

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

ADOPTED BY
THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
Effective January 1, 2020

S.C. Public Employee Benefit Authority
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ARTICLE 1.

ESTABLISHMENT AND PURPOSE OF PLAN

1.1 Name and Purpose

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

1.2 Establishment and Effective Date

This Plan is a continuation of and replaces the Dental Insurance Benefit Plan initially established on February 15, 1985, and this Plan Document became effective on January 1, 2020.

1.3 Applicable Law

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

1.4 Entire Plan

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

1.5 Summary Plan Guide

The Plan Administrator shall provide to eligible Subscribers the *Insurance Benefits Guide*, a summary plan guide containing a summary of the benefits of this Plan and the rights and obligations of Covered Persons under this Plan. The Guide may provide more detail than this Plan document, but in the event of a conflict between the Guide and the Plan, the Plan is controlling.

1.6 Changes to Plan

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

1.7 Effect of Changes

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

1.8 Termination of Plan

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

1.9 Written Notice

Any written notice required by law shall be deemed received if sent by regular mail, postage prepaid, to the last address on the records of the Plan Administrator. Subscribers shall be solely responsible for providing the Plan Administrator with a current address for themselves and any persons authorized on their behalf and for notifying the Plan Administrator in writing of any changes in any addresses.

1.10 Waiver

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

1.11 Clerical Error or Delay

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

Clerical Errors and delays in processing made by Employers and agents or employees of Employers (including benefits administrators) may result in an equitable adjustment. Coverage changes and contribution reimbursements may be made retroactively up to 12 months from the date of discovery.

1.12 Workers' Compensation

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

1.13 Headings

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

1.14 Misstatements and Omissions

If any relevant fact has been misstated or omitted, in whole or in part, whether intentional or not, by, or on behalf of, any person on an application, the election of benefits (whether paper or electronic), or other document, or information submitted or required to be submitted to the Plan Administrator or Third-Party Claims Processor to obtain or retain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement or omission, coverage may be terminated prospectively. If the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud,

or makes an intentional misrepresentation of material fact, coverage may be terminated retroactively to the date of the act, practice, or omission, and an equitable adjustment of any contributions will be made if this is in order and the Plan Administrator may recover the amount of any claims paid in error due to the act, practice, or omission.

1.15 Use of Social Security Numbers on Application

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

1.16 South Carolina Retiree Health Insurance Trust Fund

Where applicable, the provisions of this Plan shall constitute policies and procedures adopted as necessary for the proper administration of the South Carolina Retiree Health Insurance Trust Fund pursuant to Section 1-11-705(F) of the South Carolina Code of Laws.

ARTICLE 2.

DEFINITIONS

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

2.1 Academic Employer/ Academic Employee

- A.** Academic Employer. An Academic Employer is an Employer that is a public school district, university, college, technical college, or other educational institution that conducts business in school years, school terms, or otherwise-described academic term times and corresponding contract periods.
- B.** Academic Employee. An Academic Employee is an Employee employed by an Academic Employer and whose employment is based upon a school year or term.

2.2 Active Employee/Active Employment

An Active Employee is an Employee who is engaged in Active Employment.

Active Employment is when the Employee is actively at work on a Full-Time basis, performing all the regular duties of their occupation at an established business location of the Employer or another location to which they may be required to travel to perform the duties of their employment. An Employee shall be deemed to be engaged in Active Employment while on jury duty or on any regular nonworking day including holidays or vacation days established and published by the Employer if the Employee was engaged in Active Employment on the last preceding regular working day.

The Employee's participation in the Plan will not be prevented or delayed if (i) the Employee's absence from work is due to any health-related reason, including a medical condition, Hospital confinement, or a disability; or (ii) the Employee is on leave under the Family and Medical Leave Act on the Effective Date of this Plan. In no event, however, will an Employee be considered to be in Active Employment if they have not reported for work or if they or their Employer has terminated their employment.

2.3 Agent for Service of Process

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

2.4 Allowed Amount

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

2.5 Alternate Forms of Treatment

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

2.6 Child

A Subscriber's:

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

2.7 Clerical Error

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

2.8 Coinsurance

That percentage of the Allowed Amount for Covered Dental Benefits, in excess of the Individual or Family Deductible, that is payable by the Covered Person under the Plan selected.

2.9 Covered Dental Benefits

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

2.10 Covered Dependent

A Subscriber's Dependent, who has met the eligibility requirements and is enrolled under the Plan.

2.11 Covered Employee

An Employee who has met the eligibility requirements and is enrolled under this Plan.

2.12 Covered Person

A Subscriber, or Dependent thereof, who has met the eligibility requirements and is enrolled in this Plan.

2.13 Covered Retiree

A Retiree who has met the eligibility requirements and is enrolled under the Plan.

2.14 Deductible

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

2.15 Dental Hygienist

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

2.16 Dentist

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

2.17 Dependent

Dependent shall mean and include a Subscriber's:

- A. Dependent Spouse.** Legally recognized spouse under South Carolina law. A spouse who is also eligible for coverage or benefits as an Employee of the State, public school district or a participating entity, is not eligible for coverage as a Dependent. However, a Part-Time Teacher who is the Spouse of a Covered Employee may be covered as either an Employee or as a Dependent, but not as both;
- B. Dependent Child.** Child younger than 26 years of age. The Plan Administrator may require the Subscriber to submit due proof of the Child's relationship with the Subscriber within 31 days of enrollment, and at such other reasonable times;

- C. **Incapacitated Dependent Child.** Unmarried Child, 26 years of age or older, who is incapable of self-sustaining employment because of mental illness, intellectual disability, or physical handicap and is principally dependent (more than fifty percent) on the Subscriber for maintenance and support, provided that the Child was covered continuously under the Plan or a Predecessor Plan, prior to the date of incapacitation. The Plan Administrator may require the Subscriber to submit due proof of such incapacity and dependency satisfactory to the Plan Administrator within 31 days of initial enrollment, upon attaining age 26 and at such other reasonable times, but not more frequently than annually. It shall be the Subscriber's responsibility to notify the Plan Administrator when the Child is no longer incapacitated.

2.18 Effective Date

- A. With respect to the Plan, the date on which this Plan takes effect;
- B. With respect to a Covered Person, the date on which such person is first covered under this Plan but no earlier than January 1, 2020.

2.19 Eligibility Date

The date upon which a person becomes eligible for coverage under this Plan.

- A. For a newly hired Employee, the Eligibility Date is the date the Employee begins Active Employment.
- B. For a Retiree, the Eligibility Date is the Retiree's date of Retirement, as defined in paragraph 2.36.B of the Plan.
- C. For Employees, Retirees, and their Dependents who enroll under the Special Eligibility Situations of paragraph 3.7, the Eligibility Date is the date of occurrence of the Special Eligibility Situation.

2.20 Employee

A person employed by an Employer on a Full-Time basis, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative Employees of the General Assembly, and judges in the State courts. Retirees who return to work with an Employer are considered Employees for purposes of eligibility under the Plan.

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

2.22 Employer

A department, agency, board, commission or institution of the State, including the General Assembly, the State courts and public school districts, or other entity eligible by law that participate in the Plan, that hires and provides compensation to an Employee.

2.23 Family

A Subscriber and their Covered Dependents.

2.24 Former Spouse

An Employee's or Retiree's former spouse for whom the Employee or Retiree is required to provide insurance coverage pursuant to a court order or divorce decree and who is enrolled in coverage under the Plan.

2.25 Full-Time

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

2.26 Permanent/Permanent Position

Shall mean employment for an Employer in a position that is expected to continue indefinitely and is not time-limited. Employment in a temporary, temporary grant, time-limited, or other non-permanent position is not employment in a Permanent Position.

2.27 Incurred

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

2.28 Medically Necessary (or Medical Necessity)

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

- A. Is medically appropriate to identify or treat an existing condition, illness, disease, or injury; and
- B. Is provided for the direct care and treatment of the condition, illness, disease, or injury; and
- C. Is prescribed or ordered by a Dentist; and
- D. Is rendered in accordance with recognized, appropriate dental and surgical practices prevailing in the dental specialty or field of dentistry at the time rendered; and
- E. Is not primarily for the convenience of the patient, the patient's family, or the patient's provider.
- F. Is not experimental, investigational, or cosmetic in purpose.

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

2.29 Open Enrollment Period

The period established by the Plan Administrator when any eligible Subscriber may enroll or disenroll themselves and eligible Dependents in Basic Dental. An Open Enrollment Period will be held in October of all odd numbered years. Changes made during the Open Enrollment Period will become effective the following January 1.

2.30 Part-Time Teacher

A teacher employed by a public school district, the South Carolina Department of Corrections, or the South Carolina Department of Juvenile Justice, on a Permanent and part-time basis working at least 15, but fewer than 30, hours a week. Part-Time Teachers are eligible for coverage as an Employee but not as a Retiree.

2.31 Plan

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

2.32 Planholder

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

2.33 Plan Administrator

The South Carolina Public Employee Benefit Authority.

2.34 Plan Year

The 12-month period of time beginning January 1 and ending December 31, 2020.

2.35 Pre-Treatment Estimate

A written estimate of the benefits that may be available to you under your dental plan. This estimate is requested by your dentist for a proposed treatment and is provided to you and your dentist by your dental plan before you receive the treatment.

2.36 Provider

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

2.37.A Retiree

An Employee who meets the requirements for Retirement set out in in paragraph 2.36.B of this Plan and meets the eligibility requirements in paragraph 3.11 in order to participate in the Plan.

2.37.B Retired/Retirement

An Employee has retired and established a date of retirement for the purposes of this Plan if, on that date, the Employee: (1) has terminated from all employment for an Employer, (2) has terminated from all employment covered by a State Retirement System, and (3) is eligible to receive a service or disability retirement allowance from a State Retirement System. An Employee's date of retirement for the purposes of this Plan cannot be later than the Employee's date of retirement under a State Retirement System. To determine eligibility to receive a retirement allowance from a State Retirement System for an Employee

who participates in the State Optional Retirement Program or who is employed by an Employer that does not participate in a State Retirement System, see paragraphs 3.11(A)(3) and 3.11(A)(4) of this Plan.

2.37.C South Carolina Retiree Health Insurance (SCRHI) Trust Fund

The trust fund established to provide for the employer costs of retiree post-employment health insurance benefits for retired state employees and retired employees of public school districts pursuant to Section 1-11-705 of the South Carolina Code of Laws. An Employer is considered a participant in the SCRHI Trust Fund if it is eligible to, and does, remit the employer contributions to the SCRHI Trust Fund provided for in Sections 1-11-705(l)(1) and 1-11-710(A)(2) of the South Carolina Code of Laws (i.e., the retiree insurance surcharge).

