South Carolina Dental Association

High Option Vision Plan

Vision Coverage

February 1, 2023

VISION
PLAN OF BENEFITS

South Carolina

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

MGVint (Rev. 01/20)

Dear Member:

BlueCross BlueShield of South Carolina (BlueCross) is pleased to provide your Vision Plan of Benefits.

Please refer to the Benefits outlined in this Plan of Benefits for all your vision care coverage.

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

IMPORTANT INFORMATION ABOUT YOUR VISION COVERAGE

The Benefits you receive will depend on whether the Provider of vision services is an In-Network Provider or Out-of-Network Provider. You will receive the maximum Benefits that can be paid if you use In-Network Providers. The amount you have to pay will increase when you do not use In-Network Providers.

If you use an Out-of-Network Provider, you have no protection from balance billing from the Provider.

HOW TO GET HELP

How to get help with vision questions:

- Dial 1-866-939-3633

Healthy® Vision:

The Corporation provides you with access to ***Healthy Vision***, a managed care vision product. Healthy Vision is a product of EyeMed. EyeMed is an independent company that provides vision benefit services on behalf of BlueCross. Call 1-866-939-3633 to locate Providers, answer Plan specific Benefit questions, report issues or complaints and Plan limitations and exclusions. Automated information is available twenty-four (24) hours a day, seven (7) days a week.

You can also access EyeMed at www.eyemed.com to view Benefit information and access or print an Explanation of Benefits (EOB).

HOW TO FILE CLAIMS

In-Network Providers have agreed to file claims for vision care services they rendered to you. If you choose to use an Out-of-Network Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an EOB through www.eyemed.com or by contacting EyeMed's customer service. The EOB explains who provided the care, the kind of service or supply received, the amount billed and the amount paid. It also shows the reasons for denying or reducing a claim. Please see this Plan of Benefits for more information.

Fees charges by a Provider for services other than a covered Benefit must be paid in full by the Member to the Provider. Such fees or materials are not covered under this Plan of Benefits. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

If you receive services from an Out-of-Network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums outlined in the Vision Schedule of Benefits. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC.
Attn: OON Claims
P.O. Box 8504
Mason, Ohio 45040

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-939-3633.

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

SCHEDULE OF BENEFITS

Policyholder: South Carolina Dental Association
High Option Vision Plan
Plan of Benefits Effective Date: February 1, 2023

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

To maximize your Benefits, seek vision services from an In-Network Provider. Please access EyeMed's website at www.EyeMed.com to find out if your Provider is an In-Network Provider.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**	
Probationary Period:	Coverage for new Employees hired following the Plan of Benefits Effective Date will commence on the first of the month following the probationary period designated by each Policyholder.
In addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	A Child under the age of twenty-six (26).
Actively at Work: **Minimum hours per week:** **Minimum weeks per year:**	 At least thirty (30) hours per week. At least forty-eight (48) weeks per year.
Any Copayments must be met before any expenses for Covered Services can be paid. This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Frequency. The Anniversary Date is 02/01.	

VISION SCHEDULE OF BENEFITS (Healthy Vision)		
Vision Care Services	**In-Network Providers**	**Out-of-Network Providers Reimbursement**
Comprehensive Exam with dilation as necessary	$15 Copayment	$35
Contact lens fit and follow-up:		
Standard contact lens fit and follow-up visit	$0	$40
Premium contact lens fit and follow-up visit	$55	$40
Frames (any available frame at Provider location)	$110 Allowance, 20% off balance over $110	$55
Standard plastic lenses:		
Single vision	$0 Copayment	$25
Bifocal	$0 Copayment	$40
Trifocal & Lenticular	$0 Copayment	$55
Standard Progressive	$65 Copayment	$40
Premium Progressive	$65 Copayment, 20% off retail less $120 Allowance	$40
Lens options:		
UV treatment	$15	Non-Covered
Tint (solid and gradient)	$15	Non-Covered
Standard plastic scratch coating	$15	Non-Covered
Standard polycarbonate	$40	Non-Covered
Standard anti-reflective coating	$45	Non-Covered
Premium anti-reflective	20% off retail price	Non-Covered
Photochromic / transitions plastic	20% off retail price	Non-Covered
All other lens options	20% off retail price	Non-Covered

Vision Care Services	In-Network Providers	Out-of-Network Providers Reimbursement
Contact lenses (contact lens allowance includes materials only):		
Conventional	$110 Allowance, 15% off balance over $110	$88
Disposable	$110 Allowance, 0% off balance over $110	$88
Medically Necessary	$0 Copayment, Paid in Full	$200
Frequency:		
Examination	Once every twelve (12) months	
Frame	Once every twelve (12) months	
Lenses or contact lenses	Once every twelve (12) months	

TABLE OF CONTENTS

ARTICLE I - DEFINITIONS

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

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

Adverse Benefit Determination: a claim denial, Benefit or payment reduction or termination of vision services.

