.

D. ORTHODONTIC BENEFITS

The prevention or correction of irregularities in the alignment of the teeth and the prevention or correction of the malocclusion, as follows:

The correction of dysfunctional malocclusion consisting of the following:

1. Diagnosis, including models and radiographs;

2. Active treatment, including necessary appliances; and,

3. Retention treatment following active treatment, limited to ten (10) visits in an eighteen (18) month period.

E. CLEFT LIP AND PALATE

Benefits will be paid for teeth capping, prosthodontics and orthodontics necessary for the care and treatment of congenital cleft lip and palate. The same Benefit Year Deductible, Coinsurance and Copayments apply to these services as apply to other procedures covered by this Group Health Plan. Benefits under this Group Health Plan are primary to any Benefits available for the patient under any individual or group accident and health coverage Plan.

ARTICLE IV - DENTAL EXCLUSIONS

No Benefits will be provided under any article of this Plan of Benefits for the following:

1. Any services or charges for services not Medically Necessary;

2. Dental services or supplies that are Investigational or Experimental;

3. Any charges for supplies or dental services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date or after the Member's coverage terminates, except as provided in Articles VI and X;

4. Dental services received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trustee or similar person or group;

5. Dental services for which the Member incurs no charge;

6. Any service or charge for a service to the extent a Member is entitled to receive payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including, but not limited to, Medicare, TRICARE and Medicaid, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay;

7. Dental services or supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures;

8. Dental services for which the Member would have no legal obligation to pay in the absence of Dental Coverage;

9. Appliances or restorations necessary to increase vertical dimensions or restore the occlusion, including management of TMJ disorders, except as specified on the Schedule of Benefits;

10. Services rendered by a Provider beyond the scope of his or her license;

11. Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage hereunder;

12. Charges by a Provider for non-dental services such as broken appointments and completion of claim forms;

13. Charges for visits at home or in the hospital, except in connection with emergency care;

14. Dental care or treatment not specifically listed under Dental Covered Expenses or specified on the Schedule of Benefits;

15. Any service or supply rendered by a member of the patient's immediate family or by the patient, including the dispensing of drugs. A member of the patient's family means the Spouse, parent, grandparent, brother, sister, Child or Spouse's parent of the patient;

16. Implants and crowns, bridges and/or dentures involving implants;

17. Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war or any act of war, or while in the military service;

18. Services related to teeth missing prior to a Member's Effective Date of coverage under this Plan of Benefits are not eligible for payment of Benefits, except as specified on the Schedule of Benefits;

19. Any service for the treatment of dysfunctions or derangements of the TMJ, regardless of cause, including orthognathic surgery for the treatment of dysfunctions or derangements of the TMJ, regardless of cause, except as specified on the Schedule of Benefits;

20. Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities, regardless of cause, except as specific on the Schedule of Benefits;

21. Consultations;

22. Non-IV sedation (nitrous oxide and non-conscious sedation);

23. Services for the excision or extraction of impacted teeth, except as specified on the Schedule of Benefits;

24. Replacement Prosthodontics made necessary by loss or theft, except as specified in Article III or on the Schedule of Benefits;

25. Temporary crowns and partials;

26. Benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member.

    If the Corporation pays Benefits for an injury or illness and the Corporation determines the Member also received Workers' Compensation benefits by means of a settlement, judgment or other payment for the same injury or illness, the Corporation shall have the right of recovery as outlined in Article IX of this Plan of Benefits

27. Complications arising from a Member's receipt or use of dental services, supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services;

28. Complications that occur because a Member did not follow the course of treatment prescribed by a Provider;

29. Any illness or injury received while committing or attempting to commit a felony or while engaging in an illegal occupation;

30. Any dental service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits;

31. Any dental service, supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no Benefits will be provided;

32. Charges for a Member's appointment with a Provider that the Member did not attend;

33. Dental services or supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence;

34. Dental services or supplies or other items not specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits;

35. Orthodontics

    If this Benefit is listed on the Schedule of Benefits as a Covered Expense, the following will apply:

    a. Benefits for these services will be limited to Members to the age set forth on the Schedule of Benefits, if any;

    b. Benefits payable per Member are limited to the maximum amount specified on the Schedule of Benefits and to services rendered within a period not to exceed thirty-six (36) consecutive months;

    c. The initial payment will be equal to no more than twenty-five percent (25%) of the total liability of the Corporation, with the following sequential payments payable no more frequently than once a month. If, for any reason, the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Corporation will cease with payment through the month of termination; and,

    d. The replacement of any appliances made necessary by reason of loss or theft is not covered by this Plan of Benefits.

