

GROUP DENTAL INSURANCE BENEFIT PLAN  
FOR SOUTH CAROLINA PUBLIC EMPLOYEES,  
ACTIVE AND RETIRED

ADOPTED BY  
THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY  
Effective January 1, 2015

S.C. Public Employee Benefit Authority  
P.O. Box 11661  
Columbia, South Carolina 29211  
803-734-0600

# ARTICLE 1.

## ESTABLISHMENT AND PURPOSE OF PLAN

### 1.1 Name and Purpose

The name of this Plan is the Group Dental Insurance Benefit Plan for South Carolina Public Employees, Active and Retired (hereinafter “Plan” or “State Dental Plan”). The State of South Carolina (hereinafter the State), through the Public Employee Benefit Authority, has established a self-funded group dental insurance benefit plan for the exclusive benefit of the participants and has adopted this “Plan Document.” The purpose of this Plan is to provide for the payment of dental benefits to the participants of this Plan and their eligible dependents.

### 1.2 Establishment and Effective Date

This Plan is a continuation of and replaces the Dental Insurance Benefit Plan initially established on February 15, 1985, and this Plan Document became effective on January 1, 2015.

### 1.3 Applicable Law

This Plan is established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan that is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

### 1.4 Entire Plan

This Plan Document and the enrollment applications of the Covered Persons, if any, constitute the entire Plan of Benefits established by the Planholder.

### 1.5 Plan Description

The Plan Administrator shall provide to eligible Subscribers a summary plan description containing the benefits of this Plan and the rights and obligations of Covered Persons under this Plan.

### 1.6 Changes to Plan

The Planholder reserves the right at any time to alter, amend, change, supplement, revoke or reduce the benefits under this Plan or increase or decrease the premiums charged under this Plan. This Plan may be changed by the execution of an amendment to this Plan by the Planholder at any time without prior notice to, or the consent of, any Covered Person or of any person entitled to receive payment of benefits under the Plan. The Planholder shall provide to the Subscribers a summary of any material change to this Plan.

### 1.7 Effect of Changes

All changes to this Plan shall become effective as of a date established by the Plan Administrator, EXCEPT that no increase or reduction in benefits shall be effective with respect to expenses incurred prior to the date a material change was adopted by the Planholder, regardless of the effective date of the change.

### 1.8 Termination of Plan

The Planholder may terminate all or any portion of this Plan at any time by providing written notice to the Subscribers. Such termination will become effective on the date set forth in such notice.

#### **1.9 Written Notice**

Any written notice required by law shall be deemed received by a Subscriber if sent by regular mail, postage prepaid, to the last address of such Subscriber on the records of the Plan Administrator.

#### **1.10 Waiver**

The failure of the Plan Administrator to enforce strictly any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to enforce strictly each and every provision of this Plan at any time, regardless of prior conduct and regardless of the similarity of the circumstances or the number of prior occurrences.

#### **1.11 Clerical Error or Delay**

Clerical errors made by South Carolina Public Employee Benefit Authority (PEBA) or its agents on the records of the Plan Administrator or Third-Party Claims Processor and delays in making entries on such records shall not invalidate coverage that would otherwise be validly in force or cause coverage to be in force or to continue in force which would otherwise be terminated. Upon discovery of any such error or delay, an equitable adjustment will be made not to exceed 12 months contribution by the Subscriber.

#### **1.12 Workers' Compensation**

This Plan is not in lieu of workers' compensation and does not affect any requirement for coverage by workers' compensation insurance and is not intended to provide or duplicate benefits for work related injuries that are within any workers' compensation law.

#### **1.13 Gender**

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise.

#### **1.14 Headings**

The headings used in this Plan are for the purpose of convenience of reference only. Covered Persons are advised not to rely on any heading to construe the meaning of a Plan provision. In all cases, the full text of this Plan will control.

#### **1.15 Misstatements and Omissions**

If any relevant fact has been misstated or omitted, in whole or in part, whether intentional or not, by, or on behalf of, any person on an application, the Notice of Election Form, or other document, or information submitted or required to be submitted to the Plan Administrator or Third-Party Claims Processor to obtain or retain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement or omission, coverage may be terminated prospectively. If the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, coverage may be terminate retroactively to the date of the act, practice, or omission, and an equitable adjustment of any contributions will be made if this is in order and the Plan Administrator may recover the amount of any claims paid in error due to the act, practice, or omission.

#### **1.16 Use of Social Security Numbers on Application**

The Plan is required by federal law to obtain the Social Security Number of each Covered Person. The Subscriber's Social Security Number, as well as the Benefits Identification Number (BIN), and address will be used as the identification number and address for the Dependents of the Subscriber.

## **ARTICLE 2.**

### **DEFINITIONS**

As used in this Plan, the following words shall have the meanings indicated in this Article:

#### **2.1 Active Employee**

An Employee who is engaged in Active Employment.

#### **2.2 Active Employment**

The Employee is actively at work on a Full-Time basis, performing all the regular duties of his occupation at an established business location of the Employer or another location to which he may be required to travel to perform the duties of his employment. An Employee shall be deemed to be engaged in Active Employment while on jury duty or on any regular nonworking day including holidays or vacation days established and published by the Employer if the Employee was engaged in Active Employment on the last preceding regular working day. Provided the Employee's participation in the Plan will not be prevented or delayed if (1) the Employee's absence from work is due to any health-related reason, including a medical condition, Hospital confinement, or a disability; or (2) the Employee is on leave under the Family and Medical Leave Act on the Effective Date of this Plan. In no event, however, will an Employee be considered to be in Active Employment if he has not reported for work or if he or his Employer has effectively terminated employment.

#### **2.3 Agent for Service of Process**

The Plan Administrator is the agent of the State for service of any process.

#### **2.4 Allowed Amount**

The amount established by the Plan Administrator for each dental procedure listed in the Schedule of Dental Procedures and Allowed Amounts. For covered dental procedures not included in the Schedule of Dental Procedures and Allowed Amounts, the Allowed Amount will be determined by the Third Party Claims Processor through its medical staff and/or dental consultants based on comparable or similar services, unless such procedure is specifically excluded by this Plan or by other terms and conditions of coverage.

#### **2.5 Alternate Forms of Treatment**

Another dental treatment, for the same condition, that meets accepted standards of dental practice. If the Third-Party Claims Processor determines that there is an alternative treatment that meets standards of dental practice, payment will be based upon the least costly alternative, regardless of the course of treatment actually chosen by the patient or the treating Dentist.

#### **2.6 Child**

A Subscriber's:

- A. Natural child;

- B. Stepchild;
- C. Adopted child;
- D. Child placed for adoption, which means the Subscriber has assumed and retains a legal obligation for total or partial support of the child in anticipation of adopting the child;
- E. Foster child, placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- F. Child for whom Subscriber has legal custody, which means Subscriber has guardianship responsibility as well as financial responsibility; and
- G. Child for whom Subscriber is required to provide dental insurance due to a court order.

## **2.7 Clerical Error**

An omission, mistake, misreading, or delay made by the Plan Administrator or Third-Party Claims Processor in the entry, recording, reproduction, or reporting of information relating to the operation of the State Dental Plan.

## **2.8 Covered Dental Benefits**

Dental procedures, services, or supplies that are performed by a Dentist or Dental Hygienist (under the supervision and direction of a Dentist); are recognized as acceptable dental practices by the American Dental Association; and are within the benefits provided in this Plan and not otherwise excluded by any term, condition, limitation, or exclusion of this Plan. All non-preventive procedures, services, and supplies also must be Medically Necessary to be Covered Dental Benefits.

## **2.9 Covered Dependent**

A Subscriber's Dependent, who has met the eligibility requirements and is enrolled under the Plan and to whom benefits are payable under this Plan.

## **2.10 Covered Employee**

An Employee or Retiree, who has met the eligibility requirements and is enrolled under this Plan and to whom benefits are payable under this Plan.

## **2.11 Covered Person**

A Subscriber, or Dependent thereof, who has met the eligibility requirements and is enrolled in this Plan and to whom benefits are payable under this Plan.

## **2.12 Deductible**

The amount payable by the Covered Person for Covered Dental Benefits before benefits become payable under Class II and Class III services under the Plan. For each Plan Year, each Covered Person has a \$25 Deductible, but not more than three individual deductibles for each Family.

## **2.13 Dental Hygienist**

A person licensed to practice dental hygiene, as that term is defined by statute, under the supervision of a Dentist.

## **2.14 Dentist**

A physician or oral surgeon or person licensed to practice dentistry, in the jurisdiction where the services are performed and acting within the scope of the license.

## **2.15 Dependent**

Dependent shall mean and include a Subscriber's:

- A. Legally recognized spouse or former spouse who is required to be covered by either a divorce decree or court order, but not both the spouse and former spouse. Provided, however, that if a spouse is also eligible for coverage or benefits as an Employee of the State, public school district or a participating entity, the spouse is eligible for coverage only as an Employee and not as a Dependent. However, a Part-Time Teacher who is the Spouse of a Covered Employee may be covered as either an Employee or as a Dependent, but not as both;
- B. Child younger than 26 years of age. The Plan Administrator may require the Subscriber to submit due proof of the Child's relationship with the Subscriber within 31 days of enrollment, and at such other reasonable times;
- C. Unmarried Child, 26 years of age or older, who is incapable of self-sustaining employment because of mental illness, retardation or physical handicap and is principally dependent (more than fifty percent) on the Subscriber for maintenance and support, provided that the Child was covered continuously under the Plan or a Predecessor Plan, prior to the date of incapacitation. The Plan Administrator may require the Subscriber to submit due proof of such incapacity and dependency satisfactory to the Plan Administrator within 31 days of initial enrollment, upon attaining age 26 and at such other reasonable times, but not more frequently than annually. It shall be the Subscriber's responsibility to notify the Plan Administrator when the Child is no longer incapacitated.

#### **2.16 Effective Date**

- A. With respect to the Plan, the date on which this Plan takes effect;
- B. With respect to a Covered Person, the date on which such person is first covered under this Plan but no earlier than January 1, 2015.

#### **2.17 Employee**

A person employed by an Employer on a Full-Time basis, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative Employees of the General Assembly, and judges in the State courts. If an Employer elects to obtain other dental insurance coverage for its persons employed on a nonpermanent Full-Time basis, such persons do not constitute Employees under this paragraph. For purposes of this Plan, the term shall include other Employees that the General Assembly has made eligible for coverage by law, including Employees of a public school district, county, municipality, or other State-Covered Entity that has qualified for, and is participating in, coverage under the Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or municipalities, whose council members participate in the South Carolina Retirement Systems, and Part-Time Teachers, are also Employees for purposes of the Plan.

#### **2.18 Employer**

A department, agency, board, commission or institution of the State, including the General Assembly, the State courts and public school districts and other entities participating by law, that hire and provide compensation to an Employee.

#### **2.19 Family**

A Subscriber and his Covered Dependents.

## **2.20 Full-Time**

With regard to an Employee shall mean an Employee who works at least 30 hours per week. Provided, however, an Employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean an Employee who works at least 20 hours per week, and to apply this definition, upon notification and acceptance by PEBA.. **Full-time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in paragraphs 3.18, 3.19 and 3.20 of the Plan.**

## **2.21 Full-Time Permanent**

**With regard to an Employee shall mean a permanent Employee who works at least 30 hours per week. Provided, however, an Employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean a permanent Employee who works at least 20 hours per week, and to apply this definition, upon notification and acceptance by PEBA.**

## **2.22 Incurred**

An expense, charge, or benefit is incurred for purposes of this Plan on the date on which the service or supply charged was rendered or received.

## **2.23 Medical Necessity; Medically Necessary or Necessary Service and Supply**

A dental procedure, service or supply that meets all of the following criteria:

- A. Is required to identify or treat a Dental illness or injury, or to improve a malformation of the mouth, and
- B. Is recommended or approved by a Dentist, and
- C. Is consistent with the Covered Person's Dental Illness, injury or condition and is rendered in accordance with recognized, appropriate Dental practices prevailing in the Dental specialty or practice of dentistry at the time rendered, and
- D. Is required for reasons other than the convenience of the patient, and
- E. Results in measurable, identifiable progress in treating the Covered Person's illness, injury, or condition.