Allowance: the maximum dollar amount of coverage for frames, lenses, lens options or contact lenses under this Plan of Benefits. The Allowances act like a credit toward the retail price. So long as the Member selects eyewear having a retail price that is less than or equal to the Allowance, the Member will incur no out-of-pocket expense for eyewear at the time of service, apart from any applicable Copayment. If the selected eyewear has a retail price that exceeds the Allowance, the Member will be responsible only for the balance (i.e. retail price minus the Allowance). Under select Group Vision Plans, the balance may be discounted.

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

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

Benefit Frequency: the period of time in which a Benefit is payable as set forth on the Schedule of Benefits. The Benefit Frequency begins on the Plan of Benefits Effective Date. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Benefit(s): vision care services or supplies that are:

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

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

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

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

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

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

Comprehensive Eye Examination: a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one (1) session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Copayment: the designated amount, if any, shown in the Schedule of Benefits which each Member must pay to a Provider before Benefits are payable per Benefit Frequency.

Corporation: BlueCross BlueShield of South Carolina.

Covered Services: services provided to the Member which are included on the Schedule of Benefits, subject to applicable Copayments and maximum amount limitations.

Dependent(s): an individual who is:

1. An Employee's Spouse;

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

3. An Incapacitated Dependent.

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

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

Formulary: a list, provided by EyeMed, of Vision Materials and contact lenses which are covered under the Policy and preferred for use.

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

Group Vision Plan: the employee benefit plan established, administered and/or sponsored by the Policyholder to provide vision Benefits to Employees and/or their Dependents directly or through insurance, reimbursement or otherwise.

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

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

Incapacitated Dependent: a Child who is:

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

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

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

In-Network Provider: a Provider who has signed a Preferred Provider Agreement with the PPO.

Low Vision: a severe visual problem that is not correctable with standard lenses and:

1. when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lens prescription; or,

2. when there can be a demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Aids: supplies that are classified as follows:

1. Spectacle-mounted magnifiers: a magnifying lens is mounted in spectacles (this type of system is called a microscope) or on a special headband. This allows use of both hands to complete the close-up task, such as reading;

2. Handheld or spectacle-mounted telescopes: these miniature telescopes are useful for seeing longer distances, such as across the room to watch television, and can also be modified for near (reading) tasks;

3. Handheld and stand magnifiers: these can serve as supplements to other specialized systems and are convenient for short-term reading of such things as price tags, labels and instrument dials. Both types can be equipped with lights; or,

4. Video magnification: table-top (closed-circuit television) or head-mounted systems enlarge reading material on a video display. Some systems can be used for distance viewing tasks. These are portable systems and can be used with a computer or Computer Display. Image brightness, image size, contrast, foreground/background color and illumination can be customized.

Low Vision Supplemental Testing: diagnostic evaluation beyond the Comprehensive Eye Examination and includes a history of functional difficulties that involves such things as reading, activities in the kitchen, glare problems, travel vision, the workplace, television viewing, school requirements, hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken of the Member's visual acuity using special low vision test charts which include a larger range of letters or numbers to more accurately determine a starting point for assessing the level of impairment. Visual fields may also be evaluated. A specialized refraction must be performed with each eye thoroughly examined. The eyecare professional may prescribe various treatment options, including Low Vision Aids, as well as assist the Member with identifying other resources for vision and lifestyle rehabilitation.

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

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

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

A Medical Child Support Order must clearly specify:

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

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

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

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

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

1. The name of the issuing agency;

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

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

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

Medical Supplies: supplies that are:

1. Prescribed by a Provider acting within the scope of his or her license;

2. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not be included as part of the treatment received by the Member); and,

3. Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

Medically Necessary Contact Lenses:

1. Keratoconus where the Member is not correctable to 20/30 in either or both eyes using standard spectacle lenses or the Provider attests to the specified level of visual improvement;

2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;

3. Anisometropia of 3D in spherical equivalent or more; or,

4. Vision for a Member can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

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

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

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

Out-of-Network Provider: a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Plan: any program that provides benefits or services for vision care, including:

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

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

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits.