36. Payment for dental services shall be limited as follows:

    a. In all cases involving covered services or supplies in which the Provider and Member selected a more expensive or personalized course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this agreement will be based on the charge allowed for the lesser procedure as determined by the Corporation;

    b. In the event a Member transfers from the care of one Provider to that of another Provider during the course of treatment or if more than one Provider performs services for one dental procedure, the Corporation shall be liable not more than the amount it would have been liable for had but one Provider performed the service; or,

    c. Any additional treatment that is necessitated by lack of Member cooperation with the Provider or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member.

ARTICLE V - COORDINATION OF BENEFITS

A. APPLICABILITY

Coordination of benefits is designed to avoid the duplication of payments for Benefits. Coordination of benefits under this Article V applies when a Member has healthcare coverage under one (1) or more Plans that contain a coordination of benefits provision (or are required by law to contain a coordination of benefits provision). Special rules for the coordination of benefits with Medicare may also apply.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory or if the Member is involved in an accident in a state where such coverage is mandatory and the Member's automobile insurance carrier provides the state mandated coverage, the Member's automobile coverage is primary and this Group Health Plan secondary.

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

When a Member's claim is submitted under both this Group Health Plan and another Plan, this Group Health Plan is a Secondary Plan and the availability of Benefits is determined after benefits are determined under the other Plan unless:

1. The other Plan has rules coordinating its benefits with those of this Group Health Plan;

2. There is a statutory requirement relating to the determination of benefits that is not pre-empted by ERISA; or,

3. Both the other Plan's rules and this Group Health Plan's rules require that Benefits under this Group Health Plan be determined before those of the other Plan.

D. ADDITIONAL ORDER OF DETERMINATION RULES

The coordination of benefits is determined using the first of the following rules that apply:

1. Dependents.

   The Plan that covers an individual as an Employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced.

   When this Group Health Plan and another Plan cover the same Child as a Dependent then benefits are determined in the following order:

   a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.

   b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.

   c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

The “birthday rule” does not use the years of the parents’ birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents.

   If two (2) or more Plans cover a person as a Dependent Child of divorced, separated or unmarried parents, benefits for the Child are determined in the following order:

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

   b. Second, the Plan of the Spouse of the parent with the custody of the Child;

   c. Third, the Plan of the parent not having custody of the Child; or,

   d. Fourth, the Plan of the Spouse of the parent not having custody of the Child.

   Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the healthcare 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 Plan has actual knowledge of the existence of an applicable court decree.

   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 healthcare expenses of the Child, the Plans covering the Child shall follow the order of determination rules outlined in Article V(D)(2).

4. Active and Inactive Employees.

   The benefits of the Plan that covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before those of a Plan that covers that person as a laid off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

5. Medicare.

   This Plan of Benefits is a Primary Plan except where federal law mandates that this Plan of Benefits is the Secondary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

6. Longer and Shorter Length of Coverage.

   If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

7. COBRA.

   COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. This Plan of Benefits as Primary Plan

   When this Plan of Benefits is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. This Plan of Benefits as Secondary Plan

   When this Plan of Benefits is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

   a. The Covered Expenses in the absence of this coordination of benefits provision; plus

   b. The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

   When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of this Plan of Benefits are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of this Plan of Benefits.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered for purposes of determining the appropriate level of coverage available.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Corporation is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions, and the Member and the Employer must provide any such information as reasonably requested.

G. PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan of Benefits. In such a case, the Corporation may pay that amount to the organization that made such payment. That amount will then be treated as though it has been paid under this Plan of Benefits. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

H. RIGHT OF RECOVERY

If the amount of the payments made by the Corporation is more than the Corporation should have paid under this Coordination of Benefits section, the Corporation may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, any group insurer, Plan or any other person or organization contractually obligated to such Member with respect to such overpayments.

