PLAN OF BENEFITS

FOR

INTRAMED Plus

infusion services

GROUP MEDICAL
&
DENTAL PLAN

Effective: October 1, 2014

ADMINISTRATIVE INFORMATION

Benefit Year:	Begins January 1st of each year and continues for 12 consecutive months through December 31st.
1. Plan Name:	**Intramed Plus, Inc., Health and Dental Plan**
2. Name and Address of the Employer establishing the Plan:	Intramed Plus, Inc. 112 Saluda Ridge Court, Suite 100 West Columbia, SC 29169
3. Employer's ID Number:	57-0929502
4. Plan Number:	501
5. Group Number:	788
6. Type of Welfare Plan:	Medical and Dental
7. Plan Funding:	Paid by the Employer and/or the Employee determined by the level of coverage (employee, employee spouse, family) selected.
8. Claims Administration:	Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator) PO Box 22557 Charleston, SC 29413 (843) 722-2115 / (800) 815-3314
9. Agent for Service of Legal Process:	Intramed Plus, Inc.
10. Plan Administrator Name:	Intramed Plus, Inc.
11. Named Trustee:	Intramed Plus, Inc.
12. Named Fiduciary:	Intramed Plus, Inc.
13. Plan Termination:	The Plan Administrator reserves the right, through action of its Board of Directors, to terminate, suspend, withdraw, amend or modify the Plan in whole or in part, with respect to any class or classes of employees, at any time, with proper notification and subject to the terms of the Plan and any applicable laws.
14. Plan Document	A full description of the medical benefits appears in the official Plan document which is the final authority. These papers may be examined in the company office of the Employer within 30 days after your written request is received by the Plan Administrator.

NOTICE FOR EMPLOYEES

It is the **Employee's responsibility** to ensure the Provider being seen is a current member of the Preferred Provider Organization (PPO) that is being utilized by the Plan. The employee should verify with the Provider before services are rendered as to whether the Provider is a participating member of the Plan's PPO. To verify whether your Provider is participating you may:

- Ask the Provider if they are a participating Provider in the below network(s).
- If available, review the appropriate website for Provider information (*)
- Call TCC Benefits Administrator (*)

The above noted resources with an (*) may have timing differences for when Providers are approved into the network and are terminating from the network. The preferable method of obtaining the most correct information would be asking your Provider.

For South Carolina resident employees and dependents the Blue Cross Blue Shield Preferred Blue Network is the PPO for this Plan. Employees and dependents residing outside the state of South Carolina may use the Private Health Care Systems (PHCS) Network as the Preferred Provider Organization (PPO). South Carolina residents traveling out of state who require sudden, unexpected or emergency medical care or treatment during the course of such travel may use the Private Health Care Systems (PHCS) network as the Preferred Provider Organization (PPO) so long as the purpose of the travel is not to seek the medical care in question.

NOTE: This group health Plan covers Medical & Dental services.

Because of the dramatic increase in the cost of medical care, group medical plans are being reshaped and structured to encourage and reward those covered individuals who are selective in their purchase of medical services.

We expect and encourage you to review this booklet which describes your benefit package. Be a selective medical consumer and assume the major role in keeping the cost of medical services at a minimum.

What can you do to get the most out of your Group Health Plan?

- Use Network Providers
  - This will have the biggest impact for you and your employer because you may receive discounted services that usually range 40-52%.

- Ask for prescriptions to be filled with generic drugs.

- Only go to the emergency room for a true emergency.
  - If appropriate, try the doctor's office or an urgent care center (example: Doctors Care, etc.) first before going to the emergency room.

- Pay attention to timing.
  - Once deductibles are met, try to schedule procedures and visits before the year is out.

- Use your preventive care benefit.
  - By having an annual exam, you can minimize future large dollar claims.

- Take advantage of Premier pharmacy discounts even on drugs that are not covered by your group health plan.

- Be a smart consumer and take into consideration the cost and quality of care you are searching for, there may be various options for services available.

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Please visit the website www.tccba.com and select QicLink Benefits Exchange (QBE) to:

- **View the status of your claim(s)**
- **View the status of your deductible and Out-of-Pocket maximums**
- **Order I.D. cards**
- **View an electronic version of your Plan of Benefits**
- **Leave customer service messages that will be responded to within 24 hours**

GRANDFATHERED HEALTH PLAN

Intramed Plus, Inc. health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your Health Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Intramed Plus, Inc.; 100 Saluda Ridge Court, Suite 100, West Columbia, SC 29169 (800) 733-3391 ext. 204. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

GENERAL INFORMATION

Your employer has established this Group Health Plan and the applicable benefits, rights and privileges for participating employees, ("Employees") and such Employees eligible Dependents. Benefits are provided through a fund established by the Employer.

PURPOSE
The purpose of this Plan of Benefits is to set forth the provisions of the Group Health Plan, which provide for the payment or reimbursement of all or a portion of eligible medical expenses. It is intended that the terms of this Plan of Benefits are legally enforceable and that the Plan of Benefits be maintained for the exclusive benefit of eligible Employees and their covered Dependents.

PLAN INTERPRETATION
The Plan Administrator has full discretionary authority to interpret and apply all Plan of Benefits provisions, including, but not limited to, all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Group Health Plan data, and perform other Group Health Plan connected services; however, final authority to construe and apply the provisions of the Plan of Benefits rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, shall be final and binding.

CONTRIBUTIONS TO THE PLAN
The Employer shall from time to time evaluate the costs of the Group Health Plan and determine the amount to be contributed by the Employer (if any) and the amount to be contributed (if any) by each covered Employee. The Group Health Plan will notify employees in writing of any changes.

PROTECTION AGAINST CREDITORS
No benefit payment under this Plan of Benefits shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, exception or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Employer shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Employer, in its sole discretion, may terminate the interest of such Participant or former Participant, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Employer may determine, any such application shall be a complete discharge of all liability with respect to such benefit payment.

TERMINATION OF PLAN
The Plan Administrator reserves the right at any time to terminate the Group Health Plan by a written instrument to that effect. All previous contributions by the Plan Administrator shall continue to be issued for the purpose of paying benefits under the provisions of this Plan of Benefits with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to covered Employees, until all contributions are exhausted.

PLAN IS NOT A CONTRACT
This Plan of Benefits constitutes the entire Group Health Plan. The Plan of Benefits will not be deemed to constitute a contract of employment or give any Employee of the Employer the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any employee.

MISSTATEMENT OF AGE
If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

LEGAL ACTIONS
No Participant may bring an action at law or in equity to recover on the Employer's Group Health Plan until such Participant has exhausted the administrative process (including the exhaustion of all appeals) as described in this booklet. No such action may be brought after the expiration of any applicable period prescribed by law.

ADMINISTRATIVE SERVICES ONLY
TCC Benefits Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Employer's Group Health Plan is a self-funded health plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT
Upon thirty (30) days prior written notice, the Employer may unilaterally amend this Plan of Benefits. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Notice of an amendment will be effective when addressed to the Employer. The Claims Administrator has no responsibility to provide individual notices to each Participant when an amendment to the Employer's Group Health Plan has been made.

AUTHORIZED REPRESENTATIVES
A Provider may be considered a Participant's authorized representative without a specific designation by the Participant when the Pre-Authorization request is for Urgent Care Claims. A Provider may be a Participant's authorized representative with regard to non-Urgent Care Claims only when the Participant gives the Claims Administrator or the Provider a specific designation, in a format that is reasonably acceptable to the Employer's Group Health Plan to act as an authorized representative. If the Participant has designated an authorized representative, all information and notifications will be directed to that representative unless the Participant gives contrary directions.

CLERICAL ERRORS
Clerical errors by TCC Benefits Administrator or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

DISCLOSURE OF PHI TO PLAN SPONSOR
The Employer's Group Health Plan will disclose (or will require TCC Benefits Administrator to disclose) Participant's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of paragraphs 1 and 2 of this section.

1. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.
    a. The Plan Sponsor will neither use nor further disclose Participant's PHI, except as permitted or required by the Plan Documents, as amended, or required by law.
    b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Participant PHI agrees to the restrictions and conditions of the Plan of Benefits, with respect to Participant's PHI.
    c. The Plan Sponsor will not use or disclose Participant PHI for employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.
    d. The Plan Sponsor will report Employer's Group Health Plan any use or disclosure of Participant PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
    e. The Plan Sponsor will make PHI available to the Participant who is the subject of the information in accordance with HIPAA.
    f. The Plan Sponsor will make Participant PHI available for amendment, and will on notice amend Participant PHI, in accordance with HIPAA.
    g. The Plan Sponsor will track disclosures it may make of Participant PHI so that it can make available the information required for the Employer's Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.
    h. The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of Participant PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
    i. The Plan Sponsor will, if feasible, return or destroy all Participant PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the

Employer's Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the Participant'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 Participant PHI, the Plan Sponsor will limit the use or disclosure of any Participant PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

j. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan.

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

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

   i. In determining how and how often Plan Sponsor shall report security incidents to Employer's Group Health Plan, both Plan Sponsor and Employer's Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Employer's Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:
      - Pings on a Party's firewall,
      - Port scans,
      - Attempts to log on to a system or enter a database with an invalid password or username,
      - Denial-of-service attacks that do not result in a server being taken off-line, and
      - Malware (e.g., worms, viruses)

   ii. Plan Sponsor shall, however, separately report to Employer's Group Health Plan (i) any successful unauthorized access, use, disclosure, modification, or destruction of the Group Health Plan's electronic PHI of which Plan Sponsor becomes aware if such security incident either (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 Group Health Plan's electronic PHI; or (c) results in a breach of availability of Group Health Plan's electronic PHI, 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 Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's electronic PHI.

2. Adequate Separation between the Plan Sponsor and the Employer's Group Health Plan.

   a. Certain classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to Participant PHI received from the Employer's Group Health Plan or business associate servicing the Employer's Group Health Plan.

   b. These Employees will have access to Participant PHI only to perform the plan administration functions that the Plan Sponsor provides for the Employer's Group Health Plan.

   c. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Participant PHI in breach or violation of or noncompliance with the provisions of this section to the Plan of Benefits. Plan Sponsor will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan, and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or

noncompliance on any Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

d. The Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures. Plan Sponsor certifies that the Plan of Benefits contains and that the Plan Sponsor agrees to the provisions outlined above.

GOVERNING LAW

The Employer's Group Health Plan (including the Schedule of Benefits) is governed by and subject to ERISA and any other applicable federal law. If ERISA or another federal law does not apply, the Employer's Group Health Plan 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 the Employer's Group Health Plan conflicts with such law, the Employer's Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Participant must present their Identification Card prior to receiving Benefits.

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

INFORMATION AND RECORDS

TCC Benefits Administrator and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

MEMBERSHIP APPLICATION

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

NEGLIGENCE OR MALPRACTICE

Claims Administrator and Employer do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Participant by a Provider is rendered or supplied by such Provider and not by Claims Administrator or the Employer. The Claims Administrator and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under the Employer's Group Health Plan may be given by United States mail, postage paid and addressed:

1. To Claims Administrator:
   Thomas H. Cooper & Co., Inc.
   P.O. Box 22557
   Charleston, SC 29413

2. To a Participant: To the last known name and address listed for the Employee. Participants are responsible for notifying TCC Benefits Administrator of any name or address changes within thirty-one (31) days of the change.

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

NO WAIVER OF RIGHTS
On occasion, TCC Benefits Administrator (on behalf of the Employer's Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Employer's Group Health Plan or Employer waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE
Each Participant must provide the Employer's Group Health Plan (and its designee, including TCC Benefits Administrator) and Employer with information regarding all other health insurance coverage to which such Participant is entitled.

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

PHYSICAL EXAMINATION
The Employer's Group Health Plan has the right to examine, at their own expense, a Participant whose Injury or sickness is the basis of a claim (whether Pre-Service, Post-Service, Concurrent or Urgent). Care. Such physical examination may be made as often as the Employer's Group Health Plan (through its designee, including TCC Benefits Administrator) may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

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

RESCISSION OF COVERAGE
A Participant and/or eligible Dependent's coverage will not be retroactively rescinded except in the case of fraud or intentional misrepresentation. In addition, Participants and eligible Dependents will be provided with advance notice of any rescission or termination, as required by federal law.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Promise

We understand the importance of handling your medical information with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your medical information is kept private. Federal law requires that we provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your medical information and your legal rights with respect to our use and disclosure of your medical information. We are required by law to follow the terms of the Notice currently in effect. This Notice is effective September 23, 2013, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. These changes will be effective for all medical information that we keep, including medical information we created or received before we made the changes. When we make a material change to our privacy practices, we will provide a copy of a new notice (or information about the changes to our privacy practices and how to obtain a new notice) in a mailing to members who are covered under our health plans at that time.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations
We may use and disclose your medical information for purposes of treatment, payment and health care operations.

Treatment: We may disclose your medical information to a physician or other health care professional to help him or her provide your treatment.

Payment: We may use or disclose your medical information for these and other activities related to payment:

- Paying claims from physicians, hospitals and other health care providers;
- Obtaining premiums;
- Issuing explanations of benefits to the named insured;
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities.

Health Care Operations: We may use or disclose your medical information in the normal course of conducting health care operations, including such activities as:

- Quality assessment and improvement activities;
- Reviewing the qualifications of health care professionals;
- Compliance and detection of fraud and abuse;
- Underwriting, enrollment and other activities related to creating, renewing or replacing a plan of benefits. We may not, however, use or disclose genetic information for underwriting purposes;
- Providing information to another entity bound by the federal Privacy Rules for its health care operations, in limited circumstances.

You and Your Family and Friends
We may use and disclose your medical information to communicate with you for purposes of customer service or to provide you with information you request. We may disclose your medical information to a family member, friend or other person to the extent necessary for him or her to assist with your health care or payment for your health care. Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we may, in the exercise of our professional judgment, determine whether the disclosure would be in your best interest. We may also use or disclose your medical

information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Your Employer or Organization Sponsoring Your Group Health Plan
We may disclose summary information and enrollment information to your employer (or other plan sponsor). Summary information is a summary of the claims history, claims expenses or types of claims that members of your group health plan have filed. The summary information will not include demographic information about you or others in the group health plan, but your employer or plan sponsor may be able to identify individuals from the summary information provided.

Disaster Relief
We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit
We may use or disclose our members' medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person;
- To coroners, medical examiners and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities;
- To correctional institutions regarding inmates;
- As authorized by state workers' compensation laws.

Your Authorization
We may not use or disclose your medical information without your written authorization, except as described in this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when a disclosure is required by law. We also must obtain your written authorization to sell your medical information to a third party or, in most circumstances, to send you communications about products and services. We do not need your written authorization, however, to send you communications about health-related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights

You have certain rights with respect to the medical information we maintain about you. To exercise any of these rights or to obtain more information about these rights (including any applicable fees), contact us using the information listed at the end of this notice.

Access
You have the right to inspect or receive a paper or electronic copy of your medical information, with some exceptions. To inspect or receive your medical information, you must submit the request in writing. If you request to receive a copy of your records, we are allowed to charge a reasonable, cost-based fee.

Disclosure Accounting
You have the right to request, in writing, a record of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment, health care operations, and as allowed by law. We will provide you with a record of such disclosures for up to the previous six years. If you request a record of disclosures more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request.

Restriction
You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. By law, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions will be made in writing and signed by a person authorized to make such an agreement for us.

Confidential Communications
You have the right to request, in writing that we communicate with you about your medical information by other means, or to another location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing.

Even if we agree to communicate with you in confidence, an explanation of benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

Amendment
You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

Notice of Breach
We are required to notify affected individuals following a breach of unsecured medical information.

Electronic Notice
You may request a written copy of this notice at any time or download it from our website.

Questions and Complaints

If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you believe we may have violated your privacy rights, you may submit a complaint to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information
Attn: Bruce Honeycutt, Privacy Officer
I 20 East @ Alpine Road (AX-E01)
Columbia, SC 29219

(803) 264-7258 (telephone)
(803) 264-7257 (fax)

ABOUT YOUR PLAN

Because of the dramatic increase in the cost of medical care, health plans encourage and reward those covered individuals who are selective in their purchase of medical services.

Your Employer expects and encourages you to review this booklet which describes your health plan. Be a selective medical consumer and assume the major role in keeping the cost of medical services at a minimum.

Your Employer has established a comprehensive Group Health Plan ("Plan") for its employees. Your Employer has retained the services of *Thomas H. Cooper & Co., Inc.* ("TCC Benefits Administrator") to process and pay health claims and to provide services in connection with the operation of this Plan of Benefits. TCC Benefits Administrator (also referred to as the "Claims Administrator") is located in Charleston, South Carolina.

TCC Benefits Administrator has contracted with the **BlueCross and BlueShield of South Carolina Preferred Blue** network as the Preferred Provider Organization ("PPO") for your group. Providers who participate in the PPO are called "PPO Providers".

Employees receiving service in South Carolina should use the BlueCross and BlueShield Preferred Blue network as the Preferred Provider Organization (PPO) for this Plan, go to www.southcarolinablues.com.

Employees residing outside of the State of South Carolina, or for employees and covered dependents traveling outside their respective home state, Private Healthcare Systems (PHCS) network should be used as the Preferred Provider Organization (PPO),go to www.phcs.com or call (888) 921-7427.

You will receive maximum benefits when you use PPO Providers and when you obtain authorization (when required) for services. You will pay more if you do not use PPO Providers or if you do not obtain prior authorization (unless an emergency). The following information explains what a PPO Provider is and how you obtain authorization from the Medical Services Department for services or supplies covered by your health plan.

It is your responsibility to ensure that your Provider is a PPO Provider. You should verify your Provider's status before services are rendered. To verify whether your Provider is a network Provider you may:

- Ask the Provider if they participate in the PPO.
- Review your Provider directory (*)
- If available, review the appropriate website for Provider information (*)
- Call Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator) (*)

The methods of verifying PPO participation that have an asterisk (*) may have timing differences between when a Provider is participating in the PPO or terminating from the PPO. The preferable method of obtaining the most correct information is to ask your Provider.

For South Carolina Employees, the Blue Cross and Blue Shield Preferred Blue Network is the PPO for this Group Health Plan.

PPO Providers including Hospitals, Skilled Nursing Facilities, home health agencies, hospices, doctors and other Providers of medical services and supplies (as listed in the Definitions section) have a written agreement with the PPO. Under their agreement with the PPO, PPO Providers will do the following:

- File all claims for Benefits or supplies with your Claims Administrator;
- Ask you to pay only the Deductible, per occurrence Copayments and Coinsurance amounts, if any, for Benefits;
- Accept the preferred allowance as payment in full for Covered Expenses; and
- Make sure that all necessary approvals are obtained from the Medical Services Department.

Non-PPO Providers including Hospitals, Skilled Nursing Facilities, home health agencies, hospices, doctors and other Providers of medical services and supplies are not under contract with the PPO. Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies, to file your own claims, and you will need to obtain any necessary approvals for benefits to be paid. In addition to Deductibles and Coinsurance, you may be responsible for the difference between the Non-PPO Provider's charge and the Allowed Amount for Covered Expenses.

Although Benefits are typically reduced when you use a Non-PPO Provider, Benefits provided by a Non-PPO Provider will be covered at the PPO Provider level under the following circumstances:

- In the event treatment is for an Emergency Medical Condition as defined in this Plan of Benefits and PPO Provider care is not available;
- Dependents who are living out-of-state;
- For treatment by a specialist when a PPO Provider specialist is not available; or
- For Non-PPO Provider Ancillary Services rendered in a PPO Provider Hospital.