Plan Administrator: the entity charged with the administration of the Group Vision Plan. The Policyholder is the Plan Administrator of the Group Vision Plan.

Plan of Benefits: this document which reflects the Benefits offered under the Group Vision Plan based on the Benefits Checklist. The Plan of Benefits includes the Schedule of Benefits. Policyholder agrees that the Plan of Benefits will, at a minimum, be incorporated as a part of the Group Vision Plan.

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

Plan Sponsor: the party sponsoring the Group Vision Plan. The Policyholder is the Plan Sponsor of the Group Vision Plan.

Policy: the policy issued to the Policyholder. The Policy number is shown on the Employee's Identification Card.

Policyholder: the employer named as the policyholder in the face page of the Policy and in the Employee's Identification Card.

Policyholder's Effective Date: the date the Corporation begins to provide Services under the Policy.

Preferred Provider Agreement: an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization (PPO): a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Preferred Provider Organization (PPO) Service Area: the geographical area where the PPO is located.

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

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

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

Provider: a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

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

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

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

Qualifying Event: for continuation of coverage purposes under Article VI, a Qualifying Event is any one of the following:

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

2. Death of the Employee;

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

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

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

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

Refraction: a diagnostic test to determine the presence or absence of any refractive error (nearsightedness, farsightedness or astigmatism). Refraction includes the writing of a prescription by the Provider for any refractive error.

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

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

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

Vision Examination: any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials: those materials shown on the Schedule of Benefits which are used to aid in the correction of vision. Vision Materials include, but are not limited to, lenses, lens options, frames and contact lenses.

ARTICLE II – ELIGIBILITY FOR COVERAGE

A. ELIGIBILITY

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

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

   a. Is Actively at Work; and,

   b. Has completed the Probationary Period.

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

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

B. ELECTION OF COVERAGE

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

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

C. COMMENCEMENT OF COVERAGE

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

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

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

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

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

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

3. Dependents Resulting from Marriage.

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

4. Newborn Children.

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

5. Adopted Children.

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

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

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

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

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

D. DEPENDENT CHILD'S ENROLLMENT

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

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

E. MEMBERSHIP APPLICATION

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

F. MEMBER CONTRIBUTIONS

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

G. DISCLOSURE OF MEDICAL INFORMATION

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

ARTICLE III – BENEFITS

A. PAYMENT

The payment for Benefits is subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. The Corporation will only pay for Benefits:

1. Performed or provided on or after the Member Effective Date;

2. Performed or provided prior to termination of coverage;

3. Provided by a Provider, within the scope of his or her license;

4. That are not subject to an exclusion under Article IV of this Plan of Benefits; and,

5. After the payment of all required Copayments.

The amount payable for Benefits is determined as set forth in this Plan of Benefits and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowance.

B. ASSIGNMENT

Benefits under the Policy may not be assigned.

C. SPECIFIC COVERED BENEFITS

If all of the following requirements are met, the Corporation will pay for the Benefits described in Article III (D):

1. All of the requirements of Article III must be met;

2. The Benefit must be listed in Article III;

3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits;

4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,

5. The Benefit must not be subject to one (1) or more of the exclusions set forth in Article IV.

D. BENEFITS

COMPREHENSIVE EYE EXAMINATION

A Member is eligible for one (1) Comprehensive Eye Examination in each Benefit Frequency.

IN-NETWORK PROVIDER BENEFITS

The Member must pay any Copayment or cost above the Allowance set forth on the Schedule of Benefits at the time the Covered Service is provided. Benefits will be paid to the In-Network Provider who will file a claim with EyeMed.

LOW VISION

A Member is eligible for Low Vision Supplemental Testing and Low Vision Aids if set forth on the Schedule of Benefits and if the Member has severe visual problems that are not correctable with standard lenses.

OUT-OF-NETWORK PROVIDER BENEFITS

The Member must pay an Out-of-Network Provider the full cost at the time of service is provided and file a claim with EyeMed. EyeMed will reimburse the Member for the Out-of-Network Provider Benefits up to the maximum dollar amount shown on the Schedule of Benefits.