2.37.D Earned Service

Means service that (i) is credited as earned service credit in a State Retirement System and (ii) was earned and accrued through employment with an Employer. Purchased service credit that is not credited as earned service in a State Retirement System or earned service accrued with an employer that does not participate in the State Health Plan does not constitute Earned Service for the purposes of this Plan.

2.38 Schedule of Dental Procedures and Allowed Amounts

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

2.39 State

The State of South Carolina.

2.40 State Retirement System

Any retirement plan established pursuant to Title 9 of the South Carolina Code of Laws except for the National Guard Retirement System.

2.41 Subscriber

An Employer's Active Employee, Retiree, Former Spouse, Surviving Child, Surviving Spouse, or other enrollee with continuation coverage under Article 9 or 10. A Surviving Child or a Former Spouse may not add a Dependent to their coverage.

2.42 Surviving Child

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

2.43 Surviving Spouse

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

2.44 Third-Party Claims Processor

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

2.45 Transfers

A. Academic Transfers

- 1.** Academic Transfer Employee. For purposes of this provision, an Academic Transfer Employee is an Academic Employee who completes a school year or term (generally on or around June 30) with one Academic Employer and becomes an Academic Employee at another Academic Employer at the beginning of the next school year or term (generally on or around September 1).
- 2.** An Academic Transfer Employee shall have no break in coverage due to their Academic Transfer so long as they inform their first Academic Employer of the transfer prior to the date they begin employment with the subsequent Academic Employer.

B. Transfer Employee. A Transfer Employee is any Covered Employee not described in paragraph 2.44 who moves from one Employer, as defined in paragraph 2.22, to another Employer within 15 calendar days.

C. Academic Transfer Employees and Transfer Employees continue all Plan coverage elections and refusals for the Plan Year made during employment with their first Academic Employer or first Employer. An Academic Transfer Employee or Transfer Employee shall retain all progress made toward satisfying the Plan Year's deductible and coinsurance maximum during employment with the first Academic Employer or first Employer.

ARTICLE 3.

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

3.1 Eligibility

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

- A.** All Employees and their Dependents. A Spouse of a Covered Employee who is also an Employee may be covered only as an Employee and not as a Dependent. A Child of a Covered Employee who is also an Employee may be covered as either an Employee or a Dependent, but not as both;
- B.** All Retirees and their Dependents;
- C.** The Surviving Spouse and Surviving Child of a deceased Covered Employee;
- D.** All Employees and Dependents eligible for coverage as the result of COBRA in Article 10;

- E. All Part-Time Teachers and their Dependents. A Part-Time Teacher who is the Spouse of a Covered Employee may be covered as either an Employee or as a Dependent, but not as both; and
- F. A Former Spouse of a Covered Employee or Covered Retiree.

3.2 Employee Enrollment

To enroll under this Plan, each eligible Employee must submit within 31 days of the date their coverage would commence under paragraph 3.3: (i) an election of benefits, in a manner approved by PEBA, and (ii) any other forms required by the Plan Administrator. If the Employee fails to submit such timely election of benefits, payroll deduction authorization form, and other required forms within 31 days following that date, the Employee may be enrolled for coverage only during Open Enrollment Periods or Special Eligibility Situations as may be established by the Plan Administrator.

3.3 Commencement of Employee Coverage

Employee coverage under this Plan shall commence as follows:

- A. Each Employee in Active Employment who did not elect coverage under the Plan when first eligible and who subsequently elects coverage under this Plan by filing a timely election of benefits, in a manner approved by PEBA, during an Open Enrollment Period and satisfying the other conditions shall be covered under this Plan on the subsequent January 1;
- B. Each new Employee who becomes eligible for coverage after the Effective Date of this Plan, who has elected coverage by filing a timely election of benefits, in a manner approved by PEBA, shall be covered under this Plan (i) on the first day of the month that the Employee commences Active Employment provided that the Employee commences Active Employment on the first calendar day of that month; or (ii) on the first day of the following month provided that the Employee commences Active Employment on any day other than the first calendar day and the first working day of that month. Otherwise, if the Employee commences Active Employment on the first working day of the month, other than the first calendar day of the month, the Employee may choose to commence coverage under this Plan on either the first day of that month or the first day of the following month. For purposes of this paragraph, the first working day of the month is the first day that is not a Saturday, Sunday, or holiday. The first working day of the month is not an Employer-specific first working day.
- C. An Employee who has not elected coverage during the Plan Year may elect coverage if they experience a Special Eligibility Situation set out in paragraph 3.7 of the Plan. The Employee may elect coverage by filing a timely election of benefits, in a manner approved by PEBA, within the time frame set forth in paragraph 3.7. The Employee's coverage commences in accordance with the provisions of paragraph 3.7.

3.4 Eligibility for Dependent Coverage

Each Employee, who has one or more Dependents on the date the Employee becomes eligible for coverage, shall be eligible to enroll each Dependent for coverage on such date. Each Employee without a Dependent on the date the Employee becomes eligible for coverage shall be eligible to enroll each Dependent for coverage on the date the Employee acquires a Dependent in accordance with the provisions of paragraph 3.7 of the Plan. In both cases, the Employee must meet the requirements of 3.5 below.

3.5 Dependent Enrollment

To obtain Dependent coverage under this Plan, each eligible Employee must be covered under this Plan and file a timely election of benefits, in a manner approved by PEBA, selecting Dependent coverage for eligible Dependents. If the Employee acquires a Dependent after the Effective Date of the Employee's coverage, in accordance with paragraph 3.7 of the Plan, the Employee has 31 days from the date the Dependent was acquired to enroll the Dependent in this Plan. If the Employee fails to notify the Plan Administrator within the 31-day period of time, the Dependent may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator.

3.6 Commencement of Dependent Coverage

Each eligible Employee, who has satisfied the requirements of paragraph 3.5 and has enrolled eligible Dependents, will have Dependent coverage under this Plan for those eligible, enrolled Dependents commencing on the date the Employee's coverage commences, or for Dependents acquired thereafter, on the date that they were acquired in accordance with paragraph 3.7 of the Plan,.

3.7 Special Eligibility Situations

An Open Enrollment Period will be held every two years during odd-numbered years (2019, 2021, etc.). During the Open Enrollment Period, the eligible Subscriber is given an opportunity to make enrollment changes in dental coverage. Changes made during the Open Enrollment Period will become effective the following January 1st. No other enrollment changes may be made until the next Open Enrollment Period, except in the following situations:

A. Adding Coverage. If an Employee or Retiree has not enrolled themselves or eligible Dependents for coverage within 31 days of first becoming eligible or during a prior enrollment period and subsequently wishes to elect such coverage, the Employee or Retiree may do so under the following Special Eligibility Situations. If the Employee or Retiree does not do so within the time frame specified for a Special Eligibility Situation, they must wait for the next enrollment period.

1. An Employee's or Retiree's Child may be added within 31 days of:
 - a. the Child's birth,
 - b. adoption of the Child,
 - c. the Child's placement for adoption,
 - d. the Child's placement for foster care,
 - e. the Child becoming a stepchild,
 - f. the Employee or Retiree gaining legal custody of the Child, or
 - g. the date of other court order mandating coverage of the Child by the Employee or Retiree.

Coverage under this paragraph shall commence on the day of the event described in this subparagraph. The Employee or Retiree must submit an election of benefits, in a manner

approved by PEBA, within 31 days of the date of the event. Satisfactory documentation of the circumstances surrounding the event must accompany the election of benefits. The Employee or Retiree and all eligible Dependents may be enrolled in coverage at this time.

- 2.** An Employee's or Retiree's spouse may be added within 31 days of marriage. Coverage under this paragraph shall commence on the date of the marriage. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of the marriage. Satisfactory documentation of the circumstances surrounding the marriage must accompany the election of benefits. The Employee or Retiree and all eligible Dependents may be enrolled in coverage at this time
- 3.** An Employee or Retiree, Employee's or Retiree's spouse, or Employee's or Retiree's Child covered under the dental coverage of the Employee's or Retiree's spouse and who subsequently loses coverage because
 - a.** the spouse's employer canceled its present group insurance,
 - b.** the spouse's employer canceled its contribution to its group insurance,
 - c.** the death of the Employee's or Retiree's spouse, or
 - d.** the Employee's or Retiree's spouse left such employment or experienced a reduction in hours

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee or Retiree must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised election of benefits.

- 4.** An Employee or Retiree, Employee's or Retiree's spouse, or Employee's or Retiree's Child who loses dental coverage because of
 - a.** legal separation,
 - b.** divorce,
 - c.** cessation of dependent status, or
 - d.** other similar loss of coverage

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee or Retiree must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised election of benefits.

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

Coverage for the Employee or Retiree, the Employee's or Retiree's spouse, or the Employee's or Retiree's Child enrolled under this paragraph shall commence on the date of loss of Medicaid or CHIP coverage, or the date eligibility for premium assistance is determined. The Employee or Retiree must submit an election of benefits, in a manner approved by PEBA, within 60 days of the later of the date of loss of coverage or date eligibility for premium assistance is determined. A satisfactory statement of the circumstances surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the election of benefits. The Employee or Retiree and all eligible Dependents may be enrolled in coverage at this time

6. Eligible Employees, Retirees, and their Dependents may enroll in coverage upon release from incarceration. The Employee or Retiree must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of release from incarceration.
7. An Employee or Retiree, Employee's or Retiree's spouse, or Employee's or Retiree's Child who was mobilized or called to active duty with the National Guard or a Reserve unit and who dropped coverage under this Plan may re-enroll in the Program upon discharge or release from active duty and resumption of employment with an eligible Employer. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of discharge, release from active duty, or resumption of employment, whichever is latest.

B. Dropping Coverage. An Employee, Retiree, or a Covered Dependent who otherwise continues to meet eligibility requirements under the Plan may drop coverage in the following situations. If the Employee or Retiree does not do so within the time frame specified for a Special Eligibility Situation, the Employee and Covered Dependents either must wait (i) for the next Open Enrollment Period or (ii) for the Employee, Retiree, or Covered Dependents to cease meeting eligibility requirements under the terms of the Plan for coverage to be dropped.

1. An Employee, Retiree, or Covered Dependent who acquires other group coverage may drop coverage within 31 days. Coverage under this paragraph shall end on the first of the month after the gain of other coverage or the first of the month if coverage is gained on the first of the month. The Employee or Retiree must submit an election of benefits, in a manner approved by PEBA, within 31 days of the gain of other group coverage. Satisfactory documentation of the circumstances surrounding the event must accompany the election of benefits.

