SELF-FUNDED
PLAN DOCUMENT
FOR

GROUP MEDICAL
&
DENTAL PLAN

Revised October 1st 2010

ADMINISTRATIVE INFORMATION

Benefit Year:		Begins January 1st of each year and continues for 12 consecutive months through December 31st.
ERISA Plan Name:		**INTRAMED PLUS, INC. HEALTH AND DENTAL PLAN**
Employer Establishing the Plan:		**INTRAMED PLUS, INC.** 112 SALUDA RIDGE COURT, SUITE 100 WEST COLUMBIA, SC 29169
Employer Federal ID Number:		**57-0929502**
ERISA PLAN Number:		**788**
Type of Welfare Plan:		Medical and Dental Plan
Plan Funding:		Paid by the Employer and/or the Employee determined by the level of coverage (employee, employee spouse, family) selected.
Claims Administrator:		**Thomas H. Cooper & Co., Inc. (TCC of SC)** P. O. Box 22557 Charleston, SC 29413 (843) 722-2115/(800) 815-3314
Agent for Service of Legal Process:		**INTRAMED PLUS, INC.**
Plan Administrator:		**INTRAMED PLUS, INC.**
Named Trustee:		**INTRAMED PLUS, INC.**
Named Fiduciary:		**INTRAMED PLUS, INC.**
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.
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 of SC (*)

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 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.intramedbenefits.com 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 summary plan description**
- **Leave customer service messages that will be responded to within 24 hours**

INTRODUCTION

Employer has established this Group Heath 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 are legally enforceable and that the Plan 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.

PLAN AMENDMENTS
This document contains all the terms of the Plan of Benefits and may be amended from time to time by the Plan Administrator. Any changes so made shall be binding on each Covered Participant and on any other participants referred to in this plan document. When necessary, the Claims Administrator and/or INTRAMED PLUS, INC., will have the authority and right to amend the contents of this Plan of Benefits.

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.

ERISA
It is the intention of the Employer to establish hereby a program of benefits constituting an "Employee Welfare Benefit Plan" otherwise called a "Group Benefit Plan" under the Employee Retirement Income Security Act (ERISA) of 1974 and any amendments thereto.

LEGAL ACTIONS
No action at law or in equity can be brought under the Group Health Plan until you have exhausted the administrative process (including the exhaustion of all appeals) as described in this booklet. No such action can be brought against the Group Health Plan more than six years after Claims Administrator receives a claim.

ADMINISTRATIVE SERVICES ONLY
TCC 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.

CLERICAL ERRORS
Clerical errors by TCC of SC 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.

GOVERNING LAW
The Employer's Group Health Plan 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.

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 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.

NEGLIGENCE OR MALPRACTICE
TCC 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 TCC the Employer. TCC 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 TCC:
   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 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. The Employer is responsible for notifying TCC and Participants of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS
On occasion, TCC (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) 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. Where a Participant has received Benefits from a Participating Provider or contracting provider, the Employer's Group Health Plan may pay Covered Expenses directly to such Participating Provider or contracting 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) may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
The term Medical Child Support Order means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

A. Provides for child support with respect to a child of a participant under this Plan or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and related to benefits under this contract, or

B. 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.

For further information on QMCSO please contact TCC of SC at (843) 722-2115 or (800) 815-3314 or go to www.tccofsc.com for the procedures.

Note: The QMCSO procedures for the Plan are available without charge from the Plan Administrator.

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.

Uses and Disclosures of Medical Information with Your Written Authorization

Unless expressly permitted by law, you and your dependent(s)'s Protected Health Information (PHI) generally cannot be released to any person without your or your dependent(s)'s (by South Carolina law where the dependent is over the age of 16) consent. However there may be instances when you want someone to discuss your PHI with TCC of SC, receive an explanation of benefits, etc. on your behalf to manage your care. In order for TCC of SC to be in compliance with applicable laws and comply with your request, you must provide us with a signed written authorization form. To obtain a copy of the authorization form, please visit the TCC of SC website at www.tccofsc.com, click on member services and then select "forms". Once you have printed and completed this form, please mail it to the TCC of SC address also located on the website. You can also obtain a copy of the form by calling 1-800-815-3314.

Uses and Disclosures of Medical Information without Your Written Authorization

As provided in the HIPAA Privacy Rule, a health plan, healthcare provider, and a healthcare clearinghouse are here to fore referred to as a "covered entity".

The HIPAA Privacy Rule permits a covered entity to use and disclose protected health information, without an individual's authorization, but with certain limits and protections, for treatment, payment, and health care operations activities. The following are examples of what these uses and disclosures might entail:

Treatment: includes provisions, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of patient by one provider to another.

Payment: encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual and activities of a health care provider to obtain payment or be reimbursed for the provision of a health care to an individual.

Health care operations: any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying PHI, creating a limited data set, and certain fundraising for the benefit of the covered entity.

The amount of health information used or disclosed will be limited to the minimum necessary for these purposes.

ABOUT YOUR PLAN

Your Employer has selected preferred comprehensive group Health Insurance Coverage and has retained the services of a Claims Administrator, experienced in processing and paying health claims to provide consulting services in connection with the operation of the Plan. Your Claims Administrator is **TCC of South Carolina (TCC of SC),** located in Charleston, South Carolina. The Claims Administrator has contracted with the **BlueCross and BlueShield of South Carolina Preferred Blue Network** as the Preferred Provider Organization (PPO). Employees or dependents who reside outside the state of South Carolina may use **Private Health Care Systems (PHCS)** Network as the Preferred Provider Organization (PPO). Employee or Dependent residents of South Carolina traveling outside the 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.

You will receive maximum benefits when you use PPO Providers and obtain authorization, when required, for services. You will pay more if you do not use PPO Providers and if you do not receive prior authorization (unless an emergency) as outlined within this plan document. The following information explains what a PPO Provider is and how you obtain authorization from the Medical Services Department for Medically Necessary services or supplies which this plan document outlines.

PPO Providers are Hospitals, skilled nursing facilities, home health agencies, hospices, doctors and other Providers of medical services and supplies who have a written agreement with the above referenced network(s) to do the following:

- File all claims for Benefits or supplies with your Claims Administrator for you;
- Ask you to pay only the Deductible, per occurrence Co-payments 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.

To find out if your Provider is a PPO Provider, and you are a resident of South Carolina; (1) ask your Employer for a PPO Provider Directory at no charge or (2) ask Providers if they are PPO Providers for the Blue Cross and Blue Shield of South Carolina Preferred Blue Network before you receive services or supplies, as they are subject to change, or (3) check the website at www.southcarolinablues.com for Preferred Blue Network Provider information only. For a list of PPO Providers for Employees or dependents who reside outside the state of South Carolina or for employee or dependent residents of South Carolina traveling outside the state who require sudden, unexpected or emergency medical care or treatment from Providers while traveling outside of South Carolina go to www.phcs.com. **Once benefit maximums have been satisfied, PPO discounts no longer apply.**

Providers Who Are Not Participating Providers (Non-PPO) 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 are responsible for the difference between their charge and the allowable charge for Covered Expenses.

Benefits from a Non-Preferred Provider (an Individual or Organization **not** under contract with this Plan's PPO network as a Preferred Provider) will be covered at the Preferred Provider contract benefit level under the following circumstances:

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

Customer Service

TCC of SC 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 your Claims Administrator at the following:

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

How To File Post-Service Claims

If you receive healthcare services or supplies from a Preferred Provider, the Provider will file your claims for you.

If you receive healthcare services or supplies from a Non-preferred Provider or non-Participating Network Pharmacy, you will have to file your own claims. Please follow the instructions below when you have claims for expenses other than Prescription Drugs. When filing your own claims, here are some things you will need:

1. **Itemized Bills from the Providers.** These bills should include:

- Provider's name and address
- Patient's name and date of birth
- Employee's ID number
- Description and cost of each service
- Date that each service took place
- Description of the Illness or Injury (diagnosis)

CLAIMS PROCEDURES

Complete the front of each claim form and attach the itemized bills to it. If the patient has other insurance that has already paid on the claims, be sure to attach a copy of the other plan's Explanation of Benefits (EOB) notice. This will help prevent a delay of your claims processing.

Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we cannot return them to you. Send your claims to TCC of SC, at the address found in the *Customer Service section above.*

Once your claims are processed here at TCC of SC, you will receive an Explanation of Benefits (EOB) in the mail. A sample of the EOB and the explanation of how to read is to follow:

HOW TO READ YOUR TCC
EXPLANATION OF BENEFITS (EOB)

1

INSURED GROUP NAME
TCC
PO Box 22557
Charleston, SC 29413

Return Service Requested

4

SINGLE PIECE
1 1.1128 SP 0.630

JOHN DOE
21 BENTWOOD DR
CHARLESTON, SC 29413

Questions? Please call 1-800-815-3314

2

3

Enrollee: DOE JOHN
Patient: JANE DOE
Member ID: 10001234567
Group: GROUP NAME
Group #: 123
Location 1
Claim #: 012345678-90
Patient #: 012/345678
Date: 03/30/2006

5 **Explanation of Benefits for Services Provided By:**
JAMES A. SMITH, MD

15 16 17

6

Dates of Service	Service Code	Total Charge	COB Paid	Ineligible	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-Pay Amount	Balance	Paid At	Payment Amount
01/01-01/01/2006	Pv	100.00	0.00	0.00	BC	40.00	60.00	0.00	20.00	40.00	100%	40.00
TOTALS		100.00	0.00	0.00		40.00	60.00	0.00	20.00	40.00		40.00
											Total Net Payment	40.00
											Patient Responsibility	20.00

18

7 8 9 10 11 12 13 14 19

20

Payment To:	Check No.	Amount
JAMES A. SMITH, MD	0045678	40.00

21

Service Code	
Pv	PHYSICIAN VISIT

22

Reason Code Description	
BC	BC/BS DISCOUNT: NOT PATIENT LIABILITY

23 **Messages**

*** If this claim has been wholly or partially denied, the member may appeal this decision. To appeal, please send a written request for review within 60 days

1. *Group / Employer name & our billing address.*
2. *Phone number to reach customer service.*
3. *Insured employee and patient information as well as the date the Explanation of Benefits was issued.*
4. *Name & address of the insured employee.*
5. **Explanation of Benefits for Services Provided By:** *Name of the provider of service.*
6. **Dates of Service:** *Date(s) the service/ procedure/ visit took place.*
7. **Service Code:** *Internal code which refers to the type of service. **See below for explanation.*
8. **Total Charge:** *Total charge(s) submitted for service(s)*
9. **COB Paid:** (**Coordination of Benefits)** *Amount paid by other insurance if patient has other coverage.*
10. **Ineligible:** *Any amount excluded from total charges as ineligible for consideration.*
11. **Reason Code:** *Internal code which refers to Ineligible and/ or Discount amounts. ***See below for explanation.*
12. **Discount Amount:** *Any amount excluded from total charges as a discounted amount due to provider contracts etc.*
13. **Covered By Plan:** *Amount to be considered for processing of claim after any exclusions and/ or discounts.*
14. **Deductible Amount:** *Amount applied to deductible if your plan has a deductible to be satisfied. If the deductible has already been satisfied, this amount will be $0.00.*
15. **Co-Pay Amount:** *Amount of co-payment required of the patient if your plan has a co-pay for services.*
16. **Balance:** *Amount remaining considered after any deductible and/ or co-payment has been applied.*
17. **Paid At:** *Percentage of the Balance at which the plan paid according to plan guidelines.*
18. **Payment Amount:** *Amount paid by the insurance plan.*
19. **Patient Responsibility:** *Amount due to the provider from the patient after any reduction by the plan paid amount.*
20. **Payment To:** *Whom payment was sent to, check number & check amount.*
21. ****Service Code:** *Description of the type of service/ procedure/ visit referred to by the Service Code.*
22. *****Reason Code Description:** *Description of any reduction(s) by any Ineligible and/ or Discount amount referred to by the Reason Code.*
23. **Messages:** *Message board for additional explanations, information, etc.*

Time Limits to File a Claim
Claims must be filed no later than 12 months from the incurred dates of service in which you or your Dependents receive the medical services or supplies. Exception may be made where an Employee shows they were not legally competent to file the claim.