VISION MATERIALS

If a Vision Examination results in a Member needing corrective Vision Materials for the Member's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as set forth on the Schedule of Benefits.

ARTICLE IV - EXCLUSIONS AND LIMITATIONS

THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE IV EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

ACTS OF WAR

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

PROVIDER FEES FOR NON-COVERED SERVICES

Fees charged by a Provider for services other than a covered Benefit must be paid in full by the Member to the Provider. Such fees or materials are not covered under the Policy.

VISION EXCLUSIONS

No Benefits will be paid for services or materials connected with or charges arising from unless specified in Article III or the Schedule of Benefits:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;

2. Medical and/or surgical treatment of the eye, eyes or supporting structures;

3. Any Vision Examination or Vision Materials;

4. Any Vision Examination, corrective eyewear or safety eyewear required by a Policyholder as a condition of employment;

5. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;

6. Plano (non-prescription) lenses and/or contact lenses;

7. Non-prescription sunglasses;

8. Two (2) pair of glasses in lieu of bifocals;

9. Services or materials provided by any other group benefit plan providing vision care;

10. Services rendered after the date a Member ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Member are within thirty-one (31) days from the date of such order; or,

11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

WORKERS' COMPENSATION

This Plan of Benefits is not a Workers' Compensation policy. This Plan of Benefits does not satisfy any requirement for coverage by Workers' Compensation Insurance.

ARTICLE V – TERMINATION OF THIS PLAN OF BENEFITS

A. GENERALLY

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

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

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

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

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

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

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

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

8. Upon the death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

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

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

3. During the Grace Period, the Corporation will pay for Covered Services for Benefits (including Prescription Drugs) obtained by Members during the Grace Period.

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

C. TERMINATION WHILE ON LEAVE

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

D. TERMINATION FOR LACK OF MEMBERSHIP

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

E. NOTICE OF TERMINATION TO MEMBERS

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

F. REINSTATEMENT

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

G. EXTENSION OF BENEFITS FOLLOWING TERMINATION

If this Plan of Benefits is terminated under this Article V(G), or a Member participating in this Plan of Benefits is terminated, all rights to receive Covered Services provided on or after the date of termination will automatically cease.

H. POLICYHOLDER IS AGENT OF MEMBERS

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

ARTICLE VI – CONVERSION AND CONTINUATION OF COVERAGE

A. CONVERSION FOR DIVORCED SPOUSES

Upon the entry of a valid order or decree of divorce between an Employee and such Employee's Dependent Spouse, the divorced Spouse shall be entitled (upon request) to a conversion policy, without evidence of insurability, upon submission of an application of insurance made to the Corporation within sixty (60) days following the divorce decree and upon payment of the appropriate Premium. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

B. CONTINUATION

1. State Law

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

2. COBRA

   a. Plan Administrator and Sponsor.

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

   b. Disabled Members.

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

      i. is determined to be disabled under Title II or XVI of the Social Security Act;

      ii. with a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Policyholder within:

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

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

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

   c. Notice of Qualifying Event by the Member.

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

d. Notice by the Policyholder to the Member.

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

e. Election of Coverage.

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

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

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

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

f. Premium Required.

The Member will be required to pay a Premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first Premium, which includes the period when coverage commenced, regardless of the date that the first Premium is due. Subsequent Premiums will be due monthly by the Premium due date. While a Grace Period is allowed, if Premiums are not paid by the end of the Grace Period, coverage will be canceled with no option for reinstatement.

g. Length of COBRA Coverage.

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

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

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

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

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

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

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

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

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

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

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

3. USERRA

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

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

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

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

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

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

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

C. QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

1. Procedural Requirements.

   a. Timely Notifications and Determinations.

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

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

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

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

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

      i. Shall be in writing;

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

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

c. Actions Taken by Fiduciaries.

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

2. Treatment of Alternate Recipients.

a. Under ERISA.

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

b. Direct Provision of Benefits Provided to Alternate Recipients.

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

c. Plan Enrollment and Payroll Deductions.

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

d. Termination of Coverage.