ARTICLE VI – TERMINATION OF THIS PLAN OF BENEFITS

A. GENERALLY

TERMINATION OF EMPLOYEE'S COVERAGE AND ALL OF SUCH EMPLOYEE'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS:

1. The date this Plan of Benefits is terminated pursuant to Article VI(B)-(E);

2. The date an Employee retires unless this Plan of Benefits covers such individual as a retiree;

3. The date an Employee ceases to be eligible for coverage as set forth in Article II;

4. The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed ninety (90) days from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993;

5. In addition to terminating when an Employee's coverage terminates, a Dependent Spouse's coverage terminates on the date of entry of an order or decree ending the marriage between the Dependent Spouse and the Employee regardless of whether such order or decree is subject to appeal;

6. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Plan of Benefits;

7. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent; or,

8. Upon the death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If the Premium remains unpaid after the Grace Period, this Plan of Benefits shall automatically terminate, without prior notice to the Employer, or to any Member, immediately after the last day of the Grace Period.

2. If a subgroup fails to pay the Premium after the Grace Period, this Plan of Benefits for that subgroup shall automatically terminate for nonpayment of Premium, without any prior notice to the Employer or Members, immediately after the last day of the Grace Period. Additionally, the Corporation retains the right to terminate this Plan of Benefits for the entire group in the event a subgroup fails to pay their portion of the Premium.

3. During the Grace Period, the Corporation will pay Covered Expenses for Benefits (including prescription drugs) obtained by Members during the Grace Period.

4. In the event of termination for failure to pay Premiums, Premiums received by the Corporation after the Grace Period will not automatically reinstate this Plan of Benefits absent written agreement by the Corporation. The Corporation will refund the amount of any late Premium paid if this Plan of Benefits is not reinstated, except that portion relating to coverage provided prior to or during the Grace Period.

C. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health Benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium, and the Employer will continue to pay the same Premium the Employer would have paid had the Employee been Actively at Work. If Premiums are not paid by an Employee within thirty-one (31) days of the Premium due date, coverage ends as of the due date of that Premium contribution.

D. TERMINATION FOR LACK OF MEMBERSHIP

If there is no longer any Member who lives, resides or works in South Carolina or in an area for which the Corporation is authorized to do business, the Corporation may terminate this Plan of Benefits and coverage will terminate on the date given by the Corporation in written notice to the Employer.

E. UNIFORM TERMINATION OF COVERAGE

1. The Corporation may terminate coverage under this Plan of Benefits if:

    a. The Corporation ceases to offer coverage of the type of group health insurance coverage provided by this Plan of Benefits and provides notice to the Employer and Members at least ninety (90) days prior to the date of the discontinuation of such coverage;

    b. The Corporation offers to each Employer provided coverage of this type in such market the option to purchase any other group health insurance currently being offered by the Corporation to a Group Health Plan in such market; and,

    c. The Corporation acts uniformly without regard to the claims experience of the Employer.

2. If the Corporation elects to discontinue offering all group health insurance coverage in South Carolina, coverage under this Plan of Benefits may be discontinued by the Corporation only:

    a. In accordance with applicable state law;

    b. If the Corporation provides notice to the Department of Insurance (DOI) and to the affected Employer and Members of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage;

    c. If all group health insurance coverage issued or delivered for issuance in South Carolina is discontinued and coverage under such health benefit coverage in such market is not renewed; and,

    d. If the Corporation will not issue any group health insurance coverage in the market during the five (5) year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

F. NOTICE OF TERMINATION TO MEMBERS

Other than as expressly required by law, if this Plan of Benefits is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and notifying Members that coverage of Members under this Plan of Benefits will not continue beyond the termination date. The Employer agrees to indemnify and hold the Corporation harmless for all damages, claims, causes of action, penalties, fines, charges, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Plan of Benefits.

G. REINSTATEMENT

The Corporation in its discretion (and upon such terms and conditions as the Corporation may determine) may reinstate coverage under this Plan of Benefits that has been terminated for any reason. If a Member's coverage (including coverage for the Member's Dependents) for Covered Expenses under this Plan of Benefits terminates while the Member is on leave pursuant to the Family and Medical Leave Act because the Member fails to pay such Member's portion of the Premium within the Grace Period, the Member's coverage will be reinstated without new Probationary Periods if the Member returns to work immediately after the leave period, re-enrolls and within thirty-one (31) days following such return pays all such Employee's portion of the past due amount and then current Premium.

H. EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of any notice under this Plan of Benefits. The Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by state or federal law to be given to the Members by the Corporation.