Claims Determination
There are two types of claims. They are Pre-service Claims, which includes Urgent Care Claims and Concurrent Care Claims and Post-service Claims. The time frames allowed for us to provide a determination for each of these claims are listed below:

1. **Pre-service Claim** – A determination must be provided in writing or in electronic form within 15 calendar days. An extension of 15 calendar days may be provided if we determine that, for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 15-day time period that an extension is necessary.

   If we receive incomplete information from you and additional information is required to make a determination, you will be notified within 5 calendar days. You are given 45 calendar days to provide the required information. If we do not receive the required information within the 45-day time period, the claim will be denied.

   When we require an extension due to incomplete information, we will be entitled to an additional 15 days to reach a Benefit determination after the additional information is received from you or a Provider.

   A. **Urgent Care Claim** – A determination, based on Medical Necessity, must be provided to you in writing or in electronic form within 72 hours of the original Urgent Care Claim. A Provider may be considered an authorized representative without a specific designation by you when the Approval request is for Urgent Care Claims (medical conditions which require immediate treatment).

      We will notify you or your authorized representative of the lack of information in which to render a decision within 24 hours from receipt of the original Urgent Care Claim. An extension of 48 hours may be required if we do not receive complete information in which to provide its Medical Necessity decision. If we do not receive the required information from you within 48 hours after notifying you, the claim may be denied.

   B. **Concurrent Care Decision** – If we make a decision to stop or reduce Benefits for Concurrent Care that had previously been approved, the decision is an adverse benefit determination. You must be notified sufficiently in advance of the reduction or termination of Benefits to allow you time to appeal the decision before the Benefits are reduced or terminated.

      If you request Concurrent Care Benefits to be extended and the request involves Urgent Care, the request to extend a course of treatment beyond the initially approved period of time or number of treatments must be made at least 24 hours prior to the expiration of the initially approved period. We must make a decision within 24 hours.

2. **Post-service Claim** – A determination must be provided to you in writing or in electronic form within 30 calendar days if the decision is adverse to you. An adverse decision includes any amount due that you may be held responsible for other than Co-payment amounts previously paid to the Provider.

   An extension of 15 calendar days may be provided if we determine that for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 30-day time period that an extension is necessary.

   If we receive incomplete information from you and additional information is required to make a determination, you will be notified within 30 calendar days. You are given 45 calendar days to provide the required information. If we do not receive the required information within the 45-day time period, the claim will be denied.

   When we require an extension due to incomplete information, we will be entitled to an additional 15 days to reach a Benefit determination after the additional information is received from you or a Provider.

Denial of Claims
If we deny any part or all of a claim, you will receive an Explanation of Benefits (EOB) explaining the reason(s).

If you do not understand why we denied your claim, you can:

- Read the information in this booklet. It outlines the terms and conditions of your health coverage.
- Contact TCC of SC at (843) 722-2115 or (800) 815-3314.

Time Limit to Question a Claim
You have only 180 days to question or appeal our decision regarding a claim. After that date, we will consider disposition of the claim to be final, except as provided in the *Legal Actions* section of this booklet.

Approval from TCC of SC for Pre-Service Claims

For Approval for medical or surgical treatment, call (888) 275-7146.

You also can find these numbers on the front of your ID card. Be sure to keep your card with you at all times since you never know when you may need to reach us.

If you call for review and approval, you will talk with a Medical professional. He or she will ask you for this information:

- Your name and ID number
- The patient's name and relationship to you, the Employee
- The Physician's name, address and phone number
- The Hospital or Skilled Nursing Facility's name, address and phone number
- Reason the Member needs care

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.

If you need Approval, be sure to call (888) 275-7146

To make the most of your Benefits, your plan has an Approval process in place. TCC of SC must give advance Approval for Pre-service Claims, which include all Hospital Admissions and certain other specified services for you to receive maximum Benefits (see the section on *Preauthorization Review*).

An Approval means only that a service is Medically Necessary for treatment of the Member's condition. **Approval is not a guarantee or verification of Benefits. Payment is subject to Member eligibility, Pre-existing Condition Limitations and all other Contract limitations and exclusions. Final Benefit determination will be made when we process your claim(s).** If you have any questions about whether a certain service will be covered, please contact TCC of SC.

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 done at a Provider designated by your plan. **If the 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 these services and supplies for you or you're 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's your responsibility to contact TCC of SC before receiving these services and supplies. If you do not get prior Approval, then you will pay more of your own money for these services and supplies.

A Provider may be considered an authorized representative without a specific designation by you when the Approval request is for Urgent Care Claims (medical conditions which require immediate treatment). A Provider may be an authorized representative with regard to non-Urgent Care Claims only when you give us or the Provider a specific designation to act as an authorized representative. If you have designated an authorized representative, all information and notifications should be directed to that representative unless you give contrary directions.

Please note that if you're Pre-service Claim for services or Benefits is denied, you may request further review under the guidelines set out in the *Appeal Procedures* section of this booklet. Remember that preauthorization and prior Approval denials are considered as denied claims for purposes of appeals. Determinations and appeals regarding Pre-service Claims are subject to the time frames explained in the *Claims Procedures* and *Appeal Procedures* sections of this booklet.

Types of Approval

There generally are four different types of Approval:

1. Preadmission Review
2. Emergency Admission Review
3. Continued Stay Review
4. Preauthorization Review

Preadmission Review — Before you or a Dependent is admitted to a Hospital or Skilled Nursing Facility, Preadmission Review 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 being seen by a network hospital and appropriate pre-admission approvals are not obtained then the hospital will receive a penalty as noted in their provider agreement. If seeing a network physician who isn't part of a hospital and they do not receive the appropriate pre-admission approvals then they will receive a penalty of 50% off of the total allowed amount. Neither party can bill you for this amount. Approval for Admission to a Non-Preferred facility is the patient's responsibility and will incur a penalty of 50% of the total allowable amount. You would be responsible for this penalty and your non-preferred provider can bill you for these charges.

Emergency Admission Review — If you or one of your Dependents experiences an emergency Illness or Injury, go to the nearest emergency room right away, or call 911 for help. We do not expect you to wait for Approval before you go to the Hospital.

However, Medical Services must be notified within **72** hours of the emergency Admission, or by 5 p.m. of the third working day following the Admission. (Exceptions may be made for reasons beyond your control.)

Penalty for not receiving appropriate approvals: Please see the similar paragraph under "Preadmission reviews" above.

Continued Stay Review — It's possible that you or a Dependent has to remain in the Hospital or Skilled Nursing Facility for a period longer than we originally approved. If this is the case, Continued Stay Review Approval must be obtained from Medical Services.

If Continued Stay Review Approval is not obtained, or if the continued stay is not approved, but you or your Dependent remains in the Hospital or Skilled Nursing Facility, we will not pay Benefits for any part of the room and board charges for the period of the continued stay. If a Preferred Blue Hospital or Skilled Nursing Facility does not get approval, they must write off the penalty as outlined in their Provider contract. They cannot bill you for this amount.

Preauthorization Review — A number of services and medical procedures require Preauthorization Review:

- Inpatient Hospitalizations
- MRI/CT Scans
- Durable Medical Equipment (over $2,000)
- Organ Transplants
- Physical, Occupational, Speech or Rehabilitation Therapy requiring more than 12 visits

If written advance Approval is not obtained for human organ and/or tissue transplants or the service is not done by a Provider designated by your plan, we will not pay Benefits. If a Preferred Blue Provider does not get Preauthorization, it cannot bill you for these charges.

For more information about services and supplies that require Preauthorization Review, please see the *Covered Expenses* section. If you have specific questions, please call or write TCC of SC.

Out-of-area Emergency Provision

If you or a Dependent receives Emergency Medical Care from a Non-Preferred Provider, we will pay Benefits for Benefits at a higher percentage of the **Allowed Charges** if you meet all of these conditions:

- The Member was traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- The Member was treated for an accident or new Emergency Medical Condition.

Benefits under this provision are subject to the Deductibles or Co-payments, Coinsurance and all Contract maximums, limits and exclusions.

Emergency Admission Review Approval is required within 24 hours or by 5 p.m. of the next working day for all emergency Admissions.

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

CLAIM DETERMINATIONS AND APPEALS

CLAIM DETERMINATION

There are generally two types of claims. These are: (1) Pre-service Claims, which includes Urgent Care Claims and Concurrent Care Claims and (2) Post-service Claims. The time frames allowed for the Group Health Plan to provide a determination for each of these types of claims are listed below:

3. **Pre-service Claim** – A determination for most Pre-service Claims (other than Urgent Care Claims and Concurrent Care Claims as set forth below) will be provided to you (in writing or in electronic form) within 15 calendar days of our receipt of the claim.

   An extension of 15 calendar days may be required if TCC determines that, for reasons beyond TCC's control, an extension is necessary. If TCC determines that an extension is required, TCC will notify you within the initial 15-day time period that an extension is necessary.

   When TCC requires an extension due to incomplete information, you will have 45 calendar days to provide the required information. If TCC does not receive the required information within the 45-day time period, the claim may be denied. Additionally, TCC will be entitled to an additional 15 days to reach a determination after the additional information is received from you or a Provider. If TCC receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), TCC will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

   A. **Urgent Care Claim** – A determination for Urgent Care Claims will be provided to you (in writing or in electronic form) within 72 hours of TCC's receipt of the claim.

      An extension of 48 hours may be required if TCC determines that you have failed to provide enough information for TCC to make a determination. If TCC determines that an extension is required, TCC will notify you within 24 hours of the receipt of the Urgent Care Claim. If TCC does not receive the required information from you or your Provider within 48 hours after notifying you, the claim may be denied. If TCC receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), TCC will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

      TCC will consider a Provider to be your authorized representative without a specific designation by you when the Provider has submitted an Urgent Care Claim on your behalf.

   B. **Concurrent Care Decision** – If TCC makes a decision to stop or reduce Benefits for Concurrent Care that had previously been approved, you will be notified sufficiently in advance of the reduction or termination of Benefits to allow you time to appeal the decision before the Benefits are reduced or terminated.

If you request Concurrent Care Benefits to be extended and the request involves Urgent Care, the request to extend a course of treatment or number of treatments must be made at least 24 hours prior to the expiration of the initially approved period. TCC will make a decision within 24 hours.

4. **Post-service Claim** – A determination for Pre-service Claims will be provided to you (in writing or in electronic form) within 30 calendar days of our receipt of the claim if the decision is adverse to you.

   An extension of 15 calendar days may be required if TCC determines that, for reasons beyond TCC's control, an extension is necessary. If TCC determines that an extension is required, TCC will notify you within the initial 15-day time period that an extension is necessary.

   When an extension is required due to incomplete information, you will have 45 calendar days to provide the required information. If TCC does not receive the required information within the 45-day time period, the claim will be denied. Additionally, TCC will be entitled to an additional 15 days to reach a determination after the additional information is received from you or a Provider. If TCC receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), TCC will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

Denial of Claims

If TCC denies any part or all of a claim, you will receive an Explanation of Benefits ("EOB") or determination letter explaining the reason(s). A denial will include any Adverse Benefit Determination.