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

i. The date the Employee's coverage ends;

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

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

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

ARTICLE VII – ERISA RIGHTS

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

A. RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

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

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

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

B. CONTINUATION COVERAGE

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

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

D. ENFORCEMENT OF EMPLOYEE RIGHTS

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

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

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

E. ASSISTANCE WITH QUESTIONS

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

ARTICLE VIII - CLAIMS FILING AND APPEAL PROCEDURES

NOTICE OF CLAIM

Written notice of claim must be given to EyeMed within thirty (30) days after the occurrence or commencement of any loss covered by the Policy or as soon as is reasonably possible. Notice given by or for the Member to EyeMed at EyeMed's home office, to EyeMed's authorized administrator or to any of EyeMed's authorized agents with sufficient information to identify the Member will be deemed as notice to EyeMed.

CLAIM FORMS

EyeMed will furnish claim forms to the Member within fifteen (15) days after notice of claim is received. If EyeMed does not provide the forms within that time, the Member may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

PROOF OF LOSS

Written proof of loss must be furnished to EyeMed at EyeMed's home office within ninety (90) days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one (1) year from the time proof is required.

TIME PAYMENT OF CLAIMS

Any Benefit payable under the Policy will be paid immediately, but not more than thirty (30) days, upon receipt of due written proof of loss.

PAYMENT OF CLAIMS

All claims will be paid to the Employee, unless assigned. Any Benefits payable on or after the Employee's death will be paid to the Employee's estate.

ARTICLE IX - GENERAL PROVISIONS

AMENDMENT

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

AUTHORIZED REPRESENTATIVES

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

CLERICAL ERRORS

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

DISCLOSURE TO POLICYHOLDER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

        i. Pings on a party's firewall;

        ii. Port scans;

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

        iv. Denial-of-service attacks that do not result in a server being taken offline; and,
        v. Malware (e.g., worms, viruses).

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

B. Adequate Separation Between the Policyholder and the Group Vision Plan.

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

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

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

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

The Policyholder certifies that the Group Vision Plan contains the provisions outlined above.

GOVERNING LAW

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

IDENTIFICATION CARD

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

INCONTESTABILITY

The validity of this Plan of Benefits may not be contested after it has been in force for two (2) years from its date of issue. No statement relating to insurability, except fraudulent misstatements, made by any Member may be used in contesting the validity of the coverage with respect to which the statement was made after the coverage has been in force for a period of two (2) years unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude assertion at any time of defenses based upon the person's ineligibility for coverage under the Plan of Benefits or upon other provision in the Plan of Benefits.

INFORMATION AND RECORDS

The Corporation is entitled to obtain records and other information as it may reasonably require from any Member or Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the medical necessity for care or treatment. Payment for Benefits may be denied until the requested records, documentation or information is received.

LEGAL ACTIONS

No Member can bring an action at law or in equity to recover on the Policy until more than sixty (60) days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of six (6) years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Member resides, the limit is extended to meet the minimum time allowed by such law.

LIMITED-SCOPE VISION BENEFITS

This Plan of Benefits is a limited-scope vision Benefits Plan. The Benefits are substantially for the administration of Comprehensive Eye Examinations and dispensing Visions Materials and are provided under a separate policy, certificate or contract of insurance, or are otherwise not an integral part of a group health plan. If this Plan of Benefits is sold in conjunction with a health Plan Benefits then HIPAA portability regulations may apply. If applicable, Members must refer to the health Plan of Benefits for the appropriate HIPAA portability guidelines.

MEMBERSHIP APPLICATION

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

NEGLIGENCE OR MALPRACTICE

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

NOTICES

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

1. To the Corporation:

   BlueCross BlueShield of South Carolina
   P.O. Box 100300
   Columbia, South Carolina 29202

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

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

NO WAIVER OF THE CORPORATION'S RIGHTS

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

REPLACEMENT COVERAGE

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

RIGHT OF RECOVERY

If payment for claims exceeds the amount for which the Member is eligible under any benefit provision or rider of the Policy, EyeMed has the right to recover the excess of such payment from the Provider or the Employee.

INDEX

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

Non-Discrimination Statement and Foreign Language Access

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AMENDMENT

Association Name: South Carolina Dental Association
Association Number: 26-87009, 26-87014, 26-87016, 26-87017, 26-87025, 26-87042, 26-87043, 26-87044, 26-87045, 26-87046, 26-87047, 26-87052, 26-87053, 26-87063 and appropriate subgroups
Effective Date: February 1, 2023
Amendment: 1

The Plan of Benefits between the Policyholder and the Corporation is amended as follows:

ARTICLE I - DEFINITIONS is amended by the addition of the following terms:

Association: the professional association in which the Employer participates and which has established and sponsors the Group Vision Plan.