CUSTOMER SERVICE

TCC Benefits Administrator is committed to helping you understand your coverage and obtain maximum benefits on your claims. If you have questions about your coverage, you may call or write TCC Benefits Administrator at the following:

TCC Benefits Administrator
Attn: Claims
P.O. Box 22557
Charleston, SC 29413
(843) 722-2115/(800) 815-3314

PRE-AUTHORIZATION / PRIOR APPROVAL OF TREATMENT

To ensure coverage under the Plan and to receive the maximum Benefits, the Medical Services Department or TCC Benefits Administrator must give advance approval for the services and equipment that require approval and for all Admissions.

Where to Call for Approval

For prior approval for medical or surgical treatment or an Admission, call the Medical Review Department at (888) 275-7146. These numbers are also on the back of your ID card. Be sure to keep your card with you at all times. Please do not call the TCC Benefits Administrator customer service department. A customer service representative cannot give prior approval.

All admissions require Preadmission Review or Emergency Admission Review, and Continued Stay Review. If Preadmission Review is not obtained for all Facility Admissions, room and board will be denied. If approval is not obtained for Emergency Admissions within 24 hours or by 5 p.m. of the next working day following the Admission, room and board will be denied.

Some outpatient services require Pre-Authorization Review. If Pre-Authorization is not obtained, appropriate Benefits will be paid after 50% reduction in the Allowed Amount.

- **Pre-Authorization Review** — A number of services and medical procedures require Pre-Authorization Review:
  - Inpatient Hospitalizations
  - MRI/CT and PET Scans
  - Durable Medical Equipment (over $2,000)
  - Organ Transplants
  - Physical, Occupational, Speech or Rehabilitation Therapy requiring more than 12 visits
- For more information about services and supplies that require Pre-Authorization Review, please see the *Covered Medical Expenses* section. If you have specific questions, please call or write TCC Benefits Administrator.

These numbers are also on the front of your ID card. Be sure to keep your card with you at all times.

When you or your Provider calls for review and approval, you will talk with a medical professional. He or she will ask you for the following information:

- Your name and ID number.
- The patient's name and relationship to you.
- The Provider's name, address and phone number.
- If applicable, the Hospital or Skilled Nursing Facility's name, address and phone number.
- The reason the requested service, supply or Admission is necessary.

After careful review, your Physician and Hospital will be notified whether the Admission or service is approved as Medically Necessary and how long the approval is valid.

Approval means only that a service may be Medically Necessary for treatment of the Participant's condition. **However, approval is not a guarantee that Benefits are payable or verification that Benefits are available. Benefits are subject to eligibility and all other Plan limitations and exclusions. The final determination will be made when TCC Benefits Administrator processes your claim(s).**

If you have any questions about whether a certain service will be covered, please contact TCC Benefits Administrator.

If you or a Dependent is undergoing a human organ and/or tissue transplant, written approval must be obtained in advance and the procedure must be performed by a Provider designated by your plan. **If these services are not pre-approved in writing or they are not done by a Provider designated by your plan then your plan will not pay any Benefits.**

If your Physician recommends services and supplies for you or your Dependent for any reason, make sure you tell your Physician that your health insurance plan requires advance approval. Preferred Providers will be familiar with this requirement and will get the necessary approvals.

If you or your Dependent does not use a Preferred Provider, it is your responsibility to obtain approval before receiving the service, supply or being admitted. If you do not get prior approval, then you will pay more of your own money for these services and supplies.

Please note that if your request for prior approval is denied, you may request further review under the guidelines set out in the *Appeal Procedures* section of this booklet.

Types of Approval

There are four different types of approval:

1. Preadmission
2. Emergency Admission
3. Concurrent Care
4. Pre-Authorization Review (as stated above)

Preadmission Review — Before you or a dependent are admitted to a Hospital or Skilled Nursing Facility, preadmission approval must be obtained. If you've just had a baby, approval must be obtained within 24 hours of your discharge if your Newborn is sick and must stay in the Hospital.

Penalty for not receiving appropriate approvals: If approval is not obtained or if the Admission is not approved and you or your dependent are still admitted, the Plan may not pay Benefits for any part of the room and board charges for a Preferred Hospital or Preferred Skilled Nursing Facility. While Preferred Providers are responsible for obtaining approval (and you may not be responsible for costs that result from failure to obtain pre-approval by a Preferred Provider), approval for Admission to a non-Preferred Provider facility is your responsibility and you will be responsible for 50% of the total allowable charge, in addition to other increased charges as a result of using a Non-Preferred Provider facility.

Emergency Admission — If you or a Dependent experiences an emergency Illness or Injury, go to the nearest emergency room right away or call 911 for help. TCC Benefits Administrator does not expect you to wait for approval before you go to the Hospital.

However, you must seek approval within 24 hours of the emergency Admission, or by 5 p.m. of the next working day following the Admission. (Exceptions may be made for reasons beyond your control.)

Penalty for not receiving appropriate approvals: If emergency admission approval is not obtained, or if the emergency Admission is not approved, the Plan may not pay Benefits for any part of the room and board charges for a Preferred Hospital or Preferred Skilled Nursing Facility. While Preferred Providers are responsible for obtaining approval (and you may not be responsible for costs that result from a failure to obtain pre-approval at a Preferred Provider), approval for emergency Admission to a non-Preferred Provider facility is your responsibility and you will be responsible for 50% of the total allowable charge, in addition to other increased charges as a result of using a Non-Preferred Provider facility.

Concurrent Care — It is possible that you or a Dependent may have to remain in the Hospital or Skilled Nursing Facility for a period longer than originally approved. If this is the case, concurrent care approval must be obtained.

Penalty for not receiving appropriate approvals: If concurrent care approval is not obtained, or if the concurrent care is not approved, the Plan may not pay Benefits for any part of the room and board charges for a Preferred Hospital or Preferred Skilled Nursing Facility. While Preferred Providers are responsible for obtaining approval (and you may not be responsible for costs that result from a failure to obtain pre-approval at a Preferred Provider), approval for concurrent care to a Non-Preferred Provider facility is your responsibility and you will be responsible for 50% of the total allowable charge.

Out-of-area Emergency Provision

If you or a Dependent receives care for an Emergency Medical Condition from a non-Preferred Provider, the Plan will pay for Benefits at a PPO Provider level if you meet all of these conditions:

- You were traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- You were treated for an Accidental Injury or new Emergency Medical Condition.

Benefits under this provision are subject to the Deductibles or Copayments, Coinsurance and all Plan of Benefits maximums, limits and exclusions.

If you have claims that meet all of these conditions, write or call the TCC Benefits Administrator customer service department. TCC Benefits Administrator will review your claims to determine if TCC Benefits Administrator can provide additional Benefits.

CLAIMS FILING PROCEDURES

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

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

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

    a. A claim form for each Participant. Participants can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via the Claims Administrator's website, www.tccba.com.
    b. Itemized bills from the Provider(s). These bills should contain all the following:
        i. Provider's name and address;
        ii. Participant's name and date of birth;
        iii. Participant's Identification Card number;
        iv. Description and cost of each service;
        v. Date that each service took place; and
        vi. Description of the illness or injury and diagnosis.
    c. Participants must complete each claim form and attach the itemized bill(s) to it. If a Participant has other insurance that already paid on the claim(s), the Participant should also attach a copy of the other Plan's explanation of benefits notice.
    d. Participants should make copies of all claim forms and itemized bills for the Participant's records since they will not be returned. Claims should be mailed to the Claims Administrator's address listed on the claim form.

4. The Claims Administrator must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Participant shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

5. Receipt of a claim by the Claims Administrator will be deemed written proof of loss and will serve as written authorization from the Participant to the Claims Administrator to obtain any medical or financial records and documents useful to the Plan of Benefits. The Plan of Benefits, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Claims Administrator in support of a Participant's claim will be deemed

to be acting as the agent of the Participant. If the Participant desires to appoint an Authorized Representative in connection with such Participant's claims, the Participant should contact the Claims Administrator for an Authorized Representative form.

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

   a. **Pre-Service Claim**
      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
      ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Participant will be sent notification within five (5) days of receipt of the claim.
      iii. An extension of fifteen (15) days is permitted if the Claims Administrator (on behalf of the Employer's Group Health Plan) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary the Claims Administrator will notify the Participant within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If the Claims Administrator does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Claims Administrator will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Claims Administrator receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal.

   b. **Urgent Care Claim**
      i. A determination will be sent to the Participant in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.
      ii. If the Participant's Urgent Care Claim is determined to be incomplete, the Participant will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Participant will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.
      iii. If the Participant requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Participant will be notified within twenty-four (24) hours of receipt of the request for an extension.

   c. **Post-Service Claim**
      i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.
      ii. An extension of fifteen (15) days may be necessary if the Claims Administrator (on behalf of the Employer's Group Health Plan) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary, the Claims Administrator will notify the Participant within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If the Claims Administrator does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Claims Administrator will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Claims Administrator receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal.

d. **Concurrent Care Claim**

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

7. Notice of Determination
   a. If the Participant's claim is filed properly, and the claim is in part or wholly denied, the Participant will receive notice of an Adverse Benefit Determination in the following manner:
      i. State the specific reason(s) for the Adverse Benefit Determination;
      ii. Reference the specific Plan of Benefits provisions on which the determination is based;
      iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
      i. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
      v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,
      vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
   b. The Participant will also receive a notice if the claim is approved.

APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. Participant has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:
   a. An appeal must be in writing by the Participant;
   b. An appeal must be sent (via U.S. mail) at the address below:

      Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator)
      PO Box 22557
      Charleston, SC 29413

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and
   d. An appeal must include the Participant's name, address, identification number and any other information, documentation or materials that support the Participant's appeal.
2. The Participant may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.
3. If the appealed claim involves an exercise of medical judgment, the Claims Administrator (on behalf of the Employer's Group Health Plan) will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.
4. The final decision on the appeal will be made within the time periods specified below:
   a. Pre-Service Claim
      The Claims Administrator (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.
   b. Urgent Care Claim
      The Participant may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Claims Administrator (on behalf of the Employer's Group Health Plan) will communicate with the Participant by telephone or facsimile. The Claims Administrator (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
   c. Post-Service Claim
      The Claims Administrator (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.
   d. Concurrent Care Claim
      The Claims Administrator (on behalf of the Employer's Group Health Plan) will decide the appeal of Concurrent Care Claims within the time frames set forth in paragraphs above (4) (a-c), depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.
5. Notice of Final Internal Appeals Determination
   a. If a Participant's appeal is denied in whole or in part, the Participant will receive notice of an Adverse Benefit Determination in the following manner:
      i. State specific reason(s) for the Adverse Benefit Determination;
      ii. Reference specific provision(s) of the Plan of Benefits on which the benefit determination is based;
      iii. State that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination;
v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
vi. Include a statement regarding the Participant's right to request an external review; and
vii Include a statement regarding the Participant's right to bring an action under section 502(a) of ERISA.

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

6. The Employer may retain the Claims Administrator to assist the Employer in making the determination on appeal. Regardless of its assistance, the Claims Administrator is only acting in an advisory capacity and is not acting in a fiduciary capacity. The Employer at all times retains the right to make the final determination.

C. EXTERNAL REVIEW PROCEDURES

1. After a Participant has completed the appeal process, a Participant may be entitled to an additional, external review of the Participant's claim at no cost to the Participant. An external review may be used to reconsider the Participant's claim if the Claims Administrator has denied, either in whole or in part, the Participant's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated.
2. After a Participant has completed the appeal process, (and an Adverse Benefit Determination has been made) such Participant will be notified in writing of such Participant's right to request an external review. The Participant should file a request for external review within four (4) months of receiving the notice of the Claims Administrator's decision on the Participant's appeal. In order to receive an external review, the Participant will be required to authorize the release of such Participant's medical records (if needed in the review for the purpose of reaching a decision on Participant's claim).
3. Within six (6) business days of the date of receipt of a Participant's request for an external review, the Claims Administrator will respond by either:
   a. Assigning the Participant's request for an external review to an independent review organization and forwarding the Participants records to such organization; or,
   b. Notifying the Participant in writing that the Participant's request does not meet the requirements for an external review and the reasons for the Claims Administrator's decision.
4. The external review organization will take action on the Participant's request for an external review within forty-five (45) days after it receives the request for external review from the Claims Administrator.
5. Expedited external reviews are available if the Participant's Physician certifies that the Participant has a serious medical condition. A serious medical condition, as used in this Section(C)(5), means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Participant's health in serious jeopardy. If the Participant may be held financially responsible for the treatment, a Participant may request an expedited review of the Claims Administrator's decision if the Claims Administrator's denial of Benefits involves Emergency Medical Care and the Participant has not been discharged from the treating Hospital.

LEGAL ACTIONS

No action at law or in equity can be brought against the Employer (Plan Sponsor) until sixty (60) days after the Claims Administrator receives a claim (proof of loss) and the Participant has exhausted the appeal process as described in the *Appeal Procedures* section of this Plan of Benefits. No such action can be brought against the Employer (Plan Sponsor) more than six (6) years after the Claims Administrator receives a claim.

CASE MANAGEMENT

COMPREHENSIVE CASE MANAGEMENT

In the event of a serious or catastrophic Illness or Injury, your Plan provides for a comprehensive case management program. The comprehensive case management program is a patient-centered approach to developing a comprehensive plan of cost effective health care. The services provided under the case management program include:

A. Evaluation and assistance for the Employee, their Physician, and family to help develop a plan of services to meet specific needs;

B. Assistance with obtaining unusual equipment or supply needs;

C. Assistance in home care planning and implementation;

D. Arrangements for needed nursing/caregiver services;

E. Providing help with assessment of rehabilitation needs and Provider arrangements;

F. Offering appropriate and effective alternative care/therapy suggestions for Mental Health Services and/or treatment for Substance Abuse as determined by medical care review;

G. Monitoring and assuring treatment programs and interventions for Mental Health Services and/or treatment for Substance Abuse; and

H. Functioning as an effective resource for information on treatment facilities and available care for Mental Health Services and/or treatment for Substance Abuse.

The case management program is voluntary and will not provide benefits in excess of those ordinarily available under the Plan.

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

In the course of the case management program, the Plan Administrator shall have the right to alter or waive the normal provisions of this Plan of Benefits when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Benefits provided under this section are subject to all other Plan of Benefit provisions. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Participant or any other Participant. Nothing contained in this Plan of Benefits shall obligate the Plan Administrator to approve an alternative treatment plan.

MEDICAL SCHEDULE OF BENEFITS

All benefits are subject to the Allowed Amount and Calendar Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. ***Percentages stated are those paid by the Plan.***

Unlimited Annual Maximum per Participant

Unlimited Lifetime Maximum

	IN NETWORK:	OUT OF NETWORK:
Calendar Year (C/Y) Deductible:		
Per Participant:	$500	$1,000
Per Family:	$1,000	$2,000

CALENDAR YEAR:
The C/Y for the Deductible and Out-of-Pocket accumulations is **January 1st through December 31st** of each year.

At least one family member must meet the Individual Deductible. The remaining Family Deductible may be accrued between all members. If two (2) or more Covered Family Members are injured in the same accident, only one Individual Cash Deductible will have to be paid each Calendar Year for all combined family expenses, due to that accident.

The amount of the deductible met during the (3) three months prior to the calendar year-end should be carried over to the new Calendar Year.

	IN NETWORK:	OUT OF NETWORK:
Maximum Out-of-Pocket Amount (excluding the Deductible):		
Per Participant:	$2,000	$4,000
Per Family:	$4,000	$8,000

The "**Out-of-Pocket"** Limit is the maximum dollar amount a Participant will pay for covered medical expenses in any one Calendar Year. Upon satisfaction of the Out-of-Pocket Limit, benefits for such Participant will be payable at 100% of the Allowed Amount. **The Out-of-Pocket Limit does not include Calendar Year Deductible, expenses incurred because of Cost Containment penalties, expenses incurred due to reduction of the allowed amount payment level, per-occurrence Co-payments, or Coinsurance and Deductible amounts if claim pays secondary.**

MEDICAL SCHEDULE OF BENEFITS

All benefits are subject to the Allowed Amount and Calendar Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. ***Percentages stated are those paid by the Plan.***

INPATIENT HOSPITAL EXPENSES: Pre-Authorization required	**IN NETWORK:**	**OUT OF NETWORK:**
Ancillary Charges:	80% after deductible	60% after deductible
Anesthesia:	80% after deductible	60% after deductible
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	80% after deductible	60% after deductible
Newborn Nursery:	80% after deductible	60% after deductible
Physical Rehabilitation Facility:	80% after deductible	60% after deductible
Physician Expenses:	80% after deductible	60% after deductible
Room and Board:	80% after deductible	60% after deductible
Skilled Nursing Facility: 60 days maximum per calendar year	80% after deductible	60% after deductible

OUTPATIENT EXPENSES:	**IN NETWORK:**	**OUT OF NETWORK:**
Anesthesia:	80% after deductible	60% after deductible
Cardiac Rehabilitation:	80% after deductible	60% after deductible
Diagnostic X-ray, Laboratory, Pathology, Radiology and Interpretation:	80% after deductible	60% after deductible
Elective Surgical Opinion:	80% after deductible	60% after deductible
Emergency Room Charges: Emergency Room treatment received within 72 hours of an accident or the sudden on-set of life threatening symptoms	80% deductible waived	80% deductible waived
Emergency Room for Non-Accident	80% after deductible	60% after deductible
Hospital and Physician Charges:	80% after deductible	60% after deductible
Physician Services:	80% after deductible	60% after deductible
Pre-Admission Testing:	80% after deductible	60% after deductible
Second Surgical Opinion:	80% after deductible	60% after deductible

PRIMARY CARE PHYSICIAN OFFICE EXPENSES:	**IN NETWORK:**	**OUT OF NETWORK:**
Primary Care Physician Includes General/Family Medicine, Pediatrician, Internist, OB-GYN: Physician Office Visit: Including Lab, X-ray, Pathology, Radiology, Surgery, supplies, and injections	100% after $25 copay	60% after deductible

SPECIALIST OFFICE EXPENSES:	**IN NETWORK:**	**OUT OF NETWORK:**
Physician Office Visit: Including Lab, X-ray, Pathology, Radiology, Surgery, supplies, and injections	100% after $25 copay	60% after deductible

OTHER SERVICES:	**IN NETWORK:**	**OUT OF NETWORK:**
Accident Related Dental Services:	80% after deductible	80% after deductible
All Other Benefits:	80% after deductible	60% after deductible
Allergy Injections, service and supplies:	100% after $25 copay	60% after deductible
Ambulance:	80% after deductible	80% after deductible
Chiropractic Care:	**Not covered**	**Not covered**
Dermatology & Podiatry:	100% after $25 copay	60% after deductible
Durable Medical Equipment: Pre-Authorization is required if over $2,000	80% after deductible	**Not covered**

MEDICAL SCHEDULE OF BENEFITS

All benefits are subject to the Allowed Amount and Calendar Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. ***Percentages stated are those paid by the Plan.***

OTHER SERVICES continued:	IN NETWORK:	OUT OF NETWORK:
Growth Hormone Therapy:	80% after deductible	**Not covered**
Home Health Care: Limited to 100 visits Maximum Per Calendar Year	80% after deductible	60% after deductible
Hospice Care:	80% after deductible	60% after deductible
Human Organ/Tissue Transplants:	80% after deductible	**Not covered**
Infertility Services:	**Not covered**	**Not covered**
Injectable Drugs Not Covered Under the Drug Plan:	80% after deductible	60% after deductible
Maternity Services: Routine Prenatal, Delivery, Postnatal Care	80% after deductible	60% after deductible
Outpatient Therapy: 40 Visits Maximum Per Calendar Year- Radiation Therapy and Chemotherapy; Renal Dialysis, Occupational Therapy, Physical Therapy and Speech Therapy: Pre-cert required after 12 visits.	80% after deductible	60% after deductible
Private Duty Nursing:	80% after deductible	60% after deductible
Prosthetic Devices:	80% after deductible	60% after deductible
Treatment of Temporomandibular Joint Dysfunction (TMJ):	**Not covered**	**Not covered**
Urgent Care:	100% after $50 copay	100% after $50 copay
Wisdom Teeth Extraction:	**Covered under Dental Plan**	**Covered under Dental Plan**

COLONOSCOPY:	IN-NETWORK	OUT OF NETWORK
Diagnostic Colonoscopy:	80% after deductible	60% after deductible
Routine Colonoscopy: After age 50	100% after $25 copay	**Not Covered**

WELLNESS SERVICES:	IN NETWORK:	OUT OF NETWORK:
Annual Gynecological Exam:	100% after $25 copay	**Not Covered**
Annual Physical Exam:	100% after $25 copay	**Not Covered**
Prostate Exam: (Covered for persons age 40 and older, once per Calendar Year)	100% after $25 copay	**Not Covered**
Well-Child Care:	100% after $25 copay	**Not Covered**

HUMAN ORGAN OR TISSUE TRANSPLANT PROCEDURES

When pre-approved and performed by a Provider designated by the Claims Administrator, Benefits are payable for covered expenses for medical and Surgical Services and supplies incurred while the Participant is covered under this Plan of Benefits for Human Organ/Tissue transplants as indicated in the following paragraphs. The Benefits related to Human Organ or Tissue Transplants are subject to the Deductible amount and Coinsurance percentage specified in the Medical Schedule of Benefits.