The fact that a procedure, service or supply is recommended or approved by a Dentist, or that a Dentist asserts that a service or supply is necessary to avoid the potential onset of a condition or abnormality in the future, does not automatically mean that such procedure, service or supply is Medically Necessary.

## **2.24 Notice of Election (NOE)**

The application form used to enroll or change dental coverage, or change the information relating to a Covered Person.

## **2.25 Open Enrollment Period**

The period established by the Plan Administrator when any eligible Subscriber may enroll or disenroll themselves and/or eligible Dependents in the State Dental Plan. An Open Enrollment

Period will be held in October of all odd numbered years. Changes made during the Open Enrollment Period will become effective the following January 1.

**2.26 Part-Time Teacher**

A teacher employed by a public school district, the South Carolina Department of Corrections, or the South Carolina Department of Juvenile Justice, on a permanent and part-time basis working at least 15, but fewer than 30, hours a week.

**2.27 Plan**

This Group Dental Insurance Benefit Plan for South Carolina Public Employees, Active and Retired.

**2.28 Planholder**

The State of South Carolina, which provides the State Dental Plan through the South Carolina Public Employee Benefit Authority.

**2.29 Plan Administrator**

The South Carolina Public Employee Benefit Authority.

**2.30 Plan Year**

The 12-month period of time beginning January 1 and ending December 31, 2015.

**2.31 Pre-certification or Voluntary Pre-certification**

The procedure through which a Covered Person may obtain a determination from the Third-Party Claims Processor of the part of the estimated expense for proposed dental treatment that is reimbursable under the Plan at the time the Pre-certification is made.

**2.32 Provider**

A Dentist or Dental Hygienist as those terms are defined in this Plan.

**2.33 Retiree**

An Employee who is retired under the terms and conditions of a retirement plan offered through PEBA and meets one or more of the following eligibility requirements in order to participate in the Plan.

**A. For Employees hired before May 2, 2008, an eligible Retiree shall be defined as:**

1. A person covered by the Plan who terminates employment with at least twenty (20) years of retirement service credit by a State-Covered Entity before eligibility for retirement under a State retirement system is eligible for the Plan effective with the date of retirement under a State retirement system, if the last five (5) years are consecutive and in a Full-Time permanent position with a State-Covered Entity. Provided, however, that a person covered by the Plan who terminated employment with at least eighteen (18) years retirement service credit by a State-Covered Entity before eligibility for retirement under a State retirement system prior to 1990 is eligible for the Plan effective on the date of retirement, if this person returns to a State-Covered Entity and is covered by the Plan and completes at least two (2) consecutive years in a Full-Time, permanent position prior to the date of retirement.

With respect to a retiree employed by an entity that participates in the Plan pursuant to Section 1-11-710 of the South Carolina Code who is eligible for coverage pursuant to this

subparagraph, the employer portion of the retiree's premium shall be paid by the Retiree Health Insurance Trust.

With respect to a retiree employed by an entity that participates in the Plan pursuant to Section 1-11-720 of the South Carolina Code who is eligible for coverage pursuant to this subparagraph, the retiree's employer, at its discretion, may elect to pay all or a portion of the employer portion of retiree's premium.

2. A member of the General Assembly, who leaves office or retires with at least eight (8) years of credited service in the Retirement System for Members of the General Assembly, is eligible to participate in the Plan by paying the full premium costs as determined by the PEBA Board.
3. Former municipal and county council members, who have served on council for at least twelve (12) years and were covered under the State's plans at the time of termination from council, are eligible to continue to participate in the Plan by paying full premium costs, both employer and employee portions of the premium, provided the county or municipal council elects to allow this coverage for former members.
4. An Active Employee employed by an entity that participates in the Plan pursuant to Section 1-11-710 of the South Carolina Code, retiring with 10 or more years of State-Covered Entity service credited under a State retirement system and with the last five years of earned service credit consecutive and in a Full-Time Permanent position with a State-Covered Entity shall have the employer portion of his or her premiums paid by the Retiree Health Insurance Trust.
5. A person covered by the Plan who retires with at least five (5) years of service with a State-Covered Entity credited under a State retirement system is eligible to participate in the Plan, provided the last five (5) years are consecutive and in a Full-Time, permanent position with a State-Covered Entity. With respect to a retiree employed by an entity that participates in the Plan pursuant to Section 1-11-710 of the South Carolina Code who is eligible for coverage pursuant to this subparagraph, the retiree shall pay both the employer and employee portion of the retiree's premium. With respect to a retiree employed by an entity that participates in the Plan pursuant to Section 1-11-720 of the South Carolina Code who is eligible for coverage pursuant to this subparagraph, the retiree's employer, at its discretion, may elect to pay all or a portion of the employer portion of retiree's premium.
6.
  - a. A retiree eligible for coverage under the Plan pursuant to subparagraphs (A)(1), (A)(3), (A)(4) or through (A)(5) above, who retires early under the provisions of Section 9-1-1515 must pay both the employer and the employee portion of the premium until the earlier of attaining age 60 or the date the person would have 28 years' creditable service in the South Carolina Retirement System if early retirement had not occurred. Upon attaining the earlier of age 60 or the date the person would have 28 years' creditable service in the South Carolina Retirement System had the person not retired, the retiree's premium will be determined in accordance with subparagraphs (A)(1), (A)(3), (A)(4), or (A)(5) above.
  - b. An employee of a State-Covered Entity, who terminates employment and purchases additional service credit under Section 9-1-1850 may maintain dental coverage during the period of the service purchase by paying both the employer and the employee portion of the premium until the date the person has 28 years' creditable service in the South

Carolina Retirement System if the person had not terminated employment. Upon reaching the date the retiree would have had 28 years' creditable service, the employee's eligibility to participate as a retiree in the Plan, and the amount of the premium owed, will be determined in accordance with subparagraphs (A)(1), (A)(3), (A)(4), or (A)(5) above.

7. For retired participants of the Optional Retirement Program defined contribution plan offered through PEBA, eligibility to participate as a Retiree shall be determined in accordance with subparagraphs (A)(1) through (A)(5) above. Optional Retirement Program participants are not eligible for the exceptions defined under subparagraph (A)(6) above. For the purpose of eligibility to participate as a Retiree under subparagraphs (A)(1)-(A)(5), one year of full-time employment, or its equivalent, under the Optional Retirement Program participant's employment relationship with an employer participating in the Optional Retirement Program equates to one year of earned retirement service credit under a State retirement system.

**B. For Employees hired on or after May 2, 2008, an eligible Retiree shall be defined as:**

1. An Active Employee covered by the Plan, who retires with at least five (5) years of earned retirement service credit under a State retirement system with a State-Covered Entity, is eligible to participate as a Retiree in the Plan if the last five (5) years of the person's covered employment were consecutive and in a Full-Time permanent position.
2. A person covered by the Plan who terminates employment before the person's date of retirement with at least twenty (20) years of earned retirement service credit under a State retirement system with a State-Covered Entity is eligible to participate as a Retiree in the Plan on the person's date of retirement under a State retirement system, if the last five (5) years of the person's covered employment before termination were consecutive and in a Full-Time permanent position.
3. An employee employed by an entity that participates in the Plan pursuant to Section 1-11-710 of the South Carolina Code, who retires under a State retirement system and who is eligible for Plan coverage under the provisions of subparagraphs (B)(1) or (B)(2) of this paragraph, is eligible for trust fund paid premiums as follows:
  - a. If the Retiree's earned service credit in a State retirement system is five (5) or more years but fewer than fifteen years (15) with a State-Covered Entity, then the Retiree shall pay the full premium for the Plan.
  - b. If the Retiree's earned service credit in a State retirement system is more than fifteen (15) years, but fewer than twenty-five (25) years with a State-Covered Entity, then the Retiree is eligible for fifty percent trust fund paid premiums and the Retiree shall pay the remainder of the premium cost.
  - c. If the Retiree's earned service credit in a State retirement system is twenty-five (25) or more years with a State-Covered Entity, then the Retiree is eligible for trust fund paid premiums and the Retiree is responsible for the entire Employee premium.
4. If a Retiree under a State retirement system was employed by an entity that participates in the Plan pursuant to the provisions of Section 1-11-720 and is eligible to participate in the Plan as a Retiree pursuant to subparagraphs (B)(1) or (B)(2) of this paragraph, then the

Retiree's employer, at its discretion, may elect to pay all or a portion of the premium for the Retiree's Plan.

5.
  - a. A retiree eligible for coverage under the Plan pursuant to subparagraphs (B)(1) or (B)(2) above, who retires early under the provisions of Section 9-1-1515 must pay both the employer and the employee portion of the premium until the earlier of attaining age 60 or the date the person would have 28 years' creditable service in the South Carolina Retirement System if early retirement had not occurred. Upon attaining the earlier of age 60 or the date the person would have 28 years' creditable service in the South Carolina Retirement System had the person not retired, the retiree's premium will be determined in accordance with subparagraph (B)(3) above for a retiree of an entity participating under Section 1-11-710 or subparagraph (B)(4) above for a retiree of an entity participating under Section 1-11-720.
  - b. An employee of a State-Covered Entity, who terminates employment and purchases additional service credit under Section 9-1-1850 may maintain dental coverage during the period of the service purchase by paying both the employer and the employee portion of the premium until the date the person has 28 years' creditable service in the South Carolina Retirement System if the person had not terminated employment. Upon reaching the date the retiree would have had 28 years' creditable service, the employee's eligibility to participate as a retiree in the Plan will be determined in accordance with subparagraphs (B)(1) or (B)(2) above, and the amount of the premium owed will be determined in accordance with subparagraph (B)(3) above for a retiree of an entity participating under Section 1-11-710 or subparagraph (B)(4) above for a retiree of an entity participating under Section 1-11-720.
6. For retired participants of the Optional Retirement Program defined contribution plan offered through PEBA, eligibility to participate as a Retiree shall be determined in accordance with paragraphs (B)(1) through (B)(4) above. For the purpose of eligibility to participate as a Retiree under paragraphs (B)(1)-(B)(4), one year of full-time employment, or its equivalent, under the Optional Retirement Program participant's employment relationship with an employer participating in the Optional Retirement Program equates to one year of earned retirement service credit under a State retirement system.

### **2.34 Schedule of Dental Procedures and Allowed Amounts**

The list of dental procedures and the Allowed Amounts for each listed dental procedure as established by the Plan Administrator. The Schedule is attached as Appendix A to this Plan.

### **2.35 State**

The State of South Carolina.

### **2.36 State-Covered Entity**

Any State agency, public school district, or any other entity granted the right to participate in the Plan by law and participating in the Plan.

### **2.37 Subscriber**

An Active or Retired Employee, Surviving Child/Surviving Spouse or COBRA enrollee of an Employer.

### **2.38 Surviving Child**

The surviving eligible Child of a deceased Covered Employee or Covered Retiree, who, at the time of the Covered Employee's or Covered Retiree's death, was enrolled in the Plan as a Child.

### **2.39 Surviving Spouse**

The eligible Dependent Spouse of a deceased Covered Employee or Covered Retiree, who, at the time of the Covered Employee's or Covered Retiree's death, was enrolled in the Plan as a Dependent Spouse. Remarriage terminates Surviving Spouse status under this Plan.

### **2.40 Third-Party Claims Processor**

The entity retained by the Plan Administrator to receive, process and pay claims under this Plan.

### **2.41 Transfers**

#### **A. Academic Transfers**

1. Academic Transfer Employee. For purposes of this provision, an Academic Transfer Employee is a Covered Employee who completes a school year or term (generally on or around June 30) with one Academic Employer and becomes a Covered Employee at another Academic Employer at the beginning of the next school year or term (generally on or around September 1).

2. Academic Employer. For purposes of this provision, Academic Employers include public school districts, universities, colleges, technical colleges, and other educational institutions conducting business in schools years, school terms, or otherwise-described academic term time and corresponding contract periods.