ARTICLE VII –CONTINUATION OF COVERAGE

A. CONTINUATION

1. State Law

   In addition to any extension of Benefits a Member may have, each Member has the right, upon request, to continue such Member's coverage under this Plan of Benefits for that portion of the month remaining at termination plus six (6) additional months. The Member must make payment of the appropriate Premium (including any Employer portion) to the Employer in advance for such coverage. To be eligible for such coverage, the Member must have been continuously covered under the Employer's Group Health Plan for at least six (6) months and have been terminated for a reason other than non-payment of Premium. If a Member is entitled to coverage under COBRA for a greater period of time, to Medicare benefits or for other group health coverage, such Member is not entitled to continuation coverage under this section. This Plan of Benefits or a successor Plan must remain in force and the Member must pay the applicable Premium in advance for the Member to receive this continuation coverage.

2. COBRA

a. Plan Administrator and Sponsor.

The Employer is both the Plan Administrator and Employer for this Plan of Benefits. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while this Plan of Benefits is in force. COBRA requires the Employer to allow eligible individuals to continue their health coverage for eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the Qualifying Event.

b. Disabled Members.

To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or Dependent must:

i. be determined to be disabled under Title II or XVI of the Social Security Act with a disability onset date either before the COBRA event or within the first sixty (60) days of COBRA continuation coverage;

ii. provide a copy of the notice of the determination of disability to the Employer within:

aa. sixty (60) days of the determination of disability; and,

bb. before the end of the first eighteen (18) months of COBRA coverage.

Such Employee or Dependent must also notify the Employer within thirty (30) days of any determination that the Employee or Dependent is no longer disabled.

c. Notice of Qualifying Event by the Member.

Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, legal separation or when a Dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

d. Notice by the Employer to the Member.

The Employer must notify the COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator must send a COBRA Election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the Dependent Spouse is deemed notice to any Dependent of the Spouse.

e. Election of Coverage.

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

i. The date the Member's coverage under this Plan of Benefits ceases because of the Qualifying Event;

ii. The date the Member is sent notice of the right to elect continuation coverage by the Employer; or,

iii. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002 (TAA).

f. Premium Required.

The Member will be required to pay a Premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first Premium, which includes the period when coverage commenced, regardless of the date that the first Premium is due. Subsequent Premiums are subject to a Grace Period.

The TAA created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the Premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 866-628-4282. TTD/TTY callers may call toll free at 866-626-4282. More information about the TAA is also available at www.doleta.gov/tradeact/.

g. Length of COBRA Coverage.

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is generally eighteen (18) months. An Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or Dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected Dependent who was a Member under this Plan of Benefits both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

i. Eighteen (18) months for Employees whose working hours are reduced--from full-time to part-time, for instance, and any Dependents who also lose coverage for this reason.

ii. Eighteen (18) months for Employees who voluntarily quit work and any Dependents who also lose coverage for this reason.

iii. Eighteen (18) months for Employees who are part of a layoff and any Dependents who also lose coverage for this reason.

iv. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any Dependents who also lose coverage for this reason.

v. Twenty-nine (29) months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the COBRA Administrator within sixty

(60) days of the determination of disability and before the end of the first eighteen (18) months of continuation of coverage.

vi. Thirty-six (36) months for Employees' widows or widowers and their Dependent Children.

vii. Thirty-six (36) months for legally separated or divorced husbands or wives and their Dependent Children.

viii. Thirty-six (36) months for Dependent Children who lose coverage because they no longer meet the Plan's definition of a Dependent Child.

ix. Thirty-six (36) months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer This does not apply to any Employees or their Dependents if the Employee voluntarily quit work. See Article VII(A)(2)(g)(ii) of this section for coverage for Employees who voluntarily quit.

x. For Plans providing coverage for retired Employees and their Dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy (loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing). Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to thirty-six (36) additional months.

3. USERRA

a. In any case in which an Employee or any of such Employee's Dependents has coverage under this Plan of Benefits and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under this Plan of Benefits as provided in this Article VII(A)(3). The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:

i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or,

ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

b. An Employee who elects to continue coverage under this section of this Plan of Benefits must pay one hundred and two percent (102%) of such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.

c. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under this Plan of Benefits upon re-employment. Except as otherwise provided in Article VII(A)(3)(d), upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This Article VII(A)(3)(c) applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under this Plan of Benefits by reason of the reinstatement of the coverage of such Employee.

d. Article VII(A)(3)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

B. QUALIFIED MEDICAL CHILD SUPPORT ORDER

This Plan of Benefits shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements

a. Timely Notifications and Determinations.

In the case of any Medical Child Support Order received by the Corporation:

i. The Employer shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Employer's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

b. Establishment of Procedures for Determining Qualified Status of Orders.