1. Benefits are available for human organ, tissue and bone marrow transplantation, subject to determination made on an individual, case by case basis, in order to establish medical necessity. Pre-Authorization must be obtained in writing from the Medical Services Department.

2. Benefits will be provided only when the Hospital and Physician customarily charge a transplant recipient for such care and services.

3. When only the transplant recipient is a Participant, the Benefits will be provided for the recipient. Benefits will also be provided for the donor under this Plan of Benefits to the extent that such Benefits are not provided under any other form of coverage. In no such case under the Plan of Benefits will any payment of a "personal service" fee be made to any donor. Only the necessary Hospital and Physicians' medical care and services expenses with respect to the donation will be considered for Benefits.

4. When only the donor is a Participant, the donor will receive benefits for care and services necessary to the extent that such benefits are not provided under any recipient who is not a Participant under this Plan of Benefits. The recipient will not be eligible for benefits when only the donor is a Participant.

5. When the recipient and the donor are both Participants, benefits will be provided for both in accordance with the respective Group Health Plan covered expenses.

Health care benefits for transplants include covered expenses such as patient work-up, pre-transplant care, the transplant, post-transplant care, and immunosuppressive drugs (while inpatient).

PRESCRIPTION DRUG BENEFITS

Outpatient prescription drugs will be covered in the following manner:

Through the **Premier** Prescription Drug Program:

- Participating Pharmacies:

Copay per Prescription regardless of the quantity (60-day supply maximum per prescription):

Generic Drugs	$ 5 copay, Plan pays 100%
Brand Names when Generic is Available	$35 copay, Plan pays 100%
Brand Name when Generic is not Available	$45 copay, Plan pays 100%

Specialty Drugs covered under same tiers as above base on prescription classification.

Note: The Prescription Drug Benefit co-payments do not apply to the deductible and/or out-of-pocket limitations. You are not required under your current contract, to purchase generic drugs; however, using generic drugs saves INTRAMED PLUS, INC. and ultimately you, the Employee money.

You do not have to complete any claim form or submit any paperwork. Premier is a totally electronic pharmacy network. This means that each time you obtain a prescription from a Premier pharmacy, the claim is automatically submitted for you by the pharmacy. Premier has participating pharmacies across the United States and any pharmacy, not already a member, may join free of charge. If you choose not to obtain your prescriptions from a Premier pharmacy, you will not be reimbursed for your expenses and your claims will not be applied toward you deductible. Your employer has a complete list of the participating pharmacies or you may call Premier at 1-800-247-4526 for assistance.

ONLY PRESCRIPTIONS OBTAINED FROM PARTICIPATING PREMIER PHARMACIES ARE COVERED BY YOUR PRESCRIPTION PLAN. YOU WILL NOT BE REIMBURSED IF YOU PAY CASH AND DO NOT USE YOUR PREMIER CARD. IF YOU HAVE ANY QUESTIONS, CALL PREMIER BEFORE YOU PURCHASE YOUR MEDICATION AS INDICATED ON THE ID CARD.

COVERED PRESCRIPTION DRUG BENEFITS

All legend drugs or controlled substances which bear the statements "Caution: Federal law prohibits dispensing without a prescription;" except those listed under "Excluded Drugs".

Compound medications in which at least one ingredient is a legend drug.
Insulin, Insulin Syringes and lmitrex

EXCLUDED PRESCRIPTION DRUGS

The following drug categories are **NOT** covered by your pharmacy plan:

Over-the-counter medications (Non-Legend Drugs)	All Contraceptives
Diabetic Supplies	Smoking Deterrents
Diagnostics (Example: Chemstrips)	Fertility Medications
Cosmetic Drugs	Anti-Obesity
Ostomy Supplies	Medical Supplies & Apparatus
Experimental & Investigational Drugs	Vitamins, except Pre-Natal and those with Fluoride

MEDICARE CREDITABLE COVERAGE LETTER

Important Notice from Intramed Plus, Inc.
About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Intramed Plus, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Intramed Plus, Inc. has determined that the prescription drug coverage offered by the Intramed Plus, Inc. is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Intramed Plus, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

Current Drug Benefits:

Copay per Prescription regardless of the quantity (60-day supply maximum per prescription):

Generic Drugs	$ 5 copay, Plan pays 100%
Brand Names when Generic is Available	$35 copay, Plan pays 100%
Brand Name when Generic is not Available	$45 copay, Plan pays 100%

Specialty Drugs covered under same tiers as above base on prescription classification.

Group Number:	788
Group Name:	Intramed Plus, Inc.
Effective Date of Coverage:	October 1, 2014

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Intramed Plus, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Intramed Plus, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at ww.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).
Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2014
Name of Entity/Sender:	Intramed Plus, Inc.
Contact—Position/Office:	Human Resources Department
Address:	112 Saluda Ridge Court, Suite 100 West Columbia, SC 29169
Phone Number:	(803) 794-0200

COVERED MEDICAL EXPENSES

1. Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. The Employer pays the percentage of Billed Charges for Covered Expenses as indicated on the Schedule of Benefits. Covered Expenses will only be paid for Benefits:

a. Performed or provided on or after the Participant Effective Date;
b. Performed or provided prior to termination of coverage;
c. Provided by a Provider, within the scope of his or her license;
d. For which the required Pre-Admission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from the Claims Administrator) (the Participant should refer to the Schedule of Benefits for services that require Pre-Authorization;
e. That is Medically Necessary;
f. That are not subject to an exclusion under Medical Exclusions and Limitations of this Plan of Benefits; and
g. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

2. Pre-Authorization

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Pre- Authorization to determine the Medical Necessity of such Admission or Benefit. The Employer's Group Health Plan reserves the right to add or remove Benefits that are subject to Pre-Authorization. Each Participant is responsible for obtaining Pre-Authorization and the appropriate review. If Pre-Authorization is not obtained for an Admission or if an Admission is not Pre-Authorized, and the Participant is still admitted, Benefits will be reduced (up to and including denial of all or a portion of the room and board charges associated with the Admission). Pre-Authorization is obtained through the following procedures:

a. For all Admissions that are not the result of an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Pre-Admission Review;
b. For all Admissions that result from an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Emergency Admission Review;
c. For Admissions that are anticipated to require more days than approved through the initial review process, Pre-Authorization is granted or denied for additional days in the course of the Continued Stay Review;
d. For specific Benefits that require Pre-Authorization, Pre-Authorization is granted or denied in the course of the Pre-Authorization process;
e. For items requiring Pre-Authorization, the Claims Administrator must be called at the numbers given on the Identification Card.

3. Assignment of Covered Expenses

Payment for Covered Expenses may not be assigned to Non-Participating Providers.

4. Specific Covered Benefits

If all of the following requirements are met the Employer's Group Health Plan will provide the Benefits as described in the Covered Benefits section:
a. All of the requirements of this Covered Benefits section must be met; and,
b. The Benefit must be listed in this Covered Benefits section; and,
c. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and

d. The Benefit must not be subject to one of more of the exclusions set forth in the Medical Exclusions and Limitations section.

The Employer's Group Health Plan will provide the following Benefits:

1. **Alcohol Abuse** - Charges for Alcohol Abuse Services if rendered by a licensed medical Physician (M.D.), licensed psychologist (PH.D); clinical psychologist, licensed social worker, or licensed counselor. Benefits and the treatment program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) or equal standards. This includes JCAHCO or state approved Alcohol rehabilitation programs or licensed Drug Abuse rehabilitation programs.

2. **Allergy Injections** - The Employer's Group Health Plan will pay Covered Expenses for allergy injections as set forth below:

   a. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,
   b. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) week dose; and;
   c. When any of the following conditions are met:
      i. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen;
      ii. The patient has a life threatening allergy to insect stings or food;
      iii. The patient has skin test and/or serologic evidence of a potent extract of the antigen;
      iv. Avoidance or pharmacological (drug) therapy cannot control allergic symptoms.

3. **Ambulance** - The Employer's Group Health Plan will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:
   a. Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition; and transfers between facilities when Medically Necessary.

4. **Ambulatory/Hospital Surgical Center (Outpatient)** - The Employer's Group Health Plan will pay Covered Expenses for Surgical Services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

5. **Anesthesia** - Charges for the cost and administration of an anesthetic by Physician or professional anesthetist, however, anesthesia rendered by the attending surgeon or their assistant is excluded.

6. **Assistant Surgeon** - When an assistant surgeon is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the Allowed Amount of the surgical procedure.

7. **Blood Transfusions** – Blood transfusions including cost of blood, blood plasma, blood plasma expanders, and other blood products not donated or replaced by a blood bank.

8. **Cardiac Rehabilitation** – Cardiac rehabilitation (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.

9. **Cleft Lip or Palate**- The Employer's Group Health Plan will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

   Benefits shall include, but not be limited to:
   a. Oral and facial Surgical Services, surgical management and follow-up care;
   b. Prosthetic Device treatment such as obdurators, speech appliances and feeding appliances;
   c. Orthodontic treatment and management;
   d. Prosthodontia treatment and management;
   e. Otolaryngology treatment and management;
   f. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and
   g. Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be Pre-Authorized. If a Participant with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Employer's Group Health Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Employer's Group Health Plan.

10. **Contact Lenses/Eye Glasses** - Initial contact lenses or one pair of eye glasses required following cataract surgery.

11. **Cosmetic Surgery** - Charges for cosmetic surgery, only for the following situations:

    a. When the mal-appearance or deformity is due to a congenital anomaly;
    b. When due solely to surgical removal of all or part of the breast tissue because of an Injury or Illness to the breast; or
    c. When required for the medical care and treatment of a cleft lip and palate.

    Coverage for the proposed cosmetic surgery or treatment must be pre-authorized by the Medical Review Department prior to the date of that surgery or treatment.

12. **Dental Care for Accidental Injury**- The Claims Administrator will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Benefits will be made available for injuries that occur while the Participant is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Pre-Authorization; however, the dentist must submit a plan for any future treatment to the Claims Administrator for review and Pre-Authorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only twelve (12) months from the date of the accidental injury.

13. **Diabetes Education**- The Employer's Group Health Plan will pay Covered Expenses for outpatient self-management training and education for Participants with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

14. **Durable Medical Equipment** - The Employer's Group Health Plan will pay Covered Expenses for Durable Medical Equipment. The Employer's Group Health Plan will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Employer's Group Health Plan will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Participant in a Hospital or that the Employer's Group Health Plan determines (in its sole discretion) is included in any Hospital room charge. Replacement Durable Medical Equipment is not covered unless such replacements are medically necessary due to pathological changes or normal growth. Replacement parts that are medically necessary are covered up to $400 but do not cover batteries, sales tax, or shipping and handling charges. **Pre-Authorization required for expenses over $2,000**.

15. **Electrocardiograms** - Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

16. **Emergency Medical Care**- The Employer's Group Health Plan will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition.

17. **Home Health Care** - Home Health Care, subject to the limitations, if any, stated in the Medical Schedule of Benefits, when rendered to a homebound Participant in the Participant's place of residence. Home Health Care must be rendered by or through a community Home Health agency, must be provided on a part-time visiting basis and must be provided according to a Physician-prescribed course of treatment. Benefits for Home Health Care includes those services and supplies that are usually provided by a Hospital or Skilled Nursing Facility to an inpatient by a registered or licensed practical nurse.

Specifically excluded from coverage under this benefit are the following:

a. Services and supplies not included in the Medical Schedule of Benefits, but not limited to, general housekeeping services and services for Custodial Care;
b. Services of a person who ordinarily resides in the home of the participant, or is a Close Relative of the participant; and
c. Transportation services.

18. **Hospice Care** - Charges relating to Hospice Care, provided in an inpatient or outpatient setting that the participant has a life expectancy of six (6) months or less and subject to the maximums, if any, stated in the Medical Schedule of Benefits. This coverage includes bereavement counseling. Bereavement counseling is a supportive service provided by the Hospice team to participants in the deceased's immediate family after the death of such terminally ill person. Such visits are to assist the participants in adjusting to the death, and are covered as follows: if on the date immediately before his/her death, the terminally ill person was in a hospice care program and a Participant under the Plan of Benefits; and charges for such services are incurred by the immediate family within twelve (12) months of the terminally ill person's death.

19. **Hospital Charges**- The Employer's Group Health Plan will pay Covered Expenses for Admissions as follows:
    a. Semiprivate room, board, and general nursing care;
    b. Private room, at semi-private rate as determined by the Employer's Group Health Plan;
    c. Services performed in an Intensive Care / Special Care Unit when it is Medically Necessary that such services is performed in such unit rather than in another portion of the Hospital;
    d. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
    e. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and
    f. In a Long-Term Acute Care Hospital.

    Benefits for Admissions are subject to the requirements for Pre-Admission Review, Emergency Admission Review, and Continued Stay Review.

    The day on which a Participant leaves a Hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Participant returns to the Hospital by midnight of the same day. The day a Participant enters a Hospital is treated as a day of Admission. The days during which a Participant is not physically present for inpatient care are not counted as Admission days.

20. **Human Organ and Tissue Transplants**-
    a. The Employer's Group Health Plan will pay Covered Expenses for certain Pre-Authorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Participant, and provided at a transplant center approved by the Employer's Group Health Plan. Covered Expenses shall only be provided for the human organ and tissue transplants in the amounts set forth on the Schedule of Benefits.
    b. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:
        i. When both the transplant recipient and the donor are Participants, Covered Expenses will be paid for both.
        ii. When the transplant recipient is a Participant and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.
        iii. When only the donor is a Participant, the donor will receive benefits for care and services necessary to the extent that such benefits are not provided under any recipient who is not a Participant under this Plan of Benefits. The recipient will not be eligible for benefits when only the donor is a Participant.
    c. Benefits for human organ and tissue transplants are subject to the Benefit Year Deductible amount and will be provided according to the annual maximum specified on the Schedule of Benefits.
    d. All inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy (while inpatient).
    e. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under the Employer's Group Health Plan, subject to all of the provisions of the Employer's Group Health Plan as follows:
        i. Autologous parathyroid transplants;
        ii. Corneal transplants;

iv. Bone and cartilage grafting; and
v. Skin grafting.

21. **In-Hospital Medical Service** - The Employer's Group Health Plan will pay Covered Expenses for Physician's visits to a Participant during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:
    a. In-hospital medical Benefits primarily for Mental Health Services and Substance Abuse Services;
    b. In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits;
    c. Where two (2) or more Physicians render in-hospital medical visits on the same day, payment for such services will be made only to one (1) Physician;
    d. Concurrent medical and surgical Benefits for in-hospital medical services are only provided:
        i. When the condition for which in-hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant;
        ii. When the surgical procedure performed is designated by the Employer's Group Health Plan as a warranted diagnostic procedure or as a minor surgical procedure;
        iii. When the same Physician renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

22. **Laboratory** - Charges for laboratory testing and their interpretation.

23. **Mammogram Testing** - The Employer's Group Health Plan will pay Covered Expenses for one (1) mammography test per Benefit Year according to the Schedule of Benefits regardless of Medical Necessity for female Participants. The Claims Administrator will pay Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

24. **Maternity/Obstetrical Services**- The Employer's Group Health Plan will pay Covered Expenses for obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Participant who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

    Under the terms of the Newborn and Mother's Health Act of 1996, the Employer's Group Health Plan generally may not restrict Covered Expenses for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day or surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Employer's Group Health Plan may not require that a Provider obtain authorization from the Claims Administrator for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Pre-Authorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

25. **Medical Supplies** - The Employer's Group Health Plan will pay Covered Expenses for Medical Supplies; provided that the Employer's Group Health Plan will not pay Covered Expenses separately for Medical Supplies that are (or in the Employer's Group Health Plan determination, should be) provided as part of another Benefit. Charges for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces (not dental braces) or other medical supplies determined by the Plan to be appropriate for treatment of an Illness or Injury.

26. **Mental Health Services** - Charges for inpatient or outpatient Mental Health if rendered by a licensed medical Physician (M.D.), licensed psychologist (PH.D); clinical psychologist, licensed social worker, or licensed counselor. Benefits are subject to the limitations stated in the Medical Schedule of Benefits. Expenses for Psychological Testing are also covered.

27. **Newborn** - Charges for Newborn Care. The Plan of Benefits will comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan of Benefits will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or to less than ninety-six (96) hours following a cesarean section. However, the mother's

or Newborn's attending Provider, after counseling with the mother, may discharge the mother or her Newborn earlier than the forty-eight (48) hours (or ninety-six (96) hours if applicable).

28. **Occupational Therapy** - Charges for the treatment and services rendered by a registered occupational therapist. Therapy must be ordered by a Physician, result from an Accidental Injury, surgical operation or cerebral vascular accident (stroke) or congenital birth defect. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

    After the initial occupational therapy period, continuation of Benefits will require documentation that the Participant is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

29. **Oral Surgery**- Charges for the following oral surgical procedures:

    a. Open or closed reduction of a fracture or dislocation of the jaw; and
    b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required; excision of benign bony growths of the jaw and hard palate; external incision and drainage of cellulitis and incision of sensory sinuses, salivary glands or ducts.

30. **Orthopedic Devices** – The Employer's Group Health Plan will pay Covered Expenses for Pre-Authorized Orthopedic Devices.

31. **Outpatient Rehabilitation Services** - The Employer's Group Health Plan will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

    Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

    After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Participant is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

32. **Oxygen** – The Employer's Group Health Plan will pay Covered Expenses for Pre-Authorized oxygen. Durable Medical Equipment for oxygen use in a Participant's home is covered under the Durable Medical Equipment Benefit.

33. **Pap Smear –** The Employer's Group Health Plan will pay covered Expenses for a pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. The Employer's Group Health Plan will pay Covered Expenses for additional pap smears during a Benefit Year based on Medical Necessity.