3. An Academic Transfer Employee shall have no break in coverage due to his Academic Transfer.

**B. Transfer Employee.** A Transfer Employee is any Covered Employee not described in paragraph 2.41 who moves from one Employer, as defined in paragraph 2.18, to another Employer with no break in coverage or with no more than a 15-calendar-day break in employment.

## **ARTICLE 3.**

### **ELIGIBILITY, CONDITIONS OF COVERAGE, EFFECTIVE DATES OF COVERAGE, AND TERMINATION OF COVERAGE**

#### **3.1 Eligibility**

Subject to the provisions in this section, and all other terms, conditions, limitations and exclusions of this Plan, the following individuals are eligible for coverage under this Plan:

- A. All Employees as defined in 2.17 and their Dependents, as defined in 2.15, provided however, that a spouse or a Child of a Covered Employee who is also an Employee may be covered only as an Employee and not as a Dependent.

- B. All Employees who were on leave without pay status [and disabled but not retired status] prior to January 1, 2015 and not in a Stability Period during Plan Year 2015 pursuant to paragraphs 3.18 and 3.19 of the Plan, are eligible for coverage, along with their Dependents, for up to one year after beginning leave without pay status.
- C. All Retirees as defined in 2.33 and their Dependents, as defined in 2.15;
- D. The Surviving Spouse as defined in 2.39 and Surviving Child, as defined in 2.38, of a deceased Covered Employee, as defined in 2.10;
- E. All Employees and Dependents eligible for coverage as the result of COBRA in Article 10;
- F. All Part-Time Teachers as defined in 2.26, and their Dependents, as defined in 2.15, provided however, that a Part-Time Teacher who is the Spouse of a Covered Employee may be covered as either an Employee or as a Dependent, but not as both.

### **3.2 Employee Enrollment**

To enroll under this Plan, each eligible Employee must complete within 31 days of his eligibility for coverage: (1) a Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such timely Notice of Election, payroll deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, and such Employee is not eligible for coverage due to a change in family status under 3.7, such Employee may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator.

### **3.3 Commencement of Employee Coverage**

Employee coverage under this Plan shall commence as follows:

- A. Each Employee in Active Employment on the day prior to the Effective Date of this Plan and who has elected coverage by filing a timely Notice of Election shall be covered under this Plan on the Effective Date of the Plan;
- B. Each new Employee who becomes eligible for coverage after the Effective Date of this Plan, who has elected coverage by filing a timely Notice of Election, shall be covered under this Plan (1) on the first day of the month that the Employee commences Active Employment provided that the Employee commences Active Employment on the first calendar day of that month; or (2) on the first day of the following month provided that the Employee commences Active Employment on any day other than the first calendar day and the first working day of that month. Otherwise, if the Employee commences Active Employment on the first working day of the month, other than the first calendar day of the month, the Employee may choose to commence coverage under this Plan on either the first day of that month or the first day of the following month. For purposes of this paragraph, the first working day of the month is the first day that is not a Saturday, Sunday, or holiday. The first working day of the month is not an Employer-specific first working day.

### **3.4 Eligibility for Dependent Coverage**

Each Employee, who has one or more Dependents on the date he becomes eligible for coverage, shall be eligible to enroll each Dependent for coverage on such date. Each Employee without a Dependent on the date he becomes eligible for coverage shall be eligible

to enroll each Dependent for coverage on the date he acquires a Dependent. In both cases, the Employee must meet the requirements of 3.5 below.

### **3.5 Dependent Enrollment**

To obtain Dependent coverage under this Plan, each eligible Employee must: (1) be covered under this Plan, (2) file a timely Notice of Election form selecting Dependent coverage for eligible Dependents and (3) agree in writing to make any required contributions toward the cost of the Dependents' coverage prior to his eligibility date. If the Employee acquires a Dependent as provided in paragraph 3.7 after the Effective Date of his coverage, the Employee has 31 days from the date the Dependent was acquired to enroll the Dependent in this Plan. If the Employee fails to notify the Plan Administrator within the 31-day period of time, the Dependent may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator.

### **3.6 Commencement of Dependent Coverage**

Each eligible Employee, who has satisfied the requirements of paragraph 3.5 and enrolled eligible Dependents, will have Dependent coverage under this Plan for those eligible, enrolled Dependents commencing on the date the Employee's coverage commences, or for Dependents acquired thereafter, on the date that they were acquired.

### **3.7 Coverage Changes Due to Changes in Family Status**

An enrollment period will be held every two years during odd-numbered years (2015, 2017 etc.). During the enrollment period, the eligible subscriber is given an opportunity to make enrollment changes in dental coverage. Changes made during the enrollment period will become effective the following January 1st. No other enrollment changes may be made until the next enrollment period, except in the following situations:

**A. Adding Coverage.** If an Employee has not enrolled the Employee, the Employee's spouse, and/or the Employee's Child for coverage within 31 days of first becoming eligible or during a prior enrollment period and subsequently wishes to elect such coverage, the Employee may do so under the following situations. If the Employee does not do so within the time frame specified in this section, he, his spouse, and/or his Child must wait for the next enrollment period.

1. An Employee's child may be added within 31 days of:

- (a) the Child's birth,
- (b) adoption of the Child,
- (c) the Child's placement for adoption,
- (d) the Child's placement for foster care,
- (e) the Child becoming a stepchild,
- (f) the Employee gaining legal custody of the Child, or
- (g) the date of other court order mandating coverage of the Child by the Employee.

Coverage under this paragraph shall commence on the day of the event described in this section. The Employee must submit a Notice of Election within 31 days of the date of the event. Satisfactory documentation of the circumstances surrounding the event must accompany the Notice of Election. If the Employee experiences an event described in this section, and has not enrolled himself and/or

his spouse in coverage previously, then the Employee may enroll for coverage for himself, his spouse, and/or his newly-eligible Child.

2. An Employee's spouse may be added within 31 days of marriage. Coverage under this paragraph shall commence on the date of the marriage. The Employee must submit a Notice of Election within 31 days of the date of the marriage. Satisfactory documentation of the circumstances surrounding the marriage must accompany the Notice of Election. If the Employee has not enrolled himself in coverage previously, then the Employee may enroll for coverage for himself and/or his spouse due to the marriage.
3. An Employee, Employee's spouse, or Employee's Child covered under the employer dental plan of the Employee's spouse and who subsequently loses coverage because
  - (a) the spouse's employer canceled its present group insurance,
  - (b) the spouse's employer canceled its contribution to its group insurance, or
  - (c) the Employee's spouse left such employment

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee must submit a Notice of Election within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised Notice of Election.

4. An Employee, Employee's spouse, or Employee's Child who loses coverage under another employer's dental plan because of
  - (a) legal separation,
  - (b) divorce, or
  - (c) other similar loss of coverage

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee must submit a Notice of Election within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised Notice of Election.

5. An Employee, Employee's spouse, or Employee's Child who
  - (a) loses coverage under Medicaid or CHIP because of loss of eligibility may enroll for coverage within 60 days of the loss of coverage; or
  - (b) becomes eligible for a premium assistance subsidy under Medicaid or CHIP may enroll within 60 days of when eligibility for premium assistance subsidy is determined.

Coverage for the Employee, the Employee's spouse, and/or the Employee's Child enrolled under this paragraph shall commence on the date of loss of Medicaid or CHIP coverage, or the date eligibility for premium assistance is determined. The Employee must submit a Notice of Election within 60 days of the date of loss of coverage or date eligibility for premium assistance is determined. A satisfactory statement of the circumstances surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the Notice of Election.

6. Upon the addition of an Employee's spouse or Employee's Child to the Employee's coverage under **3.7.A.1–5**, the Employee may change his selected coverage under the Plan.
7. An Employee, Employee's spouse, or Employee's Child who was mobilized or called to active duty with the National Guard or a Reserve unit and who dropped coverage under this Plan may re-enroll in the Program upon discharge or release from active duty and resumption of employment with an eligible Employer. The Employee must submit a Notice of Election within 31 days of discharge, release from active duty, or resumption of employment, whichever is latest.

**B. Dropping Coverage.** An Employee, Employee's spouse, or Employee's Child who otherwise continues to meet eligibility requirements under the Plan may drop coverage in the following situations. If the Employee does not do so within the time frame specified for a change in family status, he and his spouse or Child must wait for the next Open Enrollment Period or for the Employee, Employee's spouse, or Employee's Child to cease meeting eligibility requirements under the terms of the Plan for coverage to be dropped.

1. An Employee, Employee's spouse, or Employee's Child who acquires other group coverage may drop coverage within 31 days. Coverage under this paragraph shall end on the first of the month after the gain of other coverage or the first of the month if coverage is gained on the first of the month. The Employee must submit a Notice of Election within 31 days of the gain of other group coverage. Satisfactory documentation of the circumstances surrounding the event must accompany the Notice of Election.
2. An Employee's spouse may be dropped within 31 days of divorce or legal separation. Coverage under this paragraph shall end on the first of the month after the Notice of Election is submitted. The Employee must submit a Notice of Election within 31 days of the date of the event. Satisfactory documentation of the circumstances surrounding the event must accompany the Notice of Election.
3. An Employee, Employee's spouse, or Employee's Child who
  - (a) gains coverage under Medicaid or CHIP may drop coverage within 60 days of the gain of coverage; or
  - (b) loses eligibility for a premium assistance subsidy under Medicaid or CHIP may drop coverage within 60 days from the date of notification of loss of eligibility.

Coverage for the Employee, the Employee's spouse, and/or the Employee's Child dropped under this paragraph shall end on the date of gain of Medicaid or CHIP coverage, or the date of the notification regarding loss of eligibility for premium assistance; otherwise, coverage shall end the first of the month following the submission of a Notice of Election if provided in accordance with the time limits in this paragraph. The Employee must submit a Notice of Election within 60 days of the notification of gain of coverage or within 60 days of notification of loss of eligibility for premium assistance. A satisfactory statement of the circumstances

surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the revised Notice of Election.

### **3.8 Termination of Employee's Coverage**

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of an Employee shall cease as of midnight on the last day of the month during which:

- A. The Employee's employment terminates;
- B. The Employee ceases to qualify as an Employee;
- C. The Employee ceases to be in a class of Employees eligible for coverage;
- D. Coverage is discontinued with respect to the class of Employees to which such Employee belongs;
- E. This Plan is terminated with respect to all Employees;

Provided, however, that when an Employee requests the termination of coverage during the Open Enrollment Period, coverage will terminate at midnight the following December 31st; when the Employee's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium; and when an Employee dies, coverage terminates on the day following the date of death of the Employee.

### **3.9 Termination of Dependent's Coverage**

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of an eligible Dependent shall cease as of midnight on the last day of the month during which:

- A. The Employee ceases to be in a class of Employees eligible for Dependent coverage under this Plan;
- B. All Dependent coverage under this Plan terminates;
- C. Any particular Dependent ceases to be a Dependent of the Employee as defined in 2.15. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse.
- D. 31 days have lapsed since the date of birth of a newborn, unless the Employee has enrolled the newborn as required by paragraph 3.5, or under such conditions as established by the Planholder.

Provided, however, that when an Employee requests the termination of Dependent coverage during the Open Enrollment Period, coverage will terminate at midnight the following December 31st; when the Employee's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium; and when an Employee or a Dependent dies, coverage terminates on the day following the date of death of the Employee or the Dependent; however, after death of the Employee, coverage of the Dependent may continue under Article 9, Continuation of Coverage, or Article 10, COBRA.

### **3.10 Effect of Divorce or Annulment on Dependent Eligibility**

A Child of an Employee or Retiree, who was covered previously as a Child and whose coverage terminated upon the Child's marriage, shall again be eligible for coverage upon the Child's divorce or annulment, if the conditions of 2.15 are met.

### **3.11 Retiree Enrollment**

- A.** An Employee, who is covered under this Plan at the time he elects retirement, may elect coverage under this Plan as a Retiree by completing within 31 days of eligibility for coverage as a Retiree: (1) Notice of Election and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator or due to a change in family status as provided in 3.7.
  