Your notice that you receive will contain:

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

ii. A reference the specific Plan provisions on which the determination is based;

iii. A description of any additional material or information, if any, needed to complete the claim and the reasons such material or information are necessary;

iv. A description of the claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

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

vi. If the reason for the decision is based on an exclusion such as lack of Medical Necessity or Investigational or Experimental Services, an explanation of the scientific or clinical judgment for the determination (or a statement that such information will be provided to your free of charge upon request).

If after reviewing the notice that is provided, you do not understand why TCC denied your claim, you can:

- Read the information in this booklet. It outlines the terms and conditions of your health coverage; or,
- Contact TCC of SC at (800) 815-3314.

If you have failed to follow the Plan requirements in submitting a claim, you will be notified within 5 calendar days.

APPEAL PROCEDURES

If you wish to file a formal appeal, you must write to:

Thomas H. Cooper & Co., Inc.
Attention: Appeals
P.O. Box 22557
Charleston, SC 29413.

Your letter must state that a formal appeal is being requested and you must include all pertinent information regarding the claim that you want to have considered in the letter. The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision):

1. Pre-service Claim – You have 180 days to appeal the decision on a Pre-service Claim (including a Concurrent Care decision). TCC will complete the appeal process within 15 calendar days after receiving the appeal. If you still do not agree with the decision, you can submit a second appeal within 90 days after receiving the decision of the first appeal. TCC will complete the second appeal process within 15 calendar days after receiving the second appeal.
2. Urgent Care Claim – You have 180 days to appeal the decision on an Urgent Care Claim. TCC must complete the appeal process within 72 hours after receiving the appeal.
3. Post-service Claim – You have 180 days to appeal the decision on a Post-service Claim. TCC will complete the appeal process within 30 calendar days after receiving the appeal. If you still do not agree with the decision, you can submit a second appeal within 90 days after receiving the decision of the first appeal. TCC must complete the second appeal process within 30 calendar days after receiving the second appeal.

External Appeal Procedures

After you are notified of the second-level appeal decision and you are not satisfied with the decision, an external independent review may be available to you. If an external review is available to you, you will be provided with instructions, after the final internal appeal, on how to request this review. The decision of the external reviewer is binding upon TCC of SC or your employer but not upon you.

Time Line for Appeal Responses

1. Pre-service Claim - You have 180 days to appeal our decision on a Pre-service Claim or a Concurrent Care decision. We must complete the appeal process within 15 calendar days after receiving the appeal. If you still do not agree with our decision, you can submit a second appeal within 90 days after receiving our decision of the first appeal. We must complete the second appeal process within 15 calendar days after receiving the second appeal.

2. Urgent Care Claim - You have 180 days to appeal our decision on an Urgent Care Claim. We must complete the appeal process within 72 hours after receiving the appeal.

3. Post-service Claim - You have 180 days to appeal our decision on a Post-service Claim. We must complete the appeal process within 30 calendar days after receiving the appeal. If you still do not agree with our decision, you can submit a second appeal within 90 days after receiving our decision of the first appeal. We must complete the second appeal process within 30 calendar days after receiving the second appeal.

4. External Review - You have 60 days after the final Adverse Determination to request and external review. Within 5 business days from the date we receive the request for an external review TCC of SC shall assign the cast to an Independent Review Organization (IRO) and send the documentation for review to such IRO. Within 45 days after the receipt of the external review you will be notified in writing by the IRO of its decision to uphold or reverse the determination. The decision of the IRO is binding on TCC of SC as well as the covered person making the request. Should your request not meet the criteria for external review; TCC of SC will notify you in writing within 5 business days of receipt of your request.

5. Expedited External Review- Within15 days after receipt of the final Adverse Determination, a covered person may file a request of an expedited external review request if;

    a. The covered person's treating physician has certified that the covered person has a serious medical condition; or

b. The final Adverse Determination concerns an admission, availability of care, continued stay, or health care, but has not been discharged form a facility, if the covered person may be held financially responsible for the medical care.

Should your request meet these criteria TCC of SC will assign an IRO and send the documentation to them by overnight delivery.

COST CONTAINMENT FEATURES

****Cost Containment Features are managed by TCC of SC****

COMPREHENSIVE CASE MANAGEMENT is automatically activated for a serious or catastrophic Illness/Injury. It is a confidential, patient-centered approach to developing a comprehensive plan of cost effective health care. Case Management Services include:

A. Evaluation and assistance for the Employee, their Physician, and family to 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/Substance Abuse cases as determined by medical care review;

G. Monitoring and assuring treatment programs and interventions for Mental Health and Substance Abuse cases; and

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

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

In cases where the Patient's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of this Plan 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 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.

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 Lifetime maximum per Participant

	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 (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:**
Room and Board:	80% after deductible	60% after deductible
Skilled Nursing Facility: 60 days maximum per calendar year	80% after deductible	60% after deductible
Physical Rehabilitation Facility:	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
Physician Expenses:	80% after deductible	60% after deductible
Ancillary Charges:	80% after deductible	60% after deductible
Anesthesia:	80% after deductible	60% after deductible

OUTPATIENT EXPENSES:	**IN NETWORK:**	**OUT OF NETWORK:**
Hospital and Physician Charges:	80% after deductible	60% after deductible
Emergency Room Charges for Accident or Illness: 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 Charges for Non-Accident:	80% after deductible	60% after deductible
Pre-Admission Testing:	80% after deductible	60% after deductible
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
Second Surgical Opinion	80% after deductible	60% after deductible
Elective Surgical Opinion	80% after deductible	60% after deductible
Physician Services	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

WELLNESS SERVICES: Limited to $300 per Participant per Calendar Year for all Wellness combined.	**IN NETWORK:**	**OUT OF NETWORK:**
Annual Physical Exam: Includes Routine Physical, X-rays & Labs performed and billed at time of visit; Cholesterol Tests, Complete Blood Count, Electrocardiogram, Immunizations, Mammograms, Occult Blood Counts, Urinalysis	100% after $25 copay Not subject to the deductible	Not Covered
Prostate Exam (covered for persons age 40 and older, once per Calendar Year)	100% after $25 copay Not subject to the 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.***

WELLNESS SERVICES: **Limited to $300 per Participant per Calendar Year for all Wellness combined.**	**IN NETWORK:**	**OUT OF NETWORK:**
Annual Gynecological Exam Pap Smears	100% after $25 copay Not subject to the deductible	Not Covered
Well-Child Care: Includes routine immunizations for children required for admission to the South Carolina Public School System.	100% after $25 copay Not subject to the deductible	Not Covered

OTHER SERVICES:	**IN NETWORK:**	**OUT OF NETWORK:**
Chiropractic Care	Not covered	Not covered
Hospice Care	80% after deductible	60% after deductible
Allergy Injections, service and supplies	100% after $25 copay	60% after deductible
Dermatology & Podiatry	100% after $25 copay	60% after deductible
Home Health Care: Limited to 100 visits Maximum Per Calendar Year	80% after deductible	60% after deductible
Durable Medical Equipment: Pre-Authorization is required if over $2,000	80% after deductible	Not covered
Prosthetic Devices	80% after deductible	60% after deductible
Urgent Care	100% after $50 copay	100% after $50 copay
Maternity Services: **Routine Prenatal, Delivery, Postnatal Care**	80% after deductible	60% after deductible
Human Organ/Tissue Transplants: Limited to $250,000 Lifetime Maximum	80% after deductible	Not covered
Ambulance: $500 per trip maximum	80% after deductible	80% after deductible
Growth Hormone Therapy	80% after deductible	Not covered
Accident Related Dental Services	80% after deductible	80% after deductible
Private Duty Nursing	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**
Wisdom Teeth Extraction	**Covered under Dental Plan**	**Covered under Dental Plan**
Infertility Services	**Not covered**	**Not covered**
Treatment of Temporomandibular Joint Dysfunction (TMJ)	**Not covered**	**Not covered**
Injectable Drugs Not Covered Under the Drug Plan	**80% after deductible**	**60% after deductible**
All Other Benefits:	**80% after deductible**	**60% after deductible**

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%

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 fro 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 DRUG’S

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

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

COVERED MEDICAL EXPENSES

The Plan provides coverage for a wide range of services and supplies. The charges for these services and supplies are considered covered expenses to the extent (unless they are otherwise specified as covered) that they are: Medically Necessary; prescribed; rendered by a Physician; the allowed amount; and provided for care and treatment of a covered Illness or Injury.

Applicable Deductible and/or co-pay amounts and Benefit Percentages payable are listed in the **Medical Schedule of Benefits**. Covered medical expenses are subject to any limitations specified in the **Medical Schedule of Benefits.**

Covered medical expenses include, but are not limited to, charges for the following:

1. Charges made by an **Ambulatory Surgical Center** or minor emergency medical clinic.
2. Charges for the cost and administration of an **Anesthetic**, however, anesthesia rendered by the attending surgeon or their assistant is excluded.
3. Charges for **Artificial Limbs or Breast Prosthesis**, to replace body parts when the replacement is necessary because of physiological changes.
4. 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.
5. **Blood Transfusions**, including cost of blood, blood plasma, blood plasma expanders, and other blood products not donated or replaced by a blood bank.
6. **Cardiac Rehabilitation** will be covered under a medically supervised and controlled reconditioning program.
7. Initial **Contact Lenses or One pair of Eye Glasses** required following cataract surgery;
8. Charges for **Cosmetic Surgery**, only for the following situations:
   A. When the mal-appearance or deformity is due to a congenital anomaly; or
   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. Medical care and treatment of a frenectomy, cleft lip and palate.

   Coverage for the proposed surgery or treatment must have Pre-Service Authorization by the Medical Review Department prior to the date of that surgery or treatment.
9. Charge for **Dental Services** rendered by a Physician for treatment of an Injury to natural teeth if all treatment is rendered within twelve (12) months of the accident.
10. Charges for **Drugs** requiring a written prescription of a licensed Physician; such drugs must be necessary for the treatment of an Illness or Injury.
11. Rental cost, up to a purchase price, of **Durable Medical Equipment** (such as iron lungs, renal dialysis machines, resuscitators or Hospital-type beds), required for temporary therapeutic use in the Participants home by an individual patient for a specific condition when such equipment is not ordinarily used without the direction of a Physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Claims Administrator. Benefits will be reduced to standard equipment allowances when deluxe equipment is used. The rental or purchase benefits cannot exceed the purchase price of the equipment. Benefits will not be provided for such items as air conditioners, de-humidifiers, whirlpool baths, and other equipment which have non-therapeutic uses. Replacement Durable Medical Equipment (such as oxygen tanks, wheel chairs, hospital beds) are not covered unless such replacements are medically necessary due to pathological changes or normal growth. Replacement parts are covered up to $400 (does not cover batteries, sales tax, or shipping and handling charges). **Pre-Authorization required for expenses over $2,000**.
12. Charges for **Electrocardiograms**, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

13. Charges for professional **Ground Ambulance Service** to the Hospital where treatment is given or between medical facilities when Medically Necessary; charges for air ambulance when Medically Necessary.

14. **Home Health Care**, subject to the limitations, if any, stated in the Medical Schedule of Benefits, when rendered to an essentially 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 include 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; and

    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.

15. Charges relating to **Hospice Care**, provided 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; and charges for such services are incurred by the participant within twelve (12) months of the terminally ill person's death.

