McLeod Health

High Option Plan

Dental Coverage

January 1, 2023

DENTAL
PLAN OF BENEFITS

South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association

Dear Member:

BlueCross BlueShield of South Carolina (BlueCross) is pleased to provide administrative services for your group dental Plan as outlined in this Dental Plan of Benefits.

Please refer to the Benefits outlined in this Plan of Benefits for all your dental care coverage. You may also visit our website at www.SouthCarolinaBlues.com.

We welcome you to our family of health care coverage through BlueCross and look forward to meeting your dental care needs.

VISIT OUR WEBSITE AND MOBILE SITE

Through our Member website, www.SouthCarolinaBlues.com, you can access My Health Toolkit®, a source for instant, personalized Benefits and dental information. As a Member, you can take full advantage of this interactive website to complete a variety of self-service transactions online from wherever you have Internet access. ***Need to access your Member ID card digitally or order a replacement? Need to check the status of a claim or download claim forms? Need to print an Explanation of Benefits (EOB)?***

You also can use such self-help tools as:

View the **status** of your eligibility, deductible, out-of-pocket and any dental care account balances.

The **Find a Dentist** feature is where you get the most recent information on our network of dental Providers. Search by saved searches, name, location, county or center name. You can also get maps and driving directions.

The **Dental Resource Center** contains interactive tools where you can assess dental health risks, watch dental treatment and procedure animations and have a dentist answer dental health questions. You can also find a dentist, get dental health tips, access the dental cost estimator and learn more about dental care.

On the go? The My Health Toolkit® mobile app is available in both the App Store and Google Play. With your personal account, you can:

- Check the status of your claims
- View and share your digital ID card
- Confirm your coverage for services
- Manage your medical spending accounts, if applicable

Scan the below QR code with your smartphone camera for quick access to our Member website.

EMPLOYER DENTAL COVERAGE

Your Dental Coverage is designed to help you and your insured family members keep a healthy mouth by paying for

- Diagnostic and preventive dental services.
- Basic dental services.
- Major dental services.
- Orthodontic services.

This coverage does not, however, pay all of your dental bills. The following information explains what is and is not covered.

IMPORTANT DENTAL INFORMATION

How To Get Help On Dental Claims

For Customer Service and dental claims inquiries:

- From Columbia, South Carolina, dial 803-788-2571
- From anywhere else in or out of South Carolina, dial 800-222-7156

If you cannot call, write BlueCross at the following address:

BlueCross BlueShield of South Carolina
Claims Service Center
Post Office Box 100300
Columbia, South Carolina 29202

Be sure to put your ID number in your letter, along with your name and telephone number.

How To File Dental Claims

Participating Providers have agreed to file claims for dental care services they rendered to you. However, in the event a Provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

If you need a claim form, you may obtain one from us at the address below or print a copy from the website. You can also call us at the telephone numbers listed on your Identification Card, and we will send you a form. Ask the Provider to complete the bottom half of the form. If the Provider refuses to do this or does not have the dental claim form, ask for an itemized receipt which must contain the following information:

1. The patient's name;

2. The date or dates of service;

3. The type of service; and,

4. The charges.

If you fill out your own dental form, complete the top half of the form, attach the itemized receipt to it and mail them to the following address:

BlueCross BlueShield of South Carolina
Claims Service Center
Post Office Box 100300
Columbia, South Carolina 29202

Please refer to Article XI of this Plan of Benefits for more information on filing a claim.

PREDETERMINATION OF BENEFITS

Except in an emergency, you should discuss fees with your Provider before treatment begins. If you or a covered member of your family need dental treatment that the Provider estimates will cost $300 or more, you should ask that predetermination of Benefits be filed with the Corporation. By doing this, both you and the Provider will know in advance how much your dental Plan will pay for the course of treatment recommended. Here is how predetermination works.

Your Provider should list, on a claim form, the treatment planned and charges for that treatment and forward the form to the Dental Claims Processing Unit at BlueCross. After determining the amount eligible for payment, the Dental Claims Processing Unit will let you and your Provider know the amount of money that can be paid under your coverage for the recommended treatment.

SCHEDULE OF BENEFITS

Employer Contract Number: 71-56753-16, 20, 24, 28, 53, 54, 59, 60, 64, 67, 68, 73, 74, 79, 80, 85, 86, 91 and 92
Employer: McLeod Health
High Option Plan
Plan of Benefits Effective Date: January 1, 2023

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it, then the Benefit will be provided to Members pursuant to the terms of this Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the Plan of Benefits. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**	
Probationary Period:	Effective date is the first of the month following the eligibility date unless the eligibility date is the first day of the month and it is that date.
In addition to meeting the requirements contained in the Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	Last day of the month in which a child turns 26.
Actively at Work: **Minimum hours per week:**	Budgeted 40 hours bi-weekly
Benefit Year Deductibles	$100 per family with no one Member meeting more than $50 for Participating Providers. $100 per family with no one Member meeting more than $50 for Non-Participating Providers.
Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid.	
This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The anniversary date is 01/01.	
Employees enrolled in this Plan of Benefits for health coverage do not have to elect Dental Coverage. If elected, the Dental Coverage level may differ from the health coverage level.	