- B.** An Employee, who is not covered by this Plan at the time he elects retirement, may enroll as a Retiree by completing within 31 days of eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator due to a change in family status as provided in 3.7.

### **3.12 Enrollment of Dependents of the Retiree**

- A.** An Employee's Dependent, who is covered under this Plan at the time the Employee elects retirement, and any Dependent the Employee acquires after retirement, may be covered as the Dependent of a Retiree under this Plan provided that the Employee/Retiree completes within 31 days of eligibility for coverage as a Retiree, or the date the Dependent was acquired after retirement: (1) Notice of Election and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form and other required forms within 31 days following the Employee's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator or due to a change in status as provided in paragraph 3.7.
  
- B.** An Employee's Dependent, who is not covered by this Plan at the time the Employee elects retirement, may be enrolled as the Dependent of a Retiree provided that the Employee/Retiree completes within 31 days of the Employee's eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator or due to a change in status as provided in paragraph 3.7.

### **3.13 Commencement of Coverage for Retirees and Dependents**

Retirees and Dependents, who are Covered Persons under this Plan at the time of the retirement of the Employee and are re-enrolled as Covered Persons at the time of retirement, remain covered under this Plan. Retirees and Dependents, who are not Covered Persons under this Plan at the time of the retirement of the Employee and are enrolled in this Plan at the time of retirement, shall be covered on the first day of the month following the approval of

the application for enrollment as a Retiree or Dependent under this Plan. A Dependent who is acquired after retirement, and enrolled within 31 days of the date the Dependent is acquired, shall be covered from the date the Dependent was acquired. A Retiree, not otherwise eligible for coverage as a Retiree, who is approved for disability benefits through the South Carolina Retirement Systems (Retirement Systems), shall have the coverage under the Plan commence no earlier than the first day of the month following the Retirement Systems' approval of the disability.

### **3.14 Termination of Retiree's Coverage**

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of a Retiree shall cease as of midnight on the last day of the month during which:

- A. The Retiree ceases to be in a class of Retirees eligible for coverage under this Plan;
- B. The Retiree ceases to qualify as a Retiree;
- C. The Retiree ceases to be in a class eligible for coverage;
- D. Coverage is discontinued with respect to the class of Retirees to which such Retiree belongs;
- E. The Plan is terminated with respect to all Retirees;

Provided, however, that when a Retiree requests the termination of coverage during the Open Enrollment Period, coverage will terminate at midnight the following December 31st; when the Retiree's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Retiree paid the full premium; and when a Retiree dies, coverage terminates on the day following the date of death of the Retiree.

### **3.15 Termination of Coverage of Dependent of Retiree**

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of an eligible Dependent of a Retiree shall cease as of midnight on the last day of the month during which:

- A. The Retiree ceases to be in a class of Retirees eligible for Dependent coverage under this Plan;
- B. All Dependent coverage under this Plan terminates;
- C. Any particular Dependent ceases to be a Dependent of the Retiree as defined in 2.15. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse;

Provided, however, that when a Retiree requests the termination of Dependent coverage during the Open Enrollment Period, coverage will terminate at midnight the following December 31st; when the Retiree's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Retiree paid the full premium; and when a Retiree or a Dependent dies, coverage terminates on the day following the date of death of the Retiree or the Dependent; however, after death of the Retiree, coverage of the Dependent may continue under Article 9, Continuation of Coverage, or Article 10, COBRA.

### **3.16 Termination of Coverage of Survivors; Continuation of Coverage**

The coverage of a Surviving Spouse and Surviving Children of a deceased Employee shall terminate as provided in 3.9 or 3.15 unless extended under the Continuation of Coverage provisions in Article 9.

### **3.17 Effect of Termination of Coverage**

All rights to receive benefits provided under this Plan for services rendered to a Covered Person after the termination of coverage will automatically cease on the date established in this Plan.

### **3.18 Ongoing Employees**

**A.** An Ongoing Employee is an Employee who has been employed by an Employer for an entire Standard Measurement Period, as that term is defined in paragraph 3.18.B.

**B.** A Standard Measurement Period for Ongoing Employees begins on October 4th of each calendar year and ends on October 3rd of the next calendar year. For Plan Year 2015, the Standard Measurement Period runs from October 4, 2013 and ends on October 3, 2014.

**C.** An Ongoing Employee meeting the requirements of paragraph 3.18.E may enroll during an Open Enrollment Period with coverage effective for a Standard Stability Period beginning the following January 1st. For Plan Year 2015, the Administrative Period begins October 4, 2014, and ends on December 31, 2014.

Notwithstanding the length of the Administrative Period, all enrollment documents must be filed with PEBA during the Open Enrollment Period.

**D.** A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31, and is synonymous with the Plan Year as defined in paragraph 2.30.

**E.** An Ongoing Employee who is credited by his Employer with an average of at least 30 hours of service per week after completing a Standard Measurement Period, defined in paragraph 3.18.B, is eligible to enroll in coverage under this Plan during the Open Enrollment Period held during the Administrative Period, defined in paragraph 3.18.C, for coverage that will be effective for the entire duration of the following Standard Stability Period, as defined in paragraph 3.18.D; provided the Ongoing Employee does not otherwise experience a termination event under the Plan. An Ongoing Employee remains eligible throughout the Standard Stability Period so long as he is employed with that Employer and regardless of the number of hours worked during that Standard Stability Period. An Ongoing Employee who ceases work and is not credited with an hour of service for less than 13 weeks (26 weeks for educational institutions) and who then resumes work with the same Employer during the same Standard Stability Period will be eligible to resume participation in the Plan as of the first day of the calendar month following resumption of work (even if the Ongoing Employee resumes employment in a position that is not reasonably expected to be a Full-Time position).

**F.** An Ongoing Employee who has been found not to meet the 30-hour-per-week average during a Measurement Period is not eligible for the Plan as an Ongoing Employee through the entirety of the following Stability Period, unless he gains eligibility under another provision of this Plan.

**G.** In the case of a conflict between another provision of this Plan and this paragraph, this paragraph will govern Ongoing Employee's eligibility and coverage. The Ongoing Employee's coverage is otherwise governed by the entirety of this Plan.

### **3.19 New Variable Hour, New Part-Time, and New Seasonal Employees**

#### **A. Definitions**

1. A New Part-Time Employee is a new Employee who has not completed a Standard Measurement Period, as defined in paragraph 3.18.B, and who, upon hire, is reasonably expected to be employed on average less than 30 hours of service per week during an Initial Measurement Period, as defined in paragraph 3.19.B.

2. A New Seasonal Employee is a new Employee who has not completed a Standard Measurement Period, as defined in paragraph 3.18.B, and who is hired into a position for which the customary annual employment is six months or less. The reference to customary means that by the nature of the position, an Employee in this position typically works for a period of six months or less, and that period begins each calendar year in approximately the same part of the year, such as summer or winter.

3. A New Variable Hour Employee is a new Employee who has not completed a Standard Measurement Period, as defined in paragraph 3.19.B, and who, upon hire, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 hours of service per week during an Initial Measurement Period, as defined in paragraph 3.20.B, because the Employee's hours are variable or otherwise uncertain.

**B.** An Initial Measurement Period for New Variable Hour, Part-Time, and Seasonal Employees begins on the first day of the month following a New Variable Hour, Part-Time, or Seasonal Employee's date of hire and ends twelve months later. A Standard Measurement Period set out in paragraph 3.19.B may begin during, and run concurrently with, portions of an Initial Measurement Period.

**C.** A New Variable Hour, Part-Time or Seasonal Employee meeting the requirements of paragraph 3.20.E may enroll during an Initial Administrative Period beginning the day following the end of his Initial Measurement Period, defined in paragraph 3.20.B, and ending the last day of the same calendar month.

**D.** An Initial Stability Period for New Variable Hour, Part-Time, and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year.

**E.** A New Variable Hour, Part-Time, or Seasonal Employee who is credited by his Employer with an average of at least 30 hours of service per week after completing an Initial Measurement Period, defined in paragraph 3.19.B, is eligible to enroll in coverage under this Plan during the Administrative Period, defined in paragraph 3.19.C, and for the entire duration of the following Initial Stability Period, as defined in paragraph 3.19.D. A New Variable Hour, Part-Time, or Seasonal Employee remains eligible throughout an Initial Stability Period so long as he is employed with that Employer and regardless of the number of hours worked during that Initial Stability Period. A New Variable Hour, Part-Time, or Seasonal Employee who ceases work and is not credited with an hour of service for less than 13 weeks (26 weeks for educational institutions) and who then resumes work with the same Employer during the same Initial Stability Period will be eligible to resume participation in the Plan as of the first

day of the calendar month following resumption of work (even if the New Variable Hour, Part-Time, or Seasonal Employee resumes employment in a position that is not reasonably expected to be a Full-Time position).

**F.** A New Variable Hour, Part-Time, or Seasonal Employee who has been found not to work an average of at least 30 hours per week during an Initial Measurement Period is not eligible for benefits as a Variable Hour, Part-Time, or Seasonal Employee through the entirety of the following Initial Stability Period, unless he gains eligibility under another provision of this Plan (e.g., after becoming an Ongoing Employee and gaining coverage through the provisions of paragraph 3.18). However, if a new Variable Hour, Part-Time, or Seasonal Employee materially changes employment status before the end of the Initial Measurement Period in such a way that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, the Employee will be treated as a Full-Time Employee and will be eligible for coverage under the Plan no later than the first day of the month following the change in employment status or, if earlier, as of the first day of the first month following the end of the Initial Measurement Period if the Employee averages more than 30 Hours of Service per week during the Initial Measurement Period and related Administrative Period.

**G.** Once a New Variable Hour, Part-Time, or Seasonal Employee meets the definition of an Ongoing Employee in paragraph 3.18.A, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in paragraph 3.18.

**H.** In the case of a conflict between another provision of this Plan and this paragraph, this paragraph will govern the New Variable Hour, Part-Time, or Seasonal Employee's eligibility and coverage. The New Variable Hour, Part-Time, or Seasonal Employee's coverage is otherwise governed by the entirety of this Plan.

### **3.20 New Full-Time Employee**

- A. If an Employer reasonably determines, based on the facts and circumstances at the date of hire, that a newly hired Employee will be a Full-Time Employee as defined in paragraph 2.20, the new Employee is eligible to participate in the Plan in accordance with paragraphs 3.2 and 3.3. If the Employee's hours are reduced below the threshold for Full-Time employment as defined in paragraph 2.20 before the Employee has completed a full Standard Measurement Period as defined in paragraph 3.18.B, then the Employee's eligibility will be determined on a month-to-month basis until completion of a Standard Measurement Period.
- B. Once a New Full-Time Employee meets the definition of an Ongoing Employee in paragraph 3.18.A, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in paragraph 3.18.

## **ARTICLE 4.**

### **CONTRIBUTIONS**

#### **4.1 Employee Contribution**

The State or employing entity contributes the entire premium for single dental coverage for the eligible Active Employee or eligible funded Retiree under the State Dental Plan. Each eligible Employee or funded Retiree who elects to have his Dependents covered under this Plan shall contribute the amount determined for each Plan Year by the State for the State Dental Plan the Employee selects commencing with the pay period in which such Dependents' coverage starts. The Plan Administrator reserves the right at any time to alter, amend, change, supplement, revoke or reduce the benefits under this Plan or increase or decrease the premiums charged under this Plan.

