PLAN OF BENEFITS

Town of Mount Pleasant

GROUP MEDICAL
&
DENTAL PLAN

Effective: July 1, 2019

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The Town provides online resources to access information to its Group Health Plan ("Plan"), among other benefits, at:

www.tompbenefits.com

Information generated by the Claims Administrator, Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator) is available by selecting:

- Employee Insurance Benefits
- Claims Information
- Click Here for the TCC Claims Link

The Member can also log into the Claims Administrator's website at www.tccba.com:

- Click on members
- Manage my benefits
- Visit QicLink Benefits Exchange

After logging into the Claims Administrator's website, the following actions can be performed via its QicLink Benefits Exchange (QBE):

- View the status of medical and dental claims
- View the status of Deductible and Out-of-Pocket Maximums
- Order Insurance I.D. Cards
- View an electronic version of this document, the Plan of Benefits
- Leave messages for the Claims Administrator's Customer Department that will be responded to within twenty-four (24) hours

NON-GRANDFATHERED HEALTH PLAN

This Plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

Questions regarding non-grandfathered health plans may be addressed to the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has information regarding protections which apply to non-grandfathered health plans.

ABOUT THE PLAN

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

The Town expects and encourages its employees and dependents ("Members") to review this Plan of Benefits which describes the Town's Group Health Plan ("Plan"). Members are asked to be selective medical consumers and assume the major role in keeping the cost of medical services at a minimum.

Throughout this document, terms are capitalized when definitions are provided for them in the Definitions Section of this Plan of Benefits.

The Town has retained the services of *Thomas H. Cooper & Co., Inc.* ("TCC Benefits Administrator") to process and pay health claims and to provide services in connection with the operation of this Plan of Benefits. TCC Benefits Administrator (referred to as the "Claims Administrator") is 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") for this Plan. Providers who participate in the PPO are called "PPO Providers" or "Preferred Providers."

Plan Benefits will be paid to Preferred Providers listed in the Provider Directory.
Members are responsible for charges imposed by Non-Preferred Providers which exceed the Allowable Charge.

For Service Provided:

Throughout South Carolina: In order to receive benefits at a Preferred Provider level, Members must visit a Provider in the BlueCross BlueShield of South Carolina Preferred Personal Care Network. To find a doctor, members can call (800) 815-3314 or go to www.southcarolinablues.com.

Outside of South Carolina: In order to receive benefits at a Preferred Provider level, Members must visit a Provider in the First Health Network. To find a doctor, Members can call **(**800)-226-5116 or go to *www.firsthealth.com*. When Members use a First Health Provider, they receive In-Network Benefits (Copayment and Coinsurance). When Members use a Provider who is not in the First Health network, they receive Out-of-Network Benefits which includes being financially responsible for any amounts above the Allowable Charge.

Members receive maximum In-Network Benefits when they use PPO Providers and obtain pre-authorization (when required) for services. Members pay more if they do not use PPO Providers or obtain prior authorization (unless the need for care is due to an emergency). The following information explains what a PPO Provider is and how Members obtain authorization from the Claims Administrator's Medical Services Department for services or supplies covered by the Plan.

It is the Member's responsibility to ensure that the Provider is a PPO Provider. Members should verify their Provider's status before services are rendered. To verify whether a Provider is an In-Network Provider Members may:

- Ask the Provider if they participate in the PPO
- Review the Provider directory *
- Review the appropriate website for Provider information *
- Call TCC Benefits Administrator *

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

information is to ask the Provider.

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

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

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

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

- In the event treatment is for an Emergency Medical Condition as defined in this Plan of Benefits and PPO Provider care is not available;
- For treatment by a specialist when a PPO Provider specialist is not available;
- For Non-PPO Provider Ancillary Services rendered in a PPO Provider Hospital;
- Dependents who are living in South Carolina but Out-of-Area which is considered to be over a 50-mile radius from downtown Charleston, South Carolina who see BCBS Providers.

CUSTOMER SERVICE

The Plan's Claims Administrator is committed to helping Members understand their coverage and obtain maximum benefits on their claims. Questions about coverage may be addressed by calling or writing TCC Benefits Administrator at:

TCC Benefits Administrator
Attn: Claims
P.O. Box 63477
North Charleston, SC 29419
(843) 722-2115 / (800) 815-3314

PRE-AUTHORIZATION/PRIOR APPROVAL OF TREATMENT

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

Where to Call for Approval

For prior approval for medical and surgical treatment or an Admission, Members must call the Medical Review Department at (888) 275-7146. These numbers are also on the back of the insurance I.D. card. Members should not call the Claims Administrator's customer service department. A customer service representative cannot give prior approval.

All admissions require Preadmission Review or Emergency Admission Review, and Continued Stay Review. If Preadmission Review is not obtained for all Facility Admissions, room and board will be denied. If approval is not obtained for Emergency Admissions within 72 hours following the Admission, room and board will be denied.

If Pre-Authorization is not obtained, appropriate Benefits will be paid after a 50% reduction in the Allowable Charge.

- **Pre-Authorization Review** — A number of services and medical procedures require Pre-Authorization Review:
    - Inpatient Hospitalizations
    - Durable Medical Equipment (over $2,000)
    - Organ Transplants
    - In certain situations the following services may require Pre-Authorization: cleft lip or palate, cosmetic surgery, dental care for accidental injury, obstetrical services, orthopedic devices, rehabilitation, and home health care, continued stay care, and concurrent care.
    - TMJ/Orthognathic Surgery
- More information about services and supplies that require Pre-Authorization Review is in the *Covered Medical Expenses* section. Members who have specific questions can contact the Claims Administrator.

When Members call for review and approval, they will speak with a medical professional. He or she will ask for the following information:

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

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

Approval means only that a service may be Medically Necessary for treatment of the Member's condition.

However, approval is not a guarantee that Benefits are payable or verification that Benefits are available. Benefits are subject to eligibility and all other Plan limitations and exclusions. The final determination will be made when the Claims Administrator processes the claim(s).

Questions about whether a certain service will be covered can be answered by contacting the Claims Administrator.

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

If a Physician recommends the above services and supplies for any reason, Members need to make sure they tell their Physician that the Plan requires advance approval. Preferred Providers will be familiar with this requirement and will get the necessary approvals.

If Members do not use a Preferred Provider, it is their responsibility to obtain approval before receiving the service or supply or being admitted. If Members do not get prior approval, they will be responsible for 50% of the total Allowable Charge in addition to increased charges.

Note: if a request for prior approval is denied, Members may request further review under the guidelines set out in the *Appeal Procedures* section of this Plan of Benefits.

Types of Approval

There are four different types of approval:

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

Preadmission Review - Before the Member or a Dependent is admitted to a Hospital or Skilled Nursing Facility, preadmission approval must be obtained. If newborn delivery, approval must be obtained within 24 hours of the Member's discharge if the newborn is sick and must stay in the Hospital.

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

Emergency Admission - If the Member or a Dependent experiences an emergency illness or injury, they should go to the nearest emergency room right away or call 911 for help. The Claims Administrator does not expect Members to wait for approval before they go to the Hospital.

However, Members must seek approval within 72 hours of the Emergency Admission (exceptions may be made for reasons beyond the Member's control).

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

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

Penalty for not receiving appropriate approvals: If Concurrent Care approval is not obtained, or if the Concurrent Care is not approved, the Plan may not pay Benefits for any part of the room and board charges for a Preferred Hospital or Preferred Skilled Nursing Facility. While Preferred Providers are responsible for obtaining approval (and Members may not be responsible for costs that result from a failure to obtain pre-approval at a Preferred Provider) approval for Concurrent Care to a Non-Preferred Provider facility is the Member's responsibility and they will be responsible for 50% of the total Allowable Charge in addition to other increased charges as a result of using a Non-Preferred Provider facility.

<u>Out-of-Area Emergency Provision</u>

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

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

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

If Members have claims that meet all of these conditions, they can write or call the Claims Administrator's customer service department. The Claims Administrator will review the claims to determine if it can provide additional Benefits.

SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control.

	DIRECT PRIMARY CARE PLAN	STANDARD PLAN	RETIREE DIRECT PRIMARY CARE PLAN
CALENDAR YEAR DEDUCTIBLE			
Individual	$750	$1,500	$750
Family	$1,500	$3,000	$1,500

CALENDAR YEAR OUT-OF-POCKET MAXIMUM			
Individual Medical	$2,750	$2,750	$2,750
Individual Pharmacy	$3,850	$3,850	$3,850
Family Medical	$5,500	$5,500	$5,500
Family Pharmacy	$7,700	$7,700	$7,700

Note: The Out-of-Pocket Maximum includes Deductible, Copayments, Coinsurance, and pharmacy Copayments.

The "Out-of-Pocket Maximum" is the maximum dollar amount the Member will pay for covered medical expenses in any one Calendar Year. Upon satisfaction of the Out-of-Pocket Maximum, benefits for the Member will be payable at 100% of the Allowable Charge.

*With regard to the Family Deductible and Out-Of-Pocket Limit, one member of the family must meet the Individual Limit; afterwards, all other members of the family will collectively contribute toward to Family Limit.

In compliance with the Affordable Care Act, it includes Deductibles, Coinsurance, Physician and pharmacy Copayments, or any other expenditure which is a qualified medical expense for essential health benefits. This Maximum does not include premiums, balance billing amounts for Non-network Providers and other Out-of-Network cost sharing, or spending for non-essential health benefits.

With regard to the Plan's cost, there is an unlimited Annual and Lifetime Maximum for Members.

SCHEDULE OF BENEFITS

Please refer to the Covered Expenses section for a complete listing of Benefits and any Conditions or Limitations that may apply. When Members receive services from Preferred Providers (in-network) who are listed in the Provider Directory, the Plan Benefits listed hereafter will be paid. Members receiving services from Non-Preferred Providers (out-of-network) are responsible for charges imposed which exceed the Allowable Charge.

	COST TO MEMBERS		
OFFICE VISITS – PREVENTIVE (a.k.a ROUTINE)	**DIRECT PRIMARY CARE PLAN**	**STANDARD PLAN**	**RETIREE DIRECT PRIMARY CARE PLAN**
Paladina Primary Care Physician (PCP)	$0	$0	$0
Non-Paladina PCP	$0	$0	$0
Pediatrician	$0	$0	$0
OB/GYN	$0	$0	$0
Annual Routine Physical includes: Doctors' fees, vaccinations, cholesterol tests, complete blood count, occult blood count, electrocardiogram, urinalysis, pap smear, mammogram, CA-125 ovarian cancer screening, bone density test, prostate screening, and colonoscopy.	$0	$0	$0
Frequency Of Covered Preventive/Routine Visits Per Calendar Year: Age 0-12 Months: 6 visits Age 13-24 Months: 3 visits Age 25 Months and up: 1 visit			
Vaccinations (no age limitation on any vaccination): • Childhood vaccinations (see Script Care for a complete list) • HPV • Flu • Pneumonia • Shingles (submit receipt to TCC for reimbursement if necessary) • Tetanus • Travel	$0	$0	$0

Contraceptives and birth control devices covered under the Patient Protection and Affordable Care Act (PPACA) will pay at 100% of the Allowable Charge at Participating Providers. No Benefits are payable at Non-Participating Providers.

"Preventive Screenings": *Preventive screenings are according to:*

a. United States Preventive Services Task Force (USPSTF) preventive screenings recommendations A or B;
b. Center for Disease Control and Prevention (CDC) recommendations for immunizations;
c. Health Resources and Services Administration (HRSA) recommendations for preventive care and screenings; and
d. American Cancer Society guidelines for prostate screening/lab work.

The site that references the preventive services that are covered is: https://www.healthcare.gov/preventive-care-benefits/

SCHEDULE OF BENEFITS

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	COST TO MEMBERS		
OFFICE VISITS – DIAGNOSTIC (a.k.a. NON-ROUTINE)	**DIRECT PRIMARY CARE PLAN**	**STANDARD PLAN**	**RETIREE DIRECT PRIMARY CARE PLAN**
Paladina Primary Care Physician (PCP)	$0	$0 for PH Members	$0 for PH Members
Non-Paladina PCP	$100	$50	$25
Specialist	$25	$50	$35
Pediatrician	$25	$50	$25
OB/GYN	$25	$50	$25
Mental Health including Substance Use Disorder (see Exclusions section for details)	$25	$50	$25
Note: Surgery, labs, or tests performed within the office are covered under the Copayment.			

	COST TO MEMBERS		
OUTPATIENT EXPENSES	**DIRECT PRIMARY CARE PLAN**	**STANDARD PLAN**	**RETIREE DIRECT PRIMARY CARE PLAN**
Urgent Care Centers	$100	$100	$100
Emergency Room Charges for Life-Threatening Injury/Illness	$0	$150	$0
Emergency Room Charges for Non-Life-Threatening Injury/Illness	50%	$150 + 50%	50%
Diagnostic X-ray, Laboratory, Pathology, and Radiology	30%	50%	30%
Hospital Services	30%	50%	30%
Physician Services including Anesthesiologist	30%	50%	30%
Pre-admission Testing	$0	$0	$0
Cardiac Rehabilitation	30%	50%	30%

	COST TO MEMBERS		
INPATIENT EXPENSES	**DIRECT PRIMARY CARE PLAN**	**STANDARD PLAN**	**RETIREE DIRECT PRIMARY CARE PLAN**
Diagnostic X-ray, Laboratory, Anesthesiology, Pathology, and Radiology	30% after Deductible	50% after Deductible	30% after Deductible
Facility Expense including Room & Board	30% after Deductible	50% after Deductible	30% after Deductible
Physician Services including Anesthesiologist	30% after Deductible	50% after Deductible	30% after Deductible

SCHEDULE OF BENEFITS

Please refer to the Covered Expenses section for a complete listing of Benefits and any Conditions or Limitations that may apply. When Members receive services from Preferred Providers (in-network) who are listed in the Provider Directory, the Plan Benefits listed hereafter will be paid. Members receiving services from Non-Preferred Providers (out-of-network) are responsible for charges imposed which exceed the Allowable Charge.