	Participating Provider	Non-Participating Provider
Diagnostic and preventive Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	The Employer pays 100% of the Allowable Charge	The Employer pays 100% of the Allowable Charge The Member must pay the balance of the Provider's charge
Basic dental Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Major dental Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 50% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Orthodontic Benefits (please refer to Article III of this Plan of Benefits for a list of covered services)	The Employer pays 50% of the Allowable Charge The Member pays the remaining 50% of the Allowable Charge	The Employer pays 50% of the Allowable Charge The Member must pay the balance of the Provider's charge
Limitations:	1. Oral examinations are limited to two (2) per Benefit Year; 2. Bitewing X-rays are limited to two (2) sets per Benefit Year; 3. Prophylaxis is limited to two (2) per Benefit Year; 4. Full mouth X-rays or panoramic films are limited to once every three (3) years; 5. Topical fluoride applications are limited to one (1) application in a benefit year for Members under age nineteen (19); 6. Space maintainers are limited to permanent teeth for Members under age nineteen (19); 7. Consultations are limited to two (2) in a twelve (12) month Period; 8. Sealants are limited to Members from the ages of six (6) through thirteen (13) , which are applied to non-restored, non-decayed first and second permanent molars , once per tooth every five (5) years;	

	9. Implants and crowns, bridges and/or dentures involving implants are limited to once per tooth in a period of seven (7) years; 10. Prosthodontics may be replaced once every seven (7) years; 11. Relining and rebasing of removable dentures is covered if at least six (6) months have passed since the installation of the existing removable denture, but not more than one relining or rebasing in any twenty-four (24) month period; 12. Adjustments of dentures, If at least six (6) months have passed since the installation of the denture; 13. Simple repairs of cast restorations or dentures other than re-cementing; but not more than once in a twelve (12) month period; 14. Tissue Conditioning limited to once in a twelve (12) month period; 15. Core build-ups are limited to once per tooth in a period of seven (7) years; 16. Prefabricated stainless steel crown or prefabricated resin crown, limited to no more than one (1) replacement for the same tooth surface within seven (7) years; 17. Replacement of an immediate, temporary, full denture with a permanent, full denture if the immediate, temporary, full denture cannot be made permanent; and such replacement is done within twelve (12) months of the installation of the immediate, temporary, full denture; 18. Replacement of a non-serviceable fixed denture or removable denture if such denture was installed more than seven (7) years prior to replacement; 19. Post and cores, limited to once per tooth in a period of seven (7) years; 20. Root Canal treatment limited to once in any twenty-four (24) month period for the same tooth; 21. Replacement of any cast restoration with the same or a different type of cast restoration, limited to one (1) replacement for the same tooth surface within seven (7) years of prior replacement; 22. Periodontal maintenance is limited to four (4) times in any benefit year less the number of teeth cleanings received during such benefit year; 23. Periodontal scaling and root planning limited to one (1) quadrant in a twenty-four (24) month period;

	24. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery limited to one (1) surgical procedure per quadrant in any thirty-six (36) month period; 25. Diagnostic and preventive Benefits and basic dental Benefits are subject to a combined maximum of $1,500 per Member per Benefit Year. Major dental Benefits are subject to a maximum of $750 per Member per Benefit Year; 26. Orthodontic Benefits are subject to a maximum of $1,500 per Member per lifetime; and, 27. Orthodontic Benefits are limited to Members through the age of eighteen (18), if the orthodontic appliance is initially installed while dental insurance is in effect for such child.	
Services related to previously missing teeth	Covered	Covered
Cleft lip and palate	Covered	Covered
Temporomandibular Joint (TMJ) disorder	Non-Covered	Non-Covered
Orthognathic surgery	Non-Covered	Non-Covered
Impacted teeth	Covered	Covered

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ARTICLE I - DENTAL DEFINITIONS

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

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

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

Allowable Charge: the amount the Corporation or a licensee of the Blue Cross and Blue Shield Association (BCBSA) agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment; and,

2. In addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed Charge.

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

Authorized Representative: an individual (including a Provider) whom the Member designates in writing to act on such Member's behalf.