#### **4.2 Contribution of Entire Premium**

To be covered under this Plan, the following persons eligible for coverage shall contribute the full amount of the premium determined for each Plan Year by the State for the type of coverage selected, commencing with the period in which the person elects coverage in the categories listed below. These individuals are not eligible to receive any State contribution for dental coverage:

- A.** Employees eligible to participate under paragraph 3.1.B of this Plan.
- B.** A Surviving Spouse and/or Surviving Child of a deceased Active or Retired Employee who elects coverage under Article 9, Continuation of Coverage; provided, however:
  - 1.** For the Surviving Spouse and/or Surviving Child of an Active or Retired Employee who was killed in the line of duty after December 31, 2001, while working for a State agency or public school district, the full premium for coverage of the Surviving Spouse and/or Surviving Child is waived for a period of twelve months after the Employee's death; following the twelve-month waiver, the premium for coverage of the Surviving Spouse and/or Surviving Child is determined according to paragraph 4.1 as long as eligible;
  - 2.** For the Surviving Spouse and/or Surviving Child of a deceased Employee, who was not killed in the line of duty, the full premium for coverage is waived for a period of twelve months after the Employee's death if there was a State contribution to the premium and as long as the Surviving Spouse and/or Surviving Child is not an Employee and remains eligible for coverage; following the twelve-month waiver, the Surviving Spouse and/or Surviving Child may continue coverage as long as eligible by paying the full premium.
  - 3.** A Surviving Spouse and/or Surviving Child who becomes eligible as an Active Employee while he is still receiving the twelve-month waiver may remain covered as a Surviving Spouse or Surviving Child through the end of the twelve-month waiver, provided he may not enroll in any other benefits offered through PEBA to an Active Employee until he is no longer covered as a Surviving Spouse or Surviving Child. After the twelve-month waiver period ends, any such Surviving Spouse and/or Surviving Child is no longer eligible for coverage as a Surviving Spouse and/or Surviving Child.
- C.** Those electing to extend coverage as provided in Article 10 under COBRA;
- D.** Those hired on or after July 1, 1984, and who retired with five, but less than 10, years active service.
- E.** Those Retirees, who by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their dental insurance premium.

## ARTICLE 5.

### DUTIES AND RESPONSIBILITIES

#### 5.1 Planholder Duties

The Planholder shall be responsible for all functions assigned or reserved to it under this Plan including the authority and responsibility for:

- A. The appointment or removal of the Plan Administrator, Third-Party Claims Processor and other entities or their delegates that implement the Plan;
- B. The design of this Plan, including the right to amend this Plan and any other document relating to this Plan;
- C. The qualification of this Plan under the applicable law;
- D. The formation and maintenance of the funding policy of this Plan;
- E. The amendment and termination of this Plan;
- F. The determination of the amount of Subscriber contributions under this Plan;
- G. The exercise of all functions provided in this Plan or as may be necessary to the operation of this Plan except such functions as are assigned to others pursuant to this Plan.

#### 5.2 Plan Administrator Duties

The Plan Administrator shall have the sole responsibility for the administration of this Plan, and any construction or interpretation of the Plan, determination of eligibility or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decision of the Plan Administrator or its duly authorized agent is not arbitrary or capricious or in violation of applicable statutory law, and in addition, the Plan Administrator shall have such duties and powers as may be necessary to administer this Plan, including, but not limited to, the following:

- A. To administer this Plan according to its terms and to be accountable to the State with regard to the administration of this Plan;
- B. To construe and interpret this Plan in a nondiscriminatory manner; to decide all questions of eligibility; and to determine all questions arising in the administration and application of this Plan;
- C. To determine the types of benefits allowable under this Plan;
- D. To be responsible for the reporting and disclosure requirements imposed upon administrators under applicable law;

- E. To receive from the State and from Subscribers and Dependents such information as shall be necessary for the proper administration of this Plan, and to furnish the State, upon request, such reports with respect to the administration of this Plan as are responsible and appropriate;
- F. To receive, review, and keep on file (as it deems convenient or proper) reports of the financial condition, and of the receipts and disbursements;
- G. To maintain all records of this Plan;
- H. To review as necessary, all claims for benefits under this Plan;
- I. To determine the manner and time of payment of benefits under this Plan;
- J. To apprise the State as to the amounts and timing of disbursements for payment of benefits and expenses under this Plan;
- K. To prescribe procedures to be followed by Subscribers and Dependents in filing claims for benefits under this Plan;
- L. To furnish the State such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;
- M. To do all other acts or things as may be necessary for the proper administration of this Plan.

### **5.3 Duties and Powers of Third-Party Claims Processor**

The Third-Party Claims Processor shall have such duties and powers as may be necessary to process claims and make payments under this Plan, consistent with the contract between the Plan Administrator and the Third-Party Claims Processor and including, but not limited to, the following:

- A. To act under the direction and control of the Plan Administrator;
- B. To receive, review, and verify and investigate as necessary, all claims for benefits under this Plan;
- C. To determine the amounts, manner, and item of payment of benefits under this Plan;
- D. To apprise the Plan Administrator as to the amounts and dates of disbursements for payment of benefits and expenses under this Plan;
- E. To receive from the State, the Plan Administrator, Subscribers and Dependents such information as shall be necessary for the proper processing and payment of claims under this Plan;
- F. To furnish the Plan Administrator, upon request, such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;
- G. To maintain records relating to claims for benefits, processing of claims, and payment or denial of claims for benefits;

H. Any other related duties.

## ARTICLE 6.

### PAYMENT OR REIMBURSEMENT FOR COVERED DENTAL BENEFITS

**6.1** Subject to all other terms, conditions, limitations and exclusions of this Plan, the Plan Administrator, upon receipt of invoices from providers of dental care and/or of completed claim forms as may be required by the Plan Administrator, and after the claims have been processed by the Third-Party Claims Processor will make payment for a Covered Person's Covered Dental Benefits, provided the expense is not covered or reimbursable under any other group plan, insured or otherwise. If expenses for dental care are partially paid or reimbursed under any other group plan as provided in Article 7, Coordination of Benefits, that part of the expenses which is not so paid or reimbursed by the other plan shall be paid or reimbursed to, or for the benefit of, the Covered Person as provided in this Plan.

#### **6.2 Payment**

Subject to the Deductible and maximums established in the Plan, the Plan will pay for Covered Dental Benefits provided by a Dentist or Dental Hygienist to a Covered Person by paying the lesser of the billed charge or the Allowed Amount as provided in paragraph 2.4.

#### **6.3 Annual Maximum Benefit**

The maximum amount payable for Covered Dental Benefits for a Covered Person is \$1,000 for each Plan Year.

#### **6.4 Lifetime Orthodontia Maximum**

The Plan's payment of benefits for a Child for correction of dysfunctional malocclusion are limited to a lifetime maximum of \$1,000.

## ARTICLE 7.

### COORDINATION OF BENEFITS

#### **7.1 Definitions for this Article**

##### **A. Plan**

For purposes of this Article, Plan means any program which provides dental benefits or services for or by reason of dental care or treatment including:

1. any group insurance and group subscriber contracts;
2. any uninsured arrangements of group coverage;
3. any group coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans;

4. any group hospital indemnity plans to the extent that the benefits exceed \$100 per day;
5. any medical benefits coverage in group and individual automobile “no fault” and traditional automobile “fault” type contracts;
6. any coverage under a governmental plan, or coverage required to be provided by law, but does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the Social Security Act, as amended);
7. but does not include insurance contracts or subscriber contracts, or coverage through HMO or other prepayment, group practice or individual practice plans, to the extent that they provide individual or family coverage; and does not include blanket insurance contracts, franchise insurance contracts or a state plan under Medicaid, and shall not include a law or plan, when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Each program or other arrangement for coverage is a separate Plan for purposes of coordination of benefits (COB), and if a program or other arrangement for coverage has more than one part, and the COB provisions apply to one part, then each part of the program or arrangement is considered a separate Plan.

#### **B. Dependent**

With respect to this Article Dependent means any person included in the definition of Dependent in paragraph 2.15 herein and, with respect to any other Plan, any person who qualifies as a dependent under such Plan.

#### **C. Primary Plan**

A Plan whose benefits must be determined without taking the existence of another Plan into consideration. There may be more than one Primary Plan. The provisions of paragraph 7.2 determine whether a Plan is Primary or Secondary.

#### **D. Secondary Plan**

A Plan that is not a Primary Plan. When this Plan is a Secondary Plan its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. The provisions of paragraph 7.2 determine whether a Plan is Primary or Secondary.

### **7.2 Order of Determination of Benefits**

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan unless: (1) the other Plan has rules coordinating its benefits with those of this Plan and (2) both those rules and this Plan's rules, as specified below, require that this Plan's benefits be determined before those of the other Plan.

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

#### **A. Coverage as a Non-Dependent or Dependent**

The benefits of a Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

**B. Dependent Child - Parents Not Separated or Divorced**

Except as provided in paragraph C below, when this Plan and another Plan cover the same Child as a dependent of different persons called parents:

1. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
2. If both parents have the same birthday, the benefits of the Plan that covered a parent longer are determined before those of the Plan that covered the other parent for a shorter period of time;
3. Provided, however, that if the other Plan does not have the rule described in B(1) above (the birthday rule) but has the gender rule so that the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

**C. Dependent Child - Parents Separated or Divorced**

If two or more plans cover a person as a dependent Child of divorced or separated parents, the benefits for the dependent Child are determined in this order:

1. First, the Plan of the parent with custody of the Child;
2. Second, the Plan of the spouse of the parent with custody of the Child;
3. Third, the Plan of the parent who does not have custody of the Child;
4. Provided, however, that if the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan.
5. Provided further, that 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 dental care expenses of the child, the Plans covering the Child shall follow the order of benefit determination rules in paragraph B above.

**D. Active - Inactive Employee**

The benefits of a Plan, which covers a person as an employee who is neither laid off nor retired, or as a dependent of an employee who is neither laid off nor retired, are determined before those of a Plan, which covers that person as a laid off or retired employee, or as a dependent of a laid off or retired employee. Provided, however, this paragraph does not apply if the other Plan does not have the rule of paragraph D, and, if, as a result, the Plans do not agree on the order of benefits.

**E. Continuation of Coverage**

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

1. First, the benefits of a Plan covering the person as an employee, member or subscriber (or as that person's dependent);
2. Second, the benefits under the continuation of coverage.

**F. Longer - Shorter Length of Coverage**

If none of the above rules A-E determine the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter term.

**Note:** The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group plan caused the COBRA coverage to end. An amendment passed as part of H.R. 3299 (1989) allows the COBRA coverage to continue if the other group plan contains any pre-existing condition limitation. In this instance, two policies will cover an individual, and the above rule will be used to determine which one of them assumes the primary position.

**7.3 Effect of Order of Determination of Benefits on this Plan**

**A. This Plan is Primary.** When the order of determination rules of this Plan establish that this Plan is the Primary Plan, the benefits provided by this Plan shall be determined without consideration of the benefits of any other Plan.

**B. This Plan is Secondary.** When the order of determination rules of this Plan establish that this Plan is the Secondary Plan, this Plan will pay the lesser of

- (1) the benefits that would be payable for the Covered Dental Benefit(s) under this Plan if it were the Primary Plan, without regard to this COB provision; or
- (2) the difference between this Plan's Allowed Amount(s) and the benefits the other Plan would pay as Primary, without regard to any COB or similarly intended provision in that Plan. Payment for each Covered Dental Benefit will be determined in the manner above when this Plan is Secondary. This Plan as Secondary will not pay any benefits for expenses this Plan would not cover as Primary. The benefits this Plan pays as Secondary will not exceed the total benefits this Plan would pay as Primary or the patient's liability under the Primary Plan, nor will the payments from both Plans combined exceed the Allowed Amount(s) of this Plan. Any benefits paid under this provision are charged against any applicable benefit limit of this Plan.

**7.4 Coordination of Benefits for Oral Surgery Procedures with State Health Plan**

Some oral surgery procedures are also covered by the State Health Plan administered by BlueCross BlueShield of South Carolina, and are indicated in the Schedule of Dental Procedures and Allowed Amounts by an asterisk (\*). Some services related to the oral surgery may also be covered. The State Health Plan is the primary coverage for these procedures. Therefore, the claim for these procedures must be filed with the State Health Plan first. A copy of the Explanation of Benefits (EOB) provided by the Third-Party Claims Processor for the State Health Plan (BlueCross BlueShield) must be filed with the Third-Party Claims

Processor for the State Dental Plan before the State Dental Plan will provide payment as a secondary insurance carrier.