INPATIENT EXPENSES-CONTINUED	COST TO MEMBERS DIRECT PRIMARY CARE PLAN	STANDARD PLAN	RETIREE DIRECT PRIMARY CARE PLAN
Intensive Care Unit, Cardiac Care Unit, Burn Unit, etc.	30% after Deductible	50% after Deductible	30% after Deductible
Maternity Delivery and Inpatient Services	30% after Deductible	50% after Deductible	30% after Deductible
Newborn Nursery	30% after Deductible	50% after Deductible	30% after Deductible
Physical Rehabilitation Facility	30% after Deductible	50% after Deductible	30% after Deductible
Skilled Nursing Facility: up to 60 days/Calendar Year	30% after Deductible	50% after Deductible	30% after Deductible
Substance Use Disorder Rehabilitation	30% after Deductible	50% after Deductible	30% after Deductible

OTHER SERVICES	COST TO MEMBERS DIRECT PRIMARY CARE PLAN	STANDARD PLAN	RETIREE DIRECT PRIMARY CARE PLAN
Allergy Vaccination: Office visit for shot administration Cost of each vial of allergy extract	 $0 Physician's Copayment	 $0 Physician's Copayment	 $0 Physician's Copayment
Ambulance for Life-Threatening Injury/Illness	$0	0%	$0
Ambulance for Non-Life-Threatening Injury/Illness	50%	50%	50%
Bereavement Counseling: up to 12 counseling sessions per Calendar Year	100% above $25/visit	100% above $12.50/visit	100% above $25/visit
Breast Pump and Supplies: up to $150 paid by the Town per pregnancy	$0	$0	$0
Chemotherapy	30% after Deductible	50% after Deductible	30% after Deductible
Chiropractic Care: up to $1000 per Calendar Year paid by the Town	50% after Deductible, Town pays $50 max	50% after Deductible, Town pays $25 max	50% after Deductible, Town pays $50 max
Colonoscopy - Routine	$0	$0	$0
Colonoscopy - Diagnostic	30%	50%	30%
CT Scan (pre-authorization is **not** required)	30%	50%	30%
Durable Medical Equipment: pre-authorization is required if cost is over $2,000	30% after Deductible	50% after Deductible	30% after Deductible
Imaging Services (Diagnostic) performed inside a physician's office	Physician's Copayment	Physician's Copayment	Physician's Copayment
Imaging Services (Diagnostic) performed outside of the physician's office	30%	50%	30%

OTHER SERVICES (CONT'D)	COST TO MEMBERS DIRECT PRIMARY CARE PLAN	STANDARD PLAN	RETIREE DIRECT PRIMARY CARE PLAN
Home Health Care: up to 60 visits per Calendar Year	100% above $125/visit	100% above $62.50/visit	100% above $125/visit
Hospice Care	100% above $100/day	100% above $50/day	100% above $100/day
Human Organ/Tissue Transplants	30% after Deductible	50% after Deductible	30% after Deductible
MRI (pre-authorization is not required)	30%	50%	30%
Physical Therapy	30%	50%	30%
Occupational Therapy	30%	50%	30%
Radiation	30% after Deductible	50% after Deductible	30% after Deductible
Second Surgical Opinion (not required)	Physician's Copayment	Physician's Copayment	Physician's Copayment
Sleep Study	30% after Deductible	50% after Deductible	30% after Deductible
Speech Therapy	30%	50%	30%
Substance Use Disorder Office Visit	$25	$50	$25
TMJ Diagnosis: Office Visit with X-Ray	$25	$50	$25
Temporomandibular Joint Dysfunction (TMJ): appliance up to $1,000 Lifetime paid by the Town	30% after Deductible	50% after Deductible	30% after Deductible
Temporomandibular Joint Dysfunction (TMJ) / Orthognathic Surgery	30% after Deductible	50% after Deductible	30% after Deductible
Tobacco Cessation Physician's visit for tobacco cessation Prescriptions and OTC supplies related to tobacco cessation (maximums set by Script Care)	$0 $0	$0 $0	$0 $0
Vaccinations (no age limitation on any vaccination):	$0	$0	$0
Childhood vaccinations: (see Script Care for complete list)	$0	$0	$0
HPV Vaccination	$0	$0	$0
Flu Vaccination	$0	$0	$0
Pneumonia Vaccination	$0	$0	$0
Shingles Vaccination (submit receipt to TCC for reimbursement if necessary)	$0	$0	$0
Tetanus Vaccination	$0	$0	$0
Travel Vaccination	$0	$0	$0

OTHER SERVICES (CONT'D)	COST TO MEMBERS		
	DIRECT PRIMARY CARE PLAN	STANDARD PLAN	RETIREE DIRECT PRIMARY CARE PLAN
Nutrition Counseling for Out-of-Network Providers as required for ACA preventive care benefits:			
*For Members with diabetic or cardio vascular disease risk factors as defined below.	$0	$0	$0
For Members without diabetic or cardiovascular disease risk factors.	$25	$50	$25

*Nutrition Counseling – Nutrition Counseling for In-Network and Out-of-Network Providers as required under ACA Preventive Care Benefits as outlined below:

a. The U.S. Preventive Services Task Force (USPSTF, 2012) recommends screening adults and children for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 or higher to appropriate interventions to promote improvement in weight status.
b. For overweight or obese individuals with additional cardiovascular disease (CVD) risk factors, clinicians should offer or refer intensive counseling interventions to a healthful diet and physical activity for CVD prevention.
    1. Known CVD risk factors include hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome

NURSE LINE

24 HOUR NURSE LINE:	COST TO MEMBERS
This service supplements any doctor's care by providing access to a registered nurse **24 hours a day, 7 days a week**. **(888) 523-2583**	0%

The nurse advice line is a free **service from the Town, designed to give accurate, reliable answers and get Members on the road to recovery as quickly as possible.**

This service will supplement any doctor's care by providing access to a registered nurse 24 hours a day, 7 days a week.

The next time there is a health concern such as:

- Severe back pain in the middle of the night
- The baby has a fever
- Possible ankle sprain
- Remedy needed for poison ivy
- Allergies are unbearable
- Uncertainty of what a symptom means

Registered nurses are available to give personal healthcare advice
(888) 523-2583
24 hours a day, 7 days per week

The nurses can also answer any questions regarding medications and medical procedures under consideration.

PALADINA HEALTH MEMBERS' PHYSICIAN ACCESS

Members of Paladina Health have direct access afterhours to their Primary Care Physician via cell phone and secure email through their website's secure patient portal 24 hours a day, seven days a week.

Primary Care Physicians are available to give personal healthcare advice
(843) 408-0092 – call the office for cell phone numbers
paladinahealth.com
my.paladinahealth.com – secure portal for email and medical record
24 hours a day, 7 days per week

PRESCRIPTION DRUG BENEFITS

Outpatient Prescription Drugs will be covered through the **Script Care** Prescription Drug Program.

	COST TO MEMBERS		
PRESCRIPTION DRUG BENEFITS	**DIRECT PRIMARY CARE PLAN**	**STANDARD PLAN**	**RETIREE DIRECT PRIMARY CARE PLAN**
Generic (31 days)	$7	$14	$7
Preferred Brand Name (31 days)	$35	$70	$35
Non-Preferred Brand Name (31 days)	$50	$100	$50
Alternative Therapeutic (Nexium) (30 days only)	$125	$250	$125
Specialty (30 days only)	$250	$500	$250
Prescriptions and OTC Supplies related to tobacco cessation (maximums set by Script Care)	$0	$0	$0
Birth Control	$0	$0	$0
IUD will be covered under Prescription and Medical because the device can be obtained at both places	$0	$0	$0
Bowel Prep for Routine and Diagnostic Colonoscopies regardless of age	$0	$0	$0
Breast Cancer Preventive	$0	$0	$0
Prescriptions dispensed at Paladina Health Office	$0	$0	$0

	COST TO MEMBERS		
PRESCRIPTION DRUG BENEFITS MAIL ORDER	**DIRECT PRIMARY CARE PLAN**	**STANDARD PLAN**	**RETIREE DIRECT PRIMARY CARE PLAN**
Generic (90 days)	$14	$28	$14
Preferred Brand Name (90 days)	$70	$140	$70
Non-Preferred Brand Name (90 days)	$100	$200	$100
Alternative Therapeutic (Nexium) (90 days only)	$250	$500	$250
Specialty (30 days only)	$250	$500	$250

Non-Preferred Retail Pharmacy Copayment increases by $10 per drug.

a. CVS
b. Walgreens

The Plan has a Mandatory Generic Drug Program. For Preferred and Non-Preferred Brand Name Drugs, Members will pay the Copayment plus the difference between the actual cost of the Generic and Brand Name Drugs. When there is no Generic available, only a Copayment applies.

Members can access the list of Preferred and Non-Preferred Brand Name Drugs at scriptcare.com or they may call Customer Service at (800) 880-9988. Questions can be emailed to customerservice@scriptcare.com.

For coverage on Specialty prescriptions, Members must receive Pre-authorization from Script Care by calling Customer Service at (800)880-9988. **For clarification the following items ARE COVERED with PRIOR AUTHORIZATION & MEDICAL NECESSITY:**

- Specialty Drugs for Cialis

"It is the member's responsibility to ensure that they are using an in-network pharmacy**. Prescriptions filled at out-of-network pharmacies will not be reimbursed.** Please call Scriptcare for a list of current providers." A list of In-Network Pharmacies can be found at www.scriptcare.com or by calling Customer Service at (800) 880-9988

a. Updates from ScriptCare – on PDF

Notes about Pharmacy Benefit:
*Some prescriptions have quantity limitations.
*Prenatal vitamins are a covered benefit available at Pharmacies.
*Single Entity Vitamins are covered if they are used for treatment of specific vitamin deficiency diseases.
*B12 shots are administered at an office for a Physician's Copayment.

Some Exclusions that Apply:

- Cosmetic Agents
- Diet Control Drugs
- Dietary Products
- Erectile Dysfunction/Organic Impotence Drugs
- Fentanyl Lozenges
- Fertility Drugs
- Hair Growth Stimulants
- Over-the-Counter Drugs (OTC)
- Vitamins other than Prenatal and Single Entity Vitamins
- Non-Drug items such as stockings or devices even if a prescription is required
- Experimental drugs or drugs required to be labeled "Caution – Limited by Federal Law to Investigational Use"
- Refills obtained more than one year after the original prescription date or prior to 75% of the completion of the projected usage.

COVERED MEDICAL EXPENSES

1. Payment

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

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

2. Pre-Authorization

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Pre-Authorization to determine the Medical Necessity of such Admission or Benefit. The Plan reserves the right to add or remove Benefits that are subject to Pre-Authorization. Each Member is responsible for obtaining Pre-Authorization and the appropriate review. If Pre-Authorization is not obtained for an Admission or if an Admission is not Pre-Authorized and the Member is still admitted, If approval is not obtained or if the Admission is not approved and the Member or Dependent is still admitted, the Plan may not pay Benefits for any part of the room and board charges for a Preferred Hospital or Preferred Skilled Nursing Facility. While Preferred Providers are responsible for obtaining approval (and Members may not be responsible for costs that result from failure to obtain pre-approval by a Preferred Provider), approval for Admission to a Non-Preferred Provider facility is the Member's responsibility and Members will be responsible for 50% of the total Allowable Charge, in addition to other increased charges as a result of using a Non-Preferred Provider facility.

Pre-Authorization is obtained through the following procedures:

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

3. Assignment of Covered Expenses

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

4. Specific Covered Benefits

If all of the following requirements are met the Plan will provide the Benefits as described in the Covered Benefits section:

a. All of the requirements of this Covered Benefits section must be met; and,
b. The Benefit must be listed in this Covered Benefits section; and,
c. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and
d. The Benefit must not be subject to one of more of the exclusions set forth in the Medical Exclusions and Limitations section.

The Plan will cover the following Benefits:

1. **Ambulance** - Charges for ambulance transportation (including air ambulance when necessary) when used:
    a. Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition; and,
    b. To or from a Hospital in connection with an Admission.
2. **Anesthesia** - Charges for the cost and administration of an anesthetic by Physician or professional anesthetist, however, anesthesia rendered by the attending surgeon or their assistant is excluded.
3. **Artificial Limbs/Breast Prosthesis** - Charges for artificial limbs or breast prosthesis, to replace body parts when the replacement is necessary because of physiological changes.
4. **Assistant Surgeon** - When an assistant surgeon is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the Allowable Charge of the surgical procedure.
5. **Blood Transfusions** – Charges for blood transfusions including cost of blood, blood plasma, blood plasma expanders, and other blood products not donated or replaced by a blood bank.
6. **Breast Pump & Supplies** – Charges for Breast Pump and Supplies will be a covered expense limited to $150 per pregnancy.
7. **Cardiac Rehabilitation** – Charges for cardiac rehabilitation (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.
8. **Chiropractic Treatment** – Charges of up to $1,000 per Calendar Year for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
9. **Cleft Lip or Palate** - Charges for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

    Benefits shall include, but not be limited to:

    a. Oral and facial Surgical Services, surgical management and follow-up care;
    b. Prosthetic Device treatment such as obturators, speech appliances and feeding appliances;
    c. Orthodontic treatment and management;
    d. Prosthodontia treatment and management;
    e. Otolaryngology treatment and management;
    f. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and
    g. Physical therapy assessment and treatment.