34. **Physical Rehabilitation Facility** - Charges incurred for Admission in a physical rehabilitation facility, subject to the limitations, if any, stated in the Medical Schedule of Benefits for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment. The Participant must be under the continuous care of a Physician and the attending Physician must certify that the individual requires nursing care 24 hours a day. Nursing care must be rendered by a registered nurse or a licensed vocational or practical nurse. The confinement cannot be primarily for domiciliary, custodial, personal type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis, or mental and nervous disorders. This Benefit shall not include charges for vocational therapy or Custodial Care.

35. **Physical Therapy** - Charges for the treatment or services rendered by a physical therapist in a home setting, a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed outpatient therapy facility, subject to the limitations, if any, stated in the Medical Schedule of Benefits.

36. **Physician** - Charges for the services of a Physician for medical care and/ or surgical treatments including office, home visits, Hospital inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations, subject to the following:

    a. In-Hospital medical service consists of a Physician's visit or visits to a Participant who is a registered bed-patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or Obstetrical service is required, as follows:

b. In-Hospital medical benefits will be provided limited to one visit per specialty per day;
c. In-Hospital medical benefits in a Skilled Nursing Facility;
d. When two or more Physicians, within the same study, render in-Hospital medical services at the same time, payment for such service will be made only to one Physician; and
e. Concurrent medical/surgical care benefits for in-Hospital medical service in addition to benefits for surgical service will be provided only:
    i. When the condition for which in-Hospital medical service requires medical care not related to Surgical or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative and post-operative care but requires supplemental skills not possessed by the attending surgeon or his assistant;
    ii. When a Physician, other than a surgeon admits a Participant to the Hospital for medical treatment and it later develops that surgery becomes necessary, such benefits cease on the date of surgery for the admitting Physician and become payable under the surgeon only; or
    iii. When the surgical procedure performed is designated by the claims administrator as a "warranted diagnostic procedure" or as a "minor surgical procedure".

37. **Pre-Admission Testing** - Pre-Admission testing for a scheduled Admission when performed on an outpatient basis prior to such Admission. The tests must be in connection with the scheduled Admission and are subject to the following:
    a. The tests must be made within seven (7) days prior to Admission; and
    b. The tests must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the Illness or Injury for which the Participant is subsequently admitted to the Hospital.

38. **Prescription Drugs** –
    a. The Employer's Group Health Plan will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which Benefits are otherwise available. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Employer's Group Health Plan. Copayments likewise do not change due to receipt of any Credits by the Employer's Group Health Plan;
    b. Insulin shall be treated as a Prescription Drug whether injectable or otherwise;
    c. The Employer's Group Health Plan may, in its sole discretion, place quantity limits on Prescription Drugs.

39. **Private Duty Nursing** – The Employer's Group Health Plan will pay Covered Expenses for Private Duty Nursing as set forth on the Schedule of Benefits.

40. **Prostate Examination** – The Employer's Group Health Plan will pay Covered Expenses for one (1) prostate examination per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Participants that are within the appropriate age guidelines. The Claims Administrator will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

41. **Prosthetic Devices** - The Employer's Group Health Plan will only pay Covered Expenses for Prosthetic Devices/Breast Prosthesis when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Employer's Group Health Plan) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement, or when a change in the Participant's condition warrants replacement.

42. **Radiation/Chemotherapy** - Charges for radiation therapy or treatment and chemotherapy (to include a wig up to $500).

43. **Reconstructive Surgery Following Mastectomy** - In the case of a Participant who is receiving Covered Expenses in connection with a mastectomy the Employer's Group Health Plan will pay Covered Expenses for each of the following (if requested by such Participant):
    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prosthetic devices and physical complications at all stages of the mastectomy, including lymphedema.

44. **Rehabilitation**- The Employer's Group Health Plan will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

a. All such treatment must be ordered by a medical doctor;
b. All such treatment requires Pre-Authorization and must be performed by a Provider and at a location designated by the Employer's Group Health Plan;
c. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Participant evaluation from a medical doctor that documents that to a degree of medical certainty the Participant has rehabilitation potential such that there is an expectation that the Participant will achieve an ability to provide self-care and perform activities of daily living; and
d. All such rehabilitation Benefits are subject to periodic review by the Employer's Group Health Plan.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Participant is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

45. **Residential Treatment Center**: A licensed institution, other than a Hospital, which meets all six of these requirements:
a. Maintains permanent and full-time Facilities for bed care of resident patients; and
b. Has the services of a Psychiatrist (Addictionologist, when applicable) or Physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and PRN as indicated; and
c. Has a Physician or registered nurse (RN) present onsite who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) onsite at all times (24/7); and
d. Keeps a daily medical record for each patient; and
e. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and
f. Is operating lawfully as a residential treatment center in the area where it is located.

46. **Second Opinion** - Expenses for a Second Opinion (Not Mandatory). The Second Opinion must be rendered by a board certified surgeon who is not professionally or financially associated with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the Second Opinion is different from the first, a third opinion will also be payable provided the opinion is obtained before the procedure is performed. The conditions that apply to a Second Opinion also apply to any third surgical opinion.

47. **Skilled Nursing Facility** - The Employer's Group Health Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:
a. Semi-private room, board, and general nursing care;
b. Private room, at semi-private rate as determined by the Employer's Group Health Plan;
c. Services performed in a Special Care Unit when it is Medically Necessary that such services are performed in such unit;
d. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
e. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;
f. In a Long-Term Acute Care Hospital.

Benefits for Admissions are subject to the requirements for Pre-Admission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Participant leaves a Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Participant returns to the Skilled Nursing Facility by midnight of the same day. The day a Participant enters a Skilled Nursing Facility is treated as a day of Admission. The days during which a Participant is not physically present for inpatient care is not counted as Admission days.

48. **Sleep Apnea** - Care and treatment for sleep apnea.

49. **Speech Therapy** - Fees of a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an injury; or (iii) a sickness that is other than a learning or Mental Disorder. All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits. After the initial speech therapy period, continuation of Benefits will require documentation that the Participant is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

50. **Substance Abuse** - Treatment will be payable if rendered by a licensed medical Physician (M.D.), licensed psychologist (PH.D.), clinical psychologist, licensed social worker or licensed counselor. Services or charges for Detoxification are also covered. The amount of days needed for treatment is determined through pre-authorization as set forth in the Schedule of Benefits.

51. **Surgical Procedures** –

1. Charges for surgical procedures, subject to the following:
   a. If two or more operations or procedures are performed at the same time the total amount covered for such operations or procedures will be payable for the major procedure only, or benefits will be payable according to the recommendations of the Medical Services Department;
   b. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowed Amount for the operation or procedure bearing the highest Allowed Amount, plus one half of the Allowed Amount for all other operations or procedures performed;
   c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowed Amount for the procedure bearing the highest Allowed Amount, 50 percent (50%) for the procedure bearing the second and third highest Allowed Amount, 25 percent (25%) for the procedures bearing the fourth through the eighth highest Allowed Amount, and 10 percent (10%) for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowed Amount for the procedure bearing the highest Allowed Amount, and 50 percent (50%) of the charge for each subsequent procedure;
   d. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowed Amount set forth for such operation or procedure;
   e. If two or more Physicians or Oral Surgeons perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the Allowed Amount, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Employer's Group Health Plan when so requested by the medical doctor or oral surgeon in charge of the case; and
   f. Certain surgical procedures are designated as separate procedures by the Employer's Group Health Plan, and the Allowed Amount is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowed Amount for the major procedure only.

2. Surgical assistant services, that consists of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, Physician's assistant or in-house Physician. The Employer's Group Health Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services, that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

52. **Tubal Ligation/Vasectomy** - Charges for services of voluntary sterilization procedures for Participants, but not for the reversal of sterilization procedures.

53. **Wellness Services** - Charges for wellness services.

54. **X-rays** - Charges for diagnostic x-ray or laboratory examinations and their interpretation, excluding dental x-ray, unless rendered for treatment of a fractured jaw or Injury to sound Natural Teeth incurred as a result of an accident.

MEDICAL EXCLUSIONS AND LIMITATIONS

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN OF BENEFITS. THE ONLY EXCEPTION TO THIS IS WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED (UP TO THE CORRESPONDING DOLLAR AMOUNT AND/OR COVERAGE PERCENTAGE) IN THE SCHEDULE OF BENEFITS, ARTICLE III-BENEFITS OR AS THE LAW REQUIRES (I.E. INTENTIONAL OR UNREASONABLE INJURIES OR ILLNESSES THAT RESULT FROM MEDICAL CONDITIONS OR DOMESTIC VIOLENCE). THE EMPLOYER'S GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

1. **Abortions** - Any charges for elective abortions.
2. **Acupuncture** - Acupuncture treatment or services except when performed by a Physician in lieu of anesthesia.
3. **Admissions that are not Pre-Authorized** - If Pre-Authorization is not received for an otherwise Covered Expense related to an Admission penalties will be applied (up to and including denial of the Covered Expenses) as set forth on the Schedule of Benefits.
4. **Allowed Amounts -** Charges which are *not necessary for treatment of an active Illness or Injury* or are in excess of the Allowed Amount or are not recommended and approved by a Physician.
5. **Batteries/Tax/Shipping** - Charges for batteries, sales tax or shipping and handling charges.
6. **Benefit Limitations** - Charges which exceed any benefit limitations stated in the Medical Schedule of Benefits of this Plan of Benefits.
7. **Benefits Not Covered** – Medical Supplies or services or other items not specifically listed as a Benefit in the Covered Benefits section of this Plan of Benefits or on the Schedule of Benefits.
8. **Biofeedback Charges** – Any Biofeedback charges.
9. **Blood Donation** - Charges not included as part of Hospital bill for autologous blood donation which involves collection and storage of a patient's own blood prior to elective surgery.
10. **Certain Diagnoses or Disorders** - Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, medical supplies or services or charges for the diagnosis or treatment of learning disabilities, developmental speech delay, perceptual disorders, mental retardation, vocational rehabilitation, animal assisted therapy, rTMS, eye movement desensitization and reprocessing (EMDR), behavioral therapy for solitary maladaptive habits, or rapid opiate detoxification.
11. **Close Relative Care** – Any Medical Supplies or services rendered by a Participant to him or herself or rendered by a Participant's immediate family (parent, child, spouse, brother, sister, grandparent or in-law).
12. **Comfort or Beautification Items** – Charges incurred for services or supplies which constitute personal comfort or beautification items, such as but not limited to television or telephone use.
13. **Complications from Failure to Complete Treatment** – Complications that occur because a Participant did not follow the course of treatment prescribed by a Provider, including complications that occur because a Participant left a Hospital against medical advice.
14. **Contraceptives** – Unless otherwise set forth in the Schedule of Benefits or the Prescription Drug Benefits, Medical Supplies, services or devices for the purpose of contraception.
15. **Copying Charges** – Fees for copying or production of medical records and/or claims filing.
16. **Cosmetic Procedures** - All Cosmetic Procedures in which the purpose is improvement of appearance or correction of deformity without restoration of bodily function. Some procedures may, under certain circumstances, be considered to be restorative in nature, when they are performed to correct a loss of function, pain, a mal-appearance or deformity that was caused by physical trauma, surgery or congenital anomaly. In order for benefits to be available for such restorative surgery, coverage for the proposed surgery or treatment must have

Pre-Authorization by the Medical Review Department prior to the date of that surgery or treatment. Coverage for cosmetic surgery is available as outlined in the Covered Expenses section of this Plan of Benefits.

17. **Counseling** – Marriage, family, child, or pastoral counseling for the treatment of pre-marital, marital, family or child relationship dysfunctions.

18. **Counseling or Psychotherapy** – Counseling and psychotherapy services for the following conditions are not covered:

    a. Feeding and eating disorders in early childhood and infancy;
    b. Tic disorders except when related to Tourette's disorder;
    c. Elimination disorders;
    d. Mental disorders due to a general medical condition;
    e. Sexual function disorders;
    f. Sleep disorders;
    g. Medication induced movement disorders; or
    h. Nicotine dependence unless specifically listed as a Benefit in Covered Services of this Plan of Benefits or on the Schedule of Benefits.

19. **Cranial Orthotics** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

20. **Criminal/Illegal Acts** - Any illness you get or injury you receive while committing or attempting to commit a crime, felony or misdemeanor or while engaging in an illegal act or occupation.

21. **Dental Services** - Charges incurred for treatment on or to *the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes*. Benefits will be payable for charges incurred for treatment required because of Accidental Injury to natural teeth, or for any oral surgical procedure listed under this Plan of Benefit's Covered Medical Expenses.

22. **Discount Services** – Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Participant's use of Discount Services. Discount Services are not covered under this Plan of Benefits and Participants must pay for Discounted Services in addition.

23. **Educational Testing/Training** - Any medical, social services, recreational, vocational or milieu therapy, educational, testing or training, except as part of pre-Authorized Home Health Care or Hospice Care Program.

24. **Exercise Programs** - Exercise programs for treatment of any condition.

25. **Experimental/Investigational** - Expenses for the cost of any Experimental or Investigational treatment, procedure, service, supply or drug unless all criteria are met as shown in the Definitions section.

26. **Food Supplements** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, orthomolecular therapy including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition.

27. **Foot Care** – Charges incurred for treatment or supplies of weak, strained, or flat feet, instability or imbalance of the feet, treatment of any tarsalgia, metatarsalgia or bunion (other than operations involving the exposure of bones, tendons or ligaments), cutting or removal by any method of toe nails or superficial lesions of the feet, including treatment of corns, calluses and hyperkeratosis, unless needed in treatment of a metabolic or peripheral-vascular disease.

28. **Foreign Country Charges** - Charges incurred outside the United States if the Participant traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

29. **Hair Loss** - Care and treatment of hair loss, except for wigs used for cancer patients.

30. **Hazardous Hobby** - Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby. A hobby is hazardous if it is an unusual activity, which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies are skydiving, auto racing, hang gliding, motorcycle (without a helmet) or ATV operating, or bungee jumping.

31. **Hearing Aids** - Charges for services or supplies in connection with hearing aids or exams for their fitting.

32. **Home Health Care** - Home Health Care Exclusions. The following are excluded from coverage under the Home Health Care benefit:
    a. Services and supplies not included in the Medical Schedule of Benefits, but not limited to, general housekeeping services, Custodial Care, domiciliary care and rest cures; and
    b. Services of a person who ordinarily resides in the home of the Participant, or is a close relative of the Participant; and transportation services.

33. **Hypnotism** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, hypnotism treatment or services.

34. **Human Organ and Tissue Transplants** – Human organ and tissue transplants that are not:
    a. Pre-Authorized; or,
    b. Performed by a Provider as designated by the Claims Administrator; or
    c. Listed as a covered transplant on the Schedule of Benefits; or
    d. Expenses relating to non-human organ or tissue transplants, gene therapies, xenographs or cloning.

35. **Incapacitated Dependents** – Any Service, Supply or Charge for and Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits.

36. **Infertility** – Diagnosis, Testing or Treatment of infertility (including the reversal of voluntary sterilization).

37. **Inpatient Confinement Diagnostic and Evaluative Procedures** – Charges for inpatient confinement, primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent, custodial or rest care, or any medical examination or test *not connected with an active Illness or Injury*, unless otherwise provided under any preventable care covered under this Plan of Benefits.

38. **Intoxication or Drug Use** – Any Service (other than Substance Abuse Services), medical supplies, charges or losses resulting from a member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action for the purpose of which is to create a euphoric state or alter consciousness. The member, or member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request. If the member refuses to provide these test results, no benefits will be provided.

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

39. **Jaw Bones/TMJ** - All treatment of dysfunctional conditions related to the muscles of mastication, mal-positions or deformities of the jaw bone(s), orthognathic deformities, or Temporomandibular Joint (TMJ) disorders.

40. **Lifestyle Improvement Services** – Services or supplies relating to lifestyle improvements including, but not limited to, nutrition counseling or physical fitness programs.

41. **Litigation Expenses** – Expenses paid by Member relating to any litigation concerning this Plan of Benefits including, but not limited to, attorneys' fees, extra-contractual damages, compensatory damages and punitive damages.

42. **Long-Term Care or Custodial Services - Charges for long term care services:**
    a. Rest care;
    b. Long-term acute or chronic psychiatric care;
    c. Care to assist a Participant in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication);
    d. Care in a sanitarium;
    e. Custodial or long-term care; or
    f. Psychiatric or substance abuse residential treatment, including: Residential Treatment Centers; Therapeutic schools; Wilderness/Boot camps; Therapeutic Boarding Homes; Half-way Houses; and Therapeutic Group Homes.

43. **Maintenance Care** - Charges for maintenance care. Unless specifically mentioned otherwise, the Plan of Benefits does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

44. **Medical Equipment/Supplies** - Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, non-Prescription Drugs, and medicines, first aid supplies and non-Hospital adjustable beds.

45. **Membership Dues and Other Fees** – Amounts payable (whether in the form or initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, club, golf course, wellness center, health club, weight control organization or other similar entity or payable to a trainer of any type.

46. **Missed Provider Appointments** – Charges for a Participant's appointment with a Provider that the Participant didn't attend.

47. **Non-Covered Procedures** – Complications arising from a Participant's receipt or use of either services or Medical Supplies or other treatment that are not Benefits, including complications arising from a Participant's use of Discount Services.

48. **Not Medically Necessary** - Any service or supply that is *not Medically Necessary*. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

49. **Not Legally Obligated/Reimbursable** – Any service, supply or charge the Participant is not legally obligated to pay or which is reimbursable under another Group Health Plan, a government or privately supported medical plan or program or any other source.

50. **Nutritional Counseling** - Nutritional counseling or vitamins, food supplements and other dietary supplies even if the supplements are ordered or prescribed by a Physician. Exceptions to this exclusion are noted under the Medical Schedule of Benefits and the Prescription Drug Benefits section.

51. **Obesity Related Procedures** – Any service or supply rendered to a Participant for the treatment of obesity or for the purpose of weight reduction. This includes all procedures designed to restrict the Participant's ability to assimilate food. For example, gastric by-pass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the purpose of which is to restrict the ability of the Participant to take in food, digest food or assimilate nutrients. Also excluded from coverage are those procedures concerning the correction of complications that arise from such excluded diversionary or restrictive procedures; procedures whose purpose is the reversal of these restrictive or diversionary procedures and such reconstructive procedures as may be necessitated by the weight loss produced by these non-covered restrictive or diversionary procedures.

52. **Orthotics** - charges in connection with orthotics, except for diabetic shoes**.**

53. **Out of Network Medical Treatment** – Medical treatment for covered members who travel out of the network seeking medical care; unless referred by an in network physician.

54. **Over-The-Counter Drugs** – Drugs that are available on an over-the-counter basis or otherwise available without a prescription, except for insulin.

55. **Pain Management Programs** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, chronic pain management programs or multi-disciplinary pain management programs, including TENS units unless Medically Necessary.

56. **Penalty** - Any amount paid by Participant in excess of a negotiated provider discount, or any penalty or late charge incurred, or any discount lost.

57. **Physical Therapy Admissions** – All Admissions solely for physical therapy, except as provided for rehabilitation benefits.

58. **Physician Charges** – Charges by a Physician for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed in the Physician's office.

59. **Pregnancy Dependent Child** - Charges for a Dependent child's pregnancy, including abortions, except for pregnancy as the result of a criminal act.

60. **Pre-Marital/Employment Physicals** - Services, supplies or charges for pre-marital and pre-employment physical examinations.

61. **Pre-Operative Anesthesia Consultation** – Charges for pre-operative anesthesia consultation.