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

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

Benefit(s): services or supplies that are:

1. Medically Necessary;

2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);

3. Included in Article III of this Plan of Benefits; and,

4. Not limited or excluded under the terms of this Plan of Benefits.

Benefit Detail Report: the document (in electronic or hardcopy form) maintained by the Corporation which reflects the benefits selected by the Employer and submitted to the Corporation which outlines the Benefits to be offered under the Group Health Plan. The Corporation shall administer the Plan of Benefits in accordance with the terms of the Benefit Detail Report. In the event of any conflict between the Benefit Detail Report and this Plan of Benefits or the Schedule of Benefits, the Benefit Detail Report shall control.

Billed Charges: the actual charges as billed by a Provider.

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

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

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

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

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

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

Corporation: BlueCross BlueShield of South Carolina.

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

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

Dependent(s): an individual who is:

1. An Employee's Spouse;

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

3. An Incapacitated Dependent.

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

Employer: the entity providing this Plan of Benefits.

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

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

Grace Period: a period of time as determined by the Employer after the initial due date that the Employer allows for the Member to pay any Premium due.

Group Health Plan: the employee welfare benefit plan established, administered and/or sponsored by the Employer to provide health benefits to Employees and/or their Dependents, directly or through insurance, reimbursement or otherwise.

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

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

Incapacitated Dependent: a Child who is:

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

2. Dependent upon the Employee for at least fifty-one (51) percent of the Child's support and maintenance.

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

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

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

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

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

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

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

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

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

Maximum Payment: the maximum amount the Group Health Plan will pay (as determined by the Corporation) for a particular Benefit. The Maximum Payment will not be affected by any credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion:

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

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

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

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

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

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

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

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

A Medical Child Support Order must clearly specify:

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

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

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

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

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

1. The name of the issuing agency;

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

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

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

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

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

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

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

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

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

For the purposes of determining Medical Necessity:

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

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

3. The Corporation uses clinical review guidelines based on currently available clinical information to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies. The clinical review guidelines include, but are not limited to:

    a. Clinical outcome studies in the peer-reviewed published medical and dental literature;

    b. Regulatory status of the technology;

    c. Evidence-based guidelines of public health and health research agencies;

d. Evidence-based guidelines and positions of national health professional organizations; and,

e. Views of dentists practicing in the state services are rendered.

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

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

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

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

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

Participating Provider Agreement: an agreement between the Corporation or a designated agent of the Corporation and a Provider, under which the Provider has agreed to accept the Corporation's allowance (as set forth in the Provider Agreement) as payment in full for Benefits and other mutually acceptable terms and conditions.

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

1. Group coverage, whether insured or self-insured; and,

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

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

Plan Administrator: the entity charged with the administration of the Group Health Plan. The Employer is the Plan Administrator of the Group Health Plan.

Plan of Benefits: this document which reflects the Benefits offered under the Group Health Plan based on the Benefit Detail Report. The Plan of Benefits includes the Schedule of Benefits. Employer agrees that the Plan of Benefits will, at a minimum, be incorporated as a part of the Group Health Plan.

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

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

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

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

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

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

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

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

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

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

1. Dentistry; or,

2. Oral surgery.

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

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

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

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

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from such Employee's Spouse;

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

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

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

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

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

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

Teledentistry: the use of information technology and telecommunications to exchange Member information from one Provider to another or between Member and Provider for the purpose of providing dental care, consultation or education. This includes virtual office visits in which a Member is not physically seen or examined by a Provider.

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

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

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

Waiting Period: the period, as specified on the Schedule of Benefits, which begins upon the Member Effective Date of Dental Coverage. During the Waiting Period, the Member is only eligible to receive limited dental Benefits as set forth on the Schedule of Benefits; upon expiration of the Waiting Period, the Member will be eligible to receive all Benefits covered under the Plan of Benefits.

ARTICLE II - ELIGIBILITY FOR COVERAGE

A. ELIGIBILITY

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

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

    a. Is Actively at Work; and,

    b. Has completed the Probationary Period.

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

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

B. ELECTION OF COVERAGE

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

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

C. COMMENCEMENT OF COVERAGE

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

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

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

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

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

   Employees (and such Employee's Dependents for whom such Employee has elected coverage) who become eligible for coverage after the Plan of Benefits Effective Date will have coverage on the date chosen by the Employer, unless the Employee is not eligible at the time coverage would otherwise commence.

3. Dependents Resulting from Marriage

   Dependents resulting from the marriage of an Employee will have coverage upon enrollment provided they have been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within thirty-one (31) days after marriage. If a Dependent resulting from a marriage is not enrolled within thirty-one (31) days after the marriage, coverage will begin on the date chosen by the Employer and after the payment of the applicable Premium and administrative charge.