16. **Hospital Charges** for:

    A. Daily room and board charges in a Hospital, not to exceed the daily semi-private room rate (charges when a Hospital private room has been used will be reimbursed at the average semi-private room rate in the facility). Hospitals with all private rooms will be allowed at the prevailing private room rate;

    B. The day on which a Participant leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as the discharge day and will not be counted as an Inpatient care day, unless he returns to the Hospital by midnight of the same day. The day the participant returns to the Hospital or Skilled Nursing Facility is treated as the Admission day and is counted as an Inpatient care day. The days during which the Participant is not physically present for Inpatient care are not counted as Inpatient days;

    C. The actual expense incurred for confinement in an Intensive Care Unit, Cardiac Care Unit or Burn Unit;

    D. Miscellaneous Hospital services and supplies during Hospital confinement;

    E. Inpatient charges for a well Newborn baby for nursery Room and Board and for professional service. Eligible expenses will be subject to the allowed amount rates for pediatric services and circumcision;

    F. Outpatient Hospital services and supplies and emergency room treatment; and

    G. Fees of registered nurses (R.N.'s) or licensed practical nurses (L.P.N.'s) for Private Duty Nursing, up to the maximum in the Medical Schedule of Benefits.

17. Routine **Mammograms** subject to the limitations as stated in the Medical Schedule of Benefits. Non-Routine Mammograms are covered when Medically Necessary

18. Charges for **Maternity Care** are processed on the same basis as any Illness covered under this Plan. Dependent children are not eligible for benefits under this provision.

19. Charges for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces or other **Medical Supplies**, with the exception of dental braces or corrective shoes, which are the result of a disability, congenital condition or an Injury or Illness.

20. Medically Necessary expenses for **Mental Health Services** are payable 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.

21. **Newborn Care**, which includes inpatient Physician Hospital services, initial work-up and pediatric exam. The Plan will comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan 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).

22. **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an accidental injury, surgical operation, cerebral vascular accident (stroke) or congenital birth defect. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

23. 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.

24. Charges for **Oxygen** and other gases and their administration.

25. Charges incurred for confinement 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 health disorders. This benefit shall not include charges for vocational therapy or Custodial Care.

26. 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.

27. Charges for the services of a legally qualified **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:

    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:

    A. In-Hospital Medical Benefits in a Skilled Nursing Facility;

    B. 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

    C. Concurrent medical/surgical care benefits for In-Hospital Medical Service in addition to benefits for surgical service will be provided only:

        1) 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; or

        2) 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

3) When the surgical procedure performed is designated by the Claims Administrator as a "warranted diagnostic procedure" or as a "minor surgical procedure".

Specifically for this Plan, the term Physician shall include: a person licensed as a medical doctor, dentist, surgeon, chiropractor, osteopath, podiatrist, certified consulting psychologist or psychiatrist, certified licensed nurse-Midwife, clinical psychologist under the direction of a psychiatrist, licensed social worker or optometrist. Physician may include a person participating in a teaching program.

28. **Pre-Admission Testing** for a scheduled Hospital Admission when performed on an outpatient basis prior to such Admission. The tests must be in connection with the scheduled Hospital 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 doctor who ordered the Admission and Medically Necessary for the Illness or Injury for which the Participant is subsequently admitted to the Hospital.

29. Prosthetic devices when necessary to alleviate or correct conditions arising out of Accidental Injury, illness or birth defect, disease or anomaly.

30. Charges for **Radiation Therapy** or treatment, and **Chemotherapy (to include a wig up to $500)**.

31. Expenses for a **Second Surgical Opinion Consultation** (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 disagrees with 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 surgical opinion also apply to the third surgical opinion.

32. Medically Necessary charges incurred for confinement in a **Skilled Nursing Facility** as noted within the Medical Schedule of Benefits.

33. **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician, result from an accidental injury, surgical operation, cerebral vascular accident (stroke) or congenital birth defect. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

34. Medically Necessary expenses for **Substance Abuse Care** will be payable if rendered by a licensed medical Physician (M.D.), licensed psychologist (PH.D.), clinical psychologist, licensed social worker or licensed counselor.

35. Expenses incurred for a Medically Necessary **Surgical Procedure**, subject to the following:

    A. If two or more operations or procedures are performed at the same surgical approach, the total amount covered for the operations or procedures will be payable for the major procedure only, or benefits will be payable according to the recommendations of the Medical Review 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 paid according to the Allowed Amount for the operation or procedure bearing the highest allowance, plus one half of the amount according to 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 paid according to the Allowed Amount for the procedure bearing the highest allowance, 50 percent (50%) for procedures bearing the second and third highest allowance, 25 percent (25%) for procedures bearing the fourth through the eighth highest allowance, and 10 percent (10%) for all other procedures;

    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 allowance for such operation or procedure;

    E. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the allowance, subject to the above paragraphs, will be pro-rated between them by the Claims Administrator when so required by the Physician in charge of the case; and

F. Certain surgical procedures, which are normally exploratory in nature, are designated as "independent procedures: by the Claims Administrator, and the allowance is covered when such a procedure is performed as a separate and single entity. However, when an independent procedure is performed as an integral part of another surgical service, the total amount covered will be paid according to the Allowed Amount for the major procedure only.

Note: The above Surgical Procedure guidelines may be waived and benefits payable according to the recommendations of the Medical Review Department.

36. Charges for reversal of **sterilization** are not covered.
37. Expenses for **Wellness Services** payable according to the Medical Schedule of Benefits.
38. Charges for **X-rays**, microscopic **Tests**, and **Laboratory Tests**.
39. Any and all Charges relative to the Preferred Provider Organization savings to the Plan.

HUMAN ORGAN OR TISSUE TRANSPLANT PROCEDURES

When pre-approved by the **Intramed Plus, Inc.** [and performed by a Provider designated by your plan], Benefits are payable for all expenses for medical and surgical services and supplies incurred while covered under this Plan for Human Organ/Tissue transplants as indicated in the following paragraphs. The benefits are subject to the Deductible amount, Coinsurance percentage and/or money maximum 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 Review 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 Covered Participant, the benefits of the Plan will be provided for the recipient. Benefits will also be provided for the donor under this Plan to the extent that such benefits are not provided under any other form of coverage. In no such case under the Plan 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 Covered 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 Covered Participant under this Plan. The recipient will not be eligible for benefits when only the donor is a Covered Participant.

5. When the recipient and the donor are both Covered 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). All Benefits provided during a Transplant Benefit Period will apply toward the Transplant Lifetime Maximums listed below. For transplants not listed below, the Corporation will determine the Transplant Lifetime Maximum on an individual basis.

- Liver
- Lung (Single)
- Lung (Double)
- Heart
- Heart & Lung (Single)
- Heart & Lung (Double)
- Pancreas

- Pancreas and Kidney
- Kidney (Single)
- Kidney (Double)
- Cornea
- Bone Marrow / Stem Cell including High Dose Chemotherapy:

    a. Adult Phase III and IV Trials only using protocols reviewed and approved by the National Cancer Institute.
    b. Pediatric Phases I, II, III and IV trial using Pediatric Oncology Group protocols reviewed and approved by the National Cancer Institute.

There is a Lifetime maximum on transplants of $250,000.

Special Transplant Benefit- Sun Excel from Sunlife

In addition to any standard transplant benefit set forth in this booklet, a Special Transplant Benefit may be available when a Participant participates in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant benefits and participation in the Program is voluntary.

The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this plan:

1. Access to Centers of Excellence Transplant Facilities throughout the United States;
2. Reimbursement, up to a total of $5,000, for expenses incurred by the Participant and one companion, or both parents if the Participant is a minor child:
    (a) for travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence; and
    (b) for lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence; and
3. Waiver of the Participants deductible and co-payments up to $1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when a Participant participates in the Special Transplant Program and satisfies all of the following requirements:

1. Notification of the transplant procedure must be provided to TCC of SC in accordance with its guidelines;
2. The Participant or the Participants representative must call TCC of SC at (888) 275-7146 or call the Special Transplant Program at 1-800-432-1102 x1148, x2387, x1359 or x1135, as soon as the Participant is identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant; and
3. All transplant services must be rendered at a Centers of Excellence Transplant Facility which participates in this Program for the specific organ or tissue transplant required

MEDICAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Participants:

1. Any service or supply that is not **Medically Necessary**.
2. Expenses incurred for any illness or injury due to, or aggravated by, a **result of war or act of war whether declared or undeclared war or any act of war** or caused during service in the armed forces of any country.
3. **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.
4. **Travel expense**, whether or not recommended by a Physician.
5. Any medical **social services, vision, recreational or milieu therapy, education testing or training**, except as proven to be Medically Necessary or as part of Pre-Authorized Home Health Care or Hospice Care Program.
6. **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.
7. Services, supplies or charges for **pre-marital and pre-employment physical examinations**.
8. Any service or supply for which a Member is entitled to receive payment or Benefits (whether such payment or Benefits have been applied for or paid) under any law (now existing or that may be amended) of the United States or any state or political subdivision thereof, except for Medicaid. These include, but may not be limited to, Benefits provided by or payable under **Worker's Compensation Laws**, the Veteran's Administration for care rendered for service-related disability, or any state or federal Hospital services for which the Member is not legally obligated to pay. This exclusion applies if the Member receives such Benefits or payments in whole or in part, and is applied to any settlement or other agreement regardless of how it is characterized and even if payment for medical expenses is specifically excluded.
9. Services to the extent that the Member is entitled to payment or Benefits 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.
10. Any portion of an expense which the Participant is not obligated to pay under this Plan of Benefits, or which is reimbursable to the Member under; another Group Health Plan, a government or privately supported medical research program, any coordination of benefits or non-duplication of benefits provision of this Plan of Benefits or any other source.
11. Charges incurred for which the Participant is not in the absence of this coverage **legally obligated** to pay or for which a charge would not ordinarily be made in the absence of this coverage.
12. Charges resulting from or occurring (1) during the **commission of a crime** by the Participant; or (2) while engaged in an illegal act, illegal occupation, felonious act or aggravated assault.
13. Charges incurred for services or supplies which constitute **personal comfort or beautification items**, such as television or telephone use.
14. All services, 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 malappearance 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.
15. Expenses for any cosmetic treatment/surgery, this exclusion does not apply to expenses relating to breast reconstruction after mastectomy.
16. 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.

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

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

19. 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.

20. Charges for services rendered by a Physician, nurse or licensed therapist who is a **Close Relative** of the Participant, or resides in the same household as the Participant.

21. 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.

22. 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.

23. Charges incurred in connection with **routine vision care, eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices**. 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.

24. 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's Covered Medical Expenses.

25. Treatment of **infertility** (including the reversal of voluntary sterilization).

26. **Experimental and/or Investigational services, supplies, care and treatment** which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The Plan reserves the right to approve, upon medical review, chemotherapy agents that have been approved by the Federal Drug Administration (FDA) for cancer.

27. 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. Any surgical procedure for the correction of a **visual refractive problem**, including radial keratotomy.

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

30. 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.