    Benefits for a cleft lip or palate must be Pre-Authorized. If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the

limit of coverage provided under such dental policy prior to coverage under this Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Plan.

10. **Clinical Trials** - The Plan will pay for routine Member costs for items and services related to clinical trials when:

    a. The Member has cancer or other life-threatening disease or condition; and
    b. Either:
        i. The referring Provider is a Participating Provider that has concluded that the Member's participation in such trial would be appropriate; or,
        ii. The Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and
    c. As defined herein and services are furnished in connection with an Approved Clinical Trial.

11. **Contact Lenses/Eye Glasses** – Charges for initial contact lenses or one (1) pair of eye glasses required following cataract surgery.

12. **Contraceptives** – Prescription Drug Benefits, Medical Supplies, services or devices for the purpose of contraception.

13. **Cosmetic Surgery** - 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. When required for the medical care and treatment of a cleft lip and palate.

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

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

15. **Diabetes Education -** Charges for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

16. **Durable Medical Equipment** - Charges for Durable Medical Equipment that this Plan decides (in its sole discretion) to buy or rent, and whether to repair or replace damaged or worn Durable Medical Equipment. The Plan will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Member in a Hospital or that this Plan determines (in its sole discretion) is included in any Hospital room charge. Replacement Durable Medical Equipment is not covered unless such replacements are Medically Necessary due to pathological changes or normal growth. Replacement parts are covered up to $400 and the Plan does not cover batteries, sales tax, or shipping and handling charges. **Pre-Authorization is required for expenses over $2,000.**

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

18. **Emergency Medical Care -** Charges for care that is necessary as a result of an Emergency Medical Condition.

19. **Gynecological Examination -** Charges for routine gynecological examinations each Benefit Year for female Members.

20. **Habilitation -** Charges for habilitation, including assisting a Child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor, or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.

21. **Home Health Care** – Charges for Home Health Care, subject to the limitations stated in the Medical Schedule of Benefits, when rendered to a homebound Member in the Member's place of residence.

22. **Hospice Care** - Charges for Preauthorized Hospice Care provided in an outpatient setting.

23. **Hospital Charges** – Charges for Admissions as follows:

    a. Semiprivate room, board, and general nursing care; and
    b. Private room, at semi-private rate as determined by the Claims Administrator; and
    c. Services performed in an Intensive Care/Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital; and
    d. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms; and
    e. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,
    f. In a Long-Term Acute Care Hospital.

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

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

24. **Human Organ and Tissue Transplants –**

    a. Charges for certain Pre-Authorized human organ and tissue transplants are to be covered. Transplants must be provided from a human donor to a Member, and provided at a transplant center approved by this Plan.
    b. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:
        i. When both the transplant recipient and the donor are Members, Covered Expenses will be paid for both.
        ii. When the transplant recipient is a Member and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.
        iii. When only the donor is a Member, and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.
    c. Benefits for human organ and tissue transplants will be provided according to the percentage and/or dollar maximum if specified on the Schedule of Benefits.
    d. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.
    e. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under the Plan, subject to all of the provisions of it as follows:
        i. Autologous parathyroid transplants;
        ii. Blood Transfusions;
        iii. Corneal transplants;
        iv. Bone and cartilage grafting; and,
        v. Skin grafting.

25. **In-Hospital Medical Service** - Charges for Physician's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

    a. In-hospital medical Benefits primarily for Mental Health Services and Substance Use Disorder Services;
    b. In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits;
    c. Where two (2) or more Physicians render in-hospital medical visits on the same day, payment for such services will be made only to one (1) Physician;
    d. Concurrent medical and surgical Benefits for in-hospital medical services are only provided:
        i. When the condition for which in-hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant; and
        ii. When the surgical procedure performed is designated by the Claims Administrator as a warranted diagnostic procedure or as a minor surgical procedure.
        iii. When the same Physician renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

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

27. **Mammogram Testing** - Charges for one routine mammogram per Benefit Year and covered expenses regardless of age and Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

28. **Medical Supplies** - Charges for Medical Supplies provided that the Plan will not pay Covered Expenses separately for Medical Supplies that are (or in this Plan's determination, should be) provided as part of another Benefit.

    Charges will be paid for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces (not dental braces) or other Medical Supplies determined by this Plan to be appropriate for treatment of an Illness or Injury.

29. **Mental Health Services** - Charges for the inpatient and outpatient treatment for Mental Health Service.

30. **Nutrition Counseling –** Charges for Nutrition Counseling for Out-of-Network Providers as required under ACA Preventive Care Benefits as listed in the Medical Schedule of Benefits Section.
    a. The U.S. Preventive Services Task Force (USPSTF, 2012) recommends screening adults and children for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 or higher to appropriate interventions to promote improvement in weight status.
    b. For overweight or obese individuals with additional cardiovascular disease (CVD) risk factors, clinicians should offer or refer intensive counseling interventions to a healthful diet and physical activity for CVD prevention.
        i. Known CVD risk factors include hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome.

31. **Obstetrical Services -** Charges for obstetrical services some of which require Pre-authorization. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Member who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

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

32. **Occupational Therapy** - Charges for the treatment and services rendered by a registered occupational therapist. Therapy must be ordered by a Physician, result from an Accidental Injury, surgical operation, cerebral vascular accident (stroke), or developmental delay.

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

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

    a. Open or closed reduction of a fracture or dislocation of the jaw; and

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

34. **Orthopedic Devices** – Charges for Pre-Authorized Orthopedic Devices.

35. **Outpatient Hospital and Ambulatory Surgical Center Services** - Charges for Surgical Services and diagnostic services including radiological examinations, laboratory tests, and machine tests performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

36. **Outpatient Rehabilitation Services** – Charges for Covered Expenses subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

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

37. **Oxygen** – Charges for Pre-Authorized oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

38. **Pap Smear** - Charges for a pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. The Plan will pay Covered Expenses for additional pap smears during a Benefit Year based on Medical Necessity.

39. **Physical Examination** – This Plan will pay Covered Expenses for physical examinations.

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

41. **Physical Therapy** - Charges for the treatment and services rendered by a registered physical therapist. Covered Expenses for physical therapy services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

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

42. **Physician Services** - Charges for Physician Services provided that when different levels (as determined by the Plan Administrator) of Physician Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Plan Administrator) of Physician Services.

43. **Pre-Admission Testing** – Charges for Pre-Admission testing for a scheduled Admission when performed on an outpatient basis prior to such Admission. The tests must be in connection with the scheduled Admission and are subject to the following:

    a. The tests must be made within seven days prior to Admission; and

b. The tests must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the Illness or Injury for which the Member is subsequently admitted to the Hospital.

44. **Prescription Drugs** –

a. Unless expressly excluded under Medical Exclusions and Limitations Section or Prescription Drug Benefit Section, the Employer's Group Health Plan will pay Covered Expenses for Prescription Drugs (as specified in the Prescription Drug Benefits Section) that are listed as covered on the PDL (Prescription Drug List) and are used to treat a condition for which Benefits are otherwise available. This may include certain Over-the-Counter Drugs designated by the Claims Administrator as Prescription Drugs and listed as covered on the PDL. If so designated, these Over-the-Counter Drugs must be prescribed by a Provider. Copayments do not change due to receipt of any Credits by the Employer's Group Health Plan or the Claims Administrator.

For more information about Prescription Drugs, please refer to the PDL which can be found by visiting website www.tompbenefits.com. A list of drugs that are not covered is also on the PDL.

In certain instances, the Pharmacy Benefit Manager provides for an exception process that allows a Member or his or her designee (or the prescribing Provider) to request and obtain access, on an expedited basis, to clinically appropriate drugs that otherwise are not covered on the PDL. For more information about this exception process, please contact the Pharmacy Benefits Manager at the number provided on your Identification Card.

b. If a Provider prescribes a Brand Name Drug and an equivalent Generic Drug or Over-the-Counter Drug is available and listed on the PDL (whether or not the Provider indicates in the prescription that the substitution of a Generic Drug or Over-the-Counter Drug is not allowed), and the Member still requests the Brand Name Drug, then any difference between the cost of the covered Generic Drug or Over-the-Counter Drug and the higher cost of the Brand Name Drug shall be the responsibility of the Member. This will be in addition to any Copayment or Coinsurance appropriate to the Brand Name Drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.
c. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.
d. This Plan may, in its discretion, place quantity limits on Prescription Drugs**.**
e. Pre-authorization is required for Specialty Drugs.

45. **Preventive Services** – Charges for preventive health services required under the Affordable Care Act as follows:

a. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;
b. Immunizations as recommended by the CDC; and,
c. Preventive care and screenings as recommended by the Health Resources and Services Administration (HRSA).

The USPSTF, CDC and the HRSA are independent companies that provide health information on behalf of the Claims Administrator. These Benefits are provided without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as specified in the Schedule of Benefits.

The site that references the preventive services that are covered is:

https://www.healthcare.gov/preventive-care-benefits/

46. **Prostate Examination** – Charges for prostate examination as set forth in the Schedule of Benefits for Members. The Plan will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

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

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

49. **Reconstructive Surgery Following Mastectomy** - In the a case of a Member who is receiving Covered Expenses in connection with a mastectomy, this Plan will pay Covered Expenses for each of the following (if requested by a Member):

    a. Reconstruction of the breast on which the mastectomy has been performed; and
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prosthetic devices and physical complications at all stages of the mastectomy, including lymphedema.

50. **Rehabilitation**- Charges for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

    a. All such treatment must be ordered by a Physician; and
    b. All such treatment requires Pre-Authorization; and
    c. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Member evaluation from a Physician that documents that to a degree of medical certainty the Member has rehabilitation potential such that there is an expectation that the Member will achieve an ability to provide self-care and perform activities of daily living; and
    d. All such rehabilitation Benefits are subject to periodic review by the Plan Administrator.

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

51. **Residential Treatment Center-** Charges at a licensed institution, other than a Hospital, which meets all six requirements to be a Residential Treatment Center (see Definitions section for details).

52. **Second Surgical Opinion** - Charges for a Second Surgical Opinion. A Second Surgical Opinion is not mandatory. The Second Surgical 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.

53. **Skilled Nursing Facility** - Charges for Admissions in a Skilled Nursing Facility as follows:

    a. Semi-private room, board, and general nursing care;
    b. Private room, at semi-private rate as determined by the Plan Administrator;
    c. Services performed in a Special Care Unit when it is Medically Necessary that such services are performed in such unit;
    d. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
    e. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;
    f. In a Long-Term Acute Care Hospital.

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

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

54. **Sleep Apnea** – Care and treatment for sleep apnea.

55. **Specialty Drugs -** Charges for Specialty Drugs provided they are Pre-authorized. Charges for Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Plan. Specialty Drugs may be considered medical Benefits. For any Specialty Drugs paid as medical Benefits the Benefit Year Deductible, Out-of-Pocket Maximum will apply as set forth on the Schedule of Benefits.

56. **Speech Therapy** - Charges for speech therapy services will be paid for treatment due to illness or injury; or to treat delayed speech or other learning developmental conditions or following surgery.

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

57. **Substance Use Disorder Services** - Charges for Substance Use Disorder Services as set forth on the Schedule of Benefits.

58. **Surgical Procedures** – Charges for Surgical Services performed by a licensed Physician or oral surgeon, as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

    1. Charges for surgical procedures, subject to the following:

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

    2. Assistant Surgeon services that consist of the Medically Necessary service of one Physician or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, Physician's assistant or in-house Physician. This Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the Physician's or oral surgeon's (as applicable) actual charge.
    3. Anesthesia services that consist of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

59. **Temporamandibular Joint (TMJ) / Orthognathic Surgery -** Medically Necessary surgical correction of disorders of the temporomandibular joint that meet the following conditions:

    Medically Necessary surgical correction of disorders of the temporomandibular joint will be covered by the Plan when there is documentation that there is anatomical derangement of the joint and there is significant symptomatology. Such disorders include displacement of the joint meniscus and/or other joint structures coupled with significant locking, clicking, popping, and pain sufficient to interfere with the patient's ability to speak, masticate food, and otherwise carry on normal oral functions. Pre-Authorization by the Medical Review Department for these procedures is required.

    Non-Surgical Temporamandibular Joint (TMJ) / Orthognathic Treatment - Medical Benefits are limited to x-rays, exams and appliances. Lifetime maximum of $1,000 applies to appliance only.

60. **Tobacco Cessation Treatment** – Charges for smoking cessation expenses. Hypnosis, acupuncture and electronic cigarettes are excluded.

61. **Tubal Ligation/Vasectomy** - Charges for services of voluntary sterilization procedures for Members are covered, but not for the reversal of sterilization procedures.

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

MEDICAL EXCLUSIONS AND LIMITATIONS

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN. THE ONLY EXCEPTIONS TO THIS ARE AS FOLLOWS: (1) WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED (UP TO THE CORRESPONDING DOLLAR AMOUNT AND/OR COVERAGE PERCENTAGE) IN THE SCHEDULE OF BENEFITS; (2) SERVICES RENDERED BY A HEALTH CARE PROVIDER AS PART OF A PHYSICIAN INCENTIVE PROGRAM (SUCH AS PATIENT-CENTERED MEDICAL HOME PROGRAM), AN ACCOUNTABLE CARE ORGANIZATION, OR EPISODE-BASED ARRANGEMENT; OR (3) AS THE LAW REQUIRES. SUBJECT TO THE ABOVE-LISTED EXCEPTIONS, THE PLAN WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

1. **Abortions** - Any charges for elective abortions. Abortions performed for pregnancy as the result of a criminal act are allowed.
2. **Acts of War** - Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.
3. **Acupuncture** - Acupuncture treatment or services.
4. **Admissions that are not Pre-Authorized -** If Pre-Authorization is not received for an otherwise Covered Expense related to an Admission, penalties will be applied (up to and including denial of the Covered Expenses) as set forth in the section addressing Pre-Authorization.
5. **Allowable Charges** - Charges which are not necessary for treatment of an active Illness or Injury, which are in excess of the Allowable Charge or are not recommended and approved by a Physician.
6. **Auto Accidents** - This Plan does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.
7. **Batteries/Tax/Shipping** - Charges for batteries, sales tax or shipping and handling charges.
8. **Behavioral, Educational or Alternate Therapy Programs** - Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:
    a. ABA therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
    b. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
    c. Higashi schools/daily life;
    d. Facilitated communication;
    e. Floor time;
    f. Developmental Individual-Difference Relationship-based model (DIR);
    g. Relationship Development Intervention (RDI);
    h. Holding therapy;
    i. Movement therapies;
    j. Music therapy; and,
    k. Animal assisted therapy.
9. **Benefit Limitations** - Charges which exceed any benefit limitations stated in the Schedule of Benefits of this Plan.
10. **Benefits Provided by State or Federal Programs -** Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay.
11. **Biofeedback Charges** – Any Biofeedback charges.