4. Newborn Children

   A newborn Child will have coverage upon the date of the Child's birth provided the Child has been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within thirty-one (31) days after the Child's birth for the Child to have coverage from the date of birth. If a newborn Child is not enrolled within the time frame set forth in the prior sentence, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium and administrative charge.

5. Adopted Children

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

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

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

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

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

D. DEPENDENT CHILD'S ENROLLMENT

1. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits. For a Dependent to be eligible for coverage under this Plan of Benefits, the required Premium and administrative charge must be paid, prior to the termination of the enrollment period.

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

E. MEMBERSHIP APPLICATION

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

F. MEMBER CONTRIBUTIONS

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

G. DISCLOSURE OF MEDICAL INFORMATION

The Member agrees that the Corporation may obtain claims information, records and other information necessary for the Corporation to process a claim for Benefits under this Plan of Benefits.

ARTICLE III - DENTAL COVERED EXPENSES

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

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

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

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

Payment is provided for the following:

A. DIAGNOSTIC AND PREVENTIVE DENTAL BENEFITS

1. Oral examination, including Treatment Plan**,** if necessary;
2. Periapical, occlusal, oral x-rays, as required, and bitewing x-rays;
3. Full mouth x-rays or panoramic films;
4. X-rays, except as mentioned elsewhere in class II or class II covered services;
5. Topical fluoride applications of stannous fluoride or acid fluoride phosphate;
6. Prophylaxis, including cleaning, scaling and polishing;
7. Space maintainers for prematurely lost deciduous teeth;
8. Emergency palliative treatment for the relief of pain;
9. Pulp vitality and bacteriological studies for determination of bacteriologic agents;
10. Diagnostic casts;
11. Sealants on permanent teeth that have not had any fillings; and
12. Intraoral-periapical x-rays

B. BASIC DENTAL BENEFITS

1. Oral surgery (but not periodontal surgery) including the following:
    a. Surgical extractions;
    b. Alveoplasty;
    c. Surgical excision of lesions and tumors;
    d. Removal of cysts and neoplasms;
    e. Excision of bone tissue;
    f. Biopsies of oral tissue;
    g. Treatment of oral fistula;
    h. Excision of hyperplastic tissue; and,
    i. Frenulectomy;
2. Fillings, consisting of amalgam and tooth-colored synthetic materials;
3. Injections of therapeutic drugs
4. Simple extractions;

5. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other covered services when BCBSSC determines such anesthesia is necessary in accordance with generally accepted dental standards. Additional units of anesthesia are covered

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

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

8. Assistant at surgery when Medically Necessary;

9. Hemi-section;

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

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

    a. Surgical periodontic examination;

    b. Gingival curettage;

    c. Gingivectomy and gingivoplasty; and,

    d. Osseous surgery, including flap entry and closure;

12. Periodontal cleanings;

13. Tissue Conditioning;

14. Consultations;

15. Application of desensitizing medicaments where periodontal treatment (including scaling, root planning, and periodontal surgery, such as occeous surgery) has been performed;

16. Repair of removable dentures;

17. Relining or rebasing of removable dentures (complete and partial);

18. Re-cementing of cast restorations or dentures;

19. Simple repairs of cast restorations or dentures other than re-cementing;

20. Local chemotherapeutic agents; and,

21. Adjustments of dentures.

C. MAJOR DENTAL BENEFITS

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

1. Inlays (not part of a bridge);

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

3. Onlays (not part of a bridge);

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

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

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

5. Fixed bridge repairs.

6. Apexification/recalcification;

7. Fixed or removable appliances for correction of harmful habits;

8. Initial installation of cast restorations;

9. Core build-up;

10. Posts and cores;

11. Pulp Therapy;

12. Therapeutic pulpotomy (excluding final restorations);

13. Prefabricated stainless steel crown or prefabricated resin crown;

14. Pulp capping (excluding final restoration);

15. Full mouth debridements;

16. Replacement of an immediate, temporary, full denture with a permanent, full denture if the immediate, temporary, full denture cannot be made permanent;

17. Initial installation of full or partial dentures: when needed to replace congenitally missing teeth or when needed to replace natural teeth that are lost while the person receiving such benefits was insured for dental insurance under this plan;

18. Replacement of a non-serviceable fixed denture or removable denture;

19. Replacement of any cast restoration with the same or a different type of cast restoration;
20. Root Canal treatment;

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

22. Occlusal adjustments;

23. Other fixed denture prosthetic services not described elsewhere;

24. Periodontal maintenance, where periodontal treatment (including scaling, root planning, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed;

25. Periodontal scaling and root planning; and

26. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous Surgery.