2. An Employee's or Retiree's Spouse must be dropped from coverage within 31 days of the date of divorce or legal separation. The Employee must submit an election of benefits, in a manner approved by PEBA, and divorce or legal separation order within 31 days of the date the divorce order is signed. Coverage under this paragraph shall end on the first day of the month after the election of benefits and divorce or legal separation order are submitted. A legal separation order must be signed by a judge in a jurisdiction that recognizes legal separation as a legal status change.

3. An Employee, Retiree, or Covered Dependent who

- a. gains coverage under Medicaid or CHIP may drop coverage within 60 days from the date of notification of the gain of coverage; or
- b. loses eligibility for a premium assistance subsidy under Medicaid or CHIP may drop coverage within 60 days from the date of notification of loss of eligibility.

Coverage for the Employee, Retiree, or Covered Dependent dropped under this paragraph shall end on the date of gain of Medicaid or CHIP coverage, or the date of the notification regarding loss of eligibility for premium assistance. Otherwise, coverage shall end the first of the month following the submission of an election of benefits, in a manner approved by PEBA, if provided in accordance with the time limits in this paragraph. The Employee or Retiree must submit an election of benefits, in a manner approved by PEBA, within 60 days from the later of the date of the notification of gain of coverage or the date of notification of loss of eligibility for premium assistance. A satisfactory statement of the circumstances surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the revised election of benefits.

4. A Covered Person who becomes incarcerated may drop coverage due to incarceration. The Employee or Retiree must submit an election of benefits, in a manner approved by PEBA, within 31 days from the date of incarceration.

C. **Transfers.** A Transfer Employee does not have a Special Eligibility Situation due to their transfer unless they experience one of the situations in paragraphs 3.7.A or 3.7.B.

D. **Notification Obligations.** Each Employee or Retiree must notify the Plan Administrator as soon as possible of:

- (i) a change in address;
- (ii) entrance into the military;
- (iii) an individual ceasing to be a Dependent under the terms of the Plan; or
- (iv) any other change in status or other applicable event that might affect the Employee's, Retiree's or the Covered Dependents' coverage under Plan.

If an Employee or Retiree does not provide such notice, the Employee or Retiree may be liable for the costs, fees, and expenses incurred by the Plan, the Plan Sponsor, the Plan Administrator, or an

Employer for failure to notify. The Plan Administrator may request whatever documentation it deems necessary to substantiate a claimed change in status or other applicable event. The failure to notify the Plan Administrator of any event listed above or other events affecting eligibility or coverage under the Plan may be deemed by the Plan Administrator to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the Plan, which may result in a retroactive termination of coverage. Coverage under the Plan will not continue beyond the first of the month after the last date of eligibility even if an Employee or Retiree has failed to provide notice as required by this paragraph.

3.8 Termination of Employee's Coverage

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of an Employee shall cease as of 11:59 p.m. on the last day of the month during which:

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

When an Employee requests the termination of coverage during the Open Enrollment Period, coverage will terminate at 11:59 p.m. the following December 31st. When the Employee's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium. When an Employee dies, coverage terminates on the day following the date of death of the Employee.

3.9 Termination of Dependent's Coverage

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of an eligible Dependent shall cease as of 11:59 p.m. on the last day of the month during which:

- A. The Employee ceases to be in a class of Employees eligible for Dependent coverage under this Plan;
- B. The Employee is no longer covered under this Plan;
- C. All Dependent coverage under this Plan terminates;
- D. Any particular Dependent ceases to be a Dependent of the Employee. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse.
- E. 31 days have lapsed since the date of birth of a newborn, unless the Employee has enrolled the newborn as required by paragraph 3.5, or under such conditions as established by the Planholder.

When an Employee requests the termination of Dependent coverage during the Open Enrollment Period, coverage will terminate at 11:59 p.m. the following December 31st. When the Employee's contribution

becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium. When an Employee or a Dependent dies, coverage terminates on the day following the date of death of the Employee or the Dependent. However, after death of the Employee, coverage of the Dependent may continue under Article 9, Continuation of Coverage, or Article 10, COBRA.

3.10

[Reserved]

3.11 Retiree Eligibility

A. Except for the Employees described in subparagraph B below, an eligible Retiree shall be defined as:

1. Termination after Retirement eligibility

An Employee who terminated from all employment for an Employer after reaching eligibility to receive a retirement allowance from a State Retirement System and who has Retired is eligible to participate as a Retiree if, at the time of Retirement, (a) the Employee had at least five (5) years of Earned Service and (b) the Employee's last five (5) years of Active Employment prior to Retirement were consecutive and in a Full-Time Permanent position.

2. Termination before Retirement eligibility

An Employee who terminated from all employment for an Employer before eligibility to receive a retirement allowance from a State Retirement System and who has Retired is eligible to participate as a Retiree if, at the time of termination, (a) the Employee had at least twenty (20) years of Earned Service and (b) the Employee's last five (5) years of Active Employment prior to termination were consecutive and in a Full-Time Permanent position.

3. Participation in the State Optional Retirement Program

For the purposes of determining whether an Employee who participated in the State Optional Retirement Program (State ORP) is eligible to participate as a Retiree pursuant to subparagraph (A)(1) or (A)(2) of this paragraph, the Employee is considered eligible to receive a retirement allowance from a State Retirement System if the Employee would have met the eligibility requirements to receive a retirement allowance from the South Carolina Retirement System (SCRS) had the Employee been a member of SCRS, rather than participating in the State ORP, during the period of employment. In making this determination, one year of Full-Time, paid employment while participating in the State ORP and making regular contributions to an ORP account equates to one year of Earned Service in SCRS.

4. Employment not covered by a State Retirement System

For the purposes of determining whether an Employee who was employed by an Employer that does not participate in a State Retirement System is eligible to participate as a Retiree pursuant to subparagraph (A)(1) or (A)(2) of this paragraph, the Employee is considered eligible to receive a retirement allowance from a State Retirement System if the Employee would have met the eligibility requirements to receive a retirement allowance from the South Carolina Retirement System (SCRS) had the Employee been a member of SCRS during the period of employment for the Employer. In making this determination, one year of Full-Time, paid employment for the non-State Retirement System Employer equates to one year of Earned Service in SCRS.

5. Employment for a solicitor's office

For the sole purpose of determining whether an Employee who was employed by a solicitor's office is eligible to participate as a Retiree pursuant to subparagraph (A)(1) or (A)(2) of this paragraph, the Employee's employment with the solicitor's office is considered Active Employment with an Employer if at least one county in the judicial circuit covered by the solicitor's office participates in the Plan. A Retiree who participates in the Plan pursuant to this subparagraph is not eligible for funding from the SCRHI Trust Fund for any portion of the total premium required for the Retiree's coverage under the Plan.

6. Subsequent service after reaching eligibility

If an Employee reaches a date such that, if the Employee terminated employment on that date, the Employee would be eligible to participate as a Retiree upon Retirement without any additional service credit in a State Retirement System or employment with an Employer, continued or subsequent employment for an Employer will not disqualify the Employee from being eligible to participate as a Retiree upon Retirement.

7. Retirees of optional employers

In addition to satisfying the requirements of this paragraph, in order to participate as a Retiree, a Retiree's last Employer prior to Retirement must continue to participate in the Plan. If an Employer withdraws from participation in Plan, retired employees of that Employer are no longer eligible to participate as Retirees. If an employee retired from an Employer prior to the Employer electing to participate in the Plan, the employee is eligible to participate as a Retiree when the Employer joins the Plan only if the employee meets the eligibility requirements of this paragraph.

8. Disability retirement

The initial requirements for participation as a Retiree are the same regardless of whether an Employee is eligible for a service retirement allowance or a disability retirement allowance under a State Retirement System. However, for an Employee who participates as a Retiree solely as the result of being eligible for a disability retirement allowance under a State Retirement System, the Employee will no longer be eligible to participate as a Retiree if the Employee's eligibility to receive a disability retirement allowance is permanently discontinued.

- B.** For certain Employees described below who began employment in an insurance-eligible position before May 2, 2008, an eligible Retiree shall be defined as:

1. Certain employees with at least 18 years of service prior to 1990

An Employee who terminated from employment for an Employer before eligibility to receive a retirement allowance from a State Retirement System prior to 1990 with at least eighteen (18) years of Earned Service is eligible to participate as a Retiree upon Retirement, if (a) the Employee returned to Active Employment and (b) completed at least two consecutive years of employment in a Full-Time Permanent position with an Employer prior to Retirement.

2. Former members of the General Assembly

A member of the General Assembly, who leaves office or retires with at least eight (8) years of credited service in the Retirement System for Members of the General Assembly, is eligible to participate as a Retiree.

3. Former members of a municipal or county council

A former municipal or county council member is eligible to participate as a Retiree if, at the time the council member left office, (a) the council member had served on the council for at least twelve (12) years, (b) the council member was covered under the Plan, and (c) the council has elected to provide such coverage for former members.

3.12 Retiree Premiums

A. Retirees of local governmental Employers

1. State funding

A Retiree whose last Employer prior to Retirement does not participate in the SCRHI Trust Fund is not eligible for funding from the SCRHI Trust Fund for any portion of the total premium required for the Retiree's coverage under the Plan.

2. Employer funding

An Employer that does not participate in the SCRHI Trust Fund, at its discretion, may elect to pay none, all, or a portion of the total premium for its Retirees' coverage. The Retiree is responsible for any portion of the total premium not paid by the Employer.

B. Retirees of the State and public school districts

1. General rule

If a Retiree whose last Employer prior to Retirement participates in the SCRHI Trust Fund does not meet any of the requirements in subparagraphs (B)(2) or (B)(3) below for funding

from the SCRHI Trust Fund, the Retiree is responsible for paying the total premium (i.e., both the employee and employer portion) for Retiree coverage under the Plan.