Employer: the entity which has elected coverage through a written agreement with the Association.

The definition entitled **COBRA Administrator** in **Article I – DEFINITIONS** is deleted in its entirety.

The following definitions in **Article I – DEFINITIONS** are deleted in their entirety and the following substituted therefore:

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

Policyholder: the Association named as the policyholder in the face page of the Policy and in the Employee's Identification Card.

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

Qualifying Event: for continuation of coverage purposes under Article VI, a Qualifying Event is any one of the following:

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

2. Death of the Employee;

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

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

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

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

Section E in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

E. MEMBERSHIP APPLICATION

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

The following exclusion in **ARTICLE IV – EXCLUSIONS AND LIMITATIONS** is deleted in its entirety and the following substituted therefore:

VISION EXCLUSIONS

No Benefits will be paid for services or materials connected with or charges arising from unless specified in Article III or the Schedule of Benefits:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;

2. Medical and/or surgical treatment of the eye, eyes or supporting structures;

3. Any Vision Examination or Vision Materials;

4. Any Vision Examination, corrective eyewear or safety eyewear required by an employer as a condition of employment;

5. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;

6. Plano (non-prescription) lenses and/or contact lenses;

7. Non-prescription sunglasses;

8. Two (2) pair of glasses in lieu of bifocals;

9. Services or materials provided by any other group benefit plan providing vision care;

10. Services rendered after the date a Member ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Member are within thirty-one (31) days from the date of such order; or,

11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Sections B(1) and B(2) in **Article V – TERMINATION OF THIS PLAN OF BENEFITS** are deleted in their entirety and the following substituted therefore:

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

2. If an Employer fails to pay its Premium after the Grace Period, this Plan of Benefits for that Employer shall terminate at the discretion of the Policyholder for nonpayment of Premium, without any prior notice to the Employer or Members, immediately after the last day of the Grace Period. Additionally, the Corporation retains the right to terminate this Plan of Benefits for the Policyholder, Employer and Members in the event the Policyholder fails to pay any or all of the Premium.

Section B(2) in **Article VI – CONVERSION AND CONTINUATION OF COVERAGE** is deleted in its entirety.

Section C(1)(b) in **Article VI – CONVERSION AND CONTINUATION OF COVERAGE** is deleted in its entirety and the following substituted therefore:

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

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

i. Shall be in writing;

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

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

Section C(2)(d) in **Article VI – CONVERSION AND CONTINUATION OF COVERAGE** is deleted in its entirety and the following substituted therefore:

d. Termination of Coverage.

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

i. The date the Employee's coverage ends;

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

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

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

Section B in **Article VII – ERISA RIGHTS** is deleted in its entirety and the following substituted therefore:

B. CONTINUATION COVERAGE

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

Section D(3) in **Article VII – ERISA RIGHTS** is deleted in its entirety and the following substituted therefore:

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

The section entitled **MEMBERSHIP APPLICATION** in **Article IX – GENERAL PROVISIONS** is deleted in its entirety and the following substituted therefore:

MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Policyholder. The Corporation will not accept Membership Applications directly from Employers, Employee or Dependent.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Association Name: South Carolina Dental Association
Association Number: 26-87009, 26-87014, 26-87016, 26-87017, 26-87025, 26-87042, 26-87043, 26-87044, 26-87045, 26-87046, 26-87047, 26-87052, 26-87053, 26-87063 and appropriate subgroups
Effective Date: February 1, 2023
Amendment: 2

The Plan of Benefits between the Policyholder and the Corporation is amended as follows:

Article VII – ERISA Rights is amended by the deletion of **Section C. PRUDENT ACTIONS BY PLAN FIDUCIARIES** in its entirety and the following substituted therefore:

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan are called “fiduciaries,” and have a duty to do so prudently and in the interest of the Members. The Policyholder is the fiduciary of this Plan of Benefits only as to those fiduciary duties it has not assigned and delegated to the Corporation. The Corporation is a fiduciary of this Plan of Benefits only as to those fiduciary duties it was assigned and delegated by Policyholder.

THIS IS AN AMENDMENT TO YOUR PRESENT VISION PLAN OF BENEFITS.

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