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

32. Any service or treatment for complications resulting from any **non-covered procedures**.

33. Any service or supply rendered to a Participant for the diagnosis or treatment of **sexual dysfunction** except when Medically Necessary due to an organic disease. This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition.
34. Any charges for **elective abortions**.
35. Charges for a **Dependent child's pregnancy** including abortions.
36. 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.
37. Charges incurred to **take home drugs** upon discharge from the Hospital.
38. **Sitters** or **companions**.
39. **Charges for services or supplies in connection with hearing aids or exams for their fitting; charges in connection with orthotics, except for diabetic shoes, or replacement prosthetics or braces of the leg, arm, back, neck, or artifical arms or legs,** unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
40. Care and treatment of **hair loss,** except for wigs used for cancer patients.
41. **Exercise programs** for treatment of any condition.
42. 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, devices for stimulating natural female contours, except for post-mastectomy surgery, Non-Prescription Drugs, and medicines, first aid supplies and non-Hospital adjustable beds.
43. **Acupuncture or hypnosis**.
44. Care and treatment for **sleep apnea**, unless Medically Necessary.
45. **Prescription drugs used for or related to birth control, and smoking cessation** unless noted as covered under the Medical Schedule of Benefits or the Prescription Drug Benefits.
46. All treatment of **dysfunctional conditions** related to the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities, or Temporomandibular Joint (TMJ) disorders.
47. Expenses for annual routine **physical exam, annual Pap smear or prostate exam, and routine mammograms** not covered within this Plan's Schedule of Benefits.
48. Charges which exceed any **benefit limitations** stated in the Medical Schedule of Benefits of this Plan Document.
49. Services and supplies received as the result of any intentionally **Self-inflicted Injury** (or injuries resulting from attempted suicide) that does not result from a medical condition or domestic violence.
50. **Biofeedback** charges.
51. Any expenses incurred in obtaining **Medical Records** in order to substantiate Medical Necessity.
52. Charges for **batteries, sales tax or shipping and handling charges**.
53. 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.
54. Care, services, or treatment required as a result of **complications** from a treatment not covered under the Plan.
55. Care or treatment for Injury or Sickness resulting from the voluntary taking of or while under the influence of any **controlled substance,** drug, hallucinogen, or narcotic not prescribed by and administered according to the advise of a Physician. Expenses will be covered for Injured Covered Persons other than the person using the controlled substance.

56. Charges for **out-patient drugs**. (Out-patient drugs will only be considered for payment under the Prescription Drug Program). Except injectable drugs not covered under the drug plan, will be covered under all Other Covered Expenses as stated in the Schedule of Benefits.
57. **Services, supplies, care or treatment** of any injury or sickness that occurred as a result of a covered person's negligent or illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person using alcohol.
58. **Medical treatment** for covered persons who travel out of the network seeking medical care; unless referred by a in network physician.
59. Expenses for any transplant not included in the definition of **Transplant**.
60. Expenses relating to non-human organ or tissue transplants, gene therapies, xenographs or cloning.
61. **Prescription Drug Exclusions.** The following are not covered under the this Plan of Benefits:
    - Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, ostomy supplies, Durable Medical Equipment, and non-medical substances regardless of intended use.
    - Any over-the-counter medication, unless specified otherwise.
    - Investigational or Experimental medications. Prescription Drugs that have not been prescribed by a Physician;
    - Any vitamins except for prenatal vitamins;
    - Prescription Drugs not approved by the Food and Drug Administration;
    - Prescription Drugs for non-covered therapies, services, or conditions;
    - 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;
    - Unless different time frames are specifically listed on the Schedule of Benefits, more than a thirty-one (34) 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 program;
    - 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;
    - 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;
    - Prescription Drugs used for or related to cosmetic purposes, including hair growth, unless otherwise specified on the Schedule of Benefits;
    - Prescription Drugs related to any treatment for infertility or impotence, including but not limited to, fertility drugs;
    - 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;
    - Prescription Drugs for which there is an over the counter equivalent and over the counter supplies or supplements;

- 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);

- 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;

- Prescription Drugs or services that require Pre-Certification by the Corporation and Pre-Certification is not obtained;

- 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);

- Prescription Drugs that are not Medically Necessary;

- Prescription Drugs for obesity or weight control and smoking cessation;

- Prescription Drugs that are not authorized when a part of a Step Therapy program; and

- Prescription Drugs used for cosmetic purposes.

DENTAL BENEFITS

This benefit applies when Covered Dental Charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

A. Deductible Amount
This is an amount of dental charges 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 Unit Limit
When the amount shown in the Dental Schedule of Benefits has been earned by members 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. Payment will be made at the rate shown under Dental Percentage payable in the dental Schedule of Benefits. No benefits will be paid in excess of the maximum benefit amount.

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

DENTAL CHARGES
Dental charges that are the allowed amount made by a dentist or other Physician 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, the Claims 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.

SCHEDULE OF DENTAL BENEFITS

All benefits are subject to the allowed amount and Calendar 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:		$50
Per Family		$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 overdentures 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

No benefits will be provided under any provisions of this Plan for the following:

1. **Services and supplies** for which the dentist does not charge.
2. Services and supplies primarily for **cosmetic or aesthetic purposes**, including personalization of characterization of dentures.
3. Appliances or restoration necessary to increase **vertical dimensions** or to restore an **occlusion**.
4. 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).
5. Charges for **missed appointment** or for completion of claim forms.
6. Services or supplies that do not meet **accepted standard of dental practice**.
7. Services rendered by a dentist **beyond the scope** of his license.
8. Charges for **visits at home or in the Hospital**, except in connection with emergency care.
9. Services or supplies covered by **Worker's Compensation**.
10. **Implants and/or bridges** involving implants are not covered.
11. **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 of SC prior to termination of coverage, provided the dental services are completed within 30 days from the date of approval of the Treatment Plan.
12. Replacement of a **denture** that could have been repaired or extended.
13. Services related to teeth that were **missing before** you had this coverage.
14. 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.
15. **More expensive treatment than is necessary** - 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.
16. Services or supplies that are **not Medically Necessary**.
17. Charges for services rendered by a Physician, nurse or licensed therapist who is a **Close Relative** of the Participant, or resides in the same household as the Participant.
18. Charges for **orthodontic procedures**, treatment and appliances.

COMMON DENTAL DEFINITIONS

NOTE: *The following definitions are for informational purposes only. Please refer to your Schedule of Benefits for the 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 abnormailities 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 for employees and their Dependents shall be in accordance with the Eligibility, Effective Date and Termination provisions as stated in this plan document.

ELIGIBILITY

A person is eligible for Employee coverage when all of the following are satisfied:

1. The person is an active Employee of the Covered Employer.
2. The person is in a class eligible for coverage.

3. Benefits shall become effective (30) thirty days after full-time employment, coverage will become effective the first day of the following month.

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

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.

Eligible Classes of Employees - All active full time and part time employees who are regularly scheduled for work at least 30 hours per week.

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 Special Enrollment is applicable. Coverage will become effective the **first day of January.**

A covered Employee's Spouse and children from birth to the limiting age of 26 years. When the child reaches either limiting age, coverage will end on 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, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children.

Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

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.

A covered 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.

After such two-year period, the Plan Administrator may require 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.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any Spouse who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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

EMPLOYEE EFFECTIVE DATE
Employee coverage under this Plan shall become effective with respect to an eligible employee on the date this Plan's enrollment requirements have been met, provided the employee is Actively at Work on that date and written application for such coverage is made on or before such date. If application is made within thirty-one **(31)** days after such date, the Employee coverage shall become effective on the date that application is made. If an eligible person is not in active service on the date this coverage would otherwise become effective, this coverage shall become effective on the date he returns to active service.

Late Enrollee Provision
An employee, who enrolls for coverage more than thirty-one **(31)** days from his initial effective date of coverage, will be considered a Late Enrollee unless he/she meets the definition of special enrollee. Late enrollees will be subject to eighteen **(18)** month Pre-existing Condition exclusion. Exception: Should a life event/family status change or Special Enrollment event occur, coverage can 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.

Special Enrollment Period (as legislated by the Health Insurance Portability and Accountability Act of 1996)
The Employer shall permit an Employee or Dependent who is eligible but not enrolled, to enroll any time during the year 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 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; or
C. The Employee's or Dependent's coverage described above was: 1) under COBRA but such coverage was exhausted, or 2) terminated as a result of loss of eligibility, or 3) Employer's contributions to such coverage were terminated; and
D. The Employee or Dependent requests such enrollment not more than thirty (30) days after date of exhaustion of coverage or termination of coverage or Employer contribution.

If an Employee is enrolled in or is eligible under a Plan and he/she marries, has a child or adopts a child (or child placed for adoption), the new Dependent(s) may obtain coverage under the Plan. The employee and employee's spouse may also enroll at this time as long as they meet the Plan's eligibility requirements.

E. The Dependent was not a member 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.

Twelve (12) months Pre-existing Condition limitation will apply to Special Enrollees; however, this can be reduced by any Creditable Coverage submitted by the Employee/Dependent.

DEPENDENT EFFECTIVE DATE

Each employee who makes written request for Dependent coverage hereunder, on a form approved by the Employer, shall be subject to the further provisions of this section. Coverage will commence as follows:

A. If the employee submits an enrollment form requesting Dependent coverage during his initial eligibility period, he shall become covered with respect to such Dependents on the same date that employee coverage becomes effective, unless the enrollment application for Dependent Coverage is not submitted until after the date on which the Employee becomes effective.

B. If the covered employee requests Dependent coverage <u>within</u> thirty-one **(31)** days from his, but after the date on which Employee Coverage became effective, coverage for the Dependent will become effective on the date on which the properly completed application is received by the Plan.

C. If employee requests Dependent coverage under this Plan <u>more than</u> thirty-one **(31)** days from his effective date of coverage, such Dependent will be considered a Late Enrollee and subject to all Late Enrollee provisions. <u>Exception:</u> Dependent coverage can be added any time during the year due to a Special Enrollment situation (as defined in this plan document). Such enrollees will not be considered a Late Enrollee, provided coverage is added within thirty-one **(31)** days of the event. If coverage is added more than thirty-one **(31)** days from the event, such enrollee will be considered a Late Enrollee and subject to all Late Enrollee provisions.

D. Provided the child is properly enrolled as a Dependent of the participant within thirty-one **(31)** days of the child's date of birth, Newborn children of a covered employee will be covered from the moment of birth, subject to the covered medical expenses and exclusions of this Plan. 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. Coverage shall be retroactive to the moment of birth for a child for whom a decree of adoption by the employee has been provided within thirty-one **(31)** days after the date of the child's birth.

   2. Coverage shall be retroactive to the moment of birth for a child for whom adoption proceedings have been instituted by the employee within thirty-one **(31)** days after the date of the child's birth and of whom the employee has obtained temporary custody.

   3. For adopted children other than Newborns, coverage shall begin upon temporary custody and may continue for up to a year. The court may also extend coverage. In all cases, any required premium must be paid before coverage will become effective.

      (Note: 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.)

F. For any Employee or Dependent enrolling during an Open Enrollment Period (December of each year), coverage will become effective January 1st of the following year.

PRE-EXISTING CONDITION PROVISION

DEFINITIONS

The following terms shall mean:

A. A **"Pre-existing Condition"** is a condition (whether physical or mental and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period prior to an individual's "Enrollment Date." *Genetic information will not be treated as a Pre-existing condition in the absence of a diagnosis of a specific condition. Pregnancy will not be treated as a Pre-existing Condition.*

B. **"Enrollment date"** means the first day of an individual's coverage or, if there is a Waiting Period before an individual's coverage becomes effective, the first day of the Waiting Period; therefore, conditions first diagnosed or treated during the Waiting Period will not be treated as Pre-existing Conditions. For an individual who enrolls during a Special Enrollment period or as a Late Enrollee, the Enrollment Date is the first day of the individual's coverage.

C. **"Late enrollee"** means an individual who enrolls other than during the initial enrollment period or a Special Enrollment period as provided under the **"Eligibility Requirements"** of the Plan.

D. **"Creditable coverage"** includes prior coverage under another group health Plan, group or individual Health Insurance Coverage issued by a state regulated insurer or an HMO, COBRA, Medicaid, Medicare, CHIP (the Children's Health Insurance Program), the Active Military Health Program, TRICARE, American Indian Health Care Programs, a State health benefits risk pool, the Federal Employees Health Plan, the Peace Corp Health Program, or a public health Plan.

PRE-EXISTING CONDITION EXCLUSION PERIOD

Expenses for treatment of Pre-existing Condition will not be covered for twelve (**12)** months following an individual's Enrollment Date (eighteen (**18)** months for Late Enrollees). Once this exclusion period has been satisfied, normal benefits will be payable.