2. Retirees who began employment in an insurance-eligible position before May 2, 2008:

a. Termination after retirement eligibility

For a Retiree who participates in the Plan pursuant to subparagraph (A)(1) of paragraph 3.11, the employer portion of the Retiree's premium shall be paid by the SCRHI Trust Fund if, at Retirement, (i) the Retiree had at least ten (10) years of Earned Service and (ii) the Retiree's last five (5) years of Earned Service prior to Retirement were earned consecutively in a Full-Time Permanent position with an Employer that participates in the SCRHI Trust Fund. The Retiree shall pay the employee portion of the premium. For the purposes of this subparagraph, a Retiree's Earned Service credit is considered consecutive if there were no breaks in the Retiree's Active Employment during the period the service credit was earned.

b. Termination before retirement eligibility

For a Retiree who participates in the Plan pursuant to subparagraphs (A)(2) or (B)(1) of paragraph 3.11, the employer portion of the Retiree's premium shall be paid by the SCRHI Trust Fund if the last five (5) years of the Retiree's Active Employment before Retirement were with an Employer that participates in the SCRHI Trust Fund. The Retiree shall pay the employee portion of the premium.

3. Retirees who began employment in an insurance-eligible position on or after May 2, 2008

For a Retiree who participates in the Plan pursuant to subparagraphs (A)(1) or (A)(2) of paragraph 3.11, funding for the employer portion of the Retiree's premium shall be paid by the SCRHI Trust Fund as follows, if the last five (5) years of the Retiree's Active Employment before Retirement were with an Employer that participates in the SCRHI Trust Fund:

a. No funding of the employer premium

If the Retiree has fewer than fifteen (15) years of Earned Service, the Retiree is not eligible for funding for premiums from the SCRHI Trust Fund and the Retiree must pay the total premium (i.e., both the employee and the employer portion) for coverage under the Plan.

b. Partial funding of the employer premium

If the Retiree has at least fifteen (15), but fewer than twenty-five (25) years, of Earned Service, fifty percent (50%) of the employer portion of the Retiree's premium shall be paid by the SCRHI Trust Fund. The Retiree is responsible for paying the remainder of the total premium for coverage under the Plan (i.e., fifty percent of the employer portion and the entire employee portion).

c. Full funding of the employer premium

If the Retiree has at least twenty-five (25) years of Earned Service, the employer portion of the Retiree's premium shall be paid by the SCRHI Trust Fund. The Retiree shall pay the employee portion of the premium.

4. Subsequent service after reaching eligibility

If an Employee reaches a date such that, if the Employee terminated employment on that date, the Employee would be eligible for funding for Retiree premiums from the SCRHI Trust Fund upon Retirement without any additional service credit in a State Retirement System or employment with an Employer, continued or subsequent employment for an Employer will not diminish the funding available to the Employee for Retiree coverage under the Plan upon Retirement.

5. SCRS Early Retirement (55/25)

A Retiree who participates in the Plan pursuant to subparagraphs (A)(1) or (A)(2) of paragraph 3.11 and who retired from the South Carolina Retirement System (SCRS) pursuant to the early retirement provisions of Section 9-1-1515 of the South Carolina Code of Laws (i.e., 55/25 retirement) is not eligible for funding from the SCRHI Trust Fund and must pay the total premium for Retiree coverage under the Plan (i.e., both the employee and the employer portion) until the earlier of: (a) the date the Retiree attains age sixty (60), or (b) the date the Retiree would have accrued twenty-eight (28) years of service credit in SCRS had the retiree not retired.

Upon attaining age sixty (60) or the date the Retiree would have accrued twenty-eight (28) years of service credit, the Retiree's eligibility for funding from the SCRHI Trust Fund is determined in accordance with subparagraphs (B)(1) through (B)(4) of this paragraph above.

A Retiree eligible to participate under subparagraph (A)(3) of paragraph 3.11 who otherwise meets the requirements of Section 9-1-1515 of the South Carolina Code of Laws is subject to the funding rules contained in this subparagraph.

3.13 Special Contributors in a State Retirement System

A. SCRS Special Contributors

An Employee who terminates employment and purchases additional service credit pursuant to the provisions of Section 9-1-1850 of the South Carolina Code of Laws is eligible to continue to participate in the Plan during the period of the service purchase by paying both the employer and the employee portion of the total premium for coverage. Upon the former Employee's subsequent Retirement, his or her eligibility to participate as a Retiree will be determined in accordance with paragraph 3.11 of the Plan and his or her eligibility for funding toward the total premium for any such coverage as a Retiree will be determined in accordance with paragraph 3.12 of the Plan.

B. GARS Special Contributors

For a member of the Retirement System for Members of the South Carolina General Assembly (GARS) who leaves office prior to eligibility for retirement under GARS, service established as a GARS special contributor pursuant to Section 9-9-40(2) of the South Carolina Code of Laws is considered Earned Service for the purposes of paragraphs 3.11(A)(2), 3.12(B)(2)(b), and 3.12(B)(3) of the Plan.

3.14 Retiree Enrollment

- A. An Employee who meets the eligibility requirements under paragraph 3.11 may enroll in coverage under this Plan as a Retiree. The Employee must submit, within 31 days of their Retirement: (i) an election of benefits, in a manner prescribed by PEBA, and (ii) any other information required by the Plan Administrator. If the Employee fails to submit the required forms and information within 31 days following their date of Retirement, the Employee may be enrolled for coverage as a Retiree only during Open Enrollment Periods or Special Eligibility Situations as may be established by the Plan Administrator.
- B. Retiree coverage may not become effective earlier than the Employee's date of Retirement.

3.14A Post-Retirement Employment

- A. A Retiree who returns to Active Employment in an insurance-eligible position with an Employer may not continue Retiree coverage during that employment, but must either (i) be covered as an Active Employee or (ii) decline all coverage under the Plan. Upon termination from Active Employment in an insurance-eligible position, the Employee may re-enroll in Retiree coverage by submitting an election of benefits, in a manner approved by PEBA, within 31 days of the date of termination.
- B. If an Employee returns to employment for an Employer after the Employee's date of retirement under a State Retirement System, the Employee's post-retirement employment cannot be used to reach eligibility for Retiree coverage under the Plan or to increase the funding available to the Employee for Retiree coverage under the Plan.

3.15 Enrollment of Dependents of the Retiree

An Employee's Dependent at the time of the Employee's Retirement, and any Dependent a Retiree acquires after Retirement, may be covered as the Dependent of a Retiree under this Plan provided that the Retiree submits within 31 days of their date of Retirement or the date the Dependent was acquired after Retirement: (i) an election of benefits, in a manner approved by PEBA and (ii) any other information required by the Plan Administrator. If the Retiree fails to submit the required information within 31 days following the Dependent's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment Periods or Special Eligibility Situations as may be established by the Plan Administrator in paragraph 3.7.

3.16 Commencement of Coverage for Retirees and Dependents

Retirees and Dependents, who are Covered Persons under this Plan at the time of the Retirement of the Employee and are re-enrolled as Covered Persons at the time of Retirement, remain covered under this Plan. Retirees and Dependents, who are not Covered Persons under this Plan at the time of the Retirement of the Employee and are enrolled in this Plan at the time of Retirement, shall be covered on the first day of the month following the approval of the application for enrollment as a Retiree or Dependent under

this Plan. A Dependent who is acquired after Retirement, and is enrolled within 31 days of the date the Dependent is acquired, shall be covered from the date the Dependent was acquired in accordance with the provisions of paragraph 3.7.

For an Employee who is eligible to participate as a Retiree solely as the result of being eligible for a disability retirement allowance under a State Retirement System, coverage under the Plan shall commence no earlier than the first day of the month following the date on which PEBA issues approval of the disability retirement allowance. For an Employee who participated in the State ORP or who was employed by an Employer that does not participate in a State Retirement System, the date on which PEBA issues approval of a disability retirement allowance is the date on which PEBA receives documentation establishing that the Employee would have been eligible for a disability retirement allowance under SCRS had the Employee been a member of SCRS during the period of employment.

3.17 Termination of Retiree's Coverage

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of a Retiree shall cease as of 11:59 p.m. on the last day of the month during which:

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

When a Retiree requests the termination of coverage during the Open Enrollment Period, coverage will terminate at 11:59 p.m. the following December 31st. When the Retiree's contribution becomes sixty (60) days past due, coverage will terminate retroactively to the last day of the month for which the Retiree paid the full premium. When a Retiree dies, coverage terminates on the day following the date of death of the Retiree. For a Retiree who is eligible for coverage based on the approval of disability retirement benefits, coverage shall cease as of 11:59 p.m. on the last day of the month following the date of the final check from the Retiree's disability retirement.

3.18 Termination of Coverage of Dependent of Retiree

Except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, the coverage of an eligible Dependent of a Retiree shall cease as of 11:59 p.m. on the last day of the month during which:

- A. The Retiree ceases to be in a class of Retirees eligible for Dependent coverage under this Plan;
- B. The Retiree is no longer covered under this Plan;
- C. All Dependent coverage under this Plan terminates; or
- D. Any particular Dependent ceases to be a Dependent of the Retiree as defined in 2.17.

When a Retiree requests the termination of Dependent coverage during the Open Enrollment Period, coverage will terminate at 11:59 p.m. the following December 31st. When the Retiree's contribution becomes sixty (60) days past due, coverage will terminate retroactively to the last day of the month for which the Retiree paid the full premium. When a Retiree or a Dependent dies, coverage terminates on the day following the date of death of the Retiree or the Dependent. However, after death of the Retiree, coverage of the Dependent may continue under Article 9, Continuation of Coverage, or Article 10, COBRA. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse.

3.19 Termination of Coverage of Survivors; Continuation of Coverage

The coverage of a Surviving Spouse and Surviving Children of a deceased Employee shall terminate as provided in 3.9 or 3.18 unless extended under the Continuation of Coverage provisions in Article 9.

3.20 Effect of Termination of Coverage

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

3.21 Ongoing Employees

- A.** An Ongoing Employee is an Employee who has been employed by an Employer for an entire Standard Measurement Period, as that term is defined in paragraph 3.21.B.
- B.** A Standard Measurement Period for Ongoing Employees begins on October 4th of each calendar year and ends on October 3rd of the next calendar year. For Plan Year 2020, the Standard Measurement Period runs from October 4, 2018 and ends on October 3, 2019.
- C.** An Ongoing Employee meeting the requirements of paragraph 3.21.E may enroll during an Open Enrollment Period with coverage effective for a Standard Stability Period beginning the following January 1st. For Plan Year 2020, the Administrative Period begins October 4, 2019, and ends on December 31, 2019.