12. **Blood Donation** - Charges not included as part of a Hospital bill for autologous blood donation which involves collection and storage of the Member's own blood prior to elective surgery.

13. **Charges** - Deductibles, Copayment amounts, or any other charges which are not payable under the terms of the Plan or charges which are payable from any other source.

14. **Claims** - Claims for the Member and Eligible Dependents who, on the date that coverage under this Plan of Benefits is not Actively at Work for the Employer in a full-time position or has not completed the Waiting Period.

15. **Comfort or Beautification Items** – Charges incurred for services or supplies which constitute personal comfort or beautification items, such as but not limited to television or telephone use.

16. **Complications from Failure to Complete Treatment** – Complications that occur because a Member did not follow the course of treatment prescribed by a Provider, including complications that occur because a Member left a Hospital against medical advice.

17. **Complications from Non-Covered Services** - Complications arising from a Member's receipt or use of either services or Medical Supplies or other treatment that are not covered Benefits, including complications arising from a Member's use of excluded or Discount Services.

18. **Copying Charges** – Fees for copying or production of medical records and/or claims filing.

19. **Cosmetic Procedures -** This Plan excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive, which are not covered, include, but are not limited to, the following:

    a. Rhinoplasty (nose);
    b. Mentoplasty (chin);
    c. Rhytidoplasty (face lift);
    d. Glabellar rhytidoplasty (forehead lift);
    e. Surgical planing (dermabrasion);
    f. Blepharoplasty (eyelid);
    g. Mammoplasty (reduction, suspension or augmentation of the breast);
    h. Superficial chemosurgery (chemical peel of the face); and,
    i. Rhytidectomy (abdomen, legs, hips, buttocks, or elsewhere including lipectomy or adipectomy).

    A cosmetic service may, under certain circumstances, be considered restorative in nature. In order for Benefits to be available for such restorative surgery, the following requirements must be met:

    a. The service is intended to correct, improve or restore a bodily function; or,
    b. The service must be necessary due to a mal-appearance or deformity that was caused by physical trauma, accident, covered surgical service or congenital anomaly; and,
    c. The proposed surgery or treatment must be Pre-Authorized.

20. **Cranial Orthotics** –Adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

21. **Continuation of Coverage** - Expenses for any COBRA Member or retiree whose continuation of coverage was not offered in a timely manner or according to COBRA regulations.

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

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

    a. Feeding and eating disorders in early childhood and infancy;
    b. Tic disorders except when related to Tourette's disorder;
    c. Elimination disorders;
    d. Mental disorders due to a general medical condition;
    e. Sexual function disorders;
    f. Sleep disorders;
    g. Medication induced movement disorders; or

h. Nicotine dependence unless specifically listed as a Benefit in Covered Services of this Plan of Benefits or on the Schedule of Benefits.

24. **Criminal/Illegal Acts** – Any illness a Member gets or an injury a Member receives while committing or attempting to commit a crime, felony or misdemeanor or while engaging in an illegal act or occupation.

25. **Custodial Care** - Services or supplies related to Custodial Care, except as specified on the Schedule of Benefits.

26. **Dental Services** - Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, such procedures may be Pre-Authorized if the need for dental services results from an accidental injury within one year prior to the date of such services and the Member is not covered by other health or dental insurance.

27. **Discount Services** – Any charges that result from the use of Discount Services offered on Blue Cross Blue Shield's website including charges related to any Injury or Illness that results from the Member's use of Discount Services. Discount Services are not covered under this Plan of Benefits and Members must pay fully for Discounted Services.

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

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

30. **Expenses** – Expenses incurred as a result of any lost savings or discounts offered by a facility or Provider due to untimely payment of the bill.

31. Experimental or Investigational **Services –** Services, supplies or drugs that are Investigational or Experimental.

32. **Food Supplements** - Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition, except as specified on the Schedule of Benefits.

33. **Foot Care** - Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care.

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

35. **Growth Hormone Therapy** – Growth hormone therapy for patients over eighteen (18) years of age, except as specified on the Schedule of Benefits. Growth hormone therapy for patients eighteen (18) years of age or younger is excluded unless for documented growth hormone deficiency.

36. **Hair Loss** - Care and treatment of hair loss.

37. **Hearing Aids** - Hearing aids or examinations for the prescription or fitting of hearing aids.

38. **Home Health Care** - The following are excluded from coverage under the Home Health Care benefit:

    a. Services and supplies not included in the Schedule of Benefits including, but not limited to, general housekeeping services, Custodial Care, domiciliary care and rest cures; and
    b. Services of a person who ordinarily resides in the home of the Member, or is a close relative of the Member; and
    c. Transportation services.

39. **Hypnotism** – Charges for hypnotism treatment or services.

40. **Human Organ and Tissue Transplants** – Human organ and tissue transplants that are not:

    a. Pre-Authorized;
    b. Performed by a Provider as designated by the Claims Administrator;
    c. Listed as a covered transplant on the Schedule of Benefits; or
    d. Expenses or treatment relating to non-human organ/tissue transplants, gene therapy, or cloning.

41. **Infertility** – Services, supplies or drugs related to any treatment for infertility including but not limited to: fertility drugs, gynecological or urological procedures the purpose of which is primarily to treat infertility, artificial insemination, in-vitro fertilization, reversal of sterilization procedures and surrogate parenting.

42. **Inpatient Diagnostic and Evaluative Procedures** – Inpatient care and related Physician Services rendered in conjunction with an Admission which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.

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

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

44. **Legal Expenses** - Legal expenses of any kind or description, including legal expenses related to or Incurred for the confinement of a Covered Person or any compulsory process to adopt, abstain from, or cease to continue a particular mode of treatment, care or therapy.

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

46. **Long-Term Care Services -** Admissions or portions thereof for long-term care, including:

    a. Rest care;
    b. Long-term acute or chronic psychiatric care;
    c. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
    d. Custodial or long-term care; or,
    e. Psychiatric or Substance Use Disorder treatment including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

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

48. **Medical Equipment/Supplies** - Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, non-Prescription Drugs, and medicines, first aid supplies, non-Hospital adjustable beds, and any Durable Medical Equipment over $2,000 was in not Pre-authorized.

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

50. **Missed Provider Appointments** – Charges for a Member's appointment with a Provider that the Member did not attend.

51. **Non-Contractual Damages or Actions, or Legal Fees** - Charges resulting from any extra or non-contractual damages or actions, or legal fees and expenses for the defense or litigation thereof, or any fines or statutory penalties.

52. **Non-Covered Procedures** – Complications arising from a Member's receipt or use of services, Medical Supplies or other treatment that are non-covered Benefits, including complications arising from a Member's use of Discount Services.

53. **Not Medically Necessary** - Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered

Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

54. **No Legal Obligation to Pay** – Any service, supply or charge that the Member is not legally obligated to pay.

55. **Obesity Related Procedures** –

    a. Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures;
    b. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Provider or the passage of time from a Member's obesity-related treatment. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss; and
    c. Membership fees to weight control programs.

56. **Orthotics** - Charges in connection with orthotics, except for diabetic shoes**.**

57. **Over-The-Counter Drugs** – Drugs that are available on an over-the-counter basis or otherwise available without a prescription, except as specified on the Schedule of Benefits.

58. **Pain Management Programs** – Chronic pain management programs or multi-disciplinary pain management programs including Transcutaneous Electrical Nerve Stimulation (TENS) units, except as specified on the Schedule of Benefits

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

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

61. **Power Operated Vehicles** - Power operated vehicles such as scooters for mobility outside of the home setting. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity by the Claims Administrator.

62. **Pregnancy of a Dependent Child** – A covered Dependent Child's pregnancy, including childbirth is not covered; however, Dependent children are eligible for the full range of recommended preventive services applicable to them based on age and gender criteria, without cost share.

    The provision of coverage is subject to reasonable medical management techniques and includes coverage for preconception care and various services necessary for prenatal care recommended for age and developmentally appropriate adult women. A list of preventive services that are covered is available at:

    https://www.healthcare.gov/preventive-care-benefits/ .

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

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

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

    a. Prescription Drugs that are specifically listed on the PDL as excluded;
    b. Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;
    c. Any vitamins except for prenatal vitamins;
    d. Prescription Drugs not approved by the Food and Drug Administration (FDA);
    e. Prescription Drugs for non-covered therapies, services, or conditions;
    f. Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;

g. More than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy), except as specified on the Schedule of Benefits or unless the quantity is limited by a Quantity versus Time (QVT) program;
h. 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;
i. Dosages that exceed the recommended daily dosage of any Prescription Drug as determined by the Pharmacy Benefits Manager based on the following guidelines as described in the current:
   - United States Pharmacopeia (USP);
   - Facts and Comparisons;
   - Physicians' Desk Reference; and/or,
   - National Formulary.

i. Prescription Drugs used for or related to cosmetic purposes, including hair growth and skin wrinkles, except as specified on the Schedule of Benefits;
j. Prescription Drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including but not limited to, fertility drugs, except as specified on the Schedule of Benefits;
k. Prescription Drugs administered or dispensed in a Provider'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;
l. Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements;
m. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition (except for Prescription Drugs for a specific medical condition that has at least two (2) formal clinical studies or 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 (1) 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);
n. Prescription Drugs that are not consistent with the diagnosis and treatment of a Member'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;
o. Prescription Drugs or services that require Preauthorization by the Pharmacy Benefit Manager and Preauthorization is not obtained;
p. Prescription Drugs for injury or disease that are paid by workers' compensation benefits (if a workers' compensation claim is settled, it will be considered paid by workers' compensation benefits);
q. Prescription Drugs for obesity or weight control;
r. Prescription Drugs that are not authorized when part of a Step Therapy Program;
s. Prescription Drugs used for cosmetic purposes; and
t. Prescription Drugs which are new to the market and which are under clinical review by the Pharmacy Benefit Manager shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;
u. Prescription Drugs, regardless of therapeutic class, that are determined to offer no clinical or cost effective advantage over other comparable Prescription Drugs already covered under the PDL; and,
v. Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency.
w. Prescription Drugs that are Specialty Drugs, except as specified on the Schedule of Benefits.

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

67. **Private Duty Nursing** – Charges for private duty nursing during services.

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

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

70. **Provider Charges** - Charges by a Provider for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Provider's office.

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

72. **Pulmonary Rehabilitation** – Pulmonary rehabilitation, except in conjunction with a covered lung transplant or as Medically Necessary.

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

    Services for Certain Diagnoses or Disorders - Except for Medical Supplies, services, or charges for the diagnosis or treatment of learning disabilities except as outlined under the Covered Medical Services for Occupational Therapy. Medical Supplies, services or charges for the diagnosis or treatment of learning disabilities, perceptual disorders, intellectual disabilities, vocational rehabilitation, animal assisted therapy, eye movement desensitization and reprocessing (EMDR), or except as specified on the Schedule of Benefits.

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

75. **Services Rendered by an Independent Health Care Professional** - Charges for services or supplies from an independent health care professional whose services are normally included in facility charges.

76. **Services Rendered by Family** - Any Medical Supplies or services rendered by the Member to him/herself or rendered by the Member's immediate family (parent, Child, Spouse, brother, sister, grandparent or in-law).

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

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

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

80. **Sitters/Companions** – Charges for sitters or companions.

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

82. **Travel Expenses** - Travel, whether or not recommended by a Provider, unless directly related to human organ or tissue transplants when Pre-authorized and except as specified on the Schedule of Benefits.

83. **Tubal Ligation/Vasectomy** - Charges incurred for the reversal of sterilization.

84. **Varicose Vein Treatment** - Services, supplies or treatment for varicose veins and/or venous insufficiency, including but not limited to endovenous ablation, vein stripping, or the injection of sclerosing solutions, unless Medically Necessary.

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

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

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

    If the Plan pays Benefits for an injury or illness and the Plan determines the Member also received a or Employer's Workers' Compensation Carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Plan shall have the right of recovery as outlined in Workers' Compensation Section of this Plan of Benefits. If a Workers' Compensation case is settled, the Plan reserves the right to pay for Benefits on future claims related to the injured area.

DENTAL BENEFITS

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

DEDUCTIBLE

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

B. Family Deductible
This is an amount of dental charges (for individuals with family coverage) for which no benefits will be paid. One Member of the family must meet the Individual Deductible; afterwards all other members of the family will collectively contribute toward the Family Deductible.

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

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

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

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

DENTAL SCHEDULE OF BENEFITS

All benefits are subject to the Allowable Charge and Calendar Year Deductible (unless otherwise indicated). Please refer to the Covered Dental Expenses section for a complete listing of Benefits and any additional conditions/limitations that may apply.