The Pre-existing Condition Exclusion Period **will not apply** to Genetic Information in the absence of a diagnosis of the condition related to the information, pregnancy (regardless of whether the woman had previous coverage) or to a Newborn or adopted child under age nineteen (**19)** (or child placed for adoption under age nineteen (**19**) provided the child became covered under the Plan or other Creditable Coverage within thirty-one (**31)** days of birth or adoption (or adoptive placement) and provided they have not incurred a subsequent break in coverage of sixty-three (**63)** consecutive days or more.

The Plan's Pre-existing Condition Exclusion Period may be reduced by an equal period of any prior aggregate continuous health coverage (Creditable Coverage) as long as there is no break in coverage of sixty-three (**63)** consecutive days or more. Individuals have a right to demonstrate prior health coverage to reduce the Plan's pre-Existing Condition Exclusion Period by providing Certificates of Creditable Coverage.

Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.

Method of Counting Creditable Coverage

The Corporation will count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

Credit for prior coverage will be determined through a certificate indicating prior coverage or other acceptable evidence of coverage presented by the Employee. The Employee or Dependent has the right to request a Certificate of Creditable Coverage from any prior plan or issuer. This is based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law. The Corporation will request the certificate if necessary with written authorization from the Member.

The Corporation will notify the Employee of any Pre-existing Condition Limitations period and the basis for the determination. The Member has the right to submit additional evidence of prior Creditable Coverage. The Corporation has the right to reconsider its decision if it determines that the Member did not have the claimed prior Creditable Coverage.

TERMINATION OF COVERAGE

A. TERMINATION OF COVERED EMPLOYEE'S COVERAGE

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

1. The date employment 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 date the employee transfers to coverage under a Health Maintenance Organization (HMO);
5. The termination date of the Plan;
6. The date the employee dies;
7. 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 acts uniformly without regard to the claims experience of those sponsors or any health status related factor relating to any participants covered 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

C. TERMINATION OF COVERED DEPENDENT'S COVERAGE

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

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

C. EXCEPTIONS TO TERMINATION PROVISIONS - (DURING ABSENCE FROM EMPLOYMENT)

1. The participant's coverage will be continued during temporary lay-off and/or approved leave of absence, including but not limited to, any family or medical leave under the Family and Medical Leave Act of 1993 (FMLA) and the Labor Department regulations there under, and the amount of his coverage shall be the amount for which he was covered on his last day of active work. For an approved lay-off or leave of absence,

coverage will continue for a period of not longer than three (3) months, other than a family or medical leave under FMLA. Participants will be responsible for paying all required premium contributions.

2. For an Employee who is unable to work due to total disability, coverage will continue for a period of not longer than six (6) months.

D. RETURN TO WORK

Any other terminated Employee who is rehired must satisfy the Eligibility Requirement. However, an Employee returning to work directly from coverage under the Plan's COBRA continuation option need not satisfy the employment waiting period.

No evidence of insurability may be required of, and re-entry into the Plan will be immediate for any covered Employee and/or dependents who discontinued coverage during a leave of absence taken under the FMLA by the covered Employee, so long as the covered Employee returns to active employment status before or immediately following the expiration of FMLA leave.

E. STATUS CHANGE

If an employee or Dependent has a status change while covered under this Plan (i.e. employee to dependent, COBRA to active) and no interruption in coverage has occurred, the Plan will allow continuity of coverage with respect to any pre-existing condition provision and eligibility Waiting Period.

F. TERMINATION AND RENEWAL OF THIS CONTRACT

The Corporation will provide the Employee or Dependent a Certificate of Creditable Coverage at the time coverage ends or at the time the COBRA or state continuation coverage ends. If a duplicate certificate is needed at a later time, the Employee or Dependent must request the Certificate of Creditable Coverage within 24 months of the coverage ending or the COBRA or state continuation coverage ending, whichever occurs first. The Employee or Dependent may also request the Certificate of Creditable Coverage from the Corporation even if their coverage is still in force. To request the Certificate of Creditable Coverage, the Employee or Dependent must contact the Corporation.

COMMON "QUALIFYING EVENTS" AND REQUIREMENTS

Note: All applications and supporting documents must be received within 31 days of the "Qualifying Event".

QUALIFYING 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

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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Effective the first plan year on or after October 21, 1998:

Coverage for Re-constructive Surgery Following Mastectomies
A plan that provides medical and surgical benefits with respect to a mastectomy shall provide, 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's Calendar Year Deductible and Co-payment will apply to these benefits.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The COBRA law requires Employers to let the following eligible people continue their coverage, after they ordinarily would not be eligible for it, for a period of up to 18, 29 or 36 months, depending on certain circumstances called "qualifying events":

A. 18 months for Employees whose working hours are reduced – (during a non-FMLA leave of absence or when an Employee changes from full-time to part time)-and any family members who also lose coverage for this reason;

B. 18 months for Employees who voluntarily quit work and any family members who also lose coverage for this reason;

C. 18 months for Employees who are part of a layoff, and any family members who also lose coverage for this reason;

D. 18 months for Employees who are fired, unless the firing is due to gross misconduct of the Employee, and any family members who also lose coverage for this reason;

E. 29 months for Employees and all covered family members who are determined to be disabled under the Social Security Act before or during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the Employer within 60 days of the determination of disability and before the end of the first 18 months of continuation of coverage. However, if the determination was prior to termination, the Notice can be provided with COBRA election form in order to secure the extension;

F. 36 months for Employees' widows or widowers and their Dependent children who were covered by the Plan on the day before the qualifying event;

G. 36 months for separated (in states where legal separation is recognized) or divorced husbands or wives of the employee and their Dependent children who were covered by the Plan on the day before the qualifying event;

H. 36 months for Dependent children who lose coverage under the Plan because they no longer meet the Plan's definition of a Dependent child;

I. 36 months for covered family members when the employee and covered family members lose coverage due to Medicare entitlement;

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

Except for items E, G, and H, above, the Employer is responsible for getting the proper form(s) to the participant so continuation of coverage can be applied for.

For items E, G, and H, the participant is responsible for notifying the Employer within sixty (60) days that the qualifying event has occurred. The notice must be given in writing to the Employer at the address shown on page 1 of this document and should contain the following information: (1) name of benefit plan, (2) covered employee's name, (3) your name and address, and (4) the type of qualifying event and the date it occurred. Upon receipt of notice the Employer will then forward the COBRA application form to the participant or the appropriate Dependent.

The participant or the appropriate Dependent must complete a COBRA application form and return it to the Employer no later than 60 days (called the election period) from the later of; (1) the date the participants coverage ends, or (2) the date the Participant receives notice of the right to apply for continuation coverage.

An application by the participant or their spouse for continuation of coverage also applies to any other family members who also lose coverage for the same reason. However, each family member losing coverage for the same reason is entitled to make a separate application for continuation of coverage. If there is a choice among types of coverage under the Plan, each family member can make a separate selection from the available types of coverage.

During an 18-month continuation of coverage period, some persons may have another situation occur to them from among items B, C, D, and F through I. They will be entitled to continuation of coverage for an overall total of up to **36** months. For items G and H, the participant must notify the Employer within **60** days that the situation has occurred.

Premiums for continuation of coverage should be paid to the Employer or their designated party. The Employer has the right to require you to pay the entire premium, even if active employees only pay part of the premium. The Employer also has the right to charge and keep an extra two percent administration fee each month. For disabled employees who have applied for the 29 month COBRA continuation period, the Employer has the right to charge 150% of the applicable premium each month for the 19th month through the 29th month of coverage.

For those participants electing COBRA continuation of coverage, the first premium payment must be postmarked and mailed to the Employer by the 45th day after the Participant elects continuation coverage. Thereafter, premium payments are due on the first of each month. There is a 31-day grace period for payment of the monthly premiums.

Trade Adjustment Assistance

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals").

Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center at (866) 628-4282. TTD/ITY callers may call (866) 626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact/2002act_index.cfm.

COBRA Continuation of Coverage ends earlier than the maximum continuation period under the following circumstances:

A. When premiums are not paid on time.

B. When the participant who has continuation of coverage becomes covered under another group health plan or Medicare, after the date of the COBRA election, through employment or otherwise, which does not contain any

exclusion or limitation (other than such an exclusion or limitation which is not applicable under the law) with respect to any pre-existing limitation of you or any Dependent.

C. When a disabled person covered under the extended 29 months COBRA continuation period has been determined by the Social Security Administration to be no longer disabled, coverage ends for the disabled person and any covered family members on the later of 30 days after the determination or 18 months. (Notification must be given to the Employer within 30 days of final determination.)

D. When the Employer no longer has health coverage for its employees.

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) in either of the following circumstances:

I. General

A. The Employee or Dependent was covered under another Group Health Plan or had Creditable 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, or reduction in the number of hours of employment, or the employer's contributions to such coverage were terminated; or

3) was either:
   i) one of multiple plans offered by an employer and the Employee elected a different plan during an open enrollment period; or,
   ii) when an employer terminates all similarly situated individuals; or

4) was under an HMO that no longer serves the area in which the Employee lives, works or resides; or

5) was under a Group Health Plan where the member incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime 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.

II. Medicaid or SCHIP Coverage

A. The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or

B. The Employee or Dependent becomes eligible for assistance under a Medicaid or SCHIP plan; and

C. The Employee or Dependent requests such enrollment not more than sixty (60) days after either (i) date of termination of Medicaid or SCHIP coverage or (ii) determination that the Employee or Dependent is eligible for such assistance.

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:

i. The 24 month period beginning on the date on which the Staff Member's absence begins; or
ii. 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 (e.g., pre-existing condition 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.

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 all rights to recover damages in full for such benefits when the Injury or Illness occurs through the act or omission of another person, firm, corporation, or organization. The Group Health Plan shall be subrogated, at its expense, to the rights of recovery of such Participant against any such liable third party.

If, however, the Participant receives a settlement, judgment, or other payment relating to an Injury or Illness from another person, firm, corporation, organization or business entity for the Injury or Illness, the Participant agrees to reimburse the Group Health Plan in full, and in first priority, for benefits paid by the Group Health Plan relating to the Injury or Illness. The Group Health Plan's right of recovery applies 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, other specified damages, or whether the Participant has been made whole or fully compensated for his/her injuries.

The Group Health Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal Injury protection (PIP), malpractice, or any other insurance coverages 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 instruments 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 the 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.

It is further agreed that the Participant will sign a written agreement to repay the Group Health Plan in full out of any money that the Participant receives from a negligent person or organization. If the Participant fails to sign such an agreement, the Group Health Plan reserves the right to withhold payment of the Participant's claims, which relate to the negligence of another person or organization, until such time as the Participant signs the agreement to repay.

COORDINATION OF BENEFITS

This provision outlines the way benefits are payable when a Participant may be covered under more than one Plan. It applies when a Participant is covered by this Plan of Benefits and also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. This Plan of Benefits will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan of Benefits will be included for purpose of determining the maximums in the Schedule of Benefits. Through the coordination of benefits, a Participant of Dependent will not receive more than the Allowed Amount for a loss.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. The Participant agrees to provide authorization to this Plan of Benefits to obtain information as to benefits or services available from the other plan or plans, or to recover over-payments. All benefits contained in the Plan of Benefits document are subject to this provision.

When this Plan of Benefits is primary, its benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan of Benefits is secondary, its benefits are determined after those of the other plan. Its benefits may be reduced because of the other plan's benefits. When there are more than two plans this Plan of Benefits may be primary as to one and may be secondary as to another.

ORDER OF DETERMINATION

If a Participant covered hereunder is also covered for comparable benefits or services under another Plan which is the Primary Plan, benefits applicable under these plans will be reduced so that, for Benefits incurred, benefits available under all Plans shall not exceed the Allowable Expenses of such Benefits.