D. ORTHODONTIC BENEFITS

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

The correction of dysfunctional malocclusion consisting of the following:

1. Diagnosis, including models and radiographs;

2. Active treatment, including necessary appliances; and,

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

E. CLEFT LIP AND PALATE

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

ARTICLE IV - DENTAL EXCLUSIONS

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

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

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

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

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

5. Any service or charge for service to the extent a Member is entitled to receive payment or benefits relating to such service under any state or federal program that provides healthcare

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

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

7. Services rendered by a Provider beyond the scope of such Provider's license;

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

9. Charges for completion of claim forms;

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

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

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

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

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

15. Any service for the treatment of dysfunctions or derangements of the TMJ, regardless of cause, including orthognathic surgery for the treatment of dysfunctions or derangements of the TMJ, regardless of cause;

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

17. Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities, regardless of cause;

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

19. Temporary crowns and partials;

20. Dental services for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage is available under any Workers' Compensation Act or similar federal or state law regarding on the job injuries is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member waives entitlement to workers' compensation benefits for which such Member is eligible; failed to timely file a claim for workers' compensation benefits; or, the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier.

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

21. Complications arising from a Member's receipt or use of dental services, supplies or other treatment that are not Benefits;

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

23. Services or charges resulting from the use of Teledentistry;

24. Any dental service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits, unless covered under a prior Plan;

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

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

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

28. Orthodontics

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

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

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

c. The initial payment will be equal to no more than twenty-five percent (25%) of the total liability

of the Employer, with the following sequential payments payable no more frequently than once a month. If, for any reason, the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Employer will cease with payment through the month of termination; and,

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

29. Treatment of accidental injury to sound natural teeth within the first twelve (12) consecutive months following the date of the accident, if coverage is provided under the health benefit plan;

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

a. In all cases involving covered services or supplies in which the Provider and Member selected a more expensive or personalized course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this agreement will be based on the charge allowed for the lesser procedure as determined by the Corporation. In the case of a composite filling on a posterior tooth, the benefit may be based on the corresponding amalgam filling benefit. In the event multiple X-rays are performed on the same date of service, the benefit may be based on the allowed charge of a full mouth X-ray;

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

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

d. In the event that a Provider performs different levels of services on the same day, Benefits will only be paid for the highest level of service.

ARTICLE V - COORDINATION OF BENEFITS

A. APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Benefits. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one (1) or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for coordination of benefits with Medicare may also apply. The Group Health Plan does not coordinate benefits with individual Plans.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

This is a self-funded ERISA Plan which does not provide benefits for claims which are paid or payable under automobile insurance coverage. Automobile insurance coverage shall include, but is not limited to, no-fault, personal injury protection, medical payments, liability, uninsured and underinsured coverage, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

Although benefits for claims which are paid or payable under automobile insurance coverage are not covered by this Plan of Benefits, the Group Health Plan or Corporation may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, if a Member has automobile no-fault, personal injury protection or medical payments coverage, or if such coverage is extended to the Member through a group or their own automobile insurance carrier, that coverage is primary to the Group Health Plan. The Group Health Plan will always be secondary to automobile no-fault, personal injury protection or medical payments coverage plans and the Group Health Plan will coordinate benefits for claims which are payable under those automobile policies.

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory and the Member does not have the state mandated automobile coverage, the Group Health Plan will deny benefits up to the amount of the state mandated automobile coverage.

This coordination of benefits provision applies whether or not the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

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

3. Deliver to the Group Health Plan or Corporation a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

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

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

Failure to cooperate with the Group Health Plan as required under this section will entitle the Group Health Plan or Corporation to invoke the Auto Accident Exclusion and deny payment for all claims relating to the injury or illness up to the amount of available or state mandated coverage.

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

When a Member's claim is submitted under both the Group Health Plan and another Plan, the Group Health Plan is a Secondary Plan unless:

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

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

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

D. ADDITIONAL ORDER OF DETERMINATION RULES

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

1. Dependents

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

2. Dependent Child - Parents not Separated or Divorced

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

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

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

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

   The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents

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

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

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

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

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

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the dental care expenses (or dental insurance coverage) 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, that Plan is the Primary Plan. If the parent with responsibility for dental care expenses has no dental insurance coverage for the Dependent Child, but that parent's Spouse does have coverage, the Spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or Plan year during which any Benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the dental care expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined in Article V(D)(2). Once the Dependent Child reaches the age of eighteen (18) and/or the terms of the court decree are not longer applicable, the Plan which has covered the Dependent for a longer period of time will be primary.