The Employer shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

i. Shall be in writing;

ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under this Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,

iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

c. Actions Taken by Fiduciaries.

If a Plan fiduciary for this Plan of Benefits acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then this Plan of Benefits obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients

a. Under ERISA.

A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a Member under this Plan of Benefits for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

b. Direct Provision of Benefits Provided to Alternate Recipients.

Any payment for Covered Expenses made by the Corporation pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

c. Plan Enrollment and Payroll Deductions.

If an Employee remains covered under this Plan of Benefits but fails to enroll an Alternate Recipient under this Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional Premium from the Employee's paycheck.

d. Termination of Coverage.

Except for any coverage continuation rights otherwise available under this Plan of Benefits, the coverage for the Alternate Recipient shall end on the earliest of:

i. The date the Employee's coverage ends;

ii. The date the Qualified Medical Child Support Order is no longer in effect;

iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,

iv. The date the Employer eliminates family health coverage for all of its Employees.

ARTICLE VIII – SUBROGATION AND REIMBURSEMENT

A. SUBROGATION

The Member agrees, as a condition of receiving Benefits, to transfer to the Corporation all rights to recover for the amount paid for such Benefits when the need for Benefits results from an injury occurring through the act or omission of a third party (including another person, firm, corporation, organization or business entity). The Corporation shall be subrogated, at its expense, to the rights of recovery of such Member against any third party who is liable, responsible or otherwise makes a payment for the injury.

B. REIMBURSEMENT

The Member agrees, as a condition of receiving Benefits, to reimburse the Corporation for the amount paid for Benefits which are related to an injury caused by an act or omission of a liable third party when the Member receives a settlement, judgment or other payment relating to the injury from another person, firm, corporation, organization or business entity. However, under no circumstances will the amount of reimbursement exceed the amount of the Member's recovery.

For purposes of this Article, a liable third party and/or liable insurance coverage include parties and coverages that are responsible or otherwise make a payment for the Member's injury even though liability or other culpability may be denied.

C. GENERAL PROVISIONS

The Corporation's subrogation/reimbursement rights apply to any judgment and/or settlement proceeds received by the Member from or on behalf of the liable third party.

The Corporation's subrogation/reimbursement interest extends to all Benefits paid or payable relating to the injury even if claims for those Benefits were not submitted to the Corporation for payment at the time the Member received the settlement, judgment or payment.

The Corporation's right of recovery may be from the liable third party, any liability or other insurance covering the liable third party, malpractice insurance, the Member's own uninsured motorist insurance and/or underinsured motorist insurance.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Corporation of an injury for which another party may be liable, legally responsible or otherwise makes a payment in connection with the injuries;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injuries within ninety (90) days of being requested to do so;

4. Authorize the Corporation to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries under the Plan and the expenses incurred by the Corporation in collecting this amount and assign to the Corporation the Member's rights to recovery when this provision applies;

5. Include the amount paid for Benefits as a part of the damages sought against a liable third party and/or liability insurance company;

6. Immediately reimburse the Corporation, out of any recovery made from a liable third party, the amount of medical Benefits paid for the injuries by the Corporation up to the amount of the recovery;

7. Immediately notify the Corporation in writing of any proposed settlement and obtain the Corporation's written consent before signing any release or agreeing to any settlement; and,

8. Cooperate fully with the Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Corporation.

The Corporation will pay reasonable attorney's fees and costs from the amount recovered.

If the Director of Insurance, or his or her designee, upon being petitioned by the Member, determines that the exercise of subrogation and/or reimbursement by the Corporation is inequitable and commits an injustice to the Member, subrogation and/or reimbursement will not be allowed. This determination by the director or his or her designee may be appealed to the Administrative Law Judge Division as provided by law.

ARTICLE IX – WORKERS' COMPENSATION PROVISION

This plan does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Corporation may, in its discretion, agree to extend coverage to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Corporation in full from any workers' compensation recovery as described herein.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Corporation of an injury or illness for which his or her Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;

4. Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;

5. Include the amount paid for Benefits as a part of the damages sought against his/her Employer and/or Employer's Workers' Compensation carrier or Second Injury Fund;

6. Immediately notify the Corporation in writing of any proposed settlement and obtain the Corporation's written consent before signing any release or agreeing to any settlement; and,

7. Cooperate fully with the Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Corporation.

The Corporation has discretion to determine whether claims for Benefits submitted to the Corporation are related to the injuries or illness to the extent this provision applies. If the Corporation pays Benefits for an injury or illness and the Corporation determines the Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment or other payment for the same injury or illness, the Member shall reimburse the Corporation from the recovery for all Benefits paid by the Corporation relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Corporation exceed the amount of such recovery.