62. **Prescription Drug Exclusions** - The following are not covered under the this Plan of Benefits:

    a. Prescription Drugs that have not been prescribed by a Physician;
    b. Any over-the-counter medication, unless specified otherwise;
    c. Investigational or Experimental medications. Prescription Drugs that have not been prescribed by a Physician;
    d. Any vitamins except for pre-natal, prescription multi-vitamins, pediatric multi-vitamins and topical fluoride requiring a prescription;
    e. Prescription Drugs not approved by the Food and Drug Administration;
    f. Prescription Drugs for non-covered therapies, services, or conditions;
    g. Prescription Drug refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
    h. Unless different time frames are specifically listed on the Schedule of Benefits, more than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy) or unless the quantity is limited by a QVT (Quantity Versus Time) program;
    i. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
    j. Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
    k. Prescription Drugs used for or related to cosmetic purposes, including hair growth, unless otherwise specified on the Schedule of Benefits;
    l. Prescription Drugs related to any treatment for infertility or impotence, including but not limited to, fertility drugs;
    m. Prescription Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
    n. Prescription Drugs for which there is an Over the Counter equivalent and Over the Counter supplies or supplements;
    o. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);
    p. Prescription Drugs that are not consistent with the diagnosis and treatment of a Participant's Illness, Injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;
    q. Prescription Drugs or services that require Pre-Authorization by the Claims Administrator and Pre-Authorization is not obtained;
    r. Prescription Drugs for Injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits) or any other plan benefit or program public or private;
    s. Prescription Drugs that are not Medically Necessary;
    t. Prescription Drugs for obesity or weight control and smoking cessation;
    u. Prescription Drugs that are not authorized when a part of a Step Therapy program;
    v. Prescription Drugs related to birth control;

w. Prescriptions for out-patient drugs (Out-Patient prescription drugs will only be considered for payment under the Prescription Drug Program).

63. **Prescriptions Take Home** - Charges incurred for take home drugs upon discharge from the Hospital.

64. **Professional Services** - Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

65. **Prosthetics** - replacement prosthetics or braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

66. **Pulmonary Rehabilitation** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, pulmonary rehabilitation, except in conjunction with a covered lung transplant.

67. **Psychological and Educational Testing** – Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

68. **Self-Inflicted Injury** - Services and supplies received as the result of any intentionally self-inflicted Injury that does not result from a medical condition or domestic violence.

69. **Services Prior to Participant Effective Date** – Any charges for Medical Supplies or services rendered to the Participant prior to the Participant's Effective Date, the Employer's Effective Date, or after the Participant's coverage terminates, except as provided in the Termination of Benefits Section.

70. **Services/Supplies/Treatment** - Charges for services, supplies, or treatment not commonly and customarily recognized throughout the Physician's profession or by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

71. **Sex Change** – Any Medical Supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Participant's sex.

72. **Sexual Dysfunction** - Any service or supply rendered to a Participant for the diagnosis or *treatment of sexual dysfunction (including impotence)* except when Medically Necessary due to an organic disease. This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, or penile prostheses necessary due to any medical condition.

73. **Sitters/Companions** – Charges for Sitters or companions.

74. **Smoking Cessation** - Prescription drugs used for or related to smoking cessation unless noted as covered under the Medical Schedule of Benefits or the Prescription Drug Benefits.

75. **State/Federal Programs** – Any service or charge for a service to the extent that the Participant is entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that Benefits are paid or are payable under such programs.

76. **Travel Expenses** - Travel expense, whether or not recommended by a Physician.

77. **Tubal Ligation/Vasectomy** - Charges incurred for the *Reversal of sterilization*.

78. **Virtual Office Visits** – Charges incurred as a result of virtual office visits on the Internet, including Prescription Drugs or Specialty Drugs. A virtual office visit on the Internet occurs when a Participant was not physically seen or physically examined by an approved Internet Participating Provider unless otherwise included on the Schedule of Benefits.

79. **Vision Care** - Charges incurred in connection with *routine vision care, eye refractions, the purchase or fitting of eyeglasses, contact lenses.* This exclusion shall not apply to aphakic patients and soft lenses, or sclera shells intended for use as corneal bandages, or the initial purchase of eyeglasses or contact lenses following cataract surgery. This exclusion includes any surgical procedure for the correction of a visual refractive problem, including radial keratotomy.

80. **War** - Expenses incurred for any illness or injury due to, aggravated by, or the result of any war or act of war, whether declared or undeclared or caused while serving in the armed forces of any country.

81. **Wheelchairs or Power Operated Vehicles –** Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, manual or motorized wheelchairs or power operated vehicles such as scooters for mobility outside of the home setting. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity by the Claims Administrator.

82. **Worker's Compensation** - This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Participant that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Participant. Benefits will not be provided under this Plan if coverage under Workers' Compensation Act or similar law would have been available to the Participant but the Participant elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Participant sought treatment for the injury or illness from a provider which is not authorized by the Participant's employer.

    If this Plan of Benefits pays benefits for an injury or illness and the Plan determines the Participant also received Workers' Compensation benefits by means of settlement, judgment, or other payment for the same injury or illness, the Plan shall have the right of recovery.

MEDICAL AND PRESCRIPTION DRUG DEFINITIONS

NOTE: *The following definitions are for informational purposes only. Please refer to your Schedule of Benefits and Covered Medical Expenses sections for the Benefits that are available under your Plan.*

"Accidental Injury": accidental bodily Injury caused by unexpected external means, resulting, directly and independently of all other causes, in necessary care rendered by a Physician.

"Actively at Work": a permanent, full-time Employee of the Employer who works at least the minimum number of hours per week and who is not absent from work during the initial enrollment period because of a leave of absence or temporary lay-off. An absence during the initial enrollment period due to a Health Status-Related Factor will not keep an employee from qualifying for Actively at Work status.

"Admission": the period of time between a Participant's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Participant leaves or is discharged from the Hospital or Skilled Nursing Facility.

"Adverse Benefit Determination": any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, a denial reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which benefits are otherwise provide because it is determine to be Experimental or Investigational or not Medically Necessary or appropriate.

"Alcohol Abuse": the continued use, abuse and/or dependence of alcohol(s), despite significant consequences or marked problems associated with the use (as defined, described or classified in the most current version of *Diagnostic and Statistical Manual ("DSM") of Mental Disorders* published by the American Psychiatric Association) or a comparable manual if the American Psychiatric Association stops publishing DSM.

"Allowed Amount": the amount payable under this Plan of Benefits with respect to particular Benefits. The Allowed amount is based on:

a. The actual charges made for similar services, supplies or equipment by Providers and filed with TCC Benefits Administrator during the preceding calendar year;
b. The Allowed Amount for the preceding year adjusted by an index based on national or local economic factors or indices;
c. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of TCC Benefits Administrator, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Participants upon written request;
d. An amount that has been agreed upon by a Provider and the network used by TCC Benefits Administrator; or
e. An amount established by TCC Benefits Administrator in its sole discretion.

In determining the Allowed Amount under this paragraph, of SC may, through its medical staff and/or consultants, determine the Allowed Amount based on a number of factors, including, for example, comparable or similar services or procedures.

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

"Ambulatory Surgical Center" any public or private specialized facility (state licensed and approved whenever required by law) with an organized medical staff of Physicians that:

a. has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis;

b. has continuous Physician services and registered professional nursing service whenever a patient is in the facility;

c. does not provide accommodations for patients to stay overnight;

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician; and

e. Ambulatory Surgical Center includes an endoscopy center.

"Ancillary Services": services rendered in connection with inpatient or outpatient care in a Hospital or in connection with medical emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical emergency.

"Annual Maximum": the total Benefits (under this Group Health Plan) to which a Participant is entitled to each Benefit Year for essential health benefits as defined under the (PPACA). The restricted annual dollar limit is for Benefit Years beginning on or after September 23, 2010, but prior to January 1, 2014. Refer to the Schedule of Benefits for the restricted annual dollar limit.

"Application": any mechanism agreed upon by the Claims Administrator and the Employer for transmitting necessary Participant enrollment information from the Employer to the Claims Administrator.

"Autism Spectrum Disorder": the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:
a. Autistic Disorder;
b. Asperger's Syndrome;
c. Pervasive Developmental Disorder--Not Otherwise Specified

"Behavioral Therapy": any behavioral modification using Applied Behavioral Analysis (ABA) techniques to target cognition, language, and social skills.

Behavioral Therapy does not include educational or alternative programs such as, but not limited to:

a. TEACCH;
b. Auditory Integration Therapy;
c. Higashi Schools/Daily Life;
d. Facilitated Communication;
e. Floor Time (DIR, Developmental Individual-difference Relationship-based model);
f. Relationship Development Intervention (RDI), Holding Therapy;
g. Movement Therapies;
h. Music Therapy; and
i. Pet Therapy.

"Benefits": a service or supply as specified in this Plan of Benefits or on the Schedule of Benefits, medical services or medical supplies must be:
a. Medically Necessary;
b. Pre-Authorized (when required under Plan of Benefits or the Schedule of Benefits);
c. Included in this Plan of Benefits; and
d. Not limited or excluded under terms of this Plan of Benefits.

"Benefit Percentage": the portion of eligible expenses payable this Plan of Benefits in accordance with the coverage provisions as stated in the Schedule of Benefits.

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

"Benefit Year Deductible": the amount, if any, listed on the Schedule of Benefits that must be paid by the Participant each Benefit Year before the Plan Administrator will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowed Amount before Coinsurance is calculated. Participants must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

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

"Brand Name Drug": a Prescription Drug manufactured under a registered trade name or trademark. A Preferred Brand Name Drug is one preferred for use by the Prescription Benefit Manager and is normally less expensive than an equivalent Non-Preferred Brand Name Drug.

"Certificate of Creditable Coverage": a document from a Group Health Plan or insurer that states that a Participant had prior Creditable Coverage with that Group Health Plan or insurer.

"**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, a Child who is on a Medically Necessary Leave of Absence, a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. The term "Child" does not include the spouse of an eligible child.

Under the Patient Protection and Affordable Care Act and the Health Coverage and the Education Reconciliation Act, a child does not include an individual who is eligible for other employer sponsored coverage if the Group Health Plan is a "grandfathered plan" beginning for plan years before January 1, 2014.

"Claims Administrator": Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator)

"Close Relative": includes the spouse, mother, father, grandparents, sister, brother, child, or in-laws of the Participant.

"COBRA": the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto.

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

For Prescription Drug Benefits, Coinsurance is the amount payable by the Participant calculated as follows:

a. The percentage listed on the Schedule of Benefits; multiplied by
b. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale; and
c. Without regard to any Credit or allowance that may be received by the Claims Administrator.

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

"Continued Stay Review": the review that must be obtained by a Participant (or the Participant's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Pre-Authorized is Medically Necessary (when required).

"Copayment": the amount specified on the Schedule of Benefits that the Participant must pay directly to the Provider each time the Participant receives Benefits.

"Cosmetic Procedure": a procedure performed solely for the improvement of a Participant's appearance rather than for the improvement or restoration of bodily function.

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

"Creditable Coverage": with respect to an individual, means coverage of the individual under any of the following:

a. a Group Health Plan;
b. Health Insurance Coverage;
c. Medicare: Part A or Part B, Title XVIII of the Social Security Act;
d. Medicaid: Title XIX of the Social Security Act—Other than coverage consisting solely of benefits under Section 1928;
e. Title 10 United States Code Chapter 55 (i.e. medical and dental care for Participants and certain former members of the uniformed forces and their Dependents);
f. a medical care program of the Indian Health Service or of a tribal organization;
g. a state health benefits risk pool (including South Carolina Health Insurance Pool (SCHIP);
h. a health plan offered under chapter 89 of title 5. United States Code (the Federal Employee Health Benefits Program);
i. a public health plan (including that of the U.S. Federal Government as well as that of a foreign country or its political subdivision);
j. a health benefit plan under Section 5(e) of 22 United States Code 2504(e), the Peace Corps Act;
k. a State Children's Health Insurance Program (S-CHIP).

Creditable Coverage does not include coverage consisting solely of Excepted Benefits (as defined within the definition of Health Insurance coverage.

"Credit(s)": financial credits (including rebates and/or other amounts) to the Claims Administrator directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager. Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Employer or Participants.

Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these Credits. Any Coinsurance that a Participant must pay for Prescription Drugs or Specialty Drugs is based upon the Allowable Amount at the pharmacy, and does not change due to receipt of any Credit by the Claims Administrator. Copayments are not effected by any Credit.

"Custodial Care": care provided primarily for maintenance of the patient or care designed essentially to assist the patient in meeting his or her activities of daily living. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Custodial Care is not primarily provided for therapeutic value in the treatment of an Illness, Injury, disease, or condition.

"Deductible": the amount of Benefits as indicated in the Schedule of Benefits that the Participant (individually or as part of family coverage) must pay each benefit period before benefits are paid by the Group Health Plan.

"Dependent": the following individuals:

a. An Employee's spouse; or
b. A Child under the age of [26]; or
c. a Dependent who is:

    i. incapable of financially supporting himself by reason of mental or physical disability,

ii. dependent upon the Employee for at least 50 percent of his or her support and maintenance, and
iii. is living in the Employee's household. Written proof that a Dependent is incapacitated and is a Dependent shall be furnished as required by the Plan Administrator.

The term "Dependent" does not include:

a. an Employee;
b. a member of any armed forces (except if an active duty member for thirty (30) days or less per year);
c. any person who has permanent residence outside of the U.S.A.;
d. a spouse who is legally separated or divorced from the participant, unless coverage is required due to a court order or decree and provided that such spouse has met all requirements of a valid separation or divorce contract in the state granting such separation or divorce;
e. any person who is covered as a Dependent by another Participant of the same Employer.

"Detoxification": a Hospital service providing treatment to diminish or remove from a Patient's body the toxic effects of chemical substances, such as alcohol or drugs, usually as an initial step in the treatment of a chemical-dependent person. The amount of days needed for treatment is determined through the pre-approval process.

"Discount Services": services (including discounts on services) that are not Benefits, but which may be offered to Participants from time to time as a result of being a Participant.

"Durable Medical Equipment": equipment that:

a. Can stand repeated use;
b. Is Medically Necessary,
c. Is customarily used for the treatment of a Participant's Illness, injury, disease or disorder;
d. Is appropriate for use in the home;
e. Is not useful to a Participant in the absence of Illness or injury;
f. Does not include appliances that are provided solely for the Participant's comfort or convenience;
g. Is a standard, non-luxury item (as determined by the Employer's Group Health Plan); and
h. Is ordered by a medical doctor, oral surgeon, podiatrist, or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment. Items such as air conditioners, de-humidifiers, whirlpool baths, and other equipment which have non-therapeutic uses are not considered Durable Medical Equipment.

"Effective Date": the date on which an employee or dependent is covered under this Plan of Benefits.

"Electronic Protected Health Information": protected health information (see also definition of Protected Health Information) that is transmitted or maintained in any electronic media.

"Emergency Admission Review": the review that must be obtained by a Participant (or the Participant's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition.

"Emergency Medical Care": Benefits that are provided in a Hospital emergency facility to evaluate and treat an Emergency Medical Condition.

"Emergency Medical Condition": a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of the Participant, or with respect to a pregnant Participant, the health of the Participant or her unborn child, in serious jeopardy;

b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

"Employee": an individual who is eligible for coverage as provided in the eligibility section of this Plan of Benefits, and who is so designated to TCC Benefits Administrator by the Employer.

"Employer": the entity which is sponsoring this Group Health Plan and its related subsidiaries. The Employer is identified on the cover of this Plan of Benefits.

"Employers Effective Date": the date the Claims Administrator begins to provide services under the Administrative Services Agreement.

"Employer's Group Health Plan": the Group Health Plan adopted by the Employer as the Plan Sponsor. This Plan of Benefits outlines certain terms of the Employer's Group Health Plan.

"Enrollment Date": the first day of enrollment in the Employer's Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

"ERISA": the Employee Retirement Income Security Act of 1974, and any amendments thereto.

"Excepted Benefits": for purposes of HIPAA, the following insurance coverage does not constitute Creditable Coverage including the following:
a. Coverage only for accident, or disability income insurance, or any combination thereof;
b. Coverage issued as a supplement to liability insurance;
c. Liability insurance, including general liability insurance and automobile liability insurance;
d. Worker's compensation or similar insurance;
e. Automobile medical payment insurance;
f. Credit-only insurance;
g. Coverage for on-site medical clinics;
h. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

<u>If offered separately</u>:
a. Limited scope dental or vision benefits;
b. Benefits for long-term care, nursing home care, Home Health Care, community-based care, or any combination thereof;
c. Such other similar, limited benefits as specified in regulations.

<u>If offered as independent, non-coordinated benefits</u>:
a. Coverage only for a specified disease or Illness;
b. Hospital indemnity or other fixed indemnity insurance.

<u>If offered as a separate insurance policy</u>:
a. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act);
b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;
c. Similar supplemental coverage under a Group Health Plan.

"Experimental/Investigational": a treatment, procedure, service, device, or drug (treatment) which will considered to be experimental or investigational if:

a. The treatment has not been approved by the United States Food and Drug Administration (FDA) at the time the treatment is provided; or

b. The treatment is identified as a Phase I, II, III, or IV clinical trial or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis; or
c. The treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution; or
d. The treatment is being provided subject to the covered member's execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternatives; or
e. The predominant opinion of medical experts as expressed in published peer-reviewed literature is that further research is necessary in order to determine safety, toxicity, or efficacy in comparison to conventional alternatives.

Experimental or Investigational Treatment will be considered an eligible claim expense under this plan of benefits when the following criteria are met:

1. Treatment protocol identified as a Phase II, III, or IV clinical trial, or the equivalent, will be considered an eligible claim expense when all of the following criteria are met:
    a. There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative; and
    b. The clinical trial is subject to review by an IRB and has been approved by the governing local IRB; and
    c. The covered member has executed an informed consent, which has been approved by the IRB; and
    d. The treatment protocol has been approved by one or more of the following organizations, the treatment is being provided within one of the centers designated by the clinical trial sponsor as a participating center and is being provided under the direction of the principal investigator at that center:
        i. National Institutes of Health (NIH).
        ii. NIH cooperative group or center.
        iii. United States Department of Health and Human Services (HHS), which includes the Center of Medicare and Medicaid Services (CMS).
        iv. FDA.
        v. United States Department of Defense.
        vi. United States Department of Veterans Affairs; or
2. Treatment utilizing drugs previously approved by the FDA or non-approved indications when all of the following criteria are met:
    a. There is not clearly superior non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative.
    b. The provider has complied with all of the IRB's requirements for providing the treatment; or
3. Treatment utilizing Investigator sponsored trials which are done in accordance with IRB approved protocols in and academic medical center that is a recipient of NIH grants and which meets all of the criteria in 1.(a) through 1.(d) above. Investigator sponsored trials will be considered on a case-by-case basis. Investigator or drug company sponsored trials in which there is no academic medical center involvement and where the principal investigator is not affiliated with an academic medical center will not be considered for coverage except by recommendation of an independent third party reviewer.

To determine if any treatment meets the standards of coverage the Plan Administrator reserves the right to obtain an independent third party review.

"FMLA" the Family and Medical Leave Act of 1993, as amended.

"Full-time Employment": a basis whereby an Employee is employed by the Employer for at least a set number of hours determined by the Employer and stated in the Eligibility section of this document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he receives regular earnings from the Employer.

"Generic Drug": a Prescription Drug approved by the FDA as a bio-equivalent substitute and manufactured by one or more companies as a result of the expiration of the original patent for the equivalent Brand Name Drug. Brand Name Drugs that are cross-licensed to other companies, who then market the Brand Name Drug under a generic name prior to the patent expiring may be considered and processed under the Brand name level of benefits.