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

- D.** A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31, and is synonymous with the Plan Year as defined in paragraph 2.33.
- E.** An Ongoing Employee who is credited by their Employer with an average of at least thirty (30) hours of service per week after completing a Standard Measurement Period is eligible to enroll in coverage under this Plan during the Open Enrollment Period held during the Administrative Period for coverage that will be effective for the entire duration of the following Standard Stability Period; provided the Ongoing Employee does not otherwise experience a termination event under the Plan. An Ongoing Employee remains eligible throughout the Standard Stability Period so long as they are employed with that Employer and regardless of the number of hours worked during that Standard Stability Period. An Ongoing Employee who ceases work and is not credited with an hour of service for less than thirteen (13) weeks (twenty-six (26) weeks for educational institutions) and who then resumes work with the same Employer during the same Standard Stability Period will be eligible to resume participation in the Plan as of the first day of the calendar month following resumption of

work (even if the Ongoing Employee resumes employment in a position that is not reasonably expected to be a Full-Time position).

- F. An Ongoing Employee who has been found not to meet the 30-hour-per-week average during a Measurement Period is not eligible for the Plan as an Ongoing Employee through the entirety of the following Stability Period, unless they gain eligibility under another provision of this Plan.
- G. In the case of a conflict between another provision of this Plan and this paragraph, this paragraph will govern Ongoing Employee's eligibility and coverage. The Ongoing Employee's coverage is otherwise governed by the entirety of this Plan.

3.22 New Variable Hour, New Part-Time, and New Seasonal Employees

A. Definitions

1. A New Part-Time Employee is a new Employee who has not completed a Standard Measurement Period and who, upon hire, is reasonably expected to be employed on average less than thirty (30) hours of service per week during an Initial Measurement Period, as defined in paragraph 3.22.B.
 2. A New Seasonal Employee is a new Employee who has not completed a Standard Measurement Period and who is hired into a position for which the customary annual employment is six (6) months or less. The reference to customary means that by the nature of the position, an Employee in this position typically works for a period of six (6) months or less, and that period begins each calendar year in approximately the same part of the year, such as summer or winter.
 3. A New Variable Hour Employee is a new Employee who has not completed a Standard Measurement Period and who, upon hire, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least thirty (30) hours of service per week during an Initial Measurement Period, as defined in paragraph 3.20.B, because the Employee's hours are variable or otherwise uncertain.
- B. An Initial Measurement Period for New Variable Hour, Part-Time, and Seasonal Employees begins on the first day of the month following a New Variable Hour, Part-Time, or Seasonal Employee's date of hire and ends twelve months later. A Standard Measurement Period may begin during, and run concurrently with, portions of an Initial Measurement Period.
 - C. A New Variable Hour, Part-Time or Seasonal Employee meeting the requirements of paragraph 3.22.E may enroll during an Initial Administrative Period beginning the day following the end of their Initial Measurement Period and ending the last day of the same calendar month.
 - D. An Initial Stability Period for New Variable Hour, Part-Time, and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year.
 - E. A New Variable Hour, Part-Time, or Seasonal Employee who is credited by their Employer with an average of at least thirty (30) hours of service per week after completing an Initial Measurement

Period is eligible to enroll in coverage under this Plan during the Administrative Period and for the entire duration of the following Initial Stability Period. A New Variable Hour, Part-Time, or Seasonal Employee remains eligible throughout an Initial Stability Period so long as they are employed with that Employer and regardless of the number of hours worked during that Initial Stability Period. A New Variable Hour, Part-Time, or Seasonal Employee who ceases work and is not credited with an hour of service for less than thirteen (13) weeks (twenty-six (26) weeks for educational institutions) and who then resumes work with the same Employer during the same Initial Stability Period will be eligible to resume participation in the Plan as of the first day of the calendar month following resumption of work (even if the New Variable Hour, Part-Time, or Seasonal Employee resumes employment in a position that is not reasonably expected to be a Full-Time position).

- F.** A New Variable Hour, Part-Time, or Seasonal Employee who has been found not to work an average of at least thirty (30) hours per week during an Initial Measurement Period is not eligible for benefits as a Variable Hour, Part-Time, or Seasonal Employee through the entirety of the following Initial Stability Period, unless they gain eligibility under another provision of this Plan (e.g., after becoming an Ongoing Employee and gaining coverage through the provisions of paragraph 3.22). However, if a new Variable Hour, Part-Time, or Seasonal Employee materially changes employment status before the end of the Initial Measurement Period in such a way that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, the Employee will be treated as a Full-Time Employee and will be eligible for coverage under the Plan no later than the first day of the month following the change in employment status or, if earlier, as of the first day of the first month following the end of the Initial Measurement Period if the Employee averages more than 30 Hours of Service per week during the Initial Measurement Period and related Administrative Period.
- G.** Once a New Variable Hour, Part-Time, or Seasonal Employee meets the definition of an Ongoing Employee in paragraph 3.21.A, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in paragraph 3.21.
- H.** In the case of a conflict between another provision of this Plan and this paragraph, this paragraph will govern the New Variable Hour, Part-Time, or Seasonal Employee's eligibility and coverage. The New Variable Hour, Part-Time, or Seasonal Employee's coverage is otherwise governed by the entirety of this Plan.

3.23 New Full-Time Employee

- A.** If an Employer reasonably determines, based on the facts and circumstances at the date of hire, that a newly hired Employee will be a Full-Time Employee, the new Employee is eligible to participate in the Plan in accordance with paragraphs 3.2 and 3.3. If the Employee's hours are reduced below the threshold for Full-Time employment before the Employee has completed a full Standard Measurement Period, then the Employee's eligibility will be determined on a month-to-month basis until completion of a Standard Measurement Period.
- B.** Once a New Full-Time Employee meets the definition of an Ongoing Employee, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in paragraph 3.21.

ARTICLE 4.

CONTRIBUTIONS

4.1 Employee or Retiree Contribution

The State or employing entity contributes the entire premium for single dental coverage for the eligible Active Employee or eligible funded Retiree under Basic Dental. Each eligible Employee or Retiree who elects to have their Dependents covered under this Plan shall contribute the amount determined for each Plan Year by the State for Basic Dental, commencing with the pay period in which the Dependents' coverage starts. A Subscriber is responsible for all Employee premiums for any retroactive coverage initiated; the Employer must pay the Employer share of any retroactive coverage. The Plan Administrator reserves the right at any time to alter, amend, change, supplement, revoke, or reduce the benefits under this Plan, or increase or decrease the premiums charged under this Plan.

4.2 Contribution of Entire Premium

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

- A. A Surviving Spouse or Surviving Child of a deceased Employee or Retiree who elects coverage under Article 9, Continuation of Coverage;
- B. Those electing to extend coverage as provided in Article 10 under COBRA (an additional administrative fee may also apply);
- C. Those hired on or after July 1, 1984, and who retired with at least five (5) but fewer than ten (10) years active service;
- D. Those Retirees, who by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their dental insurance premium; and
- E. Former Spouses.

ARTICLE 5.

DUTIES AND RESPONSIBILITIES

5.1 Planholder Duties

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

- A. The appointment or removal of the Plan Administrator, Third-Party Claims Processor and other entities or their delegates that implement the Plan;

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

5.2 Plan Administrator Duties

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

- A. To administer this Plan according to its terms and to be accountable to the State with regard to the administration of this Plan;
- B. To construe and interpret this Plan in a nondiscriminatory manner; to decide all questions of eligibility; and to determine all questions arising in the administration and application of this Plan;
- C. To determine the types of benefits allowable under this Plan;
- D. To be responsible for the reporting and disclosure requirements imposed upon administrators under applicable law;
- E. To receive from the State and from Subscribers and Dependents such information as shall be necessary for the proper administration of this Plan, and to furnish the State, upon request, such reports with respect to the administration of this Plan as are responsible and appropriate;
- F. To receive, review, and keep on file (as it deems convenient or proper) reports of the financial condition, and of the receipts and disbursements;
- G. To maintain all records of this Plan;
- H. To review as necessary, all claims for benefits under this Plan;
- I. To determine the manner and time of payment of benefits under this Plan;

- J. To apprise the State as to the amounts and timing of disbursements for payment of benefits and expenses under this Plan;
- K. To prescribe procedures to be followed by Subscribers and Dependents in filing claims for benefits under this Plan;
- L. To furnish the State such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate; and
- M. To do all other acts or things as may be necessary for the proper administration of this Plan.

5.3 Duties and Powers of Third-Party Claims Processor

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

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

ARTICLE 6.

PAYMENT OR REIMBURSEMENT FOR COVERED DENTAL BENEFITS

6.1 Payment for Dental Services

Subject to all other terms, conditions, limitations and exclusions of this Plan, the Plan Administrator, upon receipt of invoices from providers of dental care or of completed claim forms as may be required by the Plan Administrator, and after the claims have been processed by the Third-Party Claims Processor, will

make payment for a Covered Person's Covered Dental Benefits, provided the expense is not covered or reimbursable under any other group plan, insured or otherwise. If expenses for dental care are partially paid or reimbursed under any other group plan as provided in Article 7, Coordination of Benefits, that part of the expenses that is not so paid or reimbursed by the other plan shall be paid or reimbursed to, or for the benefit of, the Covered Person as provided in this Plan.

6.2 Payment

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

6.3 Annual Maximum Benefit

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

6.4 Lifetime Orthodontia Maximum

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

6.5 Classes of Benefits

Class	Covered benefits	Annual deductible	Percent covered	Maximum payment
I Diagnostic and preventive	Exams; cleaning and scaling of teeth; fluoride treatment; space maintainers (child); x-rays	None	100% of allowed amount	\$1,000 per person each year; combined for Classes I, II and III
II Basic benefits	Fillings; extractions; oral surgery; endodontics (root canals); periodontal procedures	\$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	80% of allowed amount	\$1,000 per person each year; combined for Classes I, II and III
III Prosthodontics	Onlays; crowns; bridges; dentures; implants; repair of prosthodontic appliances	\$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	50% of allowed amount	\$1,000 per person each year; combined for Classes I, II and III
IV Orthodontics	Limited to covered children age 18 and younger. Correction of malocclusion consisting of: diagnostic services (including models and x-rays); active treatment (including necessary appliances)	None	50% of allowed amount	\$1,000 lifetime benefit for each covered child

ARTICLE 7.

COORDINATION OF BENEFITS

7.1 Definitions for this Article

A. Plan

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

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

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

B. Dependent

With respect to this Article Dependent means any person included in the definition of Dependent in paragraph 2.17 herein and, with respect to any other Plan, any person who qualifies as a dependent under such Plan.

C. Primary Plan

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

D. Secondary Plan

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

7.2 Order of Determination of Benefits

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

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

A. Coverage as a Non-Dependent or Dependent

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

B. Dependent Child - Parents Not Separated or Divorced

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

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

C. Dependent Child - Parents Separated or Divorced

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

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

2. Second, the Plan of the spouse of the parent with custody of the Child;
3. Third, the Plan of the parent who does not have custody of the Child;
4. If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan.
5. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the Child shall follow the order of benefit determination rules in paragraph B above.