#### **7.5 Right to Receive and Release Information**

For the purpose of determining the applicability of, and implementing the terms of, this Article or any provision of similar purpose of any other Plan, the Third-Party Claims Processor may, without the consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information which it deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Third-Party Claims Processor such information as may be necessary to implement this Article.

#### **7.6 Facility of Payment**

Whenever payments which should have been made under this Plan in accordance with this Article have been made under any other Plan, the Third-Party Claims Processor will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this Article, and amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments for Covered Dental Benefits, the Plan will be fully discharged from liability. The term "payments" includes providing benefits in the form of services, in which case the term "payment made" means the reasonable cash value of the benefits provided in the form of services.

#### **7.7 Right of Recovery**

Whenever payments have been made under this Plan by the Third-Party Claims Processor with respect to Covered Dental Benefits in a total amount in excess of the amount necessary to satisfy the purposes of this Article, the Third-Party Claims Processor will be entitled to recover on behalf of the Plan such excess amounts from a Covered Person or any group insurer, Plan, or other person or organization contractually obligated to such Covered Person with respect to such Covered Dental Benefits. The Subscriber, for himself or on behalf of his Dependents will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to this Plan or any other Plan.

## **ARTICLE 8.**

### **EXCLUSIONS AND LIMITATIONS**

**8.1** No benefits will be provided under any Article of this Plan for any service, supply or charges for the following:

- A.** Any service or charge for service that is:
  - 1. not Medically Necessary as defined in 2.23; or
  - 2. more costly than an Alternate Form of Treatment that meets accepted standards of dental practice, regardless of the course of treatment chosen by the Covered Person or the Dentist, in which case benefits will be limited to the benefits due had the services been the least costly alternative; or,

3. rendered by a Dentist or Dental Hygienist beyond the scope of the applicable license; or,
  4. not recommended and approved by the attending Dentist; or
  5. for a non-dental service such as broken appointments, dental records or completion of claim forms; or
  6. for treatment other than by a licensed Dentist, except that cleaning or scaling of teeth may be performed by a licensed Dental Hygienist if such treatment is rendered under the supervision of a Dentist; or
  7. a temporary procedure that is considered part of a more definitive treatment.
- B.** Any service or charge for service to the extent a Covered Person is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, or any state or political subdivision thereof. Without limiting the generality of the foregoing, this exclusion applies to benefits provided by or payable under workers' compensation laws, the Veterans Administration or any state or federal hospital for which hospital services the Covered Person is not legally obligated to pay. This exclusion applies if the Covered Person receives any benefits or payments in whole or in part, and it applies to any settlement or other agreement, including any settlement of "doubtful and disputed" claims or "clincher" agreements or any other agreement regardless of how characterized and even if the document or release specifically excludes payment for medical expenses.
- C.** Any service or charge for service to the extent a Covered Person is entitled to payment or benefits under state or federal programs of health care, excluding Medicare and amendments thereto, but only to the extent that benefits are provided or reimbursement is paid or payable hereunder;
- D.** Any charges for services or supplies required because of declared or undeclared war or any act of war, or which were furnished or paid for by reason of the past or present service of any person in the armed services of a government;
- E.** Any charges for services commencing prior to the Covered Person's coverage hereunder or rendered after the termination of coverage, except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, of this Plan, and except for charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the individual was covered under the State Dental Plan but are finally installed or delivered within 90 days after the termination of coverage;
- F.** Any charges for services and supplies which are furnished in a facility operated under the direction or at the expense of the U.S. Government (or any agency thereof) or by a Doctor or Dentist employed by such facility;
- G.** Any charges for services and supplies that are primarily for cosmetic or aesthetic purposes, including charges for personalization or characterization of dentures, except for orthodontia treatment as specifically provided for under this Plan;

- H. Any charges for the replacement of a lost or stolen prosthetic device, or a lost, stolen or broken space maintainer or orthodontic appliance, or charges for spare or duplicate dentures and/or appliances;
- I. Any charges for more than two procedures in any Plan Year of the following:
  - 1. Oral examination,
  - 2. Consultations provided by a specialist,
  - 3. Prophylaxis,
  - 4. Periodontal prophylaxis (a covered benefit available only to patients who have a history of periodontal surgery) except that two additional periodontal prophylaxis (D4910) will be allowed if substituted for two prophylaxis (D1110) provided in subpart 3 above,
  - 5. Topical fluoride applications of stannous fluoride or acid fluoride phosphate.
- J. Any charges for the procedures listed below that are performed more often than specified in the Plan, including:
  - 1. gingival curettage, surgical, exceeding four quadrants in any 36-month period;
  - 2. osseous surgery, including flap entry and closure, exceeding four quadrants in any 36-month period;
  - 3. periodontal scaling and root planing, exceeding four quadrants in any 36-month period;
  - 4. more than one osseous graft for the same site in any 36-month period;
  - 5. tissue conditioning, exceeding two procedures on the upper-per denture unit or two procedures on the lower-per denture unit in any 36-month period;
  - 6. more than one topical application in any 36-month period of sealant for unrestored recently erupted permanent molars for patient through age 15;
  - 7. more than one root canal treatment on the same tooth. (Additional treatments should be submitted with the appropriate American Dental Association Code and documentation);
  - 8. more than one treatment per lifetime for perio scaling/gingival inflammation.
- K. Any charges for bitewing X-rays more than twice during any Plan Year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period unless a special need for these services at more frequent intervals is documented as medically necessary by the Dentist.
- L. Any charges for replacement of an existing cast prosthesis, including crowns, partial or full removable denture or fixed bridgework or the addition of teeth to an existing partial,

removable denture or bridgework, unless evidence is submitted and is satisfactory to the Third-Party Claims Processor that: (1) the addition of teeth is required for the initial replacement of one or more natural teeth; (2) the existing denture or bridgework was installed at least five years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or (3) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that such replacement is delivered or installed within a period of 12 consecutive months (subject to sub-paragraph E above) following the date of installation of the immediate temporary denture.

- M.** Any charges for space maintainers for prematurely lost deciduous teeth if the dependent has attained age 19.
- N.** Any medical/dental procedures determined by the medical/dental staff of the Third-Party Claims Processor, with appropriate consultation, to be experimental or investigational or not accepted medical/dental practice. Experimental or investigational procedures are those medical/dental procedures, supplies, devices or drugs, which at the time provided or sought to be provided:
  - 1. Are not recognized as conforming to accepted dental practice in the relevant medical specialty or field of medicine; or
  - 2. The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
  - 3. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes; or
  - 4. Is not demonstrated to be as beneficial as established alternatives; or
  - 5. Has not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
  - 6. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.
- O.** Any service or supply rendered by a member of the Covered Person's immediate family (parent, child, spouse, sibling, grandparent, or in-law).
- P.** Any charges for services or supplies for:
  - 1. Crowns, when only for preventive purposes or due to erosion, abrasion or attrition;
  - 2. Myofunctional therapy (e.g., correction of tongue thrusting);
  - 3. The purpose of altering vertical dimension;
  - 4. Splinting, including extra abutments for bridges;
  - 5. Topical application of sealant per tooth for unrestored, recently erupted molars for patients age 16 and older; or

**Q.** Any charges for services or supplies for orthodontic treatment:

1. For Employees;
2. For Covered Children ages 19 and over (unless appliances were placed for Covered Children prior to age 19);
3. In excess of the lifetime maximum shown in the Schedule of Dental Procedures and Allowed Amounts; or
4. For services rendered subsequent to the month in which the individual's eligibility for coverage terminates.

**R.** Any charges made directly to a Covered Person by a Dentist for dental supplies (i.e., toothbrush, mouthwash, dental floss etc).

**S.** Any service or supply or appliance for the correction of temporomandibular joint (TMJ) syndrome, including office visits, splints, braces, guards, etc. (Note that Medically Necessary surgical correction of TMJ disorders that meet the conditions of the State Health Plan is covered by the State Health Plan but not by the State Dental Plan. Consult the State Health Plan and Medi-Call for more details.)

## ARTICLE 9.

### CONTINUATION OF COVERAGE

#### 9.1 Incapacitated Dependent Child

The coverage of an unmarried incapacitated Child under this Plan may be continued after the Child reaches age 26, provided proof of such incapacity and dependency is furnished to the Plan Administrator by the Employee within 31 days of such Child reaching the age of 26, and at such other reasonable times, but not more than annually, and provided further, that coverage remains in force for the Employee.

#### 9.2 Effect of Termination of Coverage

All rights to receive benefits provided under this Plan for services rendered to a Covered Person after the termination of coverage will automatically cease.

#### 9.3 Surviving Spouse and/or Surviving Children

The Covered Surviving Spouse and/or Covered Surviving Children of a deceased Active or Retired Employee, including any Child born after the death of the Employee but before the remarriage of the Surviving Spouse, shall be eligible to continue the coverage provided they pay the premium as set forth in paragraph 4.2, provided however:

- A. Such Surviving Spouse or Surviving Children must be covered under the Plan at the time of the Employee's death (other than any Child born after the death of the Employee but before the remarriage of the Surviving Spouse;
- B. The coverage of a Surviving Spouse provided under this paragraph shall terminate upon remarriage;
- C. The existing coverage of any Surviving Children will not be affected by the remarriage of the Surviving Spouse, but such coverage is subject to all the terms, conditions, limitations and exclusions of the Plan, including the requirement that coverage ceases on the date that a Covered Child no longer meets the definition of a Child.
- D. In no event shall any Surviving Spouse or Surviving Child who feloniously and intentionally kills the Active or Retired Employee be entitled to any premium waiver;
- E. Upon the termination of this continuation coverage for a Surviving Spouse or a Surviving Child, such Surviving Spouse or Surviving Child may not reenroll in the Plan thereafter unless:
  - 1) The Surviving Spouse or Surviving Child remains enrolled in the State Health or State Vision Plan. If enrolled in State Health or State Vision, an otherwise eligible Surviving Spouse or Surviving Child may reenroll in the Plan within 31 days of a change in family status or during open enrollment; or
  - 2) The Surviving Spouse or Surviving Child gains eligibility as an active employee and continues coverage in the Plan as an active employee. An otherwise eligible Surviving Spouse or Surviving Child may only reenroll in the Plan within 31 days of losing eligibility as an active employee.
- F. Except as provided in this paragraph and paragraph 10.4, the coverage of a Surviving Spouse and Surviving Children of a deceased Employee shall terminate as provided in paragraph 3.9.

#### **9.4 Surviving Spouse/Child Continuation Coverage and COBRA**

Upon the death of the Employee which would entitle a Surviving Spouse or Surviving Child to continuation coverage pursuant to paragraph 9.3, such Surviving Spouse or Surviving Child shall, in accordance with applicable law, be provided with an opportunity to elect COBRA continuation coverage as described in Article 10. Such Surviving Spouse or Surviving Child may elect COBRA continuation coverage. In the alternative, the Surviving Spouse or Surviving Child may elect the continuation coverage in paragraph 9.3 hereunder for the Surviving Spouse or Surviving Child. A Surviving Spouse or Surviving Child shall not be eligible for the continuation coverage provided under paragraph 9.3 unless the Surviving Spouse or Surviving Child declines to elect continuation coverage under COBRA as set forth in Article 10.

## **ARTICLE 10.**

### **COBRA**

#### **10.1 The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

COBRA requires that a Qualified Beneficiary who would otherwise lose coverage as a result of a Qualifying Event as defined in that act, is entitled to elect to temporarily extend dental coverage under this Plan. The coverage will be identical to the coverage provided to the Covered Employee before the Qualifying Event and identical to the coverage provided similarly situated Employees to whom a Qualifying Event has not occurred.

#### **10.2 Qualifying Event**

A Qualifying Event is any one of the following:

- A.** Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;
- B.** The death of the Employee;
- C.** Divorce or legal separation of the Employee from his spouse;
- D.** A Dependent Child ceasing to qualify as an eligible Dependent under the Plan;

#### **10.3 Qualified Beneficiary**

A Qualified Beneficiary is any individual who, on the day before the Qualifying Event, is a beneficiary under the plan and is any of the following:

- A.** The Employee whose employment was terminated (other than for gross misconduct) or work hours were reduced so as to render the Employee ineligible for coverage;
- B.** The Spouse of the Employee; or
- C.** The Dependent Child of the Employee, including a Child who is born to or placed for adoption with the Employee during the period of continuation coverage.