CLASSES OF EXPENSES	COST TO MEMBERS
CLASS I – Diagnostic and Preventive Dental Benefits	0%
CLASS II - Basic Dental, Oral Surgery and Periodontic Services	20% after Deductible
CLASS III - Prosthodontic Services	40% after Deductible
CLASS IV Orthodontic Benefits (available to all ages)	50%

Lifetime Maximum per Member for Orthodontic Benefits:	$1,000 paid by the Town
Maximum per Member per Calendar Year for Classes I-III:	$1,500 paid by the Town
Calendar Year Deductible: **Single:** **Family:**	 $ 50 $ 100

The Plan does not have a network of dentists. Instead, charges are based on what is determined to be "reasonable and customary" for the area. Reasonable and customary charges are also referred to as "Allowable Charges."

PREDETERMINATION OF BENEFITS

Except in an emergency, a Member should discuss dental charges with his/her Dentist before treatment begins. If a Member needs dental treatment which the Dentist estimates will cost $500 or more, he/she should ask the Dentist to file for predetermination of benefits with the Claims Administrator. By doing this, both the Member and the Dentist will know in advance how much the Plan will pay for the course of treatment the Dentist recommends.

HOW PREDETERMINATION WORKS

The Dentist should list, on a claim form, the treatment he/she plans to perform and the charges for that treatment. The Dentist should then send the form to the Claims Administrator. The Claims Administrator will let the Member and the Dentist know the amount of money that can be paid under the Plan's coverage for the recommended treatment. If treatment costs **$500** or more and the Dentist does not ask for predetermination of benefits, the claim will be paid according to the information contained on the claim form. Predetermination of Benefits is not necessary for treatment for emergency care, routine oral examinations, x-rays, fluoride treatments, cleaning, and scaling, but is advisable so that Members can anticipate what their costs will be.

COVERED DENTAL EXPENSES

Class I – DIAGNOSTIC AND PREVENTIVE DENTAL SERVICES

1. Dental examinations, cleaning, scaling, polishing and diagnosis twice per Calendar Year;
2. Full mouth x-rays once every three years;
3. Supplementary bitewing x-rays twice per Calendar Year, if the Dentist feels they are necessary;
4. Fluoride treatment twice per Calendar Year;
5. Emergency palliative treatment for the relief of pain;
6. Space maintainers for prematurely lost deciduous teeth;
7. Sealants on permanent teeth that have not had any fillings; once every two years.

CLASS II – BASIC DENTAL, ORAL SURGERY AND PERIODONTIC SERVICES

1. Fillings consisting of amalgam and tooth-colored synthetic materials;
2. Simple extractions;
3. Pulp capping and root canal treatment;
4. General anesthesia when necessary and given in connection with covered dental surgery;
5. Oral surgery;
6. Hemi-section;
7. Apicoectomy (amputation of the apex of a tooth root);
8. Surgical periodontic examination;
9. Gingival curettage, gingivectomy, and gingivoplasy;
10. Osseous surgery, including flap entry and closure;
11. Mucogingivoplastic surgery;
12. Management of acute infection and oral lesions;
13. Periodontal cleanings: once every three months after the initial periodontal treatment is documented;
14. Pulp vitality tests;

CLASS III – PROSTHODONTICS

1. Inlays that are not part of a bridge;
2. Crowns that are not part of a bridge;
3. Onlays that are not part of a bridge;
4. Removable dentures (complete and partial) and bridges (fixed and removable): once every five years except those made necessary by loss or theft;
5. Fixed bridge repairs;
6. Relining or rebasing of removable dentures: allowable six months after initial placement, then once every three (3) years thereafter;
7. Repair of removable dentures.

CLASS IV – ORTHODONTICS

This means the prevention and correction of irregularities in the alignment of the teeth and the prevention or correction of malocclusion as follows:

EVALUATION

Cephalometric x-rays or diagnostic casts: only for orthodontic evaluation prior to and in connection with Active Orthodontic Treatment.

EXPOSURE OR EXTRACTION OF TEETH

Surgical exposure of impacted un-erupted teeth or simple surgical extraction of teeth: only in connection with (and prior to) Active Orthodontic Treatment. Service is deemed to include local anesthesia and routine postoperative care.

ACTIVE TREATMENT
Fixed or removable orthodontic appliances: only for movement or guidance of the natural teeth during Active Orthodontic Treatment. Service is deemed to include periodic follow-up examinations and adjustments during the whole course of Active Orthodontic Treatment.

ORTHODONTIC SERVICES
A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained, except that with respect to charges for Orthodontic Treatment:

Twenty-five percent of the total charge for the course of treatment shall be considered as being incurred on the date the initial appliance is inserted, and the remainder of the total charge shall be divided by the number of months proposed by the Dentist or Physician for the course of treatment, and the resulting monthly pro rata portion shall be considered to be incurred as of the first day of each month thereafter.

ORTHODONTIC EXCLUSIONS AND LIMITATIONS
A. The entire course of Active Orthodontic Treatment including any preliminary Orthodontic evaluation, exposure or extraction of teeth are excluded from being Covered Dental Services (and no Benefits are payable) if the start of the Active Orthodontic Treatment is prior to the effective date of coverage.

B. Orthodontic Expense Benefits are provided only for or in connection with Active Orthodontic Treatment to correct a Handicapping Malocclusion as defined.

C. Covered Dental Expenses for Orthodontics do not include orthodontic evaluation, exposure, or extraction of teeth which is not essential to Active Orthodontic Treatment, which is actually performed.

ORTHODONTIC DEFINITIONS
Active Orthodontic Treatment: The corrective movement of natural teeth through the bone by means of one (1) or more active Appliances to correct a Handicapping Malocclusion. It does not include treatment intended to retain or maintain occlusion or the positioning or relationship of the natural teeth.

Handicapping Malocclusion: A malocclusion (deviation from normal occlusion, or abnormalities in the positioning or relationship of the natural teeth) which severely interferes with the ability of a person to chew food, as determined by the orthodontist.

DENTAL AND ORTHODONTIC EXCLUSIONS AND LIMITATIONS

The following are excluded from coverage under the Plan:

1. **Allowable Charge -** if a Dentist and Member elect a more expensive course of treatment than is usually provided by other Dentists, consistent with sound professional standards of dental practice, Benefits are payable for the less costly procedure.
2. **Close Relative** - Charges for services rendered by a Close Relative of the Member, or someone who resides in the same household as the Member.
3. **Cosmetic Procedures** - Services and supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures.
4. **Dentist Charges -** Services and supplies for which the Dentist does not charge.
5. **Dental License** - Services rendered by a Dentist beyond the scope of his license.
6. **Dentist Visits** - Charges for visits at home or in the Hospital, except in connection with emergency care.
7. **Denture Replacement** - Replacement of a denture that could have been repaired or extended.
8. **Impacted Teeth** - Removal of impacted teeth except as covered under Medical Schedule of Benefits or in connection with, and prior to, Active Orthodontic Treatment.
9. **Implants/Bridges -** Implants and/or bridges involving implants are not covered.
10. **Jaw Joints** – Also known as Temporomandibular Joint Disorders (TMJ). 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). Medical Benefits are provided for surgical and non-surgical treatment. Refer to your Medical Schedule of Benefits.
11. **Missed Appointment** - Charges for missed appointment or for completion of claim forms.
12. **Missing Teeth** - Services related to teeth that were missing before the Member had this coverage.
13. **Multiple Dentists** - Dental services done by more than one Dentist - if the Member transfers from the care of one Dentist to the care of another Dentist during the same course of treatment, or if more than one Dentist renders services for the same procedure, benefits are provided only for the amount payable if only one Dentist had performed the service.
14. **Not Accepted Standard Dental Practice** - Services or supplies that do not meet accepted standard of dental practice.
15. **Not Medically Necessary** - Services or supplies that are not Medically Necessary.
16. **Treatment and Canceled Coverage -** Treatment after a Member 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, the Member may have extended coverage for the completion of dental services under a Treatment Plan approved by TCC Benefits Administrator prior to termination of coverage, provided the dental services are completed within 30 days from the date of approval of the Treatment Plan.
17. **Vertical Dimension/Occlusion** - Appliances or restoration necessary to increase vertical dimensions or to restore an occlusion.
18. **Workers' Compensation Coverage** - Services or supplies covered by Workers' Compensation.

CLAIMS FILING PROCEDURES

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

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

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

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

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

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

connection with such Member's claims, the Member should contact the Claims Administrator for an Authorized Representative form.

6. There are four types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Plan Administrator will make a determination for each type of claim within the following time periods:

   a. **Pre-Service Claim**
      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than 15 days from receipt of the claim.
      ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Member will be sent notification within five 5 days of receipt of the claim.
      iii. An extension of 15 days is permitted if the Claims Administrator (on behalf of the Plan Administrator) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary the Claims Administrator will notify the Member within the initial 15 day time period that an extension is necessary, the circumstances requiring the extension, and the date the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least 45 days to provide the required information. If the Claims Administrator does not receive the required information within the 45 day time period, the claim will be denied. The Claims Administrator will make its determination within 15 days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Claims Administrator receives the requested information after the 45 days, but within 225 days, the claim will be reviewed as a first level appeal.
   b. **Urgent Care Claim**
      i. A determination will be sent to the Member in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than72 hours from receipt of the claim.
      ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within 24 hours of receipt of the claim. The Member will then have 48 hours to provide the additional information. Failure to provide the additional information within 48 hours may result in the denial of the claim.
      iii. If the Member requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least 24 hours prior to the expiration of the original determination period, the Member will be notified within 24 hours of receipt of the request for an extension.
   c. **Post-Service Claim**
      i. A determination will be sent within a reasonable time period, but no later than 30 days from receipt of the claim.
      ii. An extension of 15 days may be necessary if the Claims Administrator (on behalf of the Plan Administrator) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary, the Claims Administrator will notify the Member within the initial 30 day time period that an extension is necessary, the circumstances requiring the extension, and the date the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least 45 days to provide the required information. If the Claims Administrator does not receive the required information within the 45 day time period, the claim will be denied. The Claims Administrator will make its determination within 15 days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Claims Administrator receives the requested information after the 45 days, but within 225 days, the claim will be reviewed as a first level appeal.
   d. **Concurrent Care Claim**
      i. The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination

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

      i. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings);
      ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;
      iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's claim;
      iv. Reference the specific Plan of Benefits provisions on which the determination is based;
      v. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
      vi. Describe the claims review procedures in the Plan of Benefits and the time limits applicable to such procedures;
      vii. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
      viii. Explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request) if the reason for denial is based on a lack of Medical Necessity or is part of the Experimental or Investigational Services exclusion or similar limitation;
      ix. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);
      x. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals; and,
      xi. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

   b. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
   c. The Member will also receive a notice if the claim is approved.

APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Member has 180 days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. The appeal must be in writing by the Member; and,
   b. The appeal must be sent (via U.S. mail) at the address below:

      Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator)
      PO Box 63477
      North Charleston, SC 29419

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
   d. The appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.

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

3. The Member must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process, or such issues and grounds will be deemed permanently waived.

4. If the appealed claim involves an exercise of medical judgment, the Claims Administrator (on behalf of the Plan Administrator) will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

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

   a. Pre-Service Claim
      The Claims Administrator (on behalf of the Plan Administrator) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than 30 days after receipt of the appeal.
   b. Urgent Care Claim
      The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Claims Administrator (on behalf of the Plan Administrator) will communicate with the Member by telephone or facsimile. The Claims Administrator will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than 72 hours after receipt of the request for an expedited appeal.
   c. Post-Service Claim
      The Claims Administrator (on behalf of the Plan Administrator) will decide the appeal within a reasonable period of time, but no later than 60 days after receipt of the appeal.
   d. Concurrent Care Claim
      The Claims Administrator (on behalf of the Plan Administrator) will decide the appeal of Concurrent Care Claims within the time frames set forth in paragraphs above (4) (a-c), depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

6. Notice of Final Internal Appeals Determination

   a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner that will:

i. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;
iii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
iv. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
v. Describe any voluntary appeal procedures offered by the Claims Administrator (on behalf of the Plan Administrator) and the Member's right to obtain such information;
vi. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
vii. Explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request) if the reason for denial is based on a lack of Medical Necessity or is part of the Experimental or Investigational Services exclusion or similar limitation;
viii. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals; and,
ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes.

b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received, to give the Member a reasonable opportunity to respond prior to that date.
c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date.
d. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
e. The Member's claim and appeals will be decided pursuant to a good faith interpretation of the Plan of Benefits, in the best interest of the Member, without taking into account either the amount of the Benefits that will be paid to the Member or the financial impact on the Plan.
f. The Member will also receive a notice if the claim on appeal is approved.

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

EXTERNAL REVIEW PROCEDURES

1. After the Member has completed the appeal process, the Member may be entitled to an additional, external review of the Member's claim at no cost to the Member. An external review may be used to reconsider the Member's claim if the Claims Administrator has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:

   a. It does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; or,
   b. It is an Experimental or Investigational Service and it involves a life-threatening or seriously disabling condition.

2. After a Member has completed the appeal process (and an Adverse Benefit Determination has been made), the Member will be notified in writing of that Member's right to request an external review. The Member should

file a request for external review within four (4) months of receiving the notice of the Claims Administrator's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim).

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

   a. Assigning the Member's request for an external review to an independent review organization and forwarding the Member's records to such organization; or,
   b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Claims Administrator's decision.