D. Active - Inactive Employee

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

E. Continuation of Coverage

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

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

F. Longer - Shorter Length of Coverage

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

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

7.3 Effect of Order of Determination of Benefits on this Plan

- A. This Plan is Primary.** When the order of determination rules of this Plan establish that this Plan is the Primary Plan, the benefits provided by this Plan shall be determined without consideration of the benefits of any other Plan.
- B. This Plan is Secondary.** When the order of determination rules of this Plan establish that this Plan is the Secondary Plan, this Plan will pay the lesser of
1. the benefits that would be payable for the Covered Dental Benefit(s) under this Plan if it were the Primary Plan, without regard to this coordination of benefits provision; or
 2. the difference between this Plan's Allowed Amount(s) and the benefits the other Plan would pay as Primary, without regard to any coordination of benefits or similarly intended provision in that Plan. Payment for each Covered Dental Benefit will be determined in the manner above when this Plan is Secondary. This Plan as Secondary will not pay any benefits for expenses this Plan would not cover as Primary. The benefits this Plan pays as Secondary will not exceed the total benefits this Plan would pay as Primary or the patient's liability under the Primary Plan, nor will the payments from both Plans combined exceed the Allowed Amount(s) of this Plan. Any benefits paid under this provision are charged against any applicable benefit limit of this Plan.
- C. Subscriber's Responsibility.** The Subscriber is responsible for filing or processing claims through another dental insurance plan.

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

Some oral surgery procedures are also covered by the State Health Plan and are indicated in the Schedule of Dental Procedures and Allowed Amounts by an asterisk (*). Some services related to the oral surgery may also be covered. The State Health Plan is the primary coverage for these procedures. Therefore, the claim for these procedures must be filed with the State Health Plan first. A copy of the Explanation of Benefits (EOB) provided by the Third-Party Claims Processor for the State Health Plan must be filed with the Third-Party Claims Processor for Basic Dental before Basic Dental will provide payment as a secondary insurance carrier.

7.5 Right to Receive and Release Information

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

7.6 Facility of Payment

Whenever payments that should have been made under this Plan in accordance with this Article have been made under any other Plan, the Third-Party Claims Processor will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this Article, and amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments for Covered Dental Benefits, the Plan will be fully discharged from liability.

The term “payments” includes providing benefits in the form of services, in which case the term “payment made” means the reasonable cash value of the benefits provided in the form of services.

7.7 Right of Recovery

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

ARTICLE 8.

EXCLUSIONS AND LIMITATIONS

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

- A.** Any service or charge for service that is:
 - 1.** not Medically Necessary as defined in 2.28; or
 - 2.** more costly than an Alternate Form of Treatment that meets accepted standards of dental practice, regardless of the course of treatment chosen by the Covered Person or the Dentist, in which case benefits will be limited to the benefits due had the services been the least costly alternative; or,
 - 3.** rendered by a Dentist or Dental Hygienist beyond the scope of the applicable license; or,
 - 4.** not recommended and approved by the attending Dentist; or
 - 5.** for a non-dental service such as broken appointments, dental records, or completion of claim forms; or
 - 6.** for treatment other than by a licensed Dentist, except that cleaning or scaling of teeth may be performed by a licensed Dental Hygienist if such treatment is rendered under the supervision of a Dentist; or
 - 7.** a temporary procedure that is considered part of a more definitive treatment.
- B.** Any service or charge for service to the extent a Covered Person is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, or any state or political subdivision thereof. Without limiting the generality of the foregoing, this exclusion applies to benefits provided by or payable under workers’ compensation laws, the Veterans Administration or any state or

federal hospital for which hospital services the Covered Person is not legally obligated to pay. This exclusion applies if the Covered Person receives any benefits or payments in whole or in part, and it applies to any settlement or other agreement, including any settlement of “doubtful and disputed” claims or “clincher” agreements or any other agreement regardless of how characterized and even if the document or release specifically excludes payment for medical expenses.

- C. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits under state or federal programs of health care, excluding Medicare and amendments thereto, but only to the extent that benefits are provided or reimbursement is paid or payable hereunder;
- D. Any charges for services or supplies required because of declared or undeclared war or any act of war, or which were furnished or paid for by reason of the past or present service of any person in the armed services of a government;
- E. Any charges for services commencing prior to the Covered Person’s coverage hereunder or rendered after the termination of coverage, except as provided in Article 9, Continuation of Coverage, or Article 10, COBRA, of this Plan, and except for charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the individual was covered under Basic Dental but are finally installed or delivered within ninety (90) days after the termination of coverage;
- F. Any charges for services and supplies which are furnished in a facility operated under the direction or at the expense of the U.S. Government (or any agency thereof) or by a Doctor or Dentist employed by such facility;
- G. Any charges for services and supplies that are primarily for cosmetic or aesthetic purposes, including charges for personalization or characterization of dentures, except for orthodontia treatment as specifically provided for under this Plan;
- H. Any charges for the replacement of a lost or stolen prosthetic device, or a lost, stolen or broken space maintainer or orthodontic appliance, or charges for spare or duplicate dentures and/or appliances;
- I. Any charges for more than two (2) procedures in any Plan Year of the following:
 - 1. Oral examination,
 - 2. Consultations provided by a specialist,
 - 3. Prophylaxis,
 - 4. Periodontal prophylaxis (a covered benefit available only to patients who have a history of periodontal surgery) except that two additional periodontal prophylaxis (D4910) will be allowed if substituted for two prophylaxis (D1110) provided in subpart 3 above,
 - 5. Topical fluoride applications of stannous fluoride or acid fluoride phosphate.

- J.** Any charges for the procedures listed below that are performed more often than specified in the Plan, including:
- 1.** gingival curettage, surgical, exceeding four quadrants in any 36-month period;
 - 2.** osseous surgery, including flap entry and closure, exceeding four quadrants in any 36-month period;
 - 3.** periodontal scaling and root planing, exceeding four quadrants in any 36-month period;
 - 4.** more than one osseous graft for the same site in any 36-month period;
 - 5.** tissue conditioning, exceeding two procedures on the upper-per denture unit or two procedures on the lower-per denture unit in any 36-month period;
 - 6.** more than one topical application in any 36-month period of sealant for unrestored recently erupted permanent molars for patient through age 15;
 - 7.** more than one root canal treatment on the same tooth. (Additional treatments should be submitted with the appropriate American Dental Association Code and documentation); and
 - 8.** more than one treatment per lifetime for perio scaling/gingival inflammation.
- K.** Any charges for bitewing X-rays more than twice during any Plan Year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period unless a special need for these services at more frequent intervals is documented as medically necessary by the Dentist.
- L.** Any charges for replacement of an existing cast prosthesis, including crowns, partial or full removable denture or fixed bridgework or the addition of teeth to an existing partial, removable denture or bridgework, unless evidence is submitted and is satisfactory to the Third-Party Claims Processor that: (i) the addition of teeth is required for the initial replacement of one or more natural teeth; (ii) the existing denture or bridgework was installed at least five (5) years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or (ii) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that such replacement is delivered or installed within a period of twelve (12) consecutive months (subject to sub-paragraph E above) following the date of installation of the immediate temporary denture.
- M.** Any charges for space maintainers for prematurely lost deciduous teeth if the Covered Person has attained age 19.
- N.** Any medical/dental procedures determined by the medical/dental staff of the Third-Party Claims Processor, with appropriate consultation, to be experimental or investigational or not accepted medical/dental practice. Experimental or investigational procedures are those medical/dental procedures, supplies, devices or drugs, which at the time provided or sought to be provided:

1. Are not recognized as conforming to accepted dental practice in the relevant medical specialty or field of medicine; or
 2. The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
 3. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes; or
 4. Is not demonstrated to be as beneficial as established alternatives; or
 5. Has not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
 6. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.
- O.** Any service or supply rendered by a member of the Covered Person's immediate family (parent, child, spouse, sibling, grandparent, or in-law).
- P.** Any charges for services or supplies for:
1. Crowns, when only for preventive purposes or due to erosion, abrasion or attrition;
 2. Myofunctional therapy (e.g., correction of tongue thrusting);
 3. The purpose of altering vertical dimension;
 4. Splinting, including extra abutments for bridges; or
 5. Topical application of sealant per tooth for unrestored, recently erupted molars for patients age 16 and older.
- Q.** Any charges for services or supplies for orthodontic treatment:
1. For Employees;
 2. For Covered Children ages 19 and over (unless appliances were placed for Covered Children prior to age 19);
 3. In excess of the lifetime maximum shown in the Schedule of Dental Procedures and Allowed Amounts; or
 4. For services rendered subsequent to the month in which the individual's eligibility for coverage terminates.

- R. Any charges made directly to a Covered Person by a Dentist for dental supplies (i.e., toothbrush, mouthwash, dental floss etc).
- S. Any service or supply or appliance for the correction of temporomandibular joint (TMJ) syndrome, including office visits, splints, braces, guards, etc. Note that Medically Necessary surgical correction of TMJ disorders that meet the conditions of the State Health Plan is covered by the State Health Plan but not by Basic Dental. Consult the State Health Plan and Medi-Call for more details.

ARTICLE 9.

CONTINUATION OF COVERAGE

9.1 Incapacitated Dependent Child

The coverage of an unmarried incapacitated Child under this Plan may be continued after the Child reaches age 26. To continue coverage for an Incapacitated Dependent Child, the Employee's coverage must remain in force, and the Employee must provide proof of the Dependent Child's incapacity and dependency to the Plan Administrator within 31 days of the Dependent Child reaching the age of 26 and at such other reasonable times, but not more than annually.

9.2 Effect of Termination of Coverage

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

9.3 Surviving Spouse and/or Surviving Children

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

- A. The Surviving Spouse or Surviving Children must be covered under the Plan at the time of the Employee's or Retiree's death (other than any Child born to a female Surviving Spouse after the death of the Employee or Retiree but before the expiration of ten months after the date of death of the Employee or Retiree);
- B. **Termination.**
 - 1. The coverage of a Surviving Spouse shall terminate upon remarriage. If the remarriage occurs fewer than 36 months after the death of the Active Employee or Retiree, the Surviving Spouse may elect to continue coverage for the remainder of the 36 months from the date of death. The Surviving Spouse must pay the premiums for the coverage elected as detailed in paragraph 10.7.
 - 2. The existing coverage of any Surviving Children will not be affected by the remarriage of the Surviving Spouse, but such coverage is subject to all the terms, conditions, limitations, and exclusions of the Plan, including the requirement that coverage ceases on the date that the Surviving Child no longer meets the definition of a Dependent Child.