4. Active and Inactive Employees

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

5. Longer and Shorter Length of Coverage

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

6. Continuation Coverage

   In instances where a Member is covered by this Group Health Plan and other employee-sponsored coverage and only one of them is continuation coverage (e.g. COBRA or other continuation coverage), such continuation coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. The Group Health Plan as Primary Plan

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

2. The Group Health Plan as Secondary Plan

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

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

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

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

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

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

G. PAYMENT

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

H. RIGHT OF RECOVERY

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

ARTICLE VI – TERMINATION OF THIS PLAN OF BENEFITS

A. GENERALLY

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

1. The date the Group Health Plan is terminated pursuant to Article VI(B)-(E);

2. The date an Employee retires unless the Group Health Plan covers such individual as a retiree;

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

4. The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed one hundred eighty (180) days from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993;

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

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

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

8. Upon the death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If a Member fails to pay the Premium during the Grace Period, such Member shall automatically be terminated from participation in the Group Health Plan, without prior notice to such Member.

2. In the event of termination for failure to pay Premiums, Premiums received by the Employer after the Grace Period will not automatically reinstate the Member in participation under the Group Health Plan absent written agreement by the Employer. The Employer will refund the amount of any late Premium paid if the Member's participation in the Group Health Plan is not reinstated, except that portion relating to coverage provided prior to or during the Grace Period.

C. TERMINATION WHILE ON LEAVE

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

D. NOTICE OF TERMINATION TO MEMBERS

Other than as expressly required by law, if the Group Health Plan is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and that coverage will not continue beyond the termination date.

E. REINSTATEMENT

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

F. EMPLOYER IS AGENT OF MEMBERS

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

ARTICLE VII – CONTINUATION OF COVERAGE

A. CONTINUATION

1. COBRA

   a. Plan Administrator and Sponsor

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

   b. Disabled Members

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

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

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

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

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

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

   c. Notice of Qualifying Event by the Member

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

   d. Notice by the Employer to the Member

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

e. Election of Coverage

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

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

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

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

f. Premium Required

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

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

g. Length of COBRA Coverage

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

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

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

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

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

v. Twenty-nine (29) months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the COBRA Administrator within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of continuation of coverage.

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

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

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

ix. Thirty-six (36) months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer. This does not apply to any Employees or their Dependents if the Employee voluntarily quit work. See Article VII(A)(1)(g)(ii) for coverage for Employees who voluntarily quit.

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

2. USERRA

a. In any case in which an Employee or any of such Employee’s Dependents has coverage under the Plan of Benefits and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this Article VII(A)(2). The maximum period of coverage of the Employee and such Employee’s Dependents under such an election shall be the lesser of:

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

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

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

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

c. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Group Health Plan upon re-employment. Except as otherwise provided in Article VII(A)(2)(d), upon re-employment and reinstatement of coverage no new exclusion, Probationary Period or Waiting Period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This Article VII(A)(2)(c) applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under this Plan of Benefits by reason of the reinstatement of the coverage of such Employee.

d. Article VII(A)(2)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

B. QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Group Health Plan shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements

a. Timely Notifications and Determinations.

In the case of any Medical Child Support Order received by the Group Health Plan:

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

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

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

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

i. Shall be in writing;

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

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

c. Actions Taken by Fiduciaries.

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

2. Treatment of Alternate Recipients

a. Under ERISA

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

b. Direct Provision of Benefits Provided to Alternate Recipients

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

c. Plan Enrollment and Payroll Deductions

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

d. Termination of Coverage

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

i. The date the Employee's coverage ends;

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

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

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

ARTICLE VIII – SUBROGATION AND REIMBURSEMENT

A. BENEFITS SUBJECT TO THIS PROVISION

This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan of Benefits are being provided by a self-funded ERISA plan.

B. STATEMENT OF PURPOSE

Subrogation and Reimbursement represent significant Group Health Plan assets and are vital to the financial stability of the Group Health Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Group Health Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Group Health Plan. The Group Health Plan has a fiduciary obligation under the Employee Retirement Income Security Act (ERISA) to pursue and recover these Group Health Plan assets to the fullest extent possible.

C. DEFINITIONS

1. Another Party

   Another Party shall mean any individual or entity, other than this Group Health Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Member's injuries or illness.

   Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a Workers' Compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

2. Member

   As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, Dependent or representatives, other than the Group Health Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, Dependent, Spouse or person who has or will receive Benefits under the Group Health Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

3. Recovery

   Recovery shall mean any and all monies identified or paid to the Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Group Health Plan's lien. The amount owed from the Recovery as Reimbursement of the Group Health Plan's lien is an asset of the Group Health Plan.

4. Reimbursement

   Reimbursement shall mean repayment to the Group Health Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

5. Subrogation

   Subrogation shall mean the Group Health Plan's right to pursue the Member's claims for medical or other charges paid by the Group Health Plan against Another Party.

D. WHEN THIS PROVISION APPLIES

This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Group Health Plan, to transfer to the Group Health Plan all rights to recover damages in full for such Benefits.