#### **10.4 Notice by Employee, Spouse or Child**

In cases of divorce or legal separation of the Employee from his spouse or a Child ceasing to qualify as an eligible Dependent under the Plan, the Employee or eligible Dependent is responsible for notifying the benefits office of the Employer or the Plan Administrator within 60 days after the later of

- (a) the date of the Qualifying Event, or
- (b) the date the Dependent would lose coverage on account of the Qualifying Event. If the Plan Administrator is not notified within 60 days of the happening of either event, the Dependent will not be given the opportunity to continue coverage.

Provided further, that an Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act, either before the Qualifying Event or during the first 60 days of continued coverage under COBRA, must provide notice of the determination of disability before the end of the first 18 months of coverage to be eligible for up to 29 months of continuation coverage.. The notice must be provided within 60 days after the latest of: (i) the date of the determination of disability under the Social Security Act; (ii) the date the Qualifying Event occurs; (iii) the date the Qualified Beneficiary loses or would lose coverage; or (iv) the date the Qualified Beneficiary is notified of his or her notice obligation. In addition, the Qualified Beneficiary must also notify the Plan Administrator within 30 days of any determination that the Employee or Dependent is no longer disabled.

#### **10.5 Notice By Plan Administrator**

The Plan Administrator shall provide, at the time of commencement of coverage under the Plan, written notice to each Covered Employee and to the Spouse of the Covered Employee (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a Covered Employee and the Covered Employee's Spouse if they both reside at the Covered Employee's address, and the Spouse's coverage commences on or after the date on which the Covered Employee's coverage commences, but not later than the date by which this general notice must be provided. No separate notice is required to be sent to Dependent Children who share a residence with a Covered Employee or a Covered Employee's Spouse. This general notice shall be provided not later than the earlier of: (1) 90 days after such individual's coverage commencement date under the Plan; or (2) the date on which the Plan Administrator is required to furnish a COBRA election notice as described in this paragraph.

The Employer shall notify the Plan Administrator or its designee in the event of a Covered Employee's death, termination of employment (other than gross misconduct), or reduction in hours within 30 days after the later of: (1) the date of the Qualifying Event; or (2) the date that the Qualified Beneficiary would lose coverage due to the Qualifying Event.

The Covered Employee and the Covered Employee's Dependent(s) shall be notified by the Plan Administrator or its designee of their right to elect continuation coverage: (1) in the event of the Covered Employee's death, termination, or reduction in hours and (2) if the Covered Employee is notified by the Plan Administrator or its designee initially, in the event of divorce or legal separation of the Covered Employee from the Covered Employee's Spouse, disability, or in the event of a Child ceasing to be a Dependent Child under the generally applicable requirements of the Plan, within 14 days of the date on which the Plan Administrator or its designee was notified of these Qualifying Events. Election form shall be sent by U.S. Mail, postage pre-paid, to the last known address of the Qualified Beneficiaries unless the Plan Administrator has been notified in writing to the contrary. The last known address shall be

deemed to the most recent address in the records of the Plan Administrator. In the event the Covered Employee/former Covered Employee changes address, it is his or her responsibility to notify the Plan Administrator of any change in address and the Plan Administrator shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to an Covered Employee/former Covered Employee who elected spousal coverage shall be sent with an envelope marked "Mr. and Mrs. John Smith." Election forms sent to an Covered Employee/former Covered Employee that has one or more Children/Dependents covered shall be addressed to the Covered Employee (if the Spouse was not covered) or to the Covered Employee and Spouse (if spousal coverage was elected), and each shall be deemed to include notification to any Dependent Children, unless the Plan Administrator has actual knowledge of a different address for a Dependent Child before the date the election form is mailed and provided further that any such notification to the Plan Administrator was in writing sent via either U.S. Mail or facsimile.

In addition, if a Covered Employee or Dependent is not entitled to receive Continuation Coverage, he or she will be notified of this and will be provided with an explanation as to why he or she is not entitled to this Continuation Coverage. This notice shall be provided within 14 days of the date that the Plan Administrator was provided with the notice of the purported qualifying event.

#### **10.6 Election of Coverage**

Continued coverage is not automatic. Coverage must be elected within 60 days of the later of the following:

- A.** The date coverage ceases because of the Qualifying Event;
- B.** The date the Qualified Beneficiary is sent notice of the right to elect continuation coverage.

#### **10.7 Premium Required**

The Plan will determine the amount of premium to be charged for continued coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as may be provided by law.

- A.** The Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102% of the applicable premium for that period.
- B.** For Qualified Beneficiaries whose coverage is continued as a result of disability, the Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150% of the applicable premium for continued coverage months 19-29.
- C.** Contributions for coverage shall be paid in monthly installments.
- D.** If continued coverage is elected, the monthly contribution for coverage for those months up to and including the month in which the election is made must be made within 45 days of the date of election. Failure to pay this premium on the date due shall result in cancellation of continued coverage back to the initial date coverage would have terminated as a result of the Qualifying Event.

**E.** Without further notice from the Plan, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Plan within 30 days of the payment's due date, continued coverage will terminate. This 30 day grace period does not apply to the first contribution required under paragraph D.

**F.** No claim will be payable under this paragraph for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

**G.** It is Qualified Beneficiary's responsibility to pay the premium on time. If the Plan Administrator provides a Qualified Beneficiary with payment reminders or payment coupons, but later ceases to do so, it still remains the Qualified Beneficiary's responsibility to make the premium payments on time even if the Qualified Beneficiary no longer receives the payment reminders or coupons, and even if the Qualified Beneficiary is not notified of the cessation of the payment reminders or coupons.

### **10.8 Length of Coverage**

Continuation Coverage is a temporary continuation of coverage. In general the following rules will determine the length of the coverage; however, there are two situations that can extend the coverage: disability and second qualifying events.

**A.** A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Plan for up to 18 months from the date of the Qualifying Event.

**B.** A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, or legal separation, and Dependent Children who have become ineligible for coverage may continue coverage under the Plan for up to 36 months from the date of the Qualifying Event. In the event of the Covered Employee's death, the Spouse and Child are entitled to continuation coverage as described in Article 9 above in lieu of COBRA continuation coverage (see paragraph 9.4).

In the event of a disability determination, this Qualified Beneficiary is entitled to 29 months of continuation coverage if the Qualified Beneficiary provides notice of the determination of disability before the end of 18 months of coverage and within 60 days of the later of these dates:

1. The date of the SSA Disability determination notification;
2. The date of the qualifying event;
3. The date of the initial COBRA notice; or
4. The date the subscriber lost coverage because of the qualifying event.

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum continuation coverage is 18 or 29 months, and a second Qualifying Event occurs during the 18 or 29 month period, all individuals who were Qualified Beneficiaries in connection with the initial Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event may elect to continue coverage under the Plan for up to 36 months from the date of the first Qualifying Event.

For example, this extension may be available to the Spouse and any Dependent Children who are already receiving continuation coverage if the Covered Employee or former Covered

Employee dies, or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

### **10.9 Early Termination of Continuation Coverage**

Coverage under paragraph 10.8 may end before the end of the maximum coverage period and will occur on the date of the earliest of any of the following:

**A.** The date the State or the Employer associated with the Qualified Beneficiary ceases to provide any group health plan to any Employee;

**B.** The date, including any grace period provided herein, the Qualified Beneficiary fails to make any required payment;

**C.** The first date after the date of election in which the Qualified Beneficiary is covered under any other group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. Provided, however, that an Employee who, on the date of the Qualifying Event, is covered by a plan, other than this Plan, remains eligible for continuation coverage under COBRA under this Plan; and

**D.** For disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer disabled.

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (e.g., in the case of submitting fraudulent claims to the Plan).

In the event a Qualified Beneficiary's continuation coverage terminates before the duration of continuation coverage (either 18, 29 or 36 months after the Qualifying Event), the Plan Administrator shall notify the Qualified Beneficiary of the early termination date and the reason for early termination of continuation coverage. Such notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage should terminate.

### **10.10 Persons on Military Leave**

Any Covered Employee who is covered under this Plan immediately prior to the Covered Employee's covered absence for Service in the Uniformed Service shall be entitled to elect to continue coverage under this Plan, for the Covered Employee and the Covered Employee's Dependent(s), during the Covered Employee's leave for Service in the Uniformed Service pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Such coverage is available if the Covered Employee is absent from employment because of voluntary or involuntary performance of duty in the Army, Navy, Marine Corps, Air Force, Coast Guard, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, the reserve components of each of these services, and any other category of persons designated by the President of the United States in time of war or national emergency. Uniformed services also include certain types of service

by members in the National Disaster Medical System and certain types of service by certain members of the Reserve Officers' Training Corps.

The Covered Employee may elect to continue coverage described in this Article by reason of Service in the Uniformed Services for himself and his covered Dependents. Dependents do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage shall begin on the date the Covered Employee gives the Employer advance notice that he is required to report for Uniformed Service (whether such service is voluntary or involuntary) and shall end 60 days after the date the Covered Employee would lose coverage under the Plan.

If the Covered Employee is unable to give advance notice of Uniformed Service, the Covered Employee may still be able to elect USERRA continuation coverage if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such case, the election period shall begin on the date the Covered Employee leaves for Uniformed Service and shall end on the earlier of: (1) the 24-month period beginning on the date on which the Covered Employee's absence for the Uniformed Service begins; or (2) the date on which the Covered Employee fails to return from Uniformed Service or apply for a position of employment as provided under 20 CFR. §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the Employer is unavailable or the Covered Employee is required to report for Uniformed Service in an extremely short period of time.

The election of USERRA continuation coverage must be made on a form provided by the Plan Administrator and made within the 60-day period described herein. An election is considered to be made on the date it is sent to the Plan Administrator. If timely elected pursuant to this paragraph, coverage shall be reinstated as of the date the Covered Employee lost coverage due to absence for Service in the Uniformed Service and shall last for the period set forth below; provided that the Covered Employee pays all unpaid costs for the coverage as described in this paragraph.

Any Covered Employee or Dependent who elects to continue coverage under this provision shall be required to pay the applicable premium as discussed in paragraph 10.7 above; provided, however, that any Covered Employee (and the Dependents of such Covered Employee) who is on military leave for less than 31 days shall not be required to pay more than the cost of coverage typically charged to similarly situated Covered Employees (and their Dependents).

A Covered Employee who is absent from work by reason of Service in the Uniformed Services may be eligible for COBRA continuation coverage. The USERRA continuation coverage provided in this paragraph shall not limit or otherwise interfere with those COBRA continuation coverage rights detailed above; provided, however, any USERRA continuation coverage provided under this paragraph shall run concurrently with any COBRA Continuation Coverage available under this Plan.

The Employer shall promptly reinstate Plan coverage when a Covered Employee is reemployed after Service in the Uniformed Service; provided; however, a request to reinstate Plan coverage must be made by the Covered Employee within 30 days of reemployment

(presuming the Covered Employee has sought reemployment with the Plan in compliance with 20 CFR Part 1002, Subpart C). If no request is made within this time period, no coverage shall be reinstated under the Plan. When a Covered Employee's coverage under the Plan is reinstated, he or she will not be subject to any exclusion or waiting periods. However, this rule does not apply to any conditions that were Incurred or that were aggravated during the Covered Employee's service in uniformed services.

The USERRA continuation coverage provided to a Covered Employee serving in the Uniformed Services shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan who are active. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an Open Enrollment Period during which similarly situated active Employees may choose to be covered under another group dental plan or under another benefit package within the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to individuals who have elected USERRA continuation coverage.

#### **10.11 Order of Determination of Benefits**

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

1. First, the benefits of a plan covering the person as an employee, member or subscriber (or as the person's Dependent); and
2. Second, the benefits under the continuation coverage.