- D. Effective Date of Coverage.** Coverage is effective the first day of the month after the date of the court order or divorce decree.
- E. Duration of Coverage.** Coverage is effective only so long as the Employee or Retiree required to provide insurance coverage maintains insurance coverage through PEBA, and so long as required by the court order or divorce decree.
- F. Changes to Coverage.** A Former Spouse may make changes to their coverage during Open Enrollment. If a Former Spouse disenrolls from all insurance coverage through PEBA, the Former Spouse is not eligible to re-enroll at a later date.
- G. Billing and Payment.** Former Spouse coverage is billed at the full amount of the premium, as determined by PEBA. If a Former Spouse's coverage is cancelled due to non-payment, the Former Spouse is not eligible to re-enroll.
- H. Termination of Coverage.** A Former Spouse's coverage shall cease when the Employee or Retiree is no longer required to provide insurance coverage, the Plan is terminated with respect to all Former Spouses, when the Former Spouse's contribution becomes sixty (60) days past due, or for other reasons described in paragraph 10.9. In the event of coverage cancellation due to payment delinquency, coverage will terminate retroactively to the last day of the month for which the Former Spouse paid the full premium.
- I. Waiver of COBRA rights.** Upon the divorce that would entitle a Covered Dependent Spouse to continuation coverage pursuant to paragraph 9.4, the Covered Dependent Spouse shall, in accordance with applicable law, be provided with an opportunity to elect COBRA continuation coverage as described in Article 10. The Covered Dependent Spouse may elect COBRA continuation coverage or the continuation coverage in paragraph 9.4. A Covered Dependent Spouse shall not be eligible for the continuation coverage provided under paragraph 9.4 unless the Covered Dependent Spouse declines to elect continuation coverage under COBRA as set forth in Article 10.
- J. Continuation of Coverage.** Continuation of coverage is available to the Former Spouse if they lose their Former Spouse coverage as described below:

 - 1.** The Former Spouse may elect continued coverage for up to 18 months if the Former Spouse loses coverage under this paragraph because the Employee through whom the Former Spouse is provided coverage is terminated from employment (other than for gross misconduct) or has a reduction of hours worked so as to render the Active Employee ineligible for coverage.
 - 2.** The Former Spouse may elect continued coverage for up to 36 months if the Former Spouse loses coverage under this paragraph due to the death of the Employee or Retiree through whom the Former Spouse is provided coverage.
 - 3.** In the event of a disability determination, the Former Spouse is entitled to 29 months of continuation coverage if the Former Spouse provides notice of the determination of disability before the end of 18 months of coverage and within 60 days of the later of these dates: (i) the date of the SSA Disability determination notification; (ii) the date of the event that triggered the 18 months of continuation of coverage; (iii) the date on which

the Former Spouse is informed of the responsibility to notify the Plan of the disability determination; or (iv) the date the Former Spouse lost coverage or would lose coverage because of the event that triggered the 18 months of continuation of coverage.

Continuation of coverage is not automatic. Coverage must be elected within 60 days of the date coverage ceases because of the Employee's or Retiree's loss of coverage or the date the Former Spouse is sent notice of the right to elect continuation of coverage.

ARTICLE 10.

COBRA

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

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

10.2 Qualifying Event

A Qualifying Event is any one of the following:

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

10.3 Qualified Beneficiary

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

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

10.4 Notice by Employee, Spouse or Child

- A. Qualifying Event.** In cases of divorce or legal separation of the Employee or Retiree from a Spouse, or a Child ceasing to qualify as an eligible Dependent under the Plan, the Employee or eligible Dependent is responsible for notifying the benefits office of the Employer or the Plan Administrator within 60 days after the later of (i) the date of the Qualifying Event, or (ii) the date the Dependent would lose coverage on account of the Qualifying Event.

If the Plan Administrator is not notified within 60 days of the happening of either event, the Dependent will not be given the opportunity to continue coverage.

- B. Disability.** An Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act, either before the Qualifying Event or during the first 60 days of continued coverage under COBRA, must provide notice of the determination of disability before the end of the first 18 months of coverage to be eligible for up to 29 months of continuation coverage. The notice must be provided within 60 days after the latest of: (i) the date of the determination of disability under the Social Security Act; (ii) the date the Qualifying Event occurs; (iii) the date the Qualified Beneficiary loses or would lose coverage; or (iv) the date the Qualified Beneficiary is notified of their notice obligation. In addition, the Qualified Beneficiary must also notify the Plan Administrator within 30 days of any determination that the Employee or Dependent is no longer disabled.
- C. Second Qualifying Event.** In cases of a Second Qualifying Event under paragraph 11.8.E, the Qualified Beneficiary must notify the Plan Administrator within 60 days of the occurrence of the Second Qualifying Event.

10.5 Notice by Plan Administrator

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

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

The Covered Employee or Retiree and the Covered Employee's or Retiree's Dependent(s) shall be notified by the Plan Administrator or its designee of their right to elect continuation coverage: (i) in the event of the Covered Employee's or Retiree's death, termination, or reduction in hours and (ii) if the Covered Employee is notified by the Plan Administrator or its designee initially, in the event of divorce of the Covered Employee or Retiree from the Covered Employee's or Retiree's Spouse, disability, or in the event

of a Child ceasing to be a Dependent Child under the generally applicable requirements of the Plan, within 14 days of the date on which the Plan Administrator or its designee was notified of these Qualifying Events. Election form shall be sent by U.S. Mail, postage pre-paid, to the last known address of the Qualified Beneficiaries unless the Plan Administrator has been notified in writing to the contrary. The last known address shall be deemed to be the most recent address in the records of the Plan Administrator. In the event the Covered Employee/former Covered Employee changes address, it is their responsibility to notify the Plan Administrator of any change in address and the Plan Administrator shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to an Covered Employee/former Covered Employee who elected spousal coverage shall be sent with an envelope addressed to the Covered Employee and Spouse. Election forms sent to an Covered Employee/former Covered Employee that has one or more Dependent Children covered shall be addressed to the Covered Employee (if the Spouse was not covered) or to the Covered Employee and Spouse (if spousal coverage was elected), and each shall be deemed to include notification to any Dependent Children, unless the Plan Administrator has actual knowledge of a different address for a Dependent Child before the date the election form is mailed and provided further that any such notification to the Plan Administrator was in writing sent via either U.S. Mail or facsimile.

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

10.6 Election of Coverage

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

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

10.7 Premium Required

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

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

election. Failure to pay this premium on the date due shall result in cancellation of continued coverage back to the initial date coverage would have terminated as a result of the Qualifying Event.

- E. Without further notice from the Plan, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Plan within 30 days of the payment's due date, continued coverage will terminate. This 30 day grace period does not apply to the first contribution required under paragraph D.
- F. No claim will be payable under this paragraph for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.
- G. It is Qualified Beneficiary's responsibility to pay the premium on time. If the Plan Administrator provides a Qualified Beneficiary with payment reminders or payment coupons, but later ceases to do so, it still remains the Qualified Beneficiary's responsibility to make the premium payments on time even if the Qualified Beneficiary no longer receives the payment reminders or coupons, and even if the Qualified Beneficiary is not notified of the cessation of the payment reminders or coupons.

10.8 Maximum Length of Coverage

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

- A. **18 Months.** A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Plan for up to 18 months from the date of the Qualifying Event.
- B. **36 Months.** A Qualified Beneficiary who loses coverage due to the Covered Employee's or Retiree's death, divorce, or legal separation, and Dependent Children who have become ineligible for coverage, may continue coverage under the Plan for up to 36 months from the date of the Qualifying Event. In the event of the Covered Employee's death, the Spouse and Child are entitled to continuation coverage as described in Article 9 above in lieu of COBRA continuation coverage (see paragraph 9.4).
- C. **Medicare.** If a Covered Employee became entitled to Medicare benefits less than 18 months before the Participant's employment ended or their hours were reduced, the Spouse and Children of the Covered Employee may continue coverage under the Plan for up to thirty-six 36 months from the date of the Medicare entitlement
- D. **Disability.** In the event of a disability determination, this Qualified Beneficiary is entitled to 29 months of continuation coverage if the Qualified Beneficiary provides notice as required in paragraph 10.4.B.
- E. **Second Qualifying Event.** If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum continuation coverage is 18 or 29 months, and a second Qualifying Event occurs during that 18 or 29 month period, all individuals who were Qualified Beneficiaries in

connection with the initial Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event may elect to continue coverage under the Plan for up to 36 months from the date of the first Qualifying Event, if the Qualified Beneficiary provides notice as required in paragraph 10.4.C.

For example, this extension may be available to the Spouse and any Dependent Children who are already receiving continuation coverage if the Covered Employee or former Covered Employee dies, or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

10.9 Early Termination of Continuation Coverage

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

- A.** The date the State or the Employer associated with the Qualified Beneficiary ceases to provide any group dental plan to any Employee;
- B.** The date, including any grace period provided herein, the Qualified Beneficiary fails to make any required payment; and
- C.** For disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer disabled.

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

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

10.10 Persons on Military Leave

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

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

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

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

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

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

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

The Employer shall promptly reinstate Plan coverage when a Covered Employee is reemployed after Service in the Uniformed Service; provided; however, a request to reinstate Plan coverage must be made by the Covered Employee within 30 days of reemployment (presuming the Covered Employee has sought reemployment with the Plan in compliance with 20 CFR Part 1002, Subpart C). If no request is made within this time period, no coverage shall be reinstated under the Plan. When a Covered Employee's coverage

under the Plan is reinstated, they will not be subject to any exclusion or waiting periods. However, this rule does not apply to any conditions that were Incurred or that were aggravated during the Covered Employee's service in uniformed services.

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

ARTICLE 11.

CLAIMS PROCEDURE

11.1 Authority

Pursuant to Section 1-11-710(C) of the South Carolina Code, claims must be resolved by the procedures established under the Plan, which will provide the exclusive remedy for these claims. These claims will be subject only to appellate judicial review consistent with the standards provided in Section 1-23-320.

11.2 Voluntary Pre-Treatment Estimate

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

11.3 Making a Claim for Benefits

- A.** A Covered Person will present an identification card when applying for services covered under this Plan.
- B.** Written notice of care on which a claim is based must be furnished to the Third-Party Claims Processor within 90 days of the beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, the Third-Party Claims Processor will furnish or cause to be furnished to the Covered Person a claim form. If the claim form is not furnished within 15 days after the receipt of the notice by the Third-Party Claims Processor, the Covered Person will be deemed to have complied with the requirements of this Plan as to proof of loss, if the Covered Person submits

written proof covering the character and extent of the loss within the Plan time fixed for filing proof of loss.