"Genetic Information": information about genes, gene products, and inherited characteristics that may derive from the Participant or family member of the Participant. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

"Grace Period": a period of time as determined by the Employer that allows for the Participant to pay any premium due.

"Group Health Plan": an employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement or otherwise. This Plan of Benefits established by the Employer is a Group Health Plan.

"Health Insurance Coverage": benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

"Health Status-Related Factor": any of the following factors: health status, medical conditions, (including both physical and mental Illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, (including conditions arising out of acts of domestic violence), or disability.

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

"Home Health Care": part-time or intermittent care to a home-bound Participant in such Participant's private residence and:

a. Is licensed and primarily engaged in providing skilled nursing care and other therapeutic services;
b. Has policies established by a professional group associated with the agency or organization that includes at least one Physician and one registered nurse (R.N.) who provide full-time supervision of such services; and
c. Maintains complete medical records on each individual and has a full-time administrator.

"Home Health Care Plan": must meet these tests: it must be a formal written plan made by the Participant's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the Participant.

"Hospice Care": care for terminally ill patients under the supervision of a Physician, and is provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

"Hospice Care Program": a formal program directed by a Physician to provide Hospice Care. To qualify as a Hospice Care Program, the program must meet the standards set by the National Hospice Organization. If such program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a Hospice Care Program.

"Hospital": a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Physicians, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty.

The term Hospital does not include Long Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Participants.

"ID Card": the card issued by the Claims Administrator to a Participant that contains the Participant's identification number.

"Illness": a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy.

"Incapacitated Dependent": a Child who is:
a. Incapable of financial self-sufficiency by reason of mental or physical disability; and,
b. 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. The Employee will update items (1) and (2) each year or upon the Claims Administrator's request. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

"Injury": a bodily injury caused by an accident, which results directly from the accident and independently of all other causes.

"Intensive Care Unit/Special Care Unit": a specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Participants requiring extraordinary care on a concentrated and continuous basis, such as burn, intensive, or coronary care units.

"Late Enrollee": an Employee (Participant or Dependent 19 or over) who enrolls under this Plan of Benefits other than during:
a. The first period in which Employee or Dependent is eligible to enroll under the Group Health Plan if the initial enrollment period is a period of at least thirty (30) days; or
b. A Special Enrollment period.

"Long-Term Acute Care Hospital": a long-term, acute care facility licensed as a long term care hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Participants (typically over an extended period of time) although such Participants may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Participants with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Long-Term Acute Care Hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Participants.

"Mail Order/Mail Service Pharmacy": a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription by mail.

"Maximum Payment": the maximum amount the Employer's Group Health Plan will pay (as determined by the Claims Administrator) for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Claims Administrator in its discretion:

a. The actual charges made for similar services, supplies or equipment by Providers and filed with the Claims Administrator during the preceding calendar year;
b. The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices; or
c. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of the Claims Administrator, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Participants upon written request; or
d. An amount that has been agreed upon by a Provider and the Claims Administrator; or
e. An amount established by the Claims Administrator in its sole discretion. In determining the Maximum Payment under this paragraph e, the Claims Administrator may, through its medical staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

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

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

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

3. A Medical Child Support Order must clearly specify:
   a. 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; and,
   b. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined; and,
   c. The period to which such order applies; and,
   d. Each Group Health Plan to which such order applies.

4. If the Medical Child Support Order is a national medical support notice, the order must also include:
   a. The name of the issuing agency;
   b. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and
   c. The identification of the underlying Medical Child Support Order.

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

"Medically Necessary/Medical Necessity" health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

a. in accordance with generally accepted standards of medical practice;
b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
c. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medical Supplies: supplies that are:
a. Medically Necessary;
b. Prescribed by a Physician acting within the scope of his or her license (or are provided to a Participant in a Physician's office);
c. Are not available on an over-the-counter basis (unless such supplies are provided to a Participant in a Physician's office and should not (in the Claims Administrator's discretion) be included as part of the treatment received by the Participant); and
d. Are not prescribed in connection with any treatment or benefit that is excluded under this Plan of Benefits.

"Medicare": the program of medical care benefits provided under Title XVII of the Social Security Act of 1965 as amended.

"Member": an Employee or Dependent who has enrolled (and qualifies for coverage) under this Plan of Benefits

"Mental Disorder": Mental Illness includes, but is not limited to, bipolar affective disorder, schizophrenia, psychotic Illness, manic depressive Illness, depression and depressive disorders, anxiety and anxiety disorders and any other mental and nervous condition classified in *Diagnostic and Statistical Manual ("DSM") of Mental Disorders* published by the American Psychiatric Association.

"Mental Health Services": treatment (except treatment for Substance Abuse) for a condition that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

"Midwife": a person who is certified or licensed to assist women in the act of childbirth.

"Natural Teeth": teeth that:
a. Are free of active or chronic clinical decay;
b. Have at least 50% bony support;
c. Are functional in the arch;
d. Have not been excessively weakened by multiple dental procedures;
e. Teeth that have been treated for one (1) or more of the conditions referenced in a-d above, and as a result of such treatment have been restored to normal function.

"Newborn": an infant from the date of his birth until the initial Hospital discharge.

"Newborn Care": inpatient Physician Hospital services for a Newborn including initial work-up and pediatric exam, but excluding services for Illness or Injury.

"Non-Participating Provider": any Provider who does not have a current, valid Participating Provider Agreement with the Claims Administrator or another member of the Provider Network.

"Non-Preferred Drug": a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by the Claims Administrator or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an "A" rated Generic Drug available.

"Occupational Therapy": is a program of care which focuses on the physical cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye hand coordination. Therapy

sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment.

"Open Enrollment Period": is the month of December each year. During this month, Employees previously not enrolled under this Plan may apply for coverage. Coverage shall become effective the first of the following month.

"Orthopedic Device": any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

"Orthotic Device": any device used to mechanically assist, restrict, or control function of a moving part of the Participant's body.

"Outpatient Care and/or Services": is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

"Out-of-Pocket Maximum": the maximum amount (if listed on the Schedule of Benefits) or otherwise Covered Expenses incurred during a Benefit Year that a Participant will be required to pay. The Out-of-Pocket Maximum is Coinsurance payable by the Participant. Copayments and Benefit Year Deductibles may not apply toward the Out-of-Pocket Maximum (as set forth on the Schedule of Benefits).

"Over-the-Counter Drug": a drug that does not require a prescription.

"Participant": an Employee or Dependent who has enrolled (and qualifies for coverage) under this Plan of Benefits.

"**Participant Effective Date**": the date on which a Participant is covered for Benefits under the terms of this Plan of Benefits.

"Participating Pharmacy": a pharmacy that has a contract with the Claims Administrator, Employer or with the Pharmacy Benefit Manager to provide Prescription Drugs or Specialty Drugs to Participants.

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

"Participating Provider Agreement": an agreement between the Claims Administrator (or another partner of TCC Benefits Administrator) and a Provider under which the Provider has agreed to accept an allowance (as set forth in the Provider Agreement) as payment in full for Benefits and other mutually acceptable terms and conditions.

"Pharmacy": a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

"Pharmacy Benefit Manager": an entity that has contracted with the Employer or with the Claims Administrator and is responsible for the administration of the Prescription Drug Benefit in accordance with the Employer's Group Health Plan.

"Physician": a person who is:

1. Not an:
    a. Intern;
    b. Resident;
    c. In-house physician; and

2. Duly licensed by the appropriate state regulatory agency as a:
    a. Medical doctor;
    b. Oral surgeon;
    c. Osteopath;

d. Podiatrist;
e. Chiropractor;
f. Optometrist;
g. Psychologist with a doctoral degree in psychology;

3. Legally entitled to practice within the scope of his or her license; and

4. Customarily bills for his or her services.

"Physician Services": the following services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by the Claims Administrator:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury;

2. Basic diagnostic services and machine tests;

3. Physician Services includes the following services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:

a. Benefits rendered to a Participant in a Hospital or Skilled Nursing Facility;
b. Benefits rendered in a Participant's home;
c. Surgical Services;
d. Anesthesia services, including the administration of general or spinal block anesthesia;
e. Radiological examinations;
f. Laboratory tests; or
g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives.

"Plan": any program that provides benefits or services for medical or dental care or treatment including:
a. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and
b. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

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

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

"Plan of Benefits": this Preferred Provider Plan of Benefits including, the Membership Application the Schedule of Benefits, and all endorsements, amendments, riders or addendums.

"Plan of Benefits Effective Date": 12:01 AM on the date listed on the Schedule of Benefits.

"Post-service Claim": any claim that is not a Pre-service Claim or any claim that is submitted after the medical care, service or supply has been provided.

"Pre-Authorized/Pre-Authorization": the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Participant. Pre-Authorization means only that the Benefit is Medically Necessary. Pre-

Authorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Participant. Notwithstanding Pre-Authorization, payment for Benefits is subject to a Participant's eligibility, and all other limitations and exclusions contained in this Plan of Benefits. A Participant's entitlement to Benefits is not determined until the Participant's claim is processed. The Pre-Authorization process is outlined in the Pre-Authorization / Prior Approval Section.

"Preferred Brand Drug": a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

"Preferred Drug": a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager, for dispensing to Participants. Preferred Drugs are subject to periodic review and modification by the Claims Administrator, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

"Preferred Provider (PPO)": a Physician, Hospital, or other Provider who has a signed contract with one of the networks used by this Plan of Benefits and who has agreed to provide Benefits to a Participant and submit claims to TCC Benefits Administrator and to accept the Allowed Amount as payment in full for Benefits. The participating status of a Provider may change.

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

"Pre-service Claim": any claim or request for a Benefit where prior authorization or approval must be obtained from Medical Services Department before receiving the medical care, service or supply. An approval means only that a service is Medically Necessary for treatment of your condition, but is not a guarantee or verification of Benefits. Payment is subject to your eligibility, and all other Plan of Benefit limitations and exclusions. A Final Benefit determination will be made when your claim is processed.

"Prescription Drugs": a drug or medicine that is:

a. Required to be labeled that it has been approved by the Food and Drug Administration;
b. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only" prior to being dispensed or delivered, or labeled in a similar manner; or
c. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

a. Be ordered by a medical doctor or oral surgeon as a prescription;
b. Not be entirely consumed at the time and place where the prescription is dispensed; and
c. Be purchased for use outside a Hospital.

"Prescription Drug Copayment": the amount payable, if any, set forth on the Schedule of Benefits, by the Participant for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible or the Out-of-Pocket Maximum.

"Prescription Drug Pre-Authorization Program": programs that prohibit patients from obtaining medications until approvals have been obtained.

"Primary Plan": the plan with primary responsibility for the Participants claims as determined by the coordination of benefit provisions of this Plan of Benefits**.**

"Prosthetic Device": any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

"Protected Health Information (PHI)": term as defined under HIPAA.

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

- Medicine
- Dentistry
- Optometry
- Podiatry
- Chiropractic Services
- Physical Therapy
- Behavioral Health
- Oral Surgery
- Speech Therapy
- Occupational Therapy

Provider includes a Long Term Care Hospital, a Hospital, a Rehabilitation Facility, Skilled Nursing Facility, and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives or masseuses.

"QMCSO": a Medical Child Support Order that:

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

"Qualifying Event": for continuation of coverage purposes is any one of the following:

a. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under the Plan of Benefits;
b. Death of the Employee;
c. Divorce or legal separation of the Employee from his or her spouse;
d. A Child ceasing to qualify as a Dependent under this Plan of Benefits;
e. Entitlement to Medicare by an Employee, or by a parent of a Child;
   A proceeding under Title II of COBRA with respect to the Employer from whose employment an Employee retired at any time.

"Quantity versus Time (QVT) Limits": limits that restrict access by limiting the amount of Prescription Drugs that are covered under a Participant's benefit within a certain time frame. The limits established for these drugs are based on FDA approved indications.

"Rehabilitation Facility": a licensed facility operated for the purpose of assisting Participants with neurological or other physical injuries to recover as much restoration of function as possible.

"Schedule of Benefits": the pages so titled and made part of this handbook that specify the amount of coverage provided and the applicable Copayments, Coinsurance, Deductibles, and benefit limitations.

"Second Opinion": an opinion from a Physician regarding a service recommended by another Physician before the service is performed, to determine whether the proposed service is Medically Necessary and covered under the terms of this Plan of Benefits.

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

"Security Incidents": the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system.

"Skilled Nursing Facility": an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

"Special Enrollment": the period during which an Employee or eligible Dependent who is not enrolled for coverage under this Group Health Plan may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in the Eligibility For Coverage section of this Plan of Benefits.

"Specialist": a Physician that specializes in a particular branch of medicine.

"Speech Therapy": is a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but do have deficits in higher level language functioning as a result of trauma or identifiable organic disease process.

"Step Therapy Program": programs that require a Participant to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medications.

"Substance Abuse": the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association).

"Substance Abuse Services": services or treatment relating to Substance Abuse.

"Surgical Services": an operative or cutting procedure or the treatment of fractures or dislocations. Surgical Services include the usual, necessary and related pre-operative and post-operative care when performed by a medical doctor or oral surgeon.

"Totally Disabled/Total Disability": means that the Participant is able to perform none of the usual and customary duties of such Participant's occupation. With respect to a Participant who is a Dependent, the terms refer to disability to the extent that such Participant can perform none of the usual and customary duties or activities of a person in good health of the same age. The Participant must provide a Physician's statement of disability upon periodic request by the Employer's Group Health Plan.

"Transplant": The transplant of organs from human to human, including bone marrow, stem cell and cord blood transplants. Transplants include only those transplants that: (a) are approved for Medicare coverage on the date the Transplant is performed; and (b) are not otherwise excluded by this Plan of Benefits.

A Transplant must be performed at a Transplant Facility in order to be considered for reimbursement under this Plan of Benefits. Skin and Cornea transplants are not considered a Transplant for the purpose of determining eligible expenses under this Plan of Benefits.

"Transplant Facility": A hospital which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a Transplant and:

- For organ transplants: is an approved member of the United Network for Organ Sharing for such Transplant or is approved by Medicare as a transplant facility for such Transplant;
- For unrelated allogeneic bone marrow or stem cell transplants: is a participant in the National Marrow Donor Program;
- For autologous stem cell transplants: is approved to perform such Transplant by:
    a. the state where the Transplant is to be performed;
    b. Medicare;
    c. the Foundation for the Accreditation of Hemopoietic Cell Therapy

Outpatient transplant facilities must be similarly approved.

"Urgent Care": Benefits required in order treating an unexpected Illness or Injury that is life-threatening and required in order to prevent a significant deterioration of the Participant's health if treatment were delayed.

The Claims Administrator will determine whether a claim is an urgent care claim based on the information provided at the time that the claim is submitted.

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

"USERRA": The Uniformed Services Employment and Reemployment Rights Act of 1994 including any amendments thereto.

"Waiting Period": a period of continuous employment with the Employer that an Employee must complete before becoming eligible to enroll in the Plan of Benefits.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan of Benefits.

DEDUCTIBLE

A. Individual Deductible
This is an amount of dental charges (for an individual with single coverage) for which no benefits will be paid. Before benefits can be paid in a benefit year, a participant must meet the Deductible shown in the Dental Schedule of Benefits.

B. Family Deductible
This is an amount of dental charges (for individuals with family coverage) for which no benefits will be paid. When the amount shown in the Dental Schedule of Benefits has been paid by Participants of a Family Unit toward their benefit year Deductibles, the Deductibles of all that Family Unit will be considered as being satisfied for that year.

BENEFIT PAYMENT
Each benefit year, benefits will be paid to a Participant for the dental charges in excess of his Deductible, up to the Maximum Dental Benefit amount. No benefits will be paid in excess of the Maximum Dental Benefit amount. Payment will be made at the rate shown under Dental Percentage payable in the Dental Schedule of Benefits.

MAXIMUM BENEFIT AMOUNT
The Maximum Dental Benefit amount is the amount of benefits that will be paid for all dental charges of a Participant in a benefit year. The Maximum Dental Benefit amount is on the dental Schedule of Benefits.

DENTAL CHARGES
Dental charges are paid based upon the Allowed Amount for necessary care, appliance or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, TCC Benefits Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rate charge will be considered to be incurred as each visit or treatment is completed.

PREDERMINATION OF BENEFITS

Except in an emergency, you should discuss dental charges with your dentist before treatment begins. If you or a Dependent needs dental treatment which the dentist estimates will cost **$500** or more, you should ask your dentist to file for predetermination of benefits with TCC Benefits Administrator. By doing this, both you and the dentist will know in advance how much your dental plan will pay for the course of treatment your dentist recommends.

HERE'S HOW PREDETERMINATION WORKS
Your dentist should list, on a claim form, the treatment he plans to perform and his charges for that treatment. The dentist should then send the form to TCC Benefits Administrator. TCC Benefits Administrator will let you and your dentist know the amount of money that can be paid under your coverage for the recommended treatment.

DENTAL SCHEDULE OF BENEFITS

All benefits are subject to the Allowed Amount and benefit year Deductible (unless otherwise indicated). Please refer to the covered expenses section for a complete listing of benefits and any additional conditions/limitations that may apply.

CLASSES OF EXPENSES	PLAN PAYS	DEDUCTIBLE
CLASS I – Diagnostic and Preventive Dental Services	100%	None
CLASS II - Basic Dental Service	80%	Subject to the Dental Calendar Year Deductible
CLASS III - Major Dental Services	50%	Subject to the Dental Calendar Year Deductible
CLASS IV Orthodontic Benefits	Not Covered	Not Covered
Maximum per Participant per Benefit Year for Classes I-III: $1,500		
Per Benefit Year Dental Deductible - Per Participant: Per Family		 $50 $100

COVERED DENTAL EXPENSES

Class I - Diagnostic and Preventive Dental Services

1. Initial or periodic oral examinations, 2 in 12 month period;
2. Full mouth x-rays every three (3) years;
3. Bitewing x-rays (2 or 4 films) 1 in 12 month period;
4. Dental Prophylaxis, limited to one time in any (6) six-month period;
5. Fluoride treatment, for Employees and Dependents under age nineteen (19), once every six months;
6. Space maintainers and adjustments made within (6) months of installation, for prematurely lost deciduous teeth, for Dependents under age sixteen (16);
7. Sealants on permanent teeth that have not had any fillings; one time per tooth in any (36) thirty-six month period; covered on children under age 19;
8. Emergency palliative treatment and other non-routine, unscheduled visits.

Class II - Basic Dental Service
(Non-Restorative)

1. Intraoral periapical X-rays.
2. Intraoral occlusal X-rays, limited to one film in any (6) months period.
3. Extraoral X-rays, limited to one film in any (6) six month period.
4. Other X-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction).
5. Histopathological examination.
6. Stainless steel crowns, limited to: one time in any (36) thirty-six month period; Teeth not restorable by an amalgam or composite filling; and covered dependent children less than age 19.
7. Pulpotomy
8. Root canal therapy, including all re-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic test, local anesthesia and routine follow-up care, limited to one time on the same tooth in any (24) twenty-four month period.
9. Apicoectomy/periradicular surgery (anterior, bicuspid or molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic test, local anesthesia and routine follow-up care.
10. Retrograde filling – per root.
11. Root amputation – per root.
12. Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy.
13. Periodontal scaling and root planning (per quadrant), limited to one time per quadrant of the mouth in any (24) twenty-four month period.