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

A. **General** - A Plan that does not coordinate with other Plans is always the Primary Plan;

B. **Non-Dependent/Dependent** - The benefits of the Plan which covers the person as an Employee (other than a Dependent) is the Primary Plan; the Plan which covers the person as a Dependent is the Secondary Plan;

C. **Dependent Child/Parents Not Separated or Divorced** - Except as stated in (D) below, when this Plan of Benefits and another Plan cover the same child as a Dependent of different parents:

   1. The Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but

2. If both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the Primary Plan; the Plan which covered the parent the shorter time is the Secondary Plan;

3. If the other Plan does not have the birthday rule, but has the gender rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

D. **Dependent Child/Separated or Divorced Parents** - If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

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

2. Then, the Plan of the spouse of the parent with custody;

3. Finally, the Plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, then that parent's Plan is the Primary Plan. If a court decree exists stating that the parents shall share joint custody, without stating that one of the parents is financially responsible for the health care of the child, the order of liability will be determined according to the rules for Dependent children whose parents are not separated or divorced. Anyone who legally adopts the child will assume natural parent status.

E. **Active/Inactive Employee** - The Primary Plan is the Plan which covers the person as an Employee who is neither laid off or retired (or as that Employee's Dependents). The Secondary Plan is the Plan which covers that person as a laid off or retired employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as result the Plans do not agree on the order of benefits, this rule does not apply.

F. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the Primary Plan is the Plan which covered an Employee or Participant longer. The Secondary Plan is the Plan which covered that person the shorter time.

G. In the case of a Plan that contains order of benefit determination rules that declare that Plan to be excess to or **always secondary to all other Plans**, this Plan of Benefits will coordinate benefits as follows:

1. If this Plan of Benefits is Primary, it will pay or provide benefits on a Primary basis;

2. If this Plan of Benefits is secondary, it will pay or provide benefits first, but the amount of benefits payable will be determined as if this Plan of Benefits were the Secondary Plan. The liability of this Plan of Benefits will be limited to such payment;

3. If the Plan does not furnish the information needed by this Plan of Benefits to determine benefits within a reasonable time after such information is requested, this Plan of Benefits shall assume that the benefits of the other plan are the same as those provided under this Plan of Benefits, and shall pay benefits accordingly. When information becomes available as to the actual benefits of the other plan, any benefit payment made under this Plan of Benefits will be adjusted accordingly.

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

I. **Right To Coordination of Benefits Information**

The Plan Administrator and its Claims Administrator have the right:

1. To obtain or share information with any insurance company or other organization regarding coordination of benefits without the claimant's consent; and

2. To require that the claimant provide the Plan Administrator with information on such other Plans so that this provision may be implemented;

3. To pay over the amount due under this Plan of Benefits to an insurer or other organization if this is necessary, in the Plan Administrator's or its Claims Administrator's opinion, to satisfy the terms of this provision.

J. **Facility of Payment**

Whenever payments which should have been made under this Plan of Benefits in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organizations or person making such other payments any amount it will determine in order to satisfy the intent of this provision, and amount so paid will be deemed to be benefits paid under this Plan of Benefits and to the extent of such payment, the Plan Administrator will be fully discharged from liability under this Plan of Benefits. The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan of Benefits rather than the amount payable in the absence of this provision.

K. Right of Recovery

If the amount of the payments made by TCC of SC is more than TCC of SC should have paid under this Plan of Benefits or the Coordination of Benefits, TCC of SC may recover the excess or overpayment from the Member 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 Member with respect to such overpayments.

L.. **Medicare**

If the Participant is an active Employee age 65 and over, the Participant must elect either:

1. The Plan of Benefits as the participant's primary medical coverage and Medicare as the Participant's secondary medical coverage; or
2. Medicare, for the Participant's medical coverage.

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

If the Employee elects Medicare as their medical coverage, their covered Dependent spouse will also have Medicare as his or her medical coverage. If the Participant elects the Group Health Plan as their primary medical coverage, their covered Dependent spouse may elect Medicare as his or her medical coverage or he or she may continue coverage under the Group Health Plan. Unless an election is made to choose Medicare as Primary, coverage will automatically continue under the Group Health Plan, and this Plan of Benefit's benefits will be primary. If Medicare is elected, coverage under the Group Health Plan will be secondary.

This Group Health Plan 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 of Benefits would have paid in the absence of the Medicare payment. The Group Health Plan will then pay the remaining amount as secondary benefits. The benefits payable by Medicare and benefits payable by this Plan of Benefits will not total more than the Allowed Amount.

When Medicare is primary and the Group Health Plan is secondary, Medicare (Parts A and B) will be considered a plan for the purposes of coordination of benefits. The Group Health Plan will coordinate benefits with Medicare whether or not the Participant 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.

ERISA RIGHTS

As a 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 Your 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 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 Pension and Welfare Benefit Administration.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health Plan could apply if you have Creditable Coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for Late Enrollees) after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and your Dependents and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have 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 you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen, that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide

who will pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare benefits Administration.

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.

"Active Employee" is an Employee who is employed on a Full or part-time basis for a benefit to take effect. An Employee will be considered Actively at Work if the Employee is performing the regular duties of employment and works a minimum of 30 hours a week while on the regular payroll. An Employee is considered Actively at Work on each day of **regular "paid time off" and when on authorized "unpaid leave of absence" for 60 days or less for maternity, medical or military reasons** and on each regular non-work day, if the Employee was Actively at Work on the last preceding work day. **All plan exclusions are still applicable.**

"Actively at Work" a time when the Employee is permanent, full-time, and working for the Employer. The Employee must be Actively At Work on the Member's Effective Date of coverage, performing his or her normal duties, unless the employee's absence from work is due to a Health Status Related Factor other than Substance Abuse or chemical dependency.

"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 provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"Admission" the period of time between a Covered Person's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Covered Person 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.

"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 of SC during the preceding calendar year;
b. The Allowed Amount 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 TCC of SC, 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 network used by TCC of SC; or
e. An amount established by TCC of SC in its sole discretion.

In determining the Allowed Amount under this paragraph e, TCC 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.

The plan Administrator has the discretionary authority to decide whether a charge is an allowed amount.

"Ambulatory Surgical Facility" 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; and
b. has continuous Physician services and registered professional nursing service whenever a patient is in the facility; and
c. does not provide accommodations for patients to stay overnight; and
d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician,

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.

"Benefits": a service or supply as specified in this Plan of Benefits or on the Schedule of Benefits for which benefits will be provided under the terms of the Plan of Benefits. To be covered under this Plan of Benefits, medical services or medical supplies must be:

a. Medically Necessary; and,
b. Pre-Authorized (when required under Plan of Benefits or the Schedule of Benefits); and,
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 by the Plan in accordance with the coverage provisions as stated in the Plan.

"Birthing Center" a free-standing facility that:

a. is licensed to provide a setting for parental care, delivery and immediate postpartum care; and
b. has an organized staff of Physicians; and
c. has permanent facilities that are equipped and operated primarily for childbirth; and
d. has a contract with at least one nearby Hospital for immediate acceptance of patients who require Hospital care; and

e. does not provide accommodations for patients to stay overnight; and

f. provides continuous services of Physicians, registered nurses or certified nurse Midwife practitioners when a patient is in the facility.

"Brand Name Drug" a Prescription Drug manufactured by one company. 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.

"**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" includes a child of a divorced or divorcing Employee who has a right to enroll in the Plan of Benefits under a Qualified Medical Child Support Order. A Participant must provide TCC of SC with a copy of the medical child support order to review the terms of the order before coverage can begin for such a Child. Participants and beneficiaries may obtain, without charge, a copy of the QMCSO procedures from TCC of SC.

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

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

"Coinsurance": the sharing of Covered Expenses between the Member and TCC of SC. After the Member's Benefit Year Deductible requirement is met, the Corporation will pay the percentage of the Allowable Amount as set forth on the Schedule of Benefits. The member 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 member 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 Corporation.

"Common Law Marriage" due to legal variations as to what constitutes Common Law Marriage, the following rule will apply: Coverage under the Plan will extend to any dependent spouse living in a common law relationship with the Employee, if the state of residence recognizes such relationship as legal.

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

"Company" the Employer sponsoring this Plan.

"Co-payment": the amount specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

"Covered Participant" any employee or Dependent covered under this Plan.

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

"Covered Service/Expense" the amount payable by TCC of SC 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 members 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.

"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 a Sickness, Injury, disease, or condition.

"Deductible" the amount of Benefits as indicated in the Schedule of Benefits that the Member must pay each benefit period before benefits are paid by the Plan.

"Dependent": the following individuals:

a. An Employee's spouse; or
b. an Employee's 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, and
    ii. dependent upon the Employee for at least 50 percent of his or her support and maintenance, and 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.
f. If the law of the state where the Policy is issued requires that domestic partners be covered under Your Plan, then individual who are domestic partners under the law shall be considered dependents.

"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 Psychiatric Pre-Authorization.

"Durable Medical Equipment": equipment that:

a. Can stand repeated use; and,
b. Is Medically Necessary, and,
c. Is customarily used for the treatment of a Participant's illness, injury, disease or disorder; and,
d. Is appropriate for use in the home; and,
e. Is not useful to a Participant in the absence of illness or injury; and
f. Does not include appliances that are provided solely for the Participant's comfort or convenience; and,
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 TCC of SC begins to provide services 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 Medical Condition": a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that 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; or
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

"Employee": an individual or who may be eligible for coverage as provided in the eligibility section of this Plan of Benefits, and who maybe designated to TCC of SC by the Employer.

"Employer" the entity which is sponsoring this Group Health Plan and its related subsidiaries.

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

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

"Experimental or Investigational" one or more of the following is true of a treatment, procedure, device, drug or medicine:

It cannot be lawfully marketed without U.S. Food and Drug Administration approval, and approval for marketing for the condition treated has not been given at the time the device, drug or medicine is furnished.

reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, and/or efficacy (or efficacy as compared with the standard means of treatment or diagnosis): (1) it is undergoing phase I, II, or III clinical trials or is under study; or (2) further clinical trials or studies are needed, according to the experts' consensus of opinion. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug or medicine).

which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

"Excepted Benefits" benefits or coverage that do 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.

If offered separately:

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.

If offered as independent, non-coordinated Benefits:

a. Coverage only for a specified disease or Illness;

b. Hospital indemnity or other fixed indemnity insurance.

If offered as a separate insurance policy:

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.

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

"Full-time Employment" a basis whereby an Employee is employed by the Intramed Plus at least 30 thirty hours per week and as 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 individual or family member. 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.

"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 and including items and services paid for as medical care under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or health maintenance organization contract offered by a health issuer except for those types indicated in **"Medical Exclusions and Limitations"**.

"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.

"High Dose Chemotherapy" the use of chemotherapeutic agent or agents for treating, or for preventing recurrence of, cancer or cancer-like illness, with or without irradiation, in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed, and which is expected to result in effects upon the bone marrow which would likely be lethal if untreated.

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

"Home Health Care" an agency or organization that:

a. Is licensed and primarily engaged in providing skilled nursing care and other therapeutic services; and
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.

"Hospice Care" a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. The Plan provides care to meet the special needs of the family unit during the final stages of a terminal Illness. Care is provided by a team made up of trained medical personnel, homemakers, and counselors. The team acts under an independent hospice administration and it helps the family unit cope with physical, psychological, spiritual, social, and economical stress.

"Hospice Care Program" a formal program directed by a Physician to help care for a person with a life expectancy of six (6) months or less. It 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;
a. general hospital,
b children's hospital,
c. eye, ear, nose, and throat hospital,
d. maternity hospital, or
e. any other type of short-term acute care hospital licensed by the state in which it operates, which for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which provides continuous twenty-four (24) hour-a-day service by licensed, registered, graduate nurses physically present and on duty.