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

- Expedited external reviews are available if the Member's Provider certifies that the Member has a serious medical condition. A serious medical condition, as used herein, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Claims Administrator's decision if the Claims Administrator's denial of Benefits involves Emergency Medical Care and the Member has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

LEGAL ACTIONS

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

CASE MANAGEMENT

COMPREHENSIVE CASE MANAGEMENT

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

a. Evaluation and assistance for the Member, Physician, and family to help develop a plan of services to meet specific needs;
b. Assistance with obtaining unusual equipment or supply needs;
c. Assistance in home care planning and implementation;
d. Arrangements for needed nursing/caregiver services;
e. Providing help with assessment of rehabilitation needs and Provider arrangements;
f. Offering appropriate and effective alternative care/therapy suggestions for Mental Health Services and/or treatment for Substance Use Disorder as determined by medical care review;
g. Monitoring and assuring treatment programs and interventions for Mental Health Services and/or treatment for Substance Use Disorder; and
h. Functioning as an effective resource for information on treatment facilities and available care for Mental Health Services and/or treatment for Substance Use Disorder.

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

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

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

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

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan of Benefits for Members shall be in accordance with the Eligibility, Member Effective Date and Termination provisions as stated in this Plan of Benefits.

ELIGIBILITY
Members eligible for coverage under the Plan of Benefits:

A. Every Employee who is Actively at Work for the Employer in a full-time position and who has completed the Waiting Period.

   1. If an Employee is not Actively at Work for the Employer in a budgeted, full-time position or has not completed the Waiting Period, such Employee is eligible to enroll (and to enroll his or her Dependents) beginning on the next day that the Employee is:

      a. Actively at Work for the Employer in a full-time position; and,

      b. Has Completed the Waiting Period.

The Town of Mount Pleasant's plan does not cover part time or part time temporary employees unless they meet the definition of a full-time employee under the Affordable Care Act (ACA).

B. A Town Council Member or the Mayor;

C. A Retired Employee (see the Employer's Human Resource Guidelines for details);

   Group A – Employees retiring before January 1, 2013

   Note: Group A may elect the benefits of Group A or Group B

   1. The retiree and their Spouses may stay on the Town's Plan.
   2. Dependent Children may stay on the Town's plan until they no longer meet the definition as an eligible Dependent.
   3. Widow/ers of retirees may remain on the plan until they are Medicare-eligible, remarry, or become eligible for benefits under another health plan.

   Group B – Employees hired before November 1, 2008

   1. Retirees and their Spouses may stay on the Town's plan until they are Medicare-eligible.
   2. The Town will purchase a Medicare supplemental plan for retirees and their Spouses at no cost to the retiree when they become Medicare-eligible.
   3. Dependent Children may stay on the Town's plan until they no longer meet the definition as an eligible Dependent.
   4. When retirees become eligible for Medicare prior to their Spouses, Spouses can remain on the Town's plan until they are Medicare-eligible.
   5. When Spouses become eligible for Medicare prior to the retirees, retirees can remain on the Town's plan until they are Medicare-eligible.
   6. Widow/ers of retirees may remain on the plan until they are Medicare-eligible, remarry, or become eligible for benefits under another health plan.

   Group C – Employees hired after November 1, 2008

   1. Retirees and their Spouses may stay on the plan until they are Medicare-eligible.
   2. Dependent Children may stay on the Town's plan until they no longer meet the definition as an eligible Dependent.
   3. When retirees become eligible for Medicare prior to their Spouses, Spouses can remain on the Town's plan until they are Medicare-eligible.
   4. When Spouses become eligible for Medicare prior to the retirees, retirees can remain on the Town's plan until they are Medicare-eligible.

5. Widow/ers of retirees may remain on the plan until they are Medicare-eligible, remarry, or become eligible for benefits under another health plan.

D. Dependent Child under the age of 26; and

E. Spouse;

Benefits will become effective on the first day of the month following 30 consecutive days as an active Employee.

ELECTION OF COVERAGE

Employees may enroll for coverage under the Plan for themselves and their Dependents by completing and filing a Membership Application. Dependents must be enrolled within 31 days of the date on which they first become Dependents. Employees and Dependents may also enroll if eligible under the terms of any Special Enrollment procedure.

Employees must present documentation (such as marriage certificates, long form birth certificates, and court documents for adoptions and divorces) for all enrolled Dependents demonstrating they are eligible to be on the Plan.

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

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

Waiting Periods and/or contribution levels will not be based on any factor which discriminates in favor of higher wage Employees as required under the Affordable Care Act.

EFFECTIVE DATE OF COVERAGE

Benefits will become effective on the first day of the month following 30 consecutive days as an active Employee.

Coverage under the Plan will commence as follows, provided that coverage will not be effective more than 60 days before the Claims Administrator received the Employee's Membership Application:

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

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

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

2. Employees and Dependents eligible after the Plan of Benefits Effective Date

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

3. Newborn Children

   Newborn Children Newborn Children will have coverage upon the date of their birth provided they have been enrolled for coverage under this Plan within 31 days of the birth.

4. Adopted Children

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

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within 31 days after the date of the Child's birth; or
   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within 31 days after the date of the Child's birth and if the Employee has obtained temporary custody of the Child.
   c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one year unless a decree of adoption is entered in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan.

5. Special Enrollment

   In addition to enrollment, the Claims Administrator shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

   a. The Employee or Dependent was covered under a Group Health Plan or had creditable coverage at the time coverage was previously offered to the Employee or Dependent;
   b. The Employee stated in writing at the time of enrollment that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan or had creditable coverage at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and,
   c. The Employee or Dependent's coverage described above:

      i. Was under a COBRA continuation provision and the coverage under the provision was exhausted;

ii. Was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of divorce, death, termination of employment), or reduction in the number of hours of employment, or if the Employer's contributions toward the coverage were terminated
iii. Was one of multiple Plans offered by an Employer and the Employee elected a different plan during an open enrollment period or when an Employer terminates all similarly situated individuals;
iv. Was under a Health Maintenance Organization (HMO) that no longer serves the area in which the Employee lives, works or resides; or,
v. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion or termination of coverage or Employer contribution.

d. Medicaid or State Children's Health Insurance Program (SCHIP) Coverage

i. The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or,
ii. The Employee or Dependent becomes eligible for Premium assistance under a Medicaid or SCHIP plan; and,
iii. The Employee or Dependent requests such enrollment not more than 60 days after either:

aa. date of termination of Medicaid or SCHIP coverage; or,
bb. determination that the Employee or Dependent is eligible for such assistance.

A Member whose Child becomes eligible to enroll in and receive child health assistance under a SCHIP plan also may dis-enroll the Child from the Plan, pursuant to applicable procedures and deadlines established by the state.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above see the Employer.

DEPENDENT CHILD'S ENROLLMENT

1. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan.

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

MEMBERSHIP APPLICATION

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

MEMBER CONTRIBUTIONS

The Member is solely responsible for making all payments to the Employer for any Premium in order to receive Benefits.

DISCLOSURE OF MEDICAL INFORMATION

By accepting Benefits or payment of Covered Expenses, the Member agrees that this Plan (including the Claims Administrator on behalf of this Plan) may obtain claims information, medical records, and other information necessary for them to consider a request for Pre-authorization, Concurrent Care, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits.

LIFE-QUALIFYING EVENTS AND REQUIREMENTS

Employees and Dependents are generally eligible to enroll in the Plan within 31 days of being hired, during Open Enrollment, or when certain events occur during the plan year. This enrollment grid outlines the events that give rise to a right to enroll in coverage as well as the documentation required. The Effective Date outlined below will apply provided that the Employees enroll themselves or their Dependents within 31 days of the event. If Employees do not enroll themselves or their Dependents within 31 days of the event, Employees or Dependents will not be eligible to enroll until the next Open Enrollment Period.

EVENT	EFFECTIVE DATE	DOCUMENTATION REQUIRED
MARRIAGE	Date of Marriage	Marriage Certificate
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	Birth Certificate (**LONG FORM**)
DEATH	Date of Death	Proof of Death
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 of coverage.

TERMINATION OF COVERAGE

GENERALLY

Termination of Employee's and their Dependents coverage will occur on the earliest of the following conditions or on the date determined by the Employer:

1. The date employment is terminated;
2. The date the Plan is terminated;
3. The date an Employee retires unless the Plan covers such individual as a retiree;
4. The date an Employee ceases to be eligible for coverage as set forth in the Eligibility Section;
5. The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed 24 weeks from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993;
6. In addition to terminating when an Employee's coverage terminates, a Dependent Spouse's coverage terminates on the date of entry of a court order ending the marriage between the Dependent Spouse and the Employee regardless of whether such order is subject to appeal.
7. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under the Plan;
8. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent; or,
9. Death of the Employee, Retiree, Council Member or Mayor.

TERMINATION FOR FAILURE TO PAY PREMIUMS

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

TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium. If Premiums are not paid by an Employee within 60 days of the due date, health insurance will be terminated and COBRA will be offered.

NOTICE OF TERMINATION TO MEMBERS

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

REINSTATEMENT

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

EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, Members agree that the Employer is their agent for all purposes of any notice under the Plan. Members further agree that notifications received from, or given to, the Employer by the Claims Administrator are notification to the Employees except for any notice required by law to be given to the Members by the Claims Administrator.

EXCEPTIONS TO TERMINATION PROVISIONS (DURING ABSENCE FROM EMPLOYMENT)

1. The Member'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 thereunder, and the amount of coverage shall be the amount for which the Employee was covered on the last day of active work. For an approved lay-off or leave of absence, coverage will continue for a period of no longer than 24 weeks, other than a family or medical leave under FMLA. Members 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 an additional period of no longer than 24 weeks.

CONTINUATION OF COVERAGE

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will be offered in accordance with USERRA as follows:

a. In any case in which an Employee or Dependent has coverage under the Plan, and the Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under this Plan. The maximum period of coverage of the Employee and Dependents under such an election shall be the lesser of:
   i. The 24 month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or,
   ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

   The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.
b. An Employee who elects to continue coverage under this section of the Plan must pay 102% of the Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than 31 days, the Employee will pay the normal payroll premium deductions.
c. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Plan upon re-employment. Except as otherwise provided in this section upon re-employment and reinstatement of coverage no new exclusion or Waiting Period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This section applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under the Plan by reason of the reinstatement of the coverage of the Employee.
d. Item (c.) above shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

CONTINUATION OF COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

** Continuation Coverage Rights Under COBRA**

Introduction

This notice has important information about rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to Employees and their Dependents, and what Employees need to do to protect the right to get it.** When Members become eligible for COBRA, they may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available Employees and Dependents when the Plan would otherwise end. More information about rights and obligations under the Plan and under federal law can be found in this section or by contacting the Employer.

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

What is COBRA continuation coverage?

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

Employees will become a qualified beneficiary if they lose coverage under the Plan because of the following qualifying events:

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

Spouse of Employees become a qualified beneficiary if they lose coverage under the Plan because of the following qualifying events:

- Their Spouse dies;
- Their Spouse's hours of employment are reduced;
- Their Spouse's employment ends for any reason other than his/her gross misconduct;
- Their Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The Spouse becomes divorced from the Employee

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

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

- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary. The retired Employee's Spouse, surviving Spouse and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

- The end of employment or reduction of hours of employment;
- Death of the Employee;
- Commencement of a proceeding in bankruptcy with respect to the Employer; or
- The Employee becoming entitled to Medicare Benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the Employee and Spouse, or a Dependent Child losing eligibility for coverage as a Dependent Child), the Member must notify the Employer within 60 days after the qualifying event occurs. You must provide this notice to:

Name of Entity/Sender:	Town of Mount Pleasant
Contact—Position/Office:	Benefits Manager
Address:	100 Ann Edwards Lane Mount Pleasant, SC 29464
Phone Number:	843-884-8517

How is COBRA continuation coverage provided?
Once the Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

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

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

Disability extension of 18-month period of COBRA continuation coverage
This 11-month extension may be available if a qualified beneficiary is both determined by the Social Security Administration (SSA) to be disabled at some point before the 60th day of COBRA coverage, and the qualified beneficiary (or another person on his or her behalf) notifies the Employer of the SSA determination. The extension must be provided not only to the disabled qualified beneficiary but to any family member who is a qualified beneficiary in connection with the same qualifying event. The plan can set a time limit for providing this notice of disability, but the time limit cannot end before 60 days after the **latest** of:

- The date on which the SSA issues the disability determination;
- The date on which the qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
- The date on which the qualified beneficiary is furnished the COBRA general notice or Plan of Benefits (in which the qualified beneficiary is informed of the obligation to provide the disability notice).

However, the Plan may require this notice of disability to be provided before the end of the first 18 months of COBRA coverage.

The right to a disability extension may be terminated if the SSA determines that the qualified beneficiary is no longer disabled. The Plan can require qualified beneficiaries to provide notice when such a determination is made. The Plan must give the qualified beneficiary at least 30 days after the latest of the date of the SSA's final determination that the qualified beneficiary is no longer disabled; or the date on which the qualified beneficiary is informed of this notice obligation, through the furnishing of the Plan's Plan of Benefits or COBRA general notice, to provide such notice.

The Plan should describe in its Plan of Benefits, and in the election notice for any offer of COBRA coverage with a maximum duration of less than 36 months, how notice of a disability determination or a notice of no longer being disabled should be provided. It should be sent to:

Name of Entity/Sender:	Town of Mount Pleasant
Contact—Position/Office:	Benefits Manager
Address:	100 Ann Edwards Lane Mount Pleasant, SC 29464
Phone Number:	843-884-8517

Second qualifying event extension of 18-month period of continuation coverage
If the family experiences another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the Spouse and any Dependent Children getting COBRA continuation coverage if the Employee or former Employee dies; becomes entitled to Medicare Benefits (under Part A, Part B, or both); gets divorced or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Employees and their families through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Information about these options is available at www.healthcare.gov.

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

Keep the Plan informed of address changes
To protect the family's rights, Employees must let the Employer know about any changes in the addresses of family members. Employees should also keep a copy, for their records, of any notices they send to the Employer.