If the Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Corporation's right of reimbursement from the recovery will be applied even if: liability is denied, disputed or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of workers' compensation benefits due to medical or healthcare is not agreed upon or defined by the Member, Employer or the Workers' Compensation carrier; or the medical or healthcare benefits are specifically excluded from the settlement or compromise.

ARTICLE X - ERISA RIGHTS

Each Member in this Plan of Benefits is entitled to certain rights and protections under ERISA. ERISA provides that all Members shall be entitled to:

A. RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing this Plan of Benefits, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by this Plan of Benefits 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 this Plan of Benefits, 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 assess a reasonable charge for the copies.

3. Receive, upon request, a summary of this Plan of Benefits' annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. CONTINUATION COVERAGE

Members are entitled to continue healthcare coverage for themselves and their Dependents if there is a loss of coverage under this Plan of Benefits as a result of a Qualifying Event. The Member or Dependents may have to pay for such continuation coverage. Employee Members should review the documents governing COBRA continuation coverage rights.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an Employee welfare benefit Plan. The people who administer an Employee welfare benefit Plan are called "fiduciaries," and have a duty to do so prudently and in the interest of the Members. The Employer is a fiduciary of this Plan of Benefits. No one, including the Employer, may fire or otherwise discriminate against a Member in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

D. ENFORCEMENT OF EMPLOYEE RIGHTS

1. If a Member's claim for a Benefit is denied or ignored, in whole or in part, such Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps a Member can take to enforce the rights described above. For instance, if a Member requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, such Member may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay such Member up to $110 a day until such Member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Member has a claim for Benefits that is denied or ignored, in whole or in part, such Member may file suit in a state or federal court. In addition, if a Member disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, such Member may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Member is discriminated against for asserting such Member's rights, such Member may seek assistance from the U.S. Department of Labor, or such Member may file suit in a federal court. The court will decide who should pay court costs and legal fees. If a Member is successful, the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order such Member to pay these costs and fees, for example, if it finds such Member's claim is frivolous.

3. No one, including the Employer, the Members' union or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

E. ASSISTANCE WITH QUESTIONS

If a Member has any questions about this Plan of Benefits, the Member should contact the Plan Administrator. If a Member has any questions about this statement or about a Member's rights under ERISA, or if a Member needs assistance in obtaining documents from the Plan Administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Member may also obtain certain publications about the Member's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XI - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. When a Participating Provider renders services, generally, the Participating Provider should either file the claim on the Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address on the Identification Card, within twenty (20) days of the beginning of services or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after the Corporation receives the notice, the Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Member must submit written proof covering the character and extent of the services within the time fixed for filing proof of loss.

3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

    a. A claim form for each Member. Members can get claim forms from a Member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.SouthCarolinaBlues.com.

    b. Itemized bills from the Provider(s). These bills should contain all the following:

        i. Provider's name and address;

        ii. Member's name and date of birth;

        iii. Member's Identification Card number;

        iv. Description and cost of each service;

        v. Date that each service took place; and,

        vi. Description of the illness or injury and diagnosis.

    c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's EOB notice.

    d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

4. The Corporation must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.

5. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any dental, medical or financial records and documents useful to the Corporation (as determined by the Corporation). The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits dental, medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the Corporation for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims and Concurrent Care claims. The Corporation will make a determination for each type of claim within the following time periods:

    a. Pre-Service Claim.

        i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the circumstances, but no later than fifteen (15) days from receipt of the claim.

        ii. If a Pre-Service Claim is improperly filed or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.

        iii. An extension of fifteen (15) days is permitted if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article XI(B) for details regarding the appeals process.

b. Urgent Care Claim.

i. A determination will be sent to the Member in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Member requests an extension of urgent care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim.

i. A determination will be sent within a reasonable time period but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article XI(B) for details regarding the appeals process.

d. Concurrent Care Claim.

The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination.

a. If the Member's claim is filed properly and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination that will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and this Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity, Investigational or Experimental exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Member will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing;

   b. An appeal must be sent (via U.S. mail) to Blue Cross and Blue Shield of South Carolina at the address on the Member's Identification Card;

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

   d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.