The term hospital does not include long-term, chronic care institutions that are, other than incidentally, a nursing home or place for rest, the aged, drug addicts, alcoholics, the treatment of mental health conditions, or rehabilitative care whether or not such institution or facility is affiliated with or part of a Hospital..

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

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

"In Network" for employee or dependent residents of South Carolina means a Hospital, Physician, supplier, Pharmacy, Skilled Nursing Facility or home health agency which is located in South Carolina and has also entered into a written agreement with the BlueCross BlueShield Preferred Blue Network. For Employees and Dependents residing outside the state of South Carolina means a Hospital, Physician, supplier, Pharmacy, Skilled Nursing Facility or home health agency which has entered into a written agreement with the Private Health Care Systems (PHCS) Network as the Preferred Provider Organization (PPO).

"Intensive Care Unit" an accommodation in a Hospital which is reserved for critically and seriously ill patients requiring constant audiovisual observation as prescribed by the attending Physician, and which provides room and board, nursing care by registered nurses whose duties are confined to care of patients in the Intensive Care Unit, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

"Late Enrollee" a Member under a Group Health Plan who enrolls under the Plan other than during:

a. The first period in which he is eligible to enroll under the Plan if the initial enrollment period is a period of at least thirty (30) days; or

b. A Special Enrollment period.

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

"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.

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

"Mental Disorder" neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

"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.

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

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

"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.

"Out of Network" for an employee or dependent residing in the state of South Carolina, any provider with which there is not a written agreement including any licensed Hospital, Physician, supplier, Pharmacy, Skilled Nursing Facility or home health agency to participate in Blue Cross Blue Shield of South Carolina Preferred Blue Network. Whereas for an employee or dependent not residing in South Carolina or an employee or dependent resident of South Carolina traveling and in need of sudden, unexpected or emergency medical care or treatment means there is not a written agreement between afore mentioned parties with the Private Health Care Systems (PHCS) Network (PPO).

"Outpatient Care" 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.

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

"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.

"Physician" a legally licensed medical or dental doctor or surgeon to the extent that, within scope of his or her license is permitted to perform services provided under this Plan. (See Covered Expenses section for a list of Physicians covered under this Plan.)

"Plan": Any of the following providing medical or dental benefits or services:

a. This Plan of Benefits;

b. Any group, blanket of franchise health insurance;

c. A group contractual prepayment or indemnity plan;

d. A Health Maintenance Organization (HMO), whether group practice or individual practice association;

e. A labor-management trustee plan or a union welfare plan;

f. An Employer or multi-Employer plan or employee benefit plan;

g. A government program;

h. Insurance required or provided by statute;

i. Any coverage for a student which is sponsored by, or provided through, a school or other educational institution;

j. Group automobile insurance;

k. Individual automobile insurance coverage on an automobile leased or owned by a participant; or

l. Individual automobile insurance coverage such as Med-Pay, Personal Injury Protection (PIP), etc., based upon the principles of no-fault auto insurance coverage.

"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 Plan of Benefits including the Schedule of Benefits, and all endorsements, amendments, riders or addendums.

"Plan Sponsor" is the Employer.

"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-existing Condition(s)": a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was received or recommended during the six (6) month period preceding the Enrollment Date, if applicable. Genetic Information may not be treated as a Pre-Existing Condition in the absence of a diagnosis of a specific condition related to the Genetic Information.

"Condition Waiting Period": the period during which this Plan of Benefits will not provide Benefits to a Participant for Pre-Existing Conditions, not to exceed twelve (12) months (eighteen (18) months for a Late Enrollee).

"Preferred Provider": 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 of SC and to accept the Allowed Amount as payment in full for Benefits. The participating status of a Provider may change.

"Pre-service Claim" any claim or request for a Benefit where prior authorization or approval must be obtained 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, Pre-existing Condition Limitations and all other Contract limitations and exclusions. Final Benefit determination will be made when we process your claim.

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

a. Required to be labeled that it has been approved by the Food and Drug Administration; and,
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; and,
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 Drugs also include the following which may not otherwise meet the definition of Prescription Drugs:

- DESI drugs --These drugs are determined by the FDA (Food and Drug Administration) as lacking substantial evidence of effectiveness. The DESI drugs do not have studies to back up the medications' uses, but since they have been used and accepted for many years without any safety problems, they continue to be used in today's market place.
- Controlled substance 5 (CV) OTC's are covered. (Examples: Robitussin AC syrup and Naldecon-CX) Federal law designates these medications as OTC. However, depending on certain state Pharmacy laws, the medications may be considered Prescription Medications and are, therefore, all covered.
- Single entity vitamins - These vitamins have indications in addition to their use as nutritional supplements. For this reason, Claims Administrator recommends covering these medications. Single entity vitamins are used for the treatment of specific vitamin deficiency diseases. Some examples include: vitamin B12 (cyanocobalamin) for the treatment of pernicious anemia and degeneration of the nervous system, vitamin K (phytonadione) for the treatment of hypoprothrombinemia or hemorrhage, and folic acid for the treatment of megaloblastic and macrocytic anemias.

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

"Protected Health Information (PHI)" individually identifiable health information collected electronically, orally, or via paper. PHI includes information such as the patient's name, social security number, telephone number, medical record number, address, including ZIP code as well as medical records.

"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.

"Psychiatric Day Treatment Facility," as used herein, means an institution that:

a. is a mental health facility which provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program, and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology; and

b. is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Hospitals; and

c. treats its patients for not more than eight (8) hours in any twenty-four (24) hour period.

"QMCSO" a Qualified Medical Child Support Order in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA), as amended.

"Rehabilitation Hospital" a licensed facility that is engaged primarily in providing rehabilitation care to patients on an inpatient basis. Rehabilitation care consists of the combined use of medical, educational, and vocational services to enable patients disabled by disease or Injury to achieve the highest possible level of function ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

"Schedule of Benefits" the pages so titled and made part of this handbook that specify the amount of coverage provided and the applicable Co-payments, Coinsurance, Deductible, and 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": the Plan that has secondary responsibility for paying a Participant's claim as determined through the coordination of benefits provisions of this Plan of Benefits.

"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 time 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 circumstances described in the Eligibility For Coverage section of this Plan of Benefits.

"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.

"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).

"Transplant Benefit Period" for:

a. an Organ, the period which begins on the Admission date and continues for 12 months; or
b. Bone Marrow, the period which begins on the first date of mobilization therapy, marrow/stem cell harvest date or inpatient Admission date for the transplant procedure, whichever comes first, and continues for 12 months.

"Transplant Lifetime Maximum" the maximum amount of Benefits provided in a Lifetime for each of the transplants listed in the Medical Schedule of Benefits. Once the Transplant Lifetime Maximum has been met, no additional transplant benefits will be provided for that type of transplant.

"Totally Disabled" as applied to an employee means (unless specifically provided otherwise) the complete inability of an employee to substantially perform the important daily duties of the employee's own occupation, for which the employee is reasonably suited by education, training or experience. As applied to a Dependent, the term means the Dependent is prevented solely because of a non-occupational Injury or non-occupational disease from engaging in all of the normal activities of a person of like age.

"Urgent Care" Benefits required in order to treat an unexpected Illness or Injury that is not life-threatening and required in order to prevent a significant deterioration of the member's health if treatment were delayed.

"Urgent Care Claims" any claim made by you or by a Provider or Physician (with knowledge of your current medical condition), where, if the normal Pre-service Claim review time frames of the Contract were used:

a. Your life, health or ability to regain maximum function could be seriously jeopardized; or
b. You, in the opinion of the Physician, would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

TCC of SC will determine whether a claim is an urgent care claim based on the information provided at the time that the claim is submitted.

"Waiting Period" a period of continuous employment with the Employer that an Employee must complete before becoming eligible for coverage.

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

Neither the Group Health Plan nor any health insurance issuer or business associate servicing this Plan of Benefits will disclose Protected Health Information to the Employer except as set forth below or as otherwise allowed by law.

1) Disclosure of Protected Health Information to Employer.

   a) The Group Health Plan and any health insurance issuer or business associate servicing the Group Health Plan will disclose Protected Health Information to the Employer only to permit the Employer to carry out plan administration functions for the Group Health Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 CFR-Parts 160-64). Any disclosure to and use by the Employer of Protected Health Information will be subject to and consistent with the provisions of paragraphs 2 and 3 of this section.

   b) Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Protected Health Information to the Employer unless the disclosures are explained in the Notice of Privacy Practices distributed to the Participants.

   c) Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

2) Restrictions on Employer's Use and Disclosure of Protected Health Information.

   a) The Employer will neither use nor further disclose Protected Health Information, except as permitted or required by the Plan of Benefits, as amended, or required by law.

   b) The Employer will ensure that any agent, including any subcontractor, to whom it provides Protected Health Information, agrees to the restrictions and conditions of the Plan of Benefits, including this section, with respect to Protected Health Information.

   c) The Employer will not use or disclose Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer .

   d) The Employer will report to the Group Health Plan any use or disclosure of Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

   e) The Employer will make Protected Health Information available to the Participant who is the subject of the information in accordance with 45 CFR §164.524.

   f) The Employer will make Protected Health Information available for amendment, and will on notice amend Protected Health Information, in accordance with 45 CFR § 164.526.

   g) The Employer will track disclosures it may make of Protected Health Information so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

   h) The Employer will make available its internal practices, books, and records, relating to its use and disclosure of Participants' Protected Health Information, to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

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

3) Adequate Separation Between the Employer and the Group Health Plan.

   a) The following employees or classes of employees or other workforce members under the control of the Employer may be given access to Protected Health Information received from the Group Health Plan or a health insurance issuer or business associate servicing the Group Health Plan:

      Benefits Coordinator

      Chief Financial Officer

      Privacy Officer

      Human Resources Department

      This list includes every employee or class of employees or other workforce members under the control of the Employer who may receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Group Health Plan in the ordinary course of business.

   b) The employees, classes of employees or other workforce members identified in paragraph 4(a) of this section will have access to Protected Health Information only to perform the plan administration functions that the Employer provides for the Group Health Plan.

   c) The employees, classes of employees or other workforce members identified in paragraph 4(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this section of the Plan of Benefits. The Employer will promptly report such breach, violation or noncompliance to the Group Health Plan, as required by paragraph 3(d) of this section, and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

4) Employer Obligations to the security of Electronic Protected Health Information ("ePHI"):

   a) Where ePHI will be created, received, maintained or transmitted to or by the Plan Administrator on behalf of the Group Health Plan, the Plan Administrator shall reasonably safeguard the ePHI as follows:

      i) Employer shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan Administrator creates, receives, maintains or transmits on behalf of the Group Health Plan;

      ii) Employer shall ensure that they, and any agent, including subcontractor, to whom it provides ePHI agrees to, implement reasonable and appropriate security measures of ePHI;

      iii) Plan Administrator shall ensure that they apply the same requirements and restrictions for Protected Health Information (PHI) referenced within this section, PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION Numbers 1-3, to ePHI.

      iv) Employer shall report to the Group Health Plan any successful Security Incident involving the unauthorized access to or use or disclosure of ePHI.

      v) Employer shall ensure that the adequate separation required by Number 3 above is supported by reasonable and appropriate security measures.

Questions and Complaints

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

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your privacy rights, you may tell 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 can give you 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

Privacy Official: John Howard

HR Contact: Varner R. Richards

Final Acceptance by the Group for the attached Summary Plan Description dated October 1, 2010:

IN WITNESS WHEREOF, the Employer 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 President / CEO

Date 12-15-2010