E. DUTIES OF THE MEMBER

The Member will execute and deliver all required instruments and papers provided by the Group Health Plan or Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Corporation may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Group Health Plan's right to Subrogation and Reimbursement and acknowledges that the Group Health Plan precludes operation of the made-whole and common-fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's lien to the Group Health Plan under the terms of this provision. A Member who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Group Health Plan's portion of the Recovery in constructive trust for the Group Health Plan, because the Member is not the rightful owner of the Group Health Plan's portion of the Recovery and should not be in possession of the Recovery until the Group Health Plan has been fully reimbursed. The portion of the Recovery owed by the Member for the Group Health Plan's lien is an asset of the Group Health Plan.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which Another Party may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

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

3. Deliver to the Group Health Plan or Corporation a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

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

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

6. Include the amount paid for Benefits as a part of the damages sought against Another Party. Immediately reimburse the Group Health Plan or Corporation, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

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

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

F. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT

Any amounts recovered will be subject to Subrogation or Reimbursement. The Member's submission of claims for illnesses or injury caused by Another Party constitutes the Member's agreement to the terms of this provision and the Member's grant to the Group Health Plan of a first priority equitable lien by agreement. The Group Health Plan's right to recover exists regardless of whether it is based on Subrogation or Reimbursement.

The Group Health Plan will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Group Health Plan's payments. In addition, the Group Health Plan shall have a first priority equitable lien against any Recovery to the extent of benefits paid and to be payable in the future. The Group Health Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Group Health Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of the Member's damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally**,** the Group Health Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Group Health Plan and Plan of Benefits, the Member agrees that acceptance of Benefits is constructive notice of this provision.

G. WHEN A MEMBER RETAINS AN ATTORNEY

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Group Health Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's equitable lien to the Group Health Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Group Health Plan's portion of the Recovery immediately over to the Group Health Plan. A Member's attorney who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Recovery in constructive trust for the Group Health Plan, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Group Health Plan's lien. The portion of the Recovery owed for the Group Health Plan's lien is an asset of the Group Health Plan.

If the Member retains an attorney, the Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Group Health Plan in such attorney's pursuit of Recovery. The Group Health Plan will not pay the Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Member's attorneys' fees and costs, without the expressed written consent of the Corporation.

H. WHEN THE MEMBER IS A MINOR OR IS DECEASED OR INCAPACITATED

This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Group Health Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Group Health Plan or Corporation.

I. WHEN A MEMBER DOES NOT COMPLY

When a Member does not comply with the provisions of this section, the Group Health Plan or Corporation shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan of Benefits by the amount due as satisfaction for the Reimbursement to the Group Health Plan. The Group Health Plan or Corporation may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Group Health Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Group Health Plan's attorneys' fees and costs, regardless of the action's outcome.

J. PRIOR RECOVERIES

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Group Health Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Group Health Plan. In these situations, the Group Health Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Group Health Plan to consider eligible expenses. To the extent a Member's Recovery exceeds the amount of the Group Health Plan's lien, the Group Health Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Group Health Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Group Health Plan or Corporation has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under this Plan of Benefits for injuries or illness which the Member has already received a Recovery may be considered fraud, and the Member will be subject to any sanctions determined by the Group Health Plan or Corporation, in their sole discretion, to be appropriate, including denial of present or future Benefits under this Plan of Benefits.

ARTICLE IX - WORKERS' COMPENSATION PROVISION

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or the Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which the Member is eligible; failed to timely file a claim for workers' compensation benefits; or the Member sought treatment for the injury or illness from a Provider not authorized by the Member's Employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Group Health Plan or Corporation may, in its sole discretion, agree to extend coverage to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Group Health Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving benefits, to execute and deliver all required instruments and papers provided by the Group Health Plan or Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's right of recovery, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Corporation may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

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

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

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

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

5. Include the amount paid for Benefits as a part of the damages sought against the Member's Employer and/or Employer's Workers' Compensation carrier. Immediately reimburse the Group Health Plan, out of any recovery made from the Employer and/or Employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

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

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

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

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

Failure to reimburse the Group Health Plan from the recovery as required under this section will entitle the Group Health Plan or Corporation to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

ARTICLE X - ERISA RIGHTS

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

A. RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Group Health Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Group Health Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Group Health Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Plan Administrator may assess a reasonable charge for the copies.

3. Receive a summary of the Group Health Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. CONTINUATION COVERAGE

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

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan and control its assets are called "fiduciaries" and have a duty to do so prudently and in the interest of the Members. The Employer is the fiduciary of the Group Health Plan.

D. ENFORCEMENT OF EMPLOYEE RIGHTS

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

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

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

E. ASSISTANCE WITH QUESTIONS

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

ARTICLE XI - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

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

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

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

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

        i. Provider's name and address;

        ii. Member's name and date of birth;

        iii. Member's Identification Card number;

        iv. Description and cost of each service;

        v. Date that each service took place; and,

        vi. Description of the illness or injury and diagnosis.