14. Periodontal maintenance procedure (following active treatment), limited to one dental prophylaxis or one periodontal maintenance procedure in any (6) six-month period.
15. Periodontal related services as listed below, limited to: one time per quadrant of the mouth in any (36) thirty-six month period with charges combined for each of these services performed in the same quadrant within the same (36) thirty six month period; gingivectomy, gingival curettage, Mocogingival or osseous surgery.
16. Osseous grafts.
17. Pedicle grafts.
18. Tissue grafts;
19. Periodontal appliances, limited to one appliance in any (12) twelve-month period.
20. Simple extractions.
21. Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care.
    - Surgical extractions (including an allowance for local anesthesia and routine post-operative care;
    - Surgical extractions (including extraction of wisdom teeth);
    - Alveoloplasty;
    - Vestibuloplasty;
    - Removal of exostosis-maxilla or mandible;
    - Frenulectomy (frenectomy or frenotomy);
    - Excision of hyperplastic tissue – per arch.
22. Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and or alveolus.
23. Root removal – exposed roots.
24. Biopsy.
25. Incision and drainage.
26. Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other treatment (except X-rays) is rendered during the visit.
27. General anesthesia and intravenous sedation, limited as follows: considered for payment as a separate benefit only when medically necessary (as determined by us) and when administered in the dentist's office or outpatient surgical center in conjunction with complex oral surgical services, which are covered under the policy.
28. Consultation, including specialist consultations, limited as follows: Considered for payment only if billed by a dentist who is not providing operative treatment; benefits will not be considered for payment if the purpose of the consultation is to describe the dental treatment plan.
29. Therapeutic drug injections.

Restorative

1. Amalgam restorations, limited as follows:
    - Multiple restorations on one surface will be considered a single filling;
    - Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least: (12) months have passed since the existing amalgam restoration was placed if the covered person or covered

dependent is less than age 19 or; (36) months have passed since the existing amalgam restoration was placed if the covered person or covered dependent is age 19 or older;

- Mesial, lingual, buccal (MLB) and distal, lingual, buccal (DBL) restorations will be considered single surface restorations;

2. Silicate restorations.
3. Plastic restorations.
4. Composite restorations, limited as follows:
   - Mesial, lingual, distal-lingual, mesial-buccal and distal-buccal restorations on anterior teeth will be considered single surface restorations;
   - Acid etch is not covered as a separate procedure;
   - Benefits for the replacement of an existing composite restoration will only be considered for payment if at least: (12) months have passed since the existing composite restoration was placed if the covered person or covered dependent is less than age 19; or (36) months have passed since the existing composite restoration was placed if the covered person or covered dependent is age 19 or older;
   - Benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration.
5. Pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to one time per tooth.

Class III – Major Dental Service
All benefits for the services listed below include an allowance for all temporary restorations and appliances, and one-year follow-up care.

1. Benefits for dentures, bridgework, crowns, Inlays or gold fillings are excluded for a person until he or she is covered for Dental Benefits under the Group Policy for (12) twelve months.
2. Inlays and onlays: Covered only when the tooth cannot be restored by an amalgam or composite filling; covered only if more than (10) years have elapsed since last placement and limited to persons over age 16.
3. Porcelain restorations on anterior teeth.
4. Crowns; covered only when the tooth cannot be restored by an amalgam or composite filling; covered only if more than (10) ten years have elapsed since last placement and limited to persons over age 16.
5. Recementing inlays.
6. Recementing crowns.
7. Post and core, covered only for endodontically treated teeth requiring crowns.
8. Endodontic endosseous implant and endosseous implant, limited as follows: benefits for the replacement of an existing implant are payable only if the existing implant is: more than (10) ten years old and cannot be made serviceable.
9. Full dentures, limited as follows: Limited to one time per arch unless: (10) ten years have elapsed since last replacement and the denture cannot be made serviceable. We will not pay additional benefits for personalized

dentures or over dentures or associated treatment. We will not pay for any denture until it is accepted by the patient.

10. Partial dentures, including any clasps and rests and all teeth, limited as follows; limited to one partial denture per arch unless: (10) ten years have elapsed since last replacement and the partial denture cannot be made serviceable. There are not benefits for precision or semi-precision attachments.
11. Each additional clasp and rest.
12. Denture adjustments, limited to: One (1) time in any (12) twelve month period; and adjustments made more than (12) twelve months after the insertion of the denture.
13. Repairs to full or partial dentures, bridges, crown and inlays, limited to repairs or adjustments performed more than (12) twelve months after the initial insertion.
14. Relining or rebasing dentures, limited to: One time in any (36) thirty six month period; and relining or rebasing done more than (12) twelve months after the insertion of the denture.
15. Tissue conditioning, limited to repairs or adjustment performed more than (12) months after the initial insertion of the denture.
16. Fixed bridges (including Maryland bridges), limited as follows:
    - Limited to persons over age 16;
    - Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge: is more than (10) ten years old and cannot be made serviceable
    - A fixed bridge replacing the extracted portion of a hemisected tooth is not covered;
    - The date the bridge is cemented in the mouth will be used in determining the amount that will be applied to the Calendar Year Maximum shown in the Schedule.
17. Recementing bridges, limited to repairs or adjustment performed more than (12) twelve months after the initial insertion.

Class IV - Orthodontics

Not covered.

DENTAL EXCLUSIONS AND LIMITATIONS

Dental Exclusions. The following are excluded from coverage under the dental coverage:

1. **Allowed Amount** - if a dentist and Patient select a more expensive course of treatment than is usually provided by other dentists, consistent with sound professional standards of dental practice, benefits are payable for the less costly procedure.
2. **Close Relative** - Charges for services rendered by a Close Relative of the Participant, or resides in the same household as the Participant.
3. **Cosmetic Procedures** - Services and supplies primarily for cosmetic or aesthetic purposes, including personalization of characterization of dentures.
4. **Dentist Charges** - Services and supplies for which the dentist does not charge.
5. **Dental License** - Services rendered by a dentist beyond the scope of his license.
6. **Dentist Visits** - Charges for visits at home or in the Hospital, except in connection with emergency care.
7. **Denture Replacement** - Replacement of a denture that could have been repaired or extended.
8. **Impacted Teeth** - Removal of impacted teeth (except as covered under Medical Benefits).
9. **Implants/Bridges** - Implants and/or bridges involving implants are not covered.
10. **Jaw Joints** - Services or supplies related to chewing or bite problems, pain in the face, ears, jaws, or neck resulting from problems of the jaw joint(s). Also known as Temporomandibular Joint Disorders (TMJ). Benefits are limited to the x-rays and exam only.
11. **Missed Appointment** - Charges for missed appointment or for completion of claim forms.
12. **Missing Teeth** - Services related to teeth that were missing before you had this coverage.
13. **Multiple Dentists** - Dental services done by more than one dentist - if a person transfers from the care of one dentist to the care of another dentist during the same course of treatment or if more than one dentist renders services for the same procedure, benefits are provided only for the amount payable if only one dentist had performed the service.
14. **Not Accepted Standard Dental Practice** - Services or supplies that do not meet accepted standard of dental practice.
15. **Not Medically Necessary** - Services or supplies that are not Medically Necessary.
16. **Orthodontics** - Charges for orthodontic procedures, treatment and appliances.
    a. The entire course of Active Orthodontic Treatment and any preliminary Orthodontic evaluation or exposure or extraction of teeth are excluded from being Covered Dental Services (and no benefits are payable) if the Date Started for the Active Orthodontic Treatment is prior to the Enrollment Date of coverage.
    b. Orthodontic Benefits are provided only for or in connection with Active Orthodontic Treatment to correct a Handicapping Malocclusion.
    c. Covered Dental Expenses for Orthodontics do not include orthodontic evaluation or exposure or extraction of teeth, which is not an essential preliminary to Active Orthodontic Treatment, which is actually performed.
17. **Treatment and Canceled Coverage** - Treatment after a person is no longer covered by this Plan, even though treatment began before coverage ended, except that if dentures were ordered and fitted while coverage was still in force, payment will be made if the dentures are delivered within 31 days after coverage ended. Further, a person may have extended coverage for the completion of dental services under a Treatment Plan approved by TCC Benefits Administrator prior to termination of coverage, provided the dental services are completed within 30 days from the date of approval of the Treatment Plan.

18. **Vertical Dimension/ Occlusion** - Appliances or restoration necessary to increase vertical dimensions or to restore an occlusion.
19. **Workers Compensation Coverage** - Services or supplies covered by Worker's Compensation.

COMMON DENTAL DEFINITIONS

NOTE: *The following definitions are for informational purposes only. Please refer to your Schedule of Benefits for Benefits that are available under your Plan.*

"Abutment": a tooth or root that retains or supports a fixed bridge or a removable prosthesis.

"Acid Etch": the etching of a tooth with a mild acid to aid in the retention of composite filling material.

"Acrylic": plastic materials used in the fabrication of dentures and crowns and occasionally as a restorative filling material.

"Anesthesia":

a. "Local" the condition produced by the administration of specific agents to achieve the loss of pain sensation in a specific location or area of the body.
b. "General" the condition produced by the administration of specific agents to render the patient completely unconscious and without pain sensation.

"Appliance": a device used to provide function, therapeutic (healing) effect, space maintenance, or as an application of force to teeth to provide movement or growth changes as in Orthodontics.

a. "Fixed" one that is attached to the teeth by cement or by adhesive materials and cannot be removed by the patient.
b. "Removable" one that can be taken in and out of the mouth by the patient.
c. "Prosthetic" used to provide replacement for a missing tooth.

"Bitewing": a type of dental x-ray that has a central tab or wing upon which the teeth close to hold the film in position. They are commonly called decay detecting x-rays because they show decay better than other x-rays.

"Bridgework or Prosthetic Appliance":
a. "Fixed" pontics or replacement teeth retained with crowns or inlays cemented to the Natural Teeth, which are used as abutements.
b. "Fixed Removable" one which the dentist can remove but the patient cannot.
c. "Removable" a partial denture retained by attachments which permit removal of the denture, normally held by clasps.

"Caries": A disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

"Composite": tooth colored filling materials primarily used in the anterior teeth.

"Crown": a natural crown is the portion of the tooth covered by enamel. An artificial crown (cap) restores the anatomy, function, and esthetics for the natural crown.

"Dental Hygienist": a person who has been trained to clean teeth, and provide additional services and information on the prevention of oral disease.

"Dentist": any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

"Denture": a device replacing missing teeth. The term usually refers to full or partial dentures but it actually means any substitute for missing Natural Teeth.

"Endodontic Therapy": treatment of diseases of the dental pulp and their sequelae.

"Fluoride": a solution of fluorine which is applied topically to the teeth for the purpose of preventing dental decay.

"Implant": a device surgically inserted into or onto the jawbone. It may support a crown or crowns, partial denture, complete denture or may be used as an abutment for a fixed bridge.

"Impression": a negative reproduction of a given area. It is made in order to produce a positive form or cast of the recorded teeth and/or soft tissues of the mouth.

"Inlay": a restoration usually of cast metal made to fit a prepared tooth cavity and then cemented into place.

"Occlusion": the contact relationship of the upper and lower teeth when they are brought together.

"Onlay": any cast restoration that covers the entire chewing surface of the tooth.

"Orthodontics"; the branch of dentistry primarily concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in their relationship to the jaws.

"Palliative": an alleviating measure. To relieve, but not cure.

"Partial Denture": a prosthesis replacing one or more, but less than all, of the Natural Teeth and associated structures; may be removable or fixed, one side or two sides.

"Pedodontics": The specialty of children's dentistry.

"Periodontics": The science of examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth.

"Pontic": the part of a fixed bridge which is suspended between the abutments and which replaces a missing tooth or teeth.

"Prophylaxis" The removal of tartar and stains from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

"Rebase": a process of refitting a denture by the replacement of the entire denture-base material without changing the occlusal relations of the teeth.

"Reline": to resurface the tissue-borne areas of the denture with new material.

"Restoration": a broad term applied to any inlay, crown, bridge, partial dentures, or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. Restoration is achieved after repairing or reforming the shape, form and function or part or all of tooth or teeth.

"Root Canal Therapy": the complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals, and filling these spaces with a sealing material.

"Scaling": the removal of calculus (tartar) and stains from teeth with a special instrument.

"Sealant": a resinous agent applied to the teeth to reduce decay.

"Silicate": a relatively hard and translucent restorative material that is used primarily in the anterior teeth.

"Splinting": stabilizing or immobilizing teeth to gain strength and/or facilitate healing.

“Topical”: Painting the surface of teeth as in fluoride treatment, or application of an anesthetic formula to the surface of the gum.

“Vertical Dimension”: the degree of jaw separation when the teeth are in contact.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan of Benefits for Employees and their Dependents shall be in accordance with the Eligibility, Participant Effective Date and Termination provisions as stated in this Plan of Benefits document.

ELIGIBILITY

To be eligible for coverage under the Plan of Benefits an employee must:

A. Who is Actively at Work on a regular, full time basis for at least thirty (30) hours per week and has completed Probationary Period on or after the Employer Effective Date is eligible to enroll (and to enroll his or her Dependents) for coverage under this Plan of Benefits.

B. If an Employee is not Actively at work on a regular, full time basis for at least thirty (30) hours per week 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 is:

   1. Actively at Work on a regular, full time basis for at least thirty (30) hours per week; and
   2. Has Completed the Probationary Period.

C. If a part-time employee becomes eligible for full-time employee benefits, and has been employed more than thirty (30) days; coverage will become effective the first day of the following month.

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

E. Probationary Periods and/or contribution levels will not be based on any factor which discriminates in favor of higher wage employees as required under PPACA.

No corporate officer or director will be eligible solely due to the person's title. The person must be an active Employee to be eligible.

ANNUAL ENROLLMENT PERIOD

Employees who do not enroll within thirty-one (31) days from date of hire must wait until the Annual Enrollment Period (**month of December)** to enroll for coverage unless eligible for Special Enrollment. Coverage for employees enrolling during the Annual Enrollment Period or during a Special Enrollment period will become effective on the **first day of the month following enrollment.**

DEPENDENT ELIGIBILITY

Dependents of Covered Employees will be required to provide their social security number to the Claims Administrator. This is necessary to allow the Claims Administrator to comply with any and all reporting requirements imposed under federal CMS guidelines.

Dependent: an individual who is:

1. An Employee's spouse;
2. A Child under the age set forth on the Schedule of Benefits;
3. A Child who is on a physician approved, Medically Necessary Leave of Absence; or
4. An Incapacitated Dependent

(1) A covered Employee's Spouse and children from birth to the limiting age of 26 years. When the child reaches the age of 26, coverage will end on the last day of the month of the child's birthday. Notwithstanding the preceding, a dependent child under the age of 26 who is eligible to enroll in an employer sponsored health plan other than a Group Health Plan of a parent are not eligible.

Plan may request verification of a dependent child's eligibility on an annual basis between the ages of 20 and 26. Such verification shall only relate to the dependent child's eligibility to enroll in an employer sponsored health plan other than a Group Health Plan of a parent

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, legally adopted children, step child, foster child or a child under legal guardianship.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(2) A Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

Incapacitated Dependent: a Child who is:

a. Incapable of financial self-sufficiency by reason of mental or physical disability; and,
b. 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. The Employee will update items (1) and (2) each year or upon the Claims Administrator's request. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

The Plan Administrator reserves the right of subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage; A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

EFFECTIVE DATE OF COVERAGE

PARTICPANT EFFECTIVE DATE

Employee coverage under this Plan of Benefits is effective with respect to an eligible employee on the date this Plan of Benefit's enrollment requirements have been met, provided the Employee is Actively at Work on that date and the Employee has applied for coverage on or before such date. If the Employee applies for coverage within thirty-one **(31)** days of becoming eligible, the Employee's coverage shall become effective on the first day of the month following enrollment. If an Employee is not in active service on the date coverage would otherwise become effective, coverage shall become effective on the date he or she returns to active service.

If the Claims Administrator receives an Employee's Membership Application dated after the Employer Effective Date, coverage will commence on the date chosen by the Employer. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Claims Administrator receives such Employee's Membership Application.

Late Enrollee Provision

An Employee who enrolls for coverage under this Plan of Benefits other than during the first period in which the Employee is eligible to enroll (if such initial enrollment period lasts at least thirty (30) days) or during a Special Enrollment period, is a Late Enrollee and is subject to the requirements of this provision.

Special Enrollment Period

A Special Enrollment Period is a period during which an Employee or Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage under certain permitted circumstances. A Special enrollment Period applies (and the Employee or Dependent may enroll in this Plan of Benefits) if:

A. The Employee or Dependent was covered under another Group Health Plan or had Health Insurance coverage at the time coverage was previously offered to the Employee or Dependent; and
B. The Employee provided a written statement at the time of eligibility that other Health Insurance Coverage was the reason for declining enrollment, provided the Employer required such a statement and notified the Employee of this requirement and the consequences for non-compliance; and
C. The Employee's or Dependent's coverage described above:
    1. was under a COBRA continuation provision and the coverage was exhausted, or
    2. was not under a COBRA continuation provision and the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment), or reduction in the number of hours of employment, or if the employers contributions toward the coverage were terminated; or
    3. was either 1) one of multiple plans offered by an employer and the Employee elected a different plan during an open enrollment period or 2) when an employer terminates all similarly situated individuals; or
    4. was under another benefit plan that no longer serves the area in which the Employee lives, works or resides; or
    5. was under a Plan where the Participant incurs a claim that would meet or exceed an annual limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to operation of the annual limit on all benefits; and
D. The Employee or Dependent requests such enrollment not more than thirty-one (31) days after date of exhaustion of coverage or termination of coverage or Employer contribution.
F. The Dependent was not a Participant of the plan prior to revision of the Dependent eligibility section to include Dependent to age 26 and the Dependent elects to participate within 30 days of receipt of notice (by the Dependent or the Employee associated with such Dependent) of the opportunity to enroll.
G. Special Enrollment Period Related to Medicaid and SCHIP, the Participant or Dependent may be eligible for Special Enrollment in the Plan if the Participant or Dependent;
    1. lose coverage under a Medicaid or a State Children's Health Insurance Program under titles XIX and XXI of the Social Security Act (referred to, respectively, as "Medicaid Plan" and "State Plan"); or
    2. become eligible for Group Health Plan premium assistance under a Medicaid Plan or State plan; and

3. the Participant requests enrollment in the Plan within 60 days after the coverage under the Medicaid or State Plan ends and the Participant or the Dependent become eligible for premium assistance under a Medicaid or State Plan.

If the Participant meets these requirements coverage will be effective on the first day of the month following receipt of the fully completed enrollment.

To verify the Participant's eligibility for this Special Enrollment, the Claims Administrator may request and obtain additional information.

Under the Special Enrollment provisions of this Plan of Benefits, if an Employee is enrolled in or is eligible under a Plan of Benefits and he/she marries, has a child or adopts a child (or child placed for adoption), the new Dependent(s) may obtain coverage under this Plan of Benefits. The Employee and Employee's spouse may also enroll at this time as long as they meet this Plan of Benefit's eligibility requirements. Coverage must be added or terminated within thirty-one (31) days of such event. Coverage will be effective on the date of the event. If coverage is added more than thirty-one (31) days from the life event/family status change or special enrollment event, such enrollee will be considered a Late Enrollee and subject to all Late Enrollee provisions.

You may request a Certificate of Creditable Coverage at any time by contacting the TCC Benefits Administrator Customer Service Department at 1 (800) 815-3314.

DEPENDENT EFFECTIVE DATE

Coverage for Dependents will commence as follows:

A. If (during the Employee's initial eligibility period) the Employee submits an enrollment form requesting Dependent coverage, the Dependent(s) will be covered on the same date that Employee coverage becomes effective.