Plan contact information

Name of Entity/Sender:	Town of Mount Pleasant
Contact—Position/Office:	Benefits Manager
Address:	100 Ann Edwards Lane Mount Pleasant, SC 29464
Phone Number:	843-884-8517

COORDINATION OF BENEFITS

A. APPLICABILITY

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

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

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

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

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

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

As a condition of receiving Benefits, the Member must:

1. Immediately notify Plan or Claims Administrator of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
2. Execute and deliver an accident questionnaire within 180 days of the accident questionnaire being mailed to the Member;
3. Deliver to the Plan or Claims Administrator a copy of the Personal Injury Protection Log, Medical Payments log, and/or Medical Authorization within 90 days of being requested to do so;
4. Deliver to the Plan or Claims Administrator a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within 90 days of being requested to do so; and,
5. Cooperate fully with the Plan or Claims Administrator in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights, and furnish any information required by this Plan or the Claims Administrator.

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

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

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

1. The other Group Health Plan has rules coordinating its benefits with those of this Plan;
2. There is a statutory requirement establishing that this Plan is the Primary Plan; or

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

D. ADDITIONAL ORDER OF DETERMINATION RULES

This Plan coordinates Benefits for non-Employee Members using the first of the following rules that apply:

1. Dependents

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

2. Dependent Child - Parents not Divorced
   When this Plan and another Plan cover the same Child as a Dependent then benefits are determined in the following order:

   a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan. The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.
   b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.
   c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and the Claims Administrator do not agree on the order of benefits, the gender rule in the other Plan will apply.

3. Dependent Child - Divorced Parents
   If two or more Plans cover a person as a Dependent Child of divorced or unmarried parents, Benefits for the Child are determined in the following order:

   a. First, the Plan of the parent with custody of the Child;
   b. Second, the Plan of the parent's Spouse with the custody of the Child;
   c. Third, the Plan of the parent not having custody of the Child;
   d. Fourth, the Plan of the parent's Spouse not having custody of the Child.

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

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

4. Active Employees and Retirees

   Active Employees and Dependents that are age 65 and over must elect either:

   a. **To participate in the Plan.** If the Employee elects to participate in the Plan, then the Plan will be the Participant's primary medical coverage and Medicare will be the Participant's secondary medical coverage; or
   b. **To not participate in the Plan.** If the Employee elects not to participate in the Plan, Medicare will be the Member's only medical coverage.

   The Dependent Spouse, age 65 and over, of any active Employee, must also make an election to participate or not in the Plan.

If the Employee declines coverage under the Plan, then the Employee's Spouse will not be eligible to participate in the Plan. If the Employee elects to participate in the Plan, then the Employee's Spouse may elect to either participate in the Plan or decline to participate in the Plan.

Retirees:

For retirees who are eligible to participate in the Plan, the Plan is secondary to Medicare for any retirees who elect coverage under the Plan.

5. Medicare
This Plan is a Secondary Plan with respect to Medicare benefits except where federal law mandates that this Plan be the Primary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

Coordination of Benefits for retirees over 65 who have Medicare Part A and B benefits are determined by calculating the liability of this Plan in the absence of Medicare and "carving-out" or subtracting Medicare's payment.

MEDICARE FOR DISABLED BENEFICIARIES UNDER AGE 65
Medicare is primary and this Plan will be secondary for the covered Employee and their covered Spouse and/or Children who are under 65 and eligible for Medicare by reason of disability.

MEDICARE FOR PEOPLE 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 will be primary during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage. If an Employee or Dependent is age 65 or over, working and develops or is undergoing treatment for ESRD, Medicare will become primary as of the month they become entitled to ESRD benefits.

6. Longer and Shorter Length of Coverage
If none of the above rules determines the order of Benefits, the Plan that has covered the Member longer is the Primary Plan.

7. 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.

E. EFFECT ON BENEFITS

1. This Plan as Primary Plan
When this Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. This Plan as Secondary Plan
When this Plan is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

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

When the sum of these two amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of this Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of this Plan. The benefits payable by the Primary Plan and the Benefits payable by this Plan will not total more than the Allowable Charge.

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

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

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

G. PAYMENT

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

H. RIGHT OF RECOVERY

If the amount of the payments made by this Plan is more than it should have paid under this coordination of benefits section, this Plan 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.

SUBROGATION/RIGHT OF REIMBURSEMENT

A. BENEFITS SUBJECT TO THIS PROVISION

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

B. STATEMENT OF PURPOSE

Subrogation and reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and reimbursement recoveries are used to pay future claims by other Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Plan has a fiduciary responsibility to pursue and recover these Plan assets to the fullest extent possible.

C. DEFINITIONS

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

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

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

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

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

5. Subrogation
   Subrogation shall mean the Plan's right to pursue the Member's claims for medical or other charges paid by the Plan against another party.

D. WHEN THIS PROVISION APPLIES

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

E. DUTIES OF THE MEMBER

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

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Plan/Claims Administrator of an injury or illness for which another party may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
2. Execute and deliver an accident questionnaire within 180 days of the accident questionnaire being mailed to the Member;
3. Deliver to the Plan/Claims Administrator a copy of the personal injury protection log, medical payments log, and/or medical authorization within 90 days of being requested to do so;
4. Deliver to the Plan/Claims Administrator a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within 90 days of being requested to do so;
5. Authorize the Plan to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Member's rights to Recovery when this provision applies;
6. Include the Benefits paid by the Plan as a part of the damages sought against another party. Immediately reimburse the Plan, out of any recovery made from another party, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
7. Immediately notify the Plan/Claims Administrator in writing of any proposed settlement and obtain the Plan or Claims Administrator's written consent before signing any release or agreeing to any settlement; and,
8. Cooperate fully with the Plan/Claims Administrator in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights, and furnish any information required by the Plan or Claims Administrator.

F. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT

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

G. WHEN A MEMBER RETAINS AN ATTORNEY

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or

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

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

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

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

I. WHEN A MEMBER DOES NOT COMPLY

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

J. PRIOR RECOVERIES

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Coverage for Re-constructive Surgery Following Mastectomies

This Plan provides medical and surgical Benefits with respect to a mastectomy. For a Member who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage will be provided 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 Benefit Year Deductible and Coinsurance will apply to these benefits.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The 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 on the same basis as coverage would have been provided if the Employee had been continuously employed during the entire leave period.

The FMLA entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

Twelve workweeks of leave in a 12-month period for:

A. The birth of a child and to care for the newborn child within one year of birth;

B. The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;

C. To care for the employee's spouse, child, or parent who has a serious health condition;

D. A serious health condition that makes the employee unable to perform the essential functions of his or her job;

E. Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" **or**

Twenty-six workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

WORKERS' COMPENSATION

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

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan, the Plan or Claims Administrator may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Plan or Claims Administrator, including an

accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's right of recovery, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Plan or Claims Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Plan/Claims Administrator of an injury or illness for which the Employer its Workers' Compensation carrier may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
2. Execute and deliver an accident questionnaire within 180 days of the accident questionnaire being mailed to the Member;
3. Deliver to the Plan/Claims Administrator a copy of the police report, incident or accident report, or any other reports issued as a result of the injury or illness within 90 days of being requested to do so;
4. Assert a claim against the Employer and/or its Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;
5. Include the Benefits paid by the Plan as a part of the damages sought against the Employer and/or its Workers' Compensation carrier. Immediately reimburse the Plan, out of any recovery made from the Employer and/or its Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
6. Immediately notify the Plan/Claims Administrator in writing of any proposed settlement and obtain the Plan or Claims Administrator's written consent before signing any release or agreeing to any settlement; and,
7. Cooperate fully with the Plan/Claims Administrator in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights, and furnish any information required by the Plan or Claims Administrator.

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

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

Failure to reimburse the Plan from the recovery as required under this provision will entitle the Plan/Claims Administrator to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

If a Workers' Compensation case is settled, the Plan reserves the right to pay for Benefits on future claims related to the injured area.

MEDICARE CREDITABLE COVERAGE LETTER

Important Notice from the Town of Mount Pleasant about
Prescription Drug Coverage and Medicare

This notice has information about current prescription drug coverage with the Employer and about options under Medicare's prescription drug coverage. This information can help Members decide whether or not they want to join a Medicare drug plan. If they are considering joining, they should compare their current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in the area. Information about where Members can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things Members need to know about current coverage and Medicare's prescription drug coverage:

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

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

When Can Members Join A Medicare Drug Plan?

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

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

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

If Members decide to join a Medicare drug plan, their current coverage will be affected. If they do decide to join a Medicare drug plan and drop your current drug coverage through the Employer, they should be aware that they and their Dependents may not be able to get this coverage back.

Current Drug Benefits

	COST TO MEMBERS		
PRESCRIPTION DRUG BENEFITS	DIRECT PRIMARY CARE PLAN	STANDARD PLAN	RETIREE DIRECT PRIMARY CARE PLAN
Generic (31 days)	$7	$14	$7
Preferred Brand Name (31 days)	$35	$70	$35
Non-Preferred Brand Name (31 days)	$50	$100	$50
Alternative Therapeutic (Nexium) (30 days only)	$250	$500	$250
Specialty (30 days only)	$250	$500	$250

Prescriptions and OTC Supplies related to tobacco cessation (maximums set by Script Care)	$0	$0	$0
Birth Control	$0	$0	$0
IUD will be covered under Prescription and Medical because the device can be obtained at both places	$0	$0	$0
Bowel Prep for Routine and Diagnostic Colonoscopies regardless of age	$0	$0	$0
Breast Cancer Preventive	$0	$0	$0
Prescriptions dispensed at Paladina Health Office	$0	$0	$0

	COST TO MEMBERS		
PRESCRIPTION DRUG BENEFITS MAIL ORDER	**DIRECT PRIMARY CARE PLAN**	**STANDARD PLAN**	**RETIREE DIRECT PRIMARY CARE PLAN**
Generic (90 days)	$14	$28	$14
Preferred Brand Name (90 days)	$70	$140	$70
Non-Preferred Brand Name (90 days)	$100	$200	$100
Alternative Therapeutic (Nexium) (30 days only)	$250	$250	$250
Specialty (30 days only)	$250	$250	$250

Non-Preferred Retail Pharmacy Copayment increases by $10 per drug.

c. CVS
d. Walgreens

Group Number: 956
Group Name: Town of Mount Pleasant
Effective Date of Coverage: July 1, 2019

* The Employer has a Mandatory Generic Drug Program. For Preferred and Non-Preferred Brand Name Drugs, Members will pay the Copayment plus the difference between the actual cost of the Generic and Brand Name Drugs. When there is no Generic available, a Copayment only applies.

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

Members should also know that if they drop or lose their current coverage with the Employer and don't join a Medicare drug plan within 63 continuous days after the current coverage ends, they may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

Members can contact the person listed below for further information.

NOTE: Members will get this notice each year. They will also get it before the next period they can join a Medicare drug plan, and if this coverage through the Employer changes. Members also may request a copy of this notice at any time.

For More Information about Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage, Members can:

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

If Members have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, Members may visit Social Security on the web atwww.socialsecurity.gov, or call (800) 772-1213 [TTY is (800) 325-0778].

Remember: Members should keep this Creditable Coverage notice. If they decide to join one of the Medicare drug plans, they may be required to provide a copy of this notice when they join to show whether or not they have maintained creditable coverage and, therefore, whether or not they are required to pay a higher premium (a penalty).

Date:	July 1, 2019
Name of Entity/Sender:	Town of Mount Pleasant
Contact:	Benefits Manager
Address:	100 Ann Edwards Lane Mount Pleasant, SC 29464
Phone Number:	**(**843) 884-8517

DEFINITIONS

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

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

"Admission": the period of time between the Member's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Member 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 the Member's eligibility to participate in the 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, Investigational, not Medically Necessary, or not appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit), except to the extent attributable to a failure to pay any required Premiums or Employee contributions.

"Allowable Charge": the amount the Claims Administrator agrees to pay a Participating Provider or Non-Participating Provider as payment in full for a service, procedure, supply or equipment. For a Non-Participating Provider:

a. The Allowable Charge shall not exceed the Maximum Payment; and
b. In addition to the Member's liability for Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by and responsible to the Non-Participating Provider for any difference between the Allowable Charge and the billed charges.

"Ambulatory Surgical Center": a licensed facility that:

a. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
b. Provides treatment by or under the supervision of licensed Physicians or oral surgeons and provides nursing services when the Member is in the facility;
c. Does not provide inpatient accommodations; and,
d. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed Physician or oral surgeon.

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.

"Autism Spectrum Disorder": the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

a. Autistic Disorder;
b. Asperger's Syndrome;
c. Pervasive Developmental Disorder--Not Otherwise Specified

"**Behavioral Health Provider"**: a Provider who renders Mental Health Services and/or Substance Use Disorder Services.

"Benefits": a service or supply as specified in this Plan of Benefits or on the Schedule of Benefits. Medical services or medical supplies must be:

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

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

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

"Brand Name Drug": a Prescription Drug manufactured under a registered trade name or trademark.

"**Child":** an Employee's Child, whether a natural Child, adopted Child, foster Child, stepchild, or Child for whom an Employee has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, and a Child of a divorced or divorcing Employee who, under a valid court order, has a right to enroll under this Plan. The term "Child" does not include the Spouse of an eligible Child.

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

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

"Clinical Trials": an Approved Clinical Trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Department of Defense (DOD), the Department of Veterans Affairs (VA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

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

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

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

"Companion Benefit Alternatives (CBA)": a behavioral healthcare company. CBA is responsible for managing behavioral healthcare Services, including pre-certifying Mental Health and Substance Use Disorder Benefits for inpatient and outpatient Services. CBA is an independent company that provides healthcare on behalf of the Claims Administrator.

"Congenital Disorder/Congenital Disease": a condition documented as existing at birth regardless of cause.