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

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

3. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received. Claims will be processed in the order received by the Corporation and will not be reprocessed due to out of sequence dates of services.

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

5. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims and Concurrent Care Claims. Determinations for each type of claim will be made within the following time periods:

    a. Pre-Service Claim

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

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

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

    b. Urgent Care Claim

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

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

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

c. Post-Service Claim

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

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

d. Concurrent Care Claim

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

6. Notice of Determination

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

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

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

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

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

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

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

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

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

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

   a. An appeal must be in writing;

   b. An appeal must be sent (via U.S. mail) to the following address:

      BlueCross BlueShield of South Carolina
      Claims Service Center
      Post Office Box 100300
      Columbia, South Carolina 29202

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

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

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

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

4. The final decision on the appeal will be made within the time periods specified below:

   a. Pre-Service Claim

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

   b. Urgent Care Claim

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

c. Post-Service Claim

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

d. Concurrent Care Claim

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

5. Notice of Appeals Determination

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

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

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

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

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

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

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

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

6. The Employer has retained the Corporation to assist the Employer in making the initial claims determination as well as determinations on appeal as the claims fiduciary. Accordingly, Employer has delegated to the Corporation discretionary authority to construe and interpret questions related to claims for Benefits under the terms of the Group Health Plan. The Employer delegates to the Corporation the discretionary authority to make utilization review and precertification determinations for the purpose of making claim decisions under the Plan of Benefits and to interpret and construe the Plan of Benefits as necessary to make such determinations. It is understood and agreed that the Corporation is a fiduciary with respect to its exercise of such discretionary authority. In making its decision, the Corporation will rely on the Plan of Benefits, its internal procedures and will rely on eligibility data provided by the Employer. The Corporation will undertake the responsibility for providing the initial and appellate review and final determination of claims that have been denied in whole or in part in accordance with the rules set forth in applicable federal law and the regulations thereunder.

C. EXTERNAL REVIEW

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

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

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

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

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

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

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

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

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

ARTICLE XII - GENERAL PROVISIONS

ADMINISTRATIVE SERVICES ONLY

The Corporation provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self-funded dental Plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT

Upon thirty (30) days prior written notice, the Employer may unilaterally amend the Group Health Plan. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. The Corporation has no responsibility to provide individual notices to each Member when an amendment to the Group Health Plan has been made.

AUTHORIZED REPRESENTATIVES

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

CLERICAL ERRORS

Clerical errors by the Corporation or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended. Clerical errors may require an adjustment of Premiums.

DISCLOSURE OF PHI TO PLAN SPONSOR

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

A. Restrictions on the Plan Sponsor's Use and Disclosure of PHI

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

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

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

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

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

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

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

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

9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Group Health Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

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

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

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

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

        i. Pings on a party's firewall;

        ii. Port scans;

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

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

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

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

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

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

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

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

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

The Plan Sponsor certifies that the Group Health Plan contains and that the Plan Sponsor agrees to the provisions outlined above.

GOVERNING LAW

The Group Health Plan and Plan of Benefits (including the Schedule of Benefits) are governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Group Health Plan and Plan of Benefits are governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Group Health Plan or Plan of Benefits conflicts with such law, the Group Health Plan and Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Member must present the Member's Identification Card prior to receiving Benefits.

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

INFORMATION AND RECORDS

The Corporation and the Employer are entitled to obtain such dental, medical and hospital records and other information as may reasonably be required from any Provider incident to the treatment, payment and health care operations for the administration of the Benefits hereunder and the attending Provider's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover under the Group Health Plan or Plan of Benefits until such Member has exhausted the appeal process as set forth in Article XI of the Plan of Benefits. No such action may be brought after the expiration of any applicable period prescribed by law.

LIMITED-SCOPE DENTAL BENEFITS

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

MEMBERSHIP APPLICATION

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

NEGLIGENCE OR MALPRACTICE

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

NOTICES

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

1. To the Corporation:

   BlueCross BlueShield of South Carolina
   Post Office Box 100300
   Columbia, South Carolina 29202

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

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

NO WAIVER OF RIGHTS

On occasion, the Corporation (on behalf of the Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of the Group Health Plan or Plan of Benefits. Such a decision does not mean the Corporation or Employer waives or gives up any rights under the Group Health Plan or Plan of Benefits in the future.

OTHER INSURANCE

Each Member must provide the Group Health Plan (and its designee, including the Corporation) with information regarding all other health insurance coverage to which such Member is entitled.

PAYMENT OF CLAIMS

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

PHYSICAL EXAMINATION

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

REPLACEMENT COVERAGE

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

INDEX

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

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

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