2. The Member may submit written comments, documents or other information in support of the appeal and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of dental or medical judgment, the Corporation will consult with an appropriately qualified healthcare practitioner with training and experience in the relevant field of medicine. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on the appeal.

4. The Corporation will make a final decision on the appeal within the time periods specified below:

   a. Pre-Service Claim.

      The Corporation will decide the appeal within a reasonable period of time, taking into account the circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Member disagrees with the Corporation's decision, the Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Corporation will decide the second appeal within a reasonable period of time, taking into account the circumstances, but no later than fifteen (15) days after receipt of the second appeal.

b. Urgent Care Claim.

The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Corporation will communicate with the Member by telephone or facsimile. The Corporation will decide the appeal within a reasonable period of time, taking into account the circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

c. Post-Service Claim.

The Corporation will decide the appeal within a reasonable period of time but no later than thirty (30) days after receipt of the appeal. If the Member disagrees with the Corporation's decision, the Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Corporation will decide the second appeal within a reasonable period of time but no later than thirty (30) days after receipt of the second appeal.

d. Concurrent Care Claim.

The Corporation will decide the appeal of Concurrent Care claims within the time frames set forth in Article XI (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.

a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination that will:

i. State specific reason(s) for the Adverse Benefit Determination;

ii. Reference specific provision(s) of this Plan of Benefits on which the benefit determination is based;

iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

iv. Describe any voluntary appeal procedures offered by the Corporation and the Member's right to obtain such information;

v. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and,

vii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will also receive a notice if the claim on appeal is approved.

C. EXTERNAL REVIEW PROCEDURES

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at the Corporation's expense. An external review may be used to reconsider the Member's claim if the Corporation has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:

    a. It does not meet the requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness; or,

    b. It is an Investigational or Experimental service and it involves a life-threatening or seriously disabling condition.

2. After a Member has completed the appeal process (and an Adverse Benefit Determination has been made), such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within sixty (60) days of receiving the notice of the Corporation's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's dental or medical records (if needed in the review for the purpose of reaching a decision on Member's claim).

3. Within five (5) business days of a Member's request for an external review, the Corporation will respond by either:

    a. Assigning the Member's request for an external review to a dental consultant and forwarding the Members records to such organization; or,

    b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

4. The external review organization will take action on the Member's request for an external review within forty-five (45) days after it receives the request for external review from the Corporation.

5. Expedited external reviews are available if the Member's Provider certifies that the Member has a serious medical condition. A serious medical condition, as used in this Article XI (C)(5), means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Corporation's decision if the Corporation's denial of Benefits involves emergency services and the Member has not been discharged from the treating hospital.

ARTICLE XII - GENERAL PROVISIONS

AMENDMENT

Upon thirty (30) days prior written notice, the Corporation may unilaterally amend this Plan of Benefits when required by federal or state law. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Notice of an amendment will be effective when addressed to the Employer. The Corporation has no responsibility to provide individual notices to each Member when an amendment to this Plan of Benefits has been made.

AUTHORIZED REPRESENTATIVES

A Provider may be considered a Member's Authorized Representative without a specific designation by the Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Member's Authorized Representative with regard to non-Urgent Care Claims only when the Member gives the Corporation or the Provider a specific designation in a format that is reasonably acceptable to the Corporation, to act as an Authorized Representative. If the Member has designated an Authorized Representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

CLERICAL ERRORS

Clerical errors by the Corporation will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

DISCLOSURE TO EMPLOYER

The Employer's Group Health Plan will disclose (or will require the Corporation to disclose) Member's PHI to the Employer only to permit the Employer to carry out Plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Employer will be subject to and consistent with the provisions of paragraphs A and B of this section.

A. Restrictions on Employer's Use and Disclosure of PHI.

1. The Employer will neither use nor further disclose Member's PHI, except as permitted or required by the Plan documents, as amended, or required by law.

2. The Employer will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of this Plan of Benefits with respect to Member's PHI.

3. The Employer will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

4. The Employer will report to the Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Employer will make PHI available to the Member who is the subject of the information in accordance with HIPAA.

6. The Employer will make Member PHI available for amendment and will, on notice, amend Member PHI in accordance with HIPAA.

7. The Employer will track disclosures it may make of Member PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

8. The Employer will make its internal practices, books and records relating to its use and disclosure of Member PHI available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

9. The Employer will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Employer's custody or control), received from the

Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Employer will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Employer creates, receives, maintains or transmits on behalf of the Group Health Plan.