"Continuation of Care": the provision of Participating Provider-level Benefits for services rendered by certain Non-Participating Providers for a definite period of time in order to ensure continuity of care for covered Members for a Serious Medical Condition.

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

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

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

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

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

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

"Custodial Care": non-skilled services that are primarily for the purpose of assisting the Member with daily living activities or personal needs (e.g. bathing, dressing, eating), which is not specific therapy for any illness or injury.

"Deductible": the amount of Benefits as indicated in the Schedule of Benefits that the Member (individually or as part of family coverage) must pay each Benefit Year before benefits are paid by the Plan.

"Dependent": the following individuals:

a. An Employee's Spouse;
b. A Child under the age of [26]; or
c. An Incapacitated Dependent.

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

"Durable Medical Equipment": equipment that:

a. Can stand repeated use; and
b. Is Medically Necessary; and
c. Is customarily used for the treatment of the Member's Illness, Injury, disease or disorder; and
d. Is appropriate for use in the home; and
e. Is not useful to a Member in the absence of Illness or Injury; and
f. Does not include appliances that are provided solely for the Member's comfort or convenience; and
g. Is a standard, non-luxury item (as determined by the 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 when the required Preauthorization is obtained.

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

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

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

"Employee": any Employee of the Employer who is eligible for coverage, as provided in the Eligibility Section of this Plan of Benefits, and who is so designated to the Claims Administrator by the Employer, even if such classification is determined to be erroneous or is retroactively revised.

"Employer": the entity providing this Plan of Benefits, the Town of Mount Pleasant.

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

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

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

"Excepted Benefits":

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. Workers' compensation or similar insurance;
e. Automobile medical payment insurance;
f. Credit-only insurance;
g. Coverage for on-site medical clinics;
h. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

<u>If offered separately</u>:

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

<u>If offered as independent, non-coordinated benefits</u>:

a. Coverage only for a specified disease or Illness;
b. Hospital indemnity or other fixed indemnity insurance.

<u>If offered as a separate insurance policy</u>:

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

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

a. Has not received required final approval to market from appropriate government bodies;
b. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
c. Is not demonstrated to be as beneficial as established alternatives;
d. Has not been demonstrated to improve net health outcomes; or,
e. Is one in which the improvement claimed is not demonstrated to be obtainable outside the Investigational or Experimental setting.

"Generic Drug": a Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

"Genetic Information": information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from an individual or family member of the individual. Genetic Information 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. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted purposely to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

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

"Group Health Plan": an Employee welfare Benefit Plan to the extent that such Plan provides health Benefits to Employees or their Dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement, or otherwise. This Plan of Benefits is a Group Health Plan.

"Health Status-Related Factor": information about the Member's health, including:

a. Health status;
b. Medical conditions (including both physical and mental illnesses);
c. Claims experience;
d. Receipt of health care;
e. Medical history;
f. Genetic Information;
g. Evidence of insurability (including conditions arising out of acts of domestic violence); or,
h. Disability.

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

"Home Health Agency": an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

"Home Health Care": part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Member in the Member's private residence.

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

"Hospital": a short-term, acute care facility licensed as a Hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Providers, and continuous 24 hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Members.

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

"Incapacitated Dependent": a Child who is:

a. Incapable of financial self-sufficiency by reason of mental or physical disability; and,
b. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

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A Child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will provide updated information regarding items (a) and (b) each year or upon the Claims Administrator's request.

"Late Enrollee": an Employee who enrolls under this Plan of Benefits other than during:

a. The first period in which Employee is eligible to enroll under the Plan if the initial enrollment period is a period of at least 30 days; or
b. A Special Enrollment period.

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

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

a. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy; or
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

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

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

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

a. The actual charge submitted to the Claims Administrator for the service, procedure, supply or equipment by a Provider; or
b. An amount based upon the reimbursement rates established by the Plan in its Benefits Checklist; or
c. An amount that has been agreed upon in writing by a Provider and the Claims Administrator; or
d. An amount established by the Claims Administrator, based upon factors including, but not limited to:

    i. governmental reimbursement rates applicable to the service, procedure, supply or equipment; or
    ii. reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or
    iii. The lowest amount of reimbursement the Claims Administrator allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

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

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

"Medical Supplies": supplies that are:

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

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

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

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

"Mental Health Services": treatment (except Substance Use Disorder Services) 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.

"Natural Teeth": teeth that:

a. Are free of active or chronic clinical decay; and
b. Have at least 50% bony support; and
c. Are functional in the arch; and

d. Have not been excessively weakened by multiple dental procedures; or
e. Teeth that have been treated for one or more of the conditions referenced in (a)-(d) above, and as a result of such treatment have been restored to normal function.

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

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

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

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

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

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

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

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

"Plan": any program that provides benefits or services for medical or dental care or treatment including:

a. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and
b. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

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

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

"Plan of Benefits": the Benefit booklet provided by the Claims Administrator to the Employer which reflects the Claims Administrator's understanding of the Benefits offered under the Plan based on the Benefits Checklist completed by the Employer and submitted to the Claims Administrator. The Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.

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

"Plan Sponsor": the party sponsoring a Plan of Benefits. The Employer is the Plan Sponsor of the Plan.

"PPACA": the Patient Protection and Affordable Care Act of 2010, as amended.

"Pre-Authorized/Pre-Authorization": the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to the Member. Pre-Authorization means only that the Benefit is Medically Necessary. Pre-Authorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Pre-Authorization, payment for Benefits is subject to the Member's eligibility, and all other limitations and exclusions contained in this Plan of Benefits. The Member's entitlement to Benefits is not determined until the Member's claim is processed. The Pre-Authorization process is outlined in the Pre-Authorization/Prior Approval Section.

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

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

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

"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 licensed Provider acting within the scope of his or her license as a prescription;
b. Not be entirely consumed at the time and place where the prescription is dispensed; and
c. Be purchased for use outside a Hospital.

"Prescription Drug Copayment": the amount payable, set forth on the Schedule of Benefits, by the Member for each Prescription Drug filled or refilled.

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

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

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

"Private Duty Nursing": hourly or shift skilled nursing care provided in the Member's home. PDN provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a Home Health Agency. The intent of PDN is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize patient health status and outcomes. The frequency and duration of PDN services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis. PDN is not long-term care.

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

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

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

a. Medicine
b. Dentistry
c. Optometry
d. Podiatry
e. Chiropractic Services
f. Physical Therapy
g. Behavioral Health
h. Oral Surgery
i. Speech Therapy
j. Occupational Therapy
k. Certified Diabetes Educator
l. Registered Dietician

The term Provider also includes a Hospital, a Rehabilitation Facility, a Skilled Nursing Facility, a Physician assistant and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon. The term Provider does not include interns, residents, in-house Physicians, physical trainers, lay midwives or masseuses.

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

"Provider Services": includes the following services:

1. When performed by a Provider or a Behavioral Health Provider within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by the Claims Administrator:
   a. Office visits, which are for the purpose of seeking or receiving care for an illness or injury; or,
   b. Basic diagnostic services and machine tests.

2. When performed by a licensed Physician, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:
   a. Benefits rendered to the Member in a Hospital or Skilled Nursing Facility;
   b. Benefits rendered in the Member's home;
   c. Surgical Services;
   d. Anesthesia services, including the administration of general or spinal block anesthesia;
   e. Radiological examinations;
   f. Laboratory tests; and,
   g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.

3. Additionally, Provider Services shall include behavioral health services when performed by a Behavioral Health Provider, nurse practitioner, Physician assistant, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Claims Administrator.

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

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

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

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

"Residential Treatment Center (RTC)": a licensed institution, other than a Hospital, which meets all six of these requirements:

a. Maintains permanent and full-time facilities for bed care of resident patients;
b. Has the services of a psychiatrist (addictionologist, when applicable) or Physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and as needed as indicated;
c. Has a registered nurse (RN) present onsite who is in charge of patient care along with one or more RNs or licensed practical nurses (LPNs) onsite at all times 24 hours per day and seven days per week;
d. Keeps a daily medical record for each patient;
e. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and,
f. Is operating lawfully as a RTC in the area where it is located.

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

"Second Surgical Opinion": the medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed Physician has proposed to perform surgery, but before the surgery is performed. The second licensed Physician must not be associated with the primary licensed medical doctor.

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

"Serious Medical Condition": a health condition or illness that requires medical attention and for which failure to provide the current course of treatment through the current Provider would place the Member's health in serious jeopardy. This includes cancer, acute myocardial infarction, and pregnancy.

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

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

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

"Specialty Drugs": Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include but are not limited to infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

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

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

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

"Substance Use Disorder Services": services or treatment relating to Substance Use Disorder.

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

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

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

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

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

COMMON DENTAL DEFINITIONS

NOTE: *The following definitions are for informational purposes only. Members should refer to the Schedule of Benefits for Benefits that are available under the 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 abutments.
b. "Fixed Removable" one which the Dentist can remove but the patient cannot.
c. "Removable" a partial denture retained by attachments which permit removal of the denture, normally held by clasps.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Palliative": an alleviating measure used to relieve, but not cure, a problem.

"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.

ADMINISTRATIVE INFORMATION

Benefit Year:	Begins January 1st and continues for 12 consecutive months through December 31st.
Plan Name:	**Town of Mount Pleasant Group Medical and Dental Plan**
Name and Address of the Employer establishing the Plan:	**Town of Mount Pleasant** 100 Ann Edwards Lane Mount Pleasant, SC 29464 (843) 884-8517
Employer's ID Number:	57-6001079
Plan Number:	501
Group Number:	956
Type of Welfare Plan:	Medical and Dental Plan
Plan Funding:	Paid by the Employer and the Employee determined by the level of coverage and plan selected.
Claims Administration:	Thomas H. Cooper & Co., Inc. a/k/a TCC Benefits Administrator PO Box 63477 North Charleston, SC 29419
Agent for Service of Legal Process:	**Town of Mount Pleasant**
Plan Administrator Name:	**Town of Mount Pleasant**
Named Trustee:	**Town of Mount Pleasant**
Named Fiduciary:	**Town of Mount Pleasant**
Plan Termination:	The Plan Administrator reserves the right 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 / Plan of Benefits	A full description of the medical and dental 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 thirty (30) days after a written request is received by the Plan Administrator.

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

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

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

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

CONTINUATION OF CARE
If a Participating Provider's contract ends or is not renewed for any reason other than suspension or revocation of the Provider's license and the Member is receiving treatment for a Serious Medical Condition, the Member may be eligible to continue to receive In-network Benefits for that Provider's services.

In order to receive this Continuation of Care for a Serious Medical Condition, the Member must submit a request to the Claims Administrator on the appropriate form. The treating Provider should include a statement on the form confirming the Serious Medical Condition. Upon receipt of the request, the Claims Administrator will notify the Member and the Provider of the last date the Provider is part of the network and a summary of Continuation of Care requirements. The Claims Administrator will review the request to determine qualification for the Continuation of Care. If additional information is necessary to make a determination, the Claims Administrator may contact the Member or the Provider for such information. If the Claims Administrator approves the request, in-network Benefits for that Provider will be provided for 90 days or until the end of the benefit period, whichever is greater. During this time, the Provider will accept the network allowance as payment in full. Continuation of Care is subject to all other terms and conditions of this contract, including regular Benefit limits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Pings on a Party's firewall;
ii. Port scans;
iii. Attempts to log on to a system or enter a database with an invalid password or username;
iv. Denial-of-service attacks that do not result in a server being taken off-line; and,
v. Malware (e.g., worms, viruses).

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

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

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

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

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

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

Plan Sponsor certifies that the Plan of Benefits contains and that the Plan Sponsor agrees to the provisions outlined above.

GOVERNING LAW
The Plan (including the Schedule of Benefits) is governed by and subject to applicable federal laws. If a federal law does not apply, the 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 Plan conflicts with such law, the Plan shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD
Members must present their Identification Card prior to receiving Benefits.

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

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

LEGAL ACTIONS
No Member may bring an action at law or in equity to recover on the Plan until the Member has exhausted the appeal process. No such action may be brought after the expiration of any applicable period prescribed by law.

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

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

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

1. To Claims Administrator:
   Thomas H. Cooper & Co., Inc.
   P.O. Box 63477
   North Charleston, SC 29419

2. To Members: To the last known name and address listed for the Employee. Members are responsible for notifying TCC Benefits Administrator of any name or address changes within 31 days of the change.

3. To the Employer: To the name and address last given to TCC Benefits Administrator. The Employer is responsible for notifying TCC Benefits Administrator and Members of any name or address change within 31 days of the change.

NO WAIVER OF RIGHTS
On occasion, TCC Benefits Administrator (on behalf of the 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 Plan or Employer waives or gives up any rights under this Plan of Benefits in the future.

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

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

PHYSICAL EXAMINATION

The Plan has the right to examine, at its own expense, a Member whose Injury or Illness 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 Plan (through its designee, including TCC Benefits Administrator) may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

RESCISSION OF COVERAGE

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

NOTICE OF PRIVACY PRACTICES

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

Our Privacy Promise

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

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

Uses and Disclosures of Medical Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Individual Rights

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

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

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

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

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

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

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

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

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

Questions and Complaints

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

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

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

Legal disputes will occur in Charleston County, South Carolina.

Contact Information

Privacy Officer:	Louis McElveen
Address:	I-20 @ Alpine Road (AX-E01) Columbia, SC 29219
Telephone:	(803) 264-7258
Fax:	(803) 264-7257

Final Acceptance by the Plan Administrator for the attached Plan of Benefits dated July 1, 2019.

IN WITNESS WHEREOF, TOWN OF MOUNT PLEASANT 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 Town Administrator

Date 7/26/19

Non-Discrimination Statement and Foreign Language Access

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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