B. If a Covered Employee requests coverage for his Dependent(s) within thirty-one **(31)** days from the date the Employee acquires the Dependent(s), but after the date on which Employee Coverage became effective, coverage for the Dependent will become effective on the first day of the month following enrollment.

C. If a Covered Employee requests coverage for his Dependent(s) more than thirty-one **(31)** days from his Effective Date of coverage, such Dependent will be a Late Enrollee and subject to all Late Enrollee provisions.

D. If a Dependent child is properly enrolled as a Dependent within thirty-one **(31)** days of the child's date of birth, the Child will be covered from the moment of birth, subject to the covered medical expenses and exclusions of this Plan of Benefits. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.

E. For adopted and foster children of the Employee, coverage shall commence as follows:

1. If the Employee provides the Plan Administrator with a decree of adoption thirty-one (31) days after the date of the child's birth, coverage will be retroactive to the moment of the Child's birth.

2. If the Employee institutes adoption proceedings within thirty-one (31) days after the child's birth and the Employee has obtained temporary custody of this child, coverage shall be retroactive to the moment of the Child's birth.

3. For adopted children other than Newborns, coverage shall begin upon Employee's obtaining temporary custody. Such coverage may continue for up to a year; provided that if an order of adoption is entered, the coverage shall continue so long as the child meets the definition of a Dependent. Coverage may be extended upon order of a court.

F. For any Employee or Dependent enrolling during the annual enrollment period, coverage will become effective January 1st of the following year.

In all cases, any required premium must be paid before coverage will become effective.

For a spouse taking Dependent coverage based on the birth, placement or adoption of a child, coverage shall commence on the same date for the spouse as would apply to the child.

Each Employee who wants coverage for his Dependent(s) hereunder must submit a request for coverage (on a form approved by the Plan Administrator).

SPECIAL ENROLLMENT GRID

Members and Dependents are generally eligible to enroll in the health plan within 31 days of being hired, during open enrollment or when certain events occur during the plan year. This enrollment grid outlines the events that give rise to a right to enroll in coverage as well as the documentation required. The effective date outlined below will apply provided that the Member has enrolled (or enrolled their Dependent) within 31 days of the event. If a Member does not enroll (or enroll the Member's Dependent) within 31 days of the event, the Member (or the Member's Dependent) will not be eligible to enroll until the next open enrollment period.

EVENT	**EFFECTIVE DATE**	**DOCUMENTATION REQUIRED**
MARRIAGE	date of marriage	Verification of the date of marriage and the application to add a new spouse.
DIVORCE	date of divorce	A copy of the first and last pages of the divorce decree is required. The date the ex-spouse is terminated will coincide with the date the divorce decree is signed.
BIRTH	date of birth	The application to add the newborn child.
DEATH	date of death	An application to notify Intramed Plus, Inc. of the death and company policy on continued coverage for covered survivors.
ADOPTION (placement or final)	date of legal adoption or placement for adoption	The court documents are required.
SPOUSE GAIN OR LOSS OF COVERAGE	date the coverage is lost or gained	The spouse must obtain a letter from his or her employer or prior carrier stating: a. the termination date b. the type of coverage c. reason for termination
SPOUSE HAS SIGNIFICANT DOLLAR INCREASE IN COVERAGE	date the coverage increased more than 20%	The spouse must obtain a letter from his/her employer prior carrier stating: a. the termination date b. the type of coverage c. reason for termination d. amount of old and new premiums

TERMINATION OF COVERAGE

A. TERMINATION OF COVERED EMPLOYEE'S COVERAGE

Except as provided in the Group Health Plan's COBRA continuation provision, coverage will terminate on the earliest of the following occurrences:

1. The date employment is terminated except when the covered employee has dependent coverage and contributes toward the cost of such coverage. Then coverage may end on the last day of the month during which the employee is terminated;
2. If the covered Employee fails to remit required contributions for his coverage when due, his coverage will terminate at the end of the period for which contribution was made;
3. The date that the covered Employee ceases to be in a class eligible for coverage;
4. The termination date of the Group Health Plan;
5. The date the Employee dies;
6. The date an Employee retires unless this Plan of Benefits covers such individual as a retiree.
7. 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.
8. In the event the Employer ceases to offer coverage for a particular type of group health insurance, they must provide notice to each Participant receiving this type of coverage at least ninety (90) days prior to said date; the Employer must offer to each Participant receiving this type of coverage the option to purchase any other Health Insurance Coverage currently being offered by the Employer, and the Employer must act uniformly without regard to the claims experience of those sponsors or any health status related factor relating to any Participants or new participants who may become eligible for such coverage.

Ceasing active work will be deemed to be termination of employment. However, if you are not at work due to one of the reasons shown below, your employment will be deemed to continue for the period of time shown:

Reason you Stopped Active Work	Period of Time
Sickness or Injury	60 days
Layoff	None
Authorized Non-Medical Leave of Absence	60 days

B. TERMINATION OF COVERED DEPENDENT'S COVERAGE

Except as provided in the Plan of Benefit's COBRA continuation provision, coverage will terminate on the earliest of the following occurrences:

2. The day on which the covered Employee's coverage is terminated;
3. At the end of the period for which contributions were made by the covered Employee for the covered Dependent;
4. The date the covered Employee ceases to be in a class eligible for Dependent coverage;
5. The date the covered Dependent becomes eligible as a covered Employee;
6. The date Dependent coverage is discontinued under the Plan of Benefits;
7. The termination date of the Plan of Benefits.

8. The date of entry of an order or decree ending the marriage between the Dependent spouse and Employee regardless of whether such order or decree is subject to appeal.
9. The date when the dependent child no longer meets the definition of a child under this Plan of Benefits.
10. The date that an incapacitated dependent no longer meets the definition of an incapacitated dependent.
11. Death of an Employee

C. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If a Participant fails to pay the Premium during the Grace Period, such Participant shall automatically be terminated from participation in the Employer's Group Health Plan, without prior notice to such Participant.
2. In the event of termination for failure to pay Premiums, Premiums received after termination will not automatically reinstate the Employee in participation under the Employer's Group Health Plan absent written agreement by the Employer. If the Employee's participation in the Employer's Group Health Plan is not reinstated, the late Premium will be refunded to the Employee.

D. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium. If Premiums are not paid by an Employee coverage ends as of the due date of that Premium contribution.

E. NOTICE OF TERMINATION TO PARTICIPANTS

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

F. REINSTATEMENT

The Employer's Group Health Plan in its sole discretion (and upon such terms and conditions as any stop-loss carrier or the Employer may determine) may reinstate coverage under the Employer's Group Health Plan that has been terminated for any reason. If a Participant's coverage (and including coverage for the Participant's Dependents) for Covered Expenses under the Employer's Group Health Plan terminates while the Participant is on leave pursuant to the Family and Medical Leave Act because the Participant fails to pay such Participant's Premium, the Participant's coverage will be reinstated without new Probationary Periods if the Participant 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. EMPLOYER IS AGENT OF PARTICIPANTS

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

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan of Benefits or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Name of Entity/Sender:	Intramed Plus, Inc.
Contact—Position/Office:	Human Resources Department
Address:	112 Saluda Ridge Court, Suite 100 West Columbia, SC 29169
Phone Number:	(803) 794-0200

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Name of Entity/Sender:	Intramed Plus, Inc.
Contact—Position/Office:	Human Resources Department
Address:	112 Saluda Ridge Court, Suite 100 West Columbia, SC 29169
Phone Number:	(803) 794-0200

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity/Sender:	Intramed Plus, Inc.
Contact—Position/Office:	Human Resources Department
Address:	112 Saluda Ridge Court, Suite 100 West Columbia, SC 29169
Phone Number:	(803) 794-0200

Or you may contact our COBRA Administrators:

Gibson & Associates, Inc.
Attn: COBRA Department
7139 Broad Rover Road
Irmo, SC 29063
(803) 772-0100 ext. 218 or toll free (800) 733-3391 ext. 218

SUBROGATION / RIGHT OF REIMBURSEMENT

In the event benefits provided to or on behalf of a Participant under the terms of this Plan of Benefits, the Participant agrees, as a condition of receiving benefits under the Plan of Benefits, to transfer to the Group Health Plan or its designee, including the Claims Administrator all rights to recover damages in full for such benefits when the Injury or Illness occurs through the act or omission of the Participant, another person, firm, corporation, organization or business entity. The Group Health Plan shall be subrogated, at its expense, to the rights of recovery of such Participant against any third party who is liable, responsible, or otherwise makes a payment for the Injury or Illness.

If, however, the Participant has an Injury or Illness from which occurred by an act or omission of the Participant or an act or omission of a third party, and the Participant receives a settlement, judgment, or other payment relating to the injury or illness from another person, firm, corporation, organization or business entity, the Participant agrees to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the Injury or Illness.

The Plan's subrogation / reimbursement rights apply regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical benefits, pain and suffering, lost wages, any other specified damages, or whether the Participant has been made whole or fully compensated for his/her injuries.

The Plan's subrogation / reimbursement interest extends to all benefits paid or payable by the Plan relating to the injury or illness, even if those expenses were not submitted to the Plan for payment at the time the Participant received the settlement, judgment or payment.

The Group Health Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, malpractice insurance; the Participant's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal Injury protection (PIP), malpractice, or any other first or third party insurance coverage's which are paid or payable.

The Group Health Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization of the Group Health Plan.

The Participant shall not do anything to hinder the Group Health Plan's right of subrogation and/or reimbursement. The Participant shall cooperate with the Group Health Plan and execute all documents and do all things necessary to protect and secure the Group Health Plan's right of subrogation and/or reimbursement, including assert a claim or lawsuit against the third party or any insurance coverage's to which the Participant may be entitled. Failure to cooperate with the Group Health Plan will entitle the Group Health Plan to withhold benefits due the Participant under this Plan of Benefits Document. Failure to reimburse the Group Health Plan as required will entitle the Group Health Plan to deny future benefit payments for all Participants under this policy until the subrogation/reimbursement amount has been paid in full.

COORDINATION OF BENEFITS

A. APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Participant for the same Covered Expenses. The rules determine which is the Primary Plan and which is the Secondary Plan. Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the Coordination of Benefits with Medicare may also apply.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

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

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE PARTICIPANTS

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

1. The other Plan has rules coordinating its benefits with those of the Employer's Group Health Plan; and,

2. Both the other Plan's rules and the Employer's Group Health Plan's rules require that Benefits be determined under the Employer's Group Health Plan before those of the other Plan; or,

3. There is a statutory requirement establishing that the Employer's Group Health Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA.

D. ADDITIONAL ORDER OF DETERMINATION RULES

The Employer's Group Health Plan coordinates Benefits for non-Employee Participants using the first of the following rules that apply:

1. Dependents

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

2. Dependent Child - Parents not Separated or Divorced

    When the Employer's Group Health Plan and another Plan cover the same Child as a Dependent then benefits are determined in the following order:
    a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.
    b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.
    c. If the other Plan and the Employer's Group Health Plan do not both use the "birthday rule" or if the "birthday rule" used by the other Plan is not consistent with a and b, above, then the Employer's Group Health Plan will pay one half of the Covered Expenses. The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents

    If two (2) or more Plans cover a person as a Dependent Child of divorced, separated, or unmarried parents, benefits for the Child are determined in the following order:
    a. First, the Plan of the parent with custody of the Child;
    b. Second, the Plan of the parent's spouse with the custody of the Child;
    c. Third, the Plan of the parent not having custody of the Child;
    d. Fourth, the Plan of the parent's spouse not having custody of the Child.

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

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined in this section (D)(2).

4. Active and Inactive Employees

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

5. Medicare

The Employer's Group Health Plan is a Secondary Plan with respect to Medicare benefits except where federal law mandates that the Employer's Group Health Plan be the Primary Plan. Any claims where Medicare is primary must be filed by the Participant after Medicare payment is made.

Active Employees

Active employees and dependents that are age 65 and over must elect either:

a. **To participate in the Plan.** If the employee elects to participate in the Plan, then the Plan will be the participant's primary medical coverage and Medicare will be the participant's secondary medical coverage' or

b. **To not participate in the Plan.** If the employee elects not to participate in the Plan, Medicare will be the participant's only medical coverage.

The Dependent spouse, age 65 and over, of any active employee, must also make an election.

If the employee declines medical coverage under the Plan, such employee's Dependent spouse will not be eligible to participate in the Plan. If the employee elects to participate in the Plan, such employee's Dependent spouse may elect to either participate in the Plan or decline to participate in the Plan.

Retirees

If Employer has a Retiree program - and retirees are eligible to participate in the Plan, the Plan is secondary to Medicare for any retirees who elect coverage under the Plan.

Coordination

This group coordinates benefits with Medicare by applying the "Carve-Out" rule. The concept of this rule is to "carve-out" or subtract Medicare's payment from what this Plan would have paid in the absence of the Medicare payment. This plan will then pay the remaining amount as secondary benefits. The benefits payable by Medicare and benefits payable by this Plan will not total more than the allowable charge.

When Medicare is primary and the Plan is secondary, Medicare (Parts A and B) will be considered a plan for the purposes of coordination of benefits. The Plan will coordinate benefits with Medicare whether or not the participate or their covered Dependent spouse is/are actually receiving Medicare benefits.

MEDICARE FOR DISABLED BENEFICIARIES UNDER AGE 65*

The Group Health Plan is primary and Medicare will be secondary for the Covered Employee and their Covered Dependent spouse or child who is under age 65 and eligible for Medicare by reason of disability.

*For Plans with 100 or more participants. (If under 100 participants, Medicare is primary for disabled individuals).

MEDICARE FOR PERSON WITH END STAGE RENAL DISEASE (ESRD)

For Employees or Dependents under age 65, or 65 and over and still Actively at Work, if Medicare eligibility is due solely to End-Stage Renal Disease (ESRD), this Plan of Benefits will be primary during the first thirty (30) months of Medicare coverage. Thereafter, this Plan of Benefits will be secondary with respect to Medicare coverage. If an Employee or Dependent is age 65 or over, working and develops or is undergoing treatment for ESRD, Medicare will become primary as of the month they become entitled to ESRD benefits.

6. Longer and Shorter Length of Coverage

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

7. COBRA

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

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. The Employer's Group Health Plan as Primary Plan

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

2. The Employer's Group Health Plan as Secondary Plan

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

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

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

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be a Covered Expense.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Participant's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Participant does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

G. PAYMENT

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

H. RIGHT OF RECOVERY

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

ERISA RIGHTS

If this Plan of Benefits is covered by ERISA, each Participant in this Group Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information about the Plan and Benefits

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

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

Receive, upon request, a summary of the Employer's Group Health Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continuation Coverage

Participants are entitled to continue health care coverage for themselves and their Dependents if there is a loss of coverage under the Group Health Plan as a result of a Qualifying Event. The Participant or Dependents may have to pay for such continuation coverage. Review this Plan of Benefits and the documents governing the Group Health Plan on the rules governing COBRA continuation coverage rights.

Participant may be entitled to a reduction or elimination of Pre-existing Conditions Waiting Periods under your Group Health Plan could apply if you have Creditable Coverage from another plan. Participants should be provided a certificate of credible coverage, free of charge, from the Participants prior Group Health Plan or health insurance issuer when:

a. The Participant loses coverage under such Group Health Plan; or,
b. When the Participant becomes entitled to elect COBRA continuation coverage; or,
c. When the Participant's COBRA continuation coverage ceases.

A Participant is entitled to a certificate of Creditable Coverage if such Participant requests it before losing coverage, or if the Participant requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, the Participant be subject to a Pre-Existing Condition Waiting Period for twelve (12) months (eighteen (18) months for Late Enrollees) after the Participants enrollment date.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, 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 Participants. The Employer is the fiduciary of the Employer's Group Health Plan.

Enforcement of Employee Rights

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

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

No one, including the Employer, the Participant' 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.

Assistance with Questions

If a Participant has any questions about the Group Health Plan, the Participant should contact the Plan Administrator. If a Participant has any questions about this statement or about a Participant's rights under ERISA, or if a Participant needs assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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 Participant may also obtain certain publications about the Participant's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

In accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), this Plan will provide continuation of coverage to covered Staff Members (and/or dependents) if the Staff Member is absent from employment by reason of service in the uniformed services. Staff Members performing military duty of more than 30 days may elect to continue coverage; however, the Staff Member may be required to contribute up to 102% of the full cost of coverage.

Health Insurance Protection:

If a Staff Member leaves employment to perform military service, the Staff Member has the right to elect to continue their existing coverage for the Staff Member and his eligible dependents for the maximum periods of coverage as follows:

A. The 24 month period beginning on the date on which the Staff Member's absence begins; or
B. The day after the date on which the Staff Member fails to apply for or return to a position of employment if deployment is less than 24 months.

If the Staff Member does not elect to continue coverage during his military service, the Staff Member has the right to be reinstated under this coverage when he is reemployed, without any waiting periods or exclusions expect for service-connected illnesses or injuries

Termination of USERRA Coverage:

Coverage continuation will terminate on the earliest of the following:

A. The date the employer ceases to provide any group health plan to any Staff Member and/or covered dependent;
B. The date the required contribution is not made;
C. The date the Staff Member is no longer considered an employee;
D. The date the Staff Member or covered dependent reaches the end of the 24 month continuation.

NOTE: At the end of the 24 month USERRA period if the Staff Member is still deployed, the Staff Member (and/or eligible dependents) will be entitled to continuation coverage under the provisions of COBRA, whether or not the coverage was continued under USERRA coverage provisions.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Coverage for Re-constructive Surgery Following Mastectomies

This Plan of Benefits provides medical and surgical benefits with respect to a mastectomy. In a case of a beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

C. Prosthesis and physical complications at all stages of mastectomy, including lymphedemas.

The Plan of Benefit's Benefit Year Deductible and Copayment will apply to these benefits.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Group Health Plan shall at all times comply with FMLA as outlined in the regulations issued by the Department of Labor. During any leave taken under the FMLA, the Employer will maintain coverage under this Plan of Benefits on the same basis as coverage would have been provided if the Employee had been continuously employed during the entire leave period.

WORKERS' COMPENSATION PROVISION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Participant that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Participant. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Participant but the Participant elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Participant sought treatment for the injury or illness from a provider which is not authorized by the Participant's employer.

If the Employer Group Health Plan, or its designee, including the Claims Administrator pays benefits for an injury or illness and the Plan determines the Participant also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, Participant shall reimburse the Plan in full all benefits paid by the Plan relating to the injury or illness.

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

As a condition of receiving benefits under this Plan of Benefits, the Participant agrees to notify the Plan of any Workers' Compensation claim he/she may make and agrees to reimburse the Plan as described herein. The Participant shall not do anything to hinder the Plan's right of recovery. The Participant shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the Workers' Compensation carrier or any other insurance coverage's to which the Participant may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold benefits due the Participant under this Plan of Benefits. Failure to reimburse the Plan as required under this section will entitle the Plan to invoke the Workers' Compensation Exclusion and deny payment for all claims relating to the injury or illness and/or deny future benefit payments for any such Participant until the reimbursement amount has been paid in full.

GENETIC INFORMATION NONDISCRIMINATION ACT ("GINA").

Genetic Information Nondiscrimination Act ("Gina"). "**GINA**" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information. The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards. "Family members" include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. "Underwriting" includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting. GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary. The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception. While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Final Acceptance by the Group for the attached Plan of Benefits dated October 1, 2014

IN WITNESS WHEREOF, Intramed Plus, Inc. has caused its name to be signed by its proper officer thereunto duly authorized to evidence the adoption of this Plan on the below date.

By _____

Title CEO

Date 12-1-14