11. The Employer will ensure that any agent, including a subcontractor, to whom the Employer provides ePHI (that the Employer creates, receives, maintains or transmits on behalf of the Group Health Plan) agrees to implement reasonable and appropriate security measures to protect this information.

12. The Employer shall report any security incident of which it becomes aware to the Group Health Plan as provided below.

    a. In determining how and how often the Employer shall report security incidents to the Group Health Plan, both the Employer and the Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both the Employer and the Group Health Plan agree that this Contract shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification or destruction of ePHI or interference with an information system:

        i. Pings on a party's firewall;

        ii. Port scans;

        iii. Attempts to log on to a system or enter a database with an invalid password or username;

        iv. Denial-of-service attacks that do not result in a server being taken offline; and,

        v. Malware (e.g., worms, viruses).

    b. The Employer shall, however, separately report to the Group Health Plan any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which the Employer becomes aware if such security incident (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Group Health Plan's ePHI; or (c) results in a breach of availability of the Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after the Employer becomes aware of the impact of such security incident upon the Group Health Plan's ePHI.

B. Adequate Separation Between the Employer and the Group Health Plan.

1. Only Employees or other workforce members under the control of the Employer ("Employees") who, in the normal course of their duties, assist in the administration of the Employer's Employee Benefits or the Group Health Plan or the Group Health Plan finances or other classes of Employees as designated in writing by the Employer, may be given access to Member PHI received from the Group Health Plan or a third party servicing the Group Health Plan.

2. These Employees will have access to Member PHI only to perform the Plan administration functions that the Employer provides for the Group Health Plan or to assist Members.

3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section to this Plan of Benefits. The Employer will promptly report such breach, violation or noncompliance to the Group Health Plan and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

4. The Employer will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

The Employer certifies that this Plan of Benefits contains the provisions outlined above.

GOVERNING LAW

This Plan of Benefits (including the Schedule of Benefits) is governed by and subject to applicable federal law. If and to the extent that federal law does not apply, this Plan of Benefits is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of this Plan of Benefits conflicts with such law, this Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law, and the Corporation shall be entitled to adjust the Premium upon thirty-one (31) days written notice.

IDENTIFICATION CARD

A Member must present his or her Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS

The Corporation is entitled to obtain such dental, medical and hospital records and other information as it may reasonably require from any Member or Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover on this Plan of Benefits until such Member has exhausted the appeal process as set forth in Article XI. No such action may be brought any later than six (6) years after the time written proof of loss is required to be furnished.

LIMITED-SCOPE DENTAL BENEFITS

This Plan of Benefits is a limited-scope dental Benefits Plan. The Benefits are substantially for the treatment of the mouth (including any organ or structure within the mouth) and are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a Group Health Plan. If this Plan of Benefits is sold in conjunction with a health Plan Benefits then HIPAA portability regulations may apply. If applicable, Members must refer to the health Plan of Benefits for the appropriate HIPAA portability guidelines.

MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Employer on behalf of its Employees. The Corporation will not accept Membership Applications directly from Employees or Dependents.

NEGLIGENCE OR MALPRACTICE

The Corporation does not practice medicine. Any treatment, service or supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation. The Corporation is not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such treatment, service, supply or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under this Plan of Benefits may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

1. To the Corporation:

   Blue Cross and Blue Shield of South Carolina
   P.O. Box 100300
   Columbia, South Carolina 29202

2. To a Member: To the last known name and address listed for the Employee related to such Member on the Membership Application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.

3. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF THE CORPORATION'S RIGHTS

On occasion, the Corporation may, at its option, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Corporation waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE

Each Member must provide the Corporation with information regarding all other health insurance coverage to which such Member is entitled.

PAYMENT OF CLAIMS

A Member is expressly prohibited from assigning any right to payment of or related to Benefits. The Corporation may pay all Benefits directly to the Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, the Corporation will pay Benefits directly to such Participating Provider.

PHYSICAL EXAMINATION

The Corporation shall at its own expense and by a Provider of its own choice have the right and opportunity to physically examine a Member with respect to the dental services provided or to be provided hereunder upon request.

REPLACEMENT COVERAGE

If this Plan of Benefits replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of this Plan of Benefits, provided such persons are enrolled for coverage as stated in Article II.

INDEX

This index contains instances of the use of defined terms in this Plan of Benefits. This index does not include Benefits or excluded items.