- C. A Covered Person must submit or cause to be submitted a claim, on forms prescribed by the Plan Administrator or Third-Party Claims Processor, and will file it or cause it to be filed, along with all documentation, including medical records, required by the Plan Administrator or Third-Party Claims Processor. The claim will be deemed written proof of loss and written authorization from the Covered Person to the Third-Party Claims Processor to obtain any medical or financial records and documents useful to the Third-Party Claims Processor; however, the Third-Party Claims Processor is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied to it at the time the claim was processed.
- D. The claim must be received by the Third-Party Claims Processor within 90 days after the beginning of care; however, failure to file the claim within the 90-day period will not prevent payment of benefits if the Covered Person shows that it was not reasonably possible to timely file the claim, provided the claim is filed as soon as is reasonably possible, but in no event, except in the absence of legal capacity, later than 12 months after the service is rendered.
- E. Any party who submits medical or financial reports and documents to the Third-Party Claims Processor in support of a Covered Person's claim will be deemed to be acting as the agent of the Covered Person.

11.4 Payment of Claims

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

11.5 Right to Examine Covered Person

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

11.6 Allocation and Apportionment of Benefits

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

11.7 Review of Claims Denied in Whole or Part

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

A. Review by Third-Party Claims Processor

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

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

B. Appeal of Denial of Benefits to Plan Administrator

After the review provided in 11.7.A., a Covered Person, who is informed that the claim has been denied in whole or in part, or that benefits will not be paid, and who desires review of that determination, may request a review of that decision from the Plan Administrator. The Covered Person must make the request for review within 90 days after notice of the denial of benefits. Appeals may be brought only by the Covered Person at issue, their Authorized Representative (who cannot be a Provider, a Provider's Representative, Employer, or agent of the Employer) or a licensed attorney admitted to practice in South Carolina. The filing of this appeal shall be deemed to be consent for the Plan Administrator or its designee to review all medical records necessary for a determination of the appeal. The Plan Administrator may appoint up to five representatives to hear the appeal who are familiar with group dental benefits and Basic Dental and who were not involved in the initial denial of benefits.

The Covered Person may submit additional information for review within 30 days of filing their appeal. The Plan Administrator or its designee may request from the Third Party Claims Processor information it reviewed, including the pertinent dental records, and may request any additional information from the Third Party Claims Processor, the Covered Person, independent medical personnel, or other sources as in its judgment may be required to make a determination. The Plan Administrator or its designee shall consider all information submitted by the Covered Person and received in response to requests for additional information, along with the terms and conditions of

the Plan. The Plan Administrator or its designee shall issue a written decision within 180 days after the receipt of all material provided by the Covered Person and requested by the Plan Administrator or its designee. In the event the Covered Person does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.

The Plan Administrator or its designees, shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may deny the claim of the Covered Person. The Plan Administrator or its designee may approve the claim or such portion as is appropriate. The Plan Administrator or the Plan Administrator's designee must state in writing the provisions of the Plan justifying the result. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to 11.7.C.

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

C. Judicial Review

The exclusive remedy for the denial of benefits shall be as provided in paragraphs 11.7.A and B and by judicial review of that decision under S.C. Code Ann §1-23-380, as amended, as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 11.7.A and B above, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence, giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility, or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary, capricious, or in violation of applicable statutes.

11.8 Identification Cards and Plan Summaries

The Plan Administrator or Third-Party Claims Processor will issue to each Covered Person an identification card evidencing coverage. Plan summaries will be available on the Plan Administrator's website and, upon request, in print. If any amendment to this Plan shall materially affect any benefits described in such Plan summary, the Plan summary will be updated accordingly.

11.9 Privacy of Protected Health Information

- A.** The Plan shall use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by Health Insurance Portability and Accountability Act of 1996, as amended, (HIPAA) and its implementing regulations (45 CFR Parts 160-64). Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations. For purposes of this paragraph, Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the HIPAA, the Public Employee Benefit Authority, which established, and maintains, the Group Dental Benefits Plan for the Employees of the State of South Carolina, the Public School Districts and Participating Entities. For purposes of this paragraph, the terms "Payment" and "Health Care Operations" (as well as any other capitalized term not otherwise defined in this Plan) shall have the meanings provided under 45 CFR Parts 160-64.

- B.** The Plan may:
- 1.** Disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of: (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan.
 - 2.** Disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has unenrolled from a health insurance issuer offered by the Plan.
 - 3.** Disclose Protected Health Information to the Plan Sponsor to carry out Plan administration functions that the Plan Sponsor performs.
 - 4.** With an authorization from the Covered Person, disclose Protected Health Information to the Plan Sponsor for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Plan Sponsor.
 - 5.** Not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the Plan Sponsor except as permitted by this paragraph.
 - 6.** Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the Plan Sponsor as otherwise permitted by this paragraph unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer with respect to the Plan) may disclose Protected Health Information to the Plan Sponsor.
 - 7.** Not disclose Protected Health Information to the Plan Sponsor for the purpose of employment related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- C.** Prior to disclosing any Protected Health Information to the Plan Sponsor, the Plan Sponsor must certify (and the Plan is hereby amended to state) that the Plan Sponsor agrees to the following (and the Plan will require that the Plan Sponsor):
- 1.** Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;
 - 2.** Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information;
 - 3.** Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;
 - 4.** Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

5. Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
 6. Make Protected Health Information available to an individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;
 7. Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;
 8. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
 9. Make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
 10. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
- D. With respect to PHI, the Plan Administrator agrees to reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Plan Administrator on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that the Plan Administrator creates, receives, maintains, or transmits on behalf of the Plan;
 2. Ensure that the adequate separation as required by 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
 3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
 4. Report to the Plan any security incident of which it becomes aware.
- E. The Plan Administrator and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, (HIPAA) and its implementing regulations (45 CFR Parts 160-64). Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the HIPAA, PEBA, which established, and maintains, the Group Dental Benefits Plan

for the Employees of the State of South Carolina, the Public School Districts and Participating Entities.

Neither the Plan Administrator nor any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Third-Party Claims Processor, as agent of the Plan Administrator, is entitled to obtain such authorization for medical and hospital records as it may reasonably require from any provider of services incident to the administration of the benefits hereunder and the attending Dentist's certification as to the Medical Necessity for care or treatment.

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

ARTICLE 11A

REVIEW OF ADMINISTRATIVE CLAIMS BY PEBA

11A.1 Review of Administrative Claims under Article 11A

An "administrative claim" is an administrative decision by PEBA that does not involve the filing of a claim for benefits under Article 11 of the Plan, including, but not limited to, decisions concerning: an individual's eligibility to participate in the Plan; an individual's COBRA eligibility; enrollment matters; and dependent documentation. An individual may request review of PEBA's determination concerning administrative claims in accordance with the procedures set forth in this Article.

11A.2 Claims for Covered Medical Benefits Reviewed under Article 11

A claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with the Plan's procedure for filing a claim for benefits as set out in Article 11 of the Plan. If an individual files a claim for benefits under Article 11, appeals regarding the denial of the claim for benefits must be reviewed under the procedures set forth in Article 11 even if the basis for the denial of the claim is ineligibility to participate in the Plan or some other non-medical administrative reason.

11A.3 Informal Denial

If an individual or their employer's benefits administrator makes an informal oral or written request regarding an administrative claim that is denied by PEBA, the individual or their employer's benefits administrator may seek review of this informal denial by filing a written request for Departmental Review in accordance with paragraph 11A.4.

11A.4 Departmental Review

- A. An individual or their employer's benefits administrator may submit a written request to PEBA for Departmental Review of an administrative claim. The individual or their employer's benefits administrator may submit the written request for Departmental Review: (i) of a previous informal denial of the administrative claim under paragraph 11A.3; or (ii) as an initial request to PEBA regarding an administrative claim.
- B. The relevant department of PEBA shall review the written request and shall make a written determination regarding the administrative claim. If the written request concerning an administrative claim is denied, the written determination shall contain an appeals notice informing the subscriber that the Departmental Review denial may be appealed to the PEBA Administrative Appeals Committee within 90 days of the date of the Departmental Review denial.

11A.5 Administrative Appeals to PEBA

- A. The individual at issue, their authorized representative (who cannot be a Provider, a Provider's representative, Employer, or agent of the Employer), or a licensed attorney admitted to practice in South Carolina may appeal an administrative claim denied in whole or in part pursuant to Departmental Review under paragraph 12A.4 may appeal the denial to the PEBA within 90 days of the date of the Departmental Review denial. The individual may submit additional information for review within 31 days of filing their appeal.
- B. The Plan Administrator or its designee shall appoint up to five representatives who are familiar with group dental benefits and Basic Dental, and who have not been involved in any previous denial determination in the matter under consideration.
- C. The Plan Administrator or its designee shall consider all written information submitted, the terms and conditions of Basic Dental, all information received in response to requests for information, and other sources as in its judgment may be required to make a determination. The Plan Administrator or its designee shall issue a written decision within 180 days after the receipt of all material provided by the individual and requested by the Plan Administrator or its designee. In the event the individual does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.

The Plan Administrator or its designee shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may deny the claim of the individual. If the Plan Administrator or its designee agrees with the individual, they may approve the claim or such portion as is appropriate. The Plan Administrator or its designee must state in writing the provisions of the Plan justifying the result. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to paragraph 11A.6.

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

11A.6 Judicial Review

The exclusive remedy for the denial of an administrative claim shall be as provided in paragraphs 11A.3, 11A.4, and 11.5, and by judicial review of that decision under S.C. Code Ann. Section 1-23-380, as

amended, as provided by statute. No appeal may be brought until an individual exhausts the review procedure set forth in paragraphs 11A.4 and 11A.5, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary, capricious, or in violation of applicable statutes.

ARTICLE 12.

NOTICE

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

ARTICLE 13.

SUBROGATION RIGHTS

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

The Plan may enforce its reimbursement rights by requiring the Covered Person to cooperate and to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. The Plan will not pay fees or costs associated with a claim or lawsuit without its express written authorization. Any

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

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

End of Plan

APPENDIX A

2020 SCHEDULE OF DENTAL PROCEDURES AND ALLOWED AMOUNTS

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

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

"NC" indicates not covered.

**THIS INFORMATION WILL BE UPDATED WHEN IT
BECOMES AVAILABLE**