## **ARTICLE 11.**

### **CLAIMS PROCEDURE**

#### **11.1 Voluntary Pre-certification**

Although it is not mandatory, it is suggested that if a Covered Person has estimated dental charges of \$250 or more, the Covered Person or attending Dentist should fill out a claim form describing the services to be performed (course of treatment) stating the cost of the services. The completed claim form and X-rays should be sent to the Third-Party Claims Processor for review. A Pre-determination of Benefits will be sent to the Covered Person and Dentist identifying what part of the estimated expenses is covered under the State Dental Plan at that time. The actual payment of benefits will be based on the State Dental Plan at the time services are rendered and the dental services actually performed. If the treatment is not rendered within one year of the date of issue of the pre-certification, it is suggested that another pre-certification form be submitted with the necessary documentation. This form can be used to claim benefits payable as the actual work is completed. The form must be filled in with the actual date(s) of services, and be signed by the Covered Person and Dentist and submitted to the Third-Party Claims Processor for the State Dental Plan.

#### **11.2 Making a Claim for Benefits**

- A. A Covered Person will present an identification card when applying for services covered under this Plan.
- B. Written notice of care on which a claim is based must be furnished to the Third-Party Claims Processor within 90 days of the beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, the Third-Party Claims Processor will furnish or cause to be furnished to the Covered Person a claim form. If the claim form is not furnished within 15 days after the receipt of the notice by the Third-Party Claims Processor, the Covered Person will be deemed to have complied with the requirements of this Plan as to proof of loss, if he submits written proof covering the character and extent of the loss within the Plan time fixed for filing proof of loss.
- C. A Covered Person must complete or cause to be completed a claim, on forms prescribed by the Plan Administrator or Third-Party Claims Processor, and will file it or cause it to be filed, along with all documentation, including medical records, required by the Plan Administrator or Third-Party Claims Processor. The claim will be deemed written proof of loss and written authorization from the Covered Person to the Third-Party Claims Processor to obtain any medical or financial records and documents useful to the Third-Party Claims Processor; however, the Third-Party Claims Processor 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 to it at the time the claim was processed.
- D. The claim must be received by the Third-Party Claims Processor within 90 days after the beginning of care; however, failure to file the claim within the 90-day period will not prevent payment of benefits if the Covered Person shows that it was not reasonably possible to timely file the claim, provided the claim is filed as soon as is reasonably possible, but in no event, except in the absence of legal capacity, later than 12 months after the service is rendered.
- E. Any party who submits medical or financial reports and document to the Third-Party Claims Processor in support of a Covered Person's claim will be deemed to be acting as the agent of the Covered Person.

### **11.3 Payment of Claims**

The Third-Party Claims Processor will pay benefits directly to the Dentist, if the Covered Person has assigned the benefits to that Dentist, and if the Dentist accepts the assignment of benefits and files a Dental Benefits Claim Form to the Third-Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third-Party Claims Processor for all services rendered. Except as provided above, the Third-Party Claims Processor on behalf of the Plan will pay all benefits directly to the Covered Person upon receipt of due proof of loss. The difference between the actual charges billed by the Dentist, and the amount reimbursed by the State Dental Plan are the responsibility of the Covered Person.

### **11.4 Right to Examine Covered Person**

The Third-Party Claims Processor on behalf of the Plan Administrator, and at its own expense has the right and opportunity to examine the person of any Covered Person whose injury or sickness is the basis of claim when and as often as it may reasonably be required during the pendency of a claim or action hereunder.

### **11.5 Allocation and Apportionment of Benefits**

The Third-Party Claims Processor, on behalf of the Plan, has the right to allocate the Deductible to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and binding upon the Covered Person and all assignees.

### **11.6 Review of Claims Denied in Whole or Part**

If the Third-Party Claims Processor or its designee determines that any person who has submitted a claim for the payment or pre-certification of benefits under the Plan is not entitled to receive all or part of the benefits sought, the Third-Party Claims Processor or its designee shall inform the claimant of such determination and the reasons therefore, with specific reference to pertinent provisions of the Plan. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of the Public Employee Benefit Authority.

#### **A. Review by Third-Party Claims Processor**

A Covered Person, after receipt of notification of the Third-Party Claims Processor's action on his claim, must request a review of any benefits denied in whole or in part within six months of notice of the denial of benefits by the Third-Party Claims Processor. To request a review of that agency's decision, the Covered Person must write the Third-Party Claims Processor giving reasons why the claim should be approved. The claimant may also request an expedited reconsideration of the decision denying benefits.

The Third-Party Claims Processor shall render its decision within 60 days after the request for review is received, unless medical records are requested, in which case the decision will be rendered no later than 30 days after the requested information is received. If the requested information is not received within 30 days, the decision will be made on the information available at that time. The decision shall be made by one not involved in the original decision to deny benefits or pre-certification. The reconsideration under this section shall be exhausted before any appeal to PEBA. The Third-Party Claims Processor will send the Covered Person a written decision stating the specific reasons for its final decision with specific reference to pertinent Plan provisions.

#### **B. Appeal of Denial of Benefits to PEBA**

After the review provided in 11.6.A., a Covered Person, who is informed that the claim has been denied in whole or in part, or that benefits will not be paid, and who desires review of that determination, may request a review of that decision from the director of PEBA within 90 days after notice of the denial of benefits after reconsideration. The filing of an appeal shall be deemed to be consent for the director or his designee to review all medical records necessary for a determination of the appeal. The director may appoint up to five representatives to hear the appeal who are familiar with group dental benefits and the State Dental Plan and who have not been involved in the denial of benefits in the case under consideration. The director, or his designees, may request from the Third-Party Claims Processor information reviewed by it, including the pertinent medical records, and may request any additional information from the Third-Party Claims Processor or the claimant, or from independent medical personnel or other source as in its judgment may be required to make a determination. The director, or his designees, shall consider all information submitted, the terms and conditions of the Plan and shall render a decision within 60 days of the receipt of any requested material. Within 120 days of making such

a decision, the director or his designees shall issue a written decision providing reasons for the decision and citation of any applicable Plan provisions.

The director, or his designee, shall provide specific reasons for the decision and citation of the pertinent Plan provisions, and may, if the director or his designee agrees with the Third-Party Claims Processor, deny the claim of the Covered Person, and if he agrees with the Covered Person, approve the claim or such portion as is appropriate, provided, however, the director, or his designee, must state in writing the provisions of the Plan justifying the result. The decision of the director or his designee on these matters is binding and conclusive, subject to review pursuant to 11.6.C.

The discretionary authority provided to the Plan Administrator's director under this provision is not in lieu of, or in derogation of, and does not alter, affect or reduce the authority or power of the director to administer this Plan.

### **C. Judicial Review**

The exclusive remedy for the denial of benefits shall be as provided in paragraphs 11.6(A) and (B) and by judicial review of that decision under S.C. Code Ann §1-23-380, as amended, as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 11.6(A) and (B) above, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence, giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility, or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary or capricious or in violation of applicable statutes.

### **11.7 Identification Cards and Booklets**

The Plan Administrator or Third-Party Claims Processor will issue to each Covered Person an identification card evidencing coverage and a booklet summarizing the benefits to which the Covered Person is entitled. If any amendment to this Plan shall materially affect any benefits described in such booklet, new booklets or booklet pages describing the changes will be issued.

### **11.8 Privacy of Protected Health Information**

**A.** The Plan Administrator and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and its implementing regulations (45 C.F.R. Parts 160-64). Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of HIPAA, the South Carolina Public Employee Benefit Authority, which established, and maintains, the Group Dental Insurance Benefit Plan for South Carolina Public Employees, Active and Retired. Neither the Plan Administrator nor any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.

**B.** As permitted under HIPAA, the Third-Party Claims Processor, as agent of the Plan Administrator, is entitled to obtain such authorization for medical and hospital records as it may reasonably require from any provider of services incident to the administration of the

benefits hereunder and the attending Dentist's certification as to the Medical Necessity for care or treatment.

**C.** The Plan Administrator will be provided access to all claims data and supporting documents of any person covered under the Plan for purpose of auditing the claims adjudication procedures. According to the guidelines set forth under HIPAA, the Plan Administrator agrees to restrict access to all such data and documents to those of the Plan Administrator's employees directly responsible for conduct of the audit and to assure that the data and documents are handled on a strictly confidential basis.

## **ARTICLE 12.**

### **NOTICE**

**12.1** Except as otherwise provided in this Plan of Benefits, any notice to the Plan Administrator that may be required hereunder shall be effective when sent to its office; any notice to the Third-Party Claims Processor, when sent to its office, and to a Covered Person when addressed to him at his address as it appears on the records of the Plan Administrator.

## **ARTICLE 13.**

### **SUBROGATION RIGHTS**

**13.1** In the event benefits are provided to, or on behalf of, a Covered Person under the terms of this Plan, the Covered Person agrees as a condition of receiving benefits under the Plan to transfer to the Plan all rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. If, however, a Covered Person receives payment for such dental expenses from another person, firm, corporation, organization, or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full for any dental expenses paid by the Plan and the Plan's right of full recovery shall not be limited by any characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a third party described above as a result of settlement, judgment, or otherwise, that person shall hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of such payments by the Plan. The Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any dental payments, no fault or malpractice insurance coverages which are paid or payable. The Plan shall have a first priority lien against the proceeds of any recovery by the Covered Person and against future benefits due under the Plan in the amount of any claims paid. The Plan shall have the right to impose a constructive trust over such proceeds, and shall be reimbursed from them. If the Covered Person fails to repay the Plan from the proceeds of any recovery, the Plan Administrator or its designee may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

The Plan may enforce its reimbursement rights by requiring the Covered Person to cooperate and to assert a claim to any of the foregoing coverages to which the Covered Person may be

entitled. The Plan will not pay fees or costs associated with a claim or lawsuit without its express written authorization. Any attorney's fees or other expenses owed by the Covered Person shall not reduce the amount of reimbursement due to the Plan. To the full extent allowed by law, the Plan hereby disclaims any "make whole" or "common fund" doctrine that might otherwise be applicable to its recovery hereunder. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor, if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation, including the giving of testimony in any action filed by the Plan. The Covered Person may not release any responsible party from its obligation, or otherwise take any other action that could prejudice recovery by the Plan, without the written consent of the Planholder. If a Covered Person fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator or its designee may deny payment of claims (regardless of whether such claims are related to the acts or omissions of the third party or other persons against whom the Covered Person may have a right of recovery) and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator or its designee. Further, if a Covered Person fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose a constructive trust over such any and all funds received by the Covered Person, or as to which the Covered Person has the right to receive. The Plan, through the Plan Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this paragraph, against any and all appropriate parties who may be in possession of the funds described herein.

In the event benefits are provided to, or on behalf of, a Covered Person under the terms of this Plan, the Planholder shall be subrogated, at its expense and unless specifically prohibited by law, to the rights of recovery of such Covered Person against any person, firm, corporation, or organization, including such Covered Person's right to uninsured motorists benefits as defined by the South Carolina Motor Vehicle Financial Responsibility Act, as amended; provided, however, that the Planholder shall not be subrogated to such Covered Person's rights to Personal Injury Protection (PIP) benefits as defined by the South Carolina Automobile Reparation Reform Act of 1974, as amended. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor, if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation. The Plan, through the Plan Administrator shall have full discretionary authority to interpret the provisions of this paragraph, and to administer and pursue the Plan's subrogation and reimbursement rights under this paragraph.

End of Plan

## **2015 SCHEDULE OF DENTAL PROCEDURES AND ALLOWED AMOUNTS**

Please note that the allowed amount is set by the State and may not reflect the total charge for the particular service by your Dentist. You are responsible for payment of any difference between the amount covered by the State as an Employee benefit and the Dentist's charge. You should discuss fees with your Dentist prior to treatment.

The allowed amount for any covered dental procedure not specified in this schedule will be determined by the Plan Administrator through its medical staff and/or dental consultants based on comparable or similar services, unless such procedure is specifically excluded in this schedule or by other terms and conditions of coverage.

"NC" indicates not covered.