SCMA

MEMBERS' INSURANCE TRUST

2019 MIT Group Health Plan
Benefits Guide

South Carolina Medical Association Members' Insurance Trust

Voluntary Employees' Beneficiary Association
Welfare Benefit Plan & Trust

+ For SCMA/MIT Members

Effective January 1, 2019

How Benefits are Provided

The healthcare benefits described on the following pages are provided directly by the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust (SCMA/MIT). The effective date of the benefits described in this booklet is January 1, 2019.

Please read your plan book carefully and call SCMA/MIT if you have any questions concerning your coverage before receiving elective procedures.

Plan changes will only be allowed during the annual Open Enrollment Period. The only exception to this rule would be a qualification under the Special Enrollment Period. See the Special Enrollment Period section for more information.

The Trustees of the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust reserve the right to make all coverage decisions. The plan and any coverage for which you may be, or are eligible, or under which you may be or are covered is subject to amendment from time to time, and may be terminated at any time. Nothing in this booklet constitutes or may be considered to constitute a continuing, permanent, lifetime or other unlimited or non-terminable right to eligibility for coverage, or for any benefits, payments or reimbursements.

Online benefits portal

Visit www.paisc.com to use the online benefits portal to view your claims, deductible status, Explanation of Benefits and much more.

Find a Provider

The SCMA/MIT uses Preferred Blue as its Preferred Provider Organization (PPO) in South Carolina. For services rendered outside of South Carolina members will utilize the First Health Network.

Visit www.paisc.com/yourplan/scmamembersinsurancetrust.aspx to view the provider directory.

Summary of Benefits

In accordance with the Patient Protection and Affordable Care Act, SCMA/MIT has developed Summary of Benefits and Coverage (SBCs) for all of our health plans. Copies of these can be requested by visiting: www.scmamit.com or by calling 1-800-327-1021.

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SCMA Members' Insurance Trust

Major Medical Health Plan Options

Please Note for all Major Medical Plans

- In-network and out-of-network deductibles and out-of-pocket amounts are separate.
- Prescription fixed dollar co-payments do apply to the out-of-pocket maximum.
- Prescription co-insurance for Major Medical Plans does apply to the deductible and out-of-pocket maximum.
- Office visit fixed dollar co-payments do apply to the out-of-pocket maximum, when the Enhancement Package is elected.
- Emergency room fixed dollar co-payments do apply to the out-of-pocket maximum
- Emergency services are paid at the in-network benefit level, regardless of provider.
- MIT will pay at in-network benefit levels for covered services rendered by out-of-network radiologist, anesthesiologist, and pathologist when the member/dependent is receiving services from an in-network provider at an in-network hospital or emergency department.
- Prescription co-payments through mail order pharmacy are two and half (2½) times the retail co-payment for a 90-day supply.
- Precertification/prior authorization required for all in-patient admissions and certain out-patient procedures. Penalty for noncompliance is $500 benefit reduction. First penalty waived and written notification issued.
- Specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill. Contact MIT directly for more information.
- Covered preventative benefits are paid at 100% when services are rendered by an in-network provider.
- Step Therapy is required for all plan designs.

MAJOR MEDICAL - CHOICE PLUS OPTION SCHEDULE OF BENEFITS		
In-Network Deductible	$500/person $1,500/family of 3	
Out-of-Network Deductible	$1,000/person $3,000/family of 3	
In-Network Maximum Out-of-Pocket Expense	$2,500/person $7,500/family of 3	
Out-of-Network Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In-Network	Out-of-Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$100 co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

ENHANCEMENT PACKAGE	
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30
In-network Office Visit* Co-pay for Specialists	$50
Prescription Card	$5/35/60
Rx $500-999	$65
Rx $1000-1499	$130
Rx $1500-2000	$200
Rx above $2000	$275

*Excludes any other procedures performed during the visit.

MAJOR MEDICAL - HD/1,000 OPTION SCHEDULE OF BENEFITS		
In-Network Deductible	$1,000/person $3,000/family of 3	
Out-of-Network Deductible	$2,000/person $6,000/family of 3	
In-Network Maximum Out-of-Pocket Expense	$3,000/person $9,000/family of 3	
Out-of-Network Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In-Network	Out-of-Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$100 co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

ENHANCEMENT PACKAGE	
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30
In-network Office Visit* Co-pay for Specialists	$50
Prescription Card	$5/35/60
Rx $500-999	$65
Rx $1000-1499	$130
Rx $1500-2000	$200
Rx above $2000	$275

*Excludes any other procedures performed during the visit.

MAJOR MEDICAL - HD/1,500 OPTION SCHEDULE OF BENEFITS		
In-Network Deductible	$1,500/person $4,500/family of 3	
Out-of-Network Deductible	$3,000/person $9,000/family of 3	
In-Network Maximum Out-of-Pocket Expense	$3,500/person $10,500/family of 3	
Out-of-Network Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In-Network	Out-of-Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$100 co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

ENHANCEMENT PACKAGE	
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30
In-network Office Visit* Co-pay for Specialists	$50
Prescription Card	$5/35/60
Rx $500-999	$65
Rx $1000-1499	$130
Rx $1500-2000	$200
Rx above $2000	$275

*Excludes any other procedures performed during the visit.

MAJOR MEDICAL - HD/2,000 OPTION SCHEDULE OF BENEFITS		
In-Network Deductible	$2,000/person $6,000/family of 3	
Out-of-Network Deductible	$4,000/person $12,000/family of 3	
In-Network Maximum Out-of-Pocket Expense	$4,000/person $12,000/family of 3	
Out-of-Network Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In-Network	Out-of-Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$100 co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

ENHANCEMENT PACKAGE	
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30
In-network Office Visit* Co-pay for Specialists	$50
Prescription Card	$5/35/60
Rx $500-999	$65
Rx $1000-1499	$130
Rx $1500-2000	$200
Rx above $2000	$275

*Excludes any other procedures performed during the visit.

MAJOR MEDICAL - HD/3,000 OPTION SCHEDULE OF BENEFITS		
In-Network Deductible	$3,000/person $9,000/family of 3	
Out-of-Network Deductible	$6,000/person $18,000/family of 3	
In-Network Maximum Out-of-Pocket Expense	$6,000/person $13,700/family of 3	
Out-of-Network Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In-Network	Out-of-Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$100 co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

ENHANCEMENT PACKAGE	
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30
In-network Office Visit* Co-pay for Specialists	$50
Prescription Card	$5/35/60
Rx $500-999	$65
Rx $1000-1499	$130
Rx $1500-2000	$200
Rx above $2000	$275

*Excludes any other procedures performed during the visit.

MAJOR MEDICAL - HD/5,000 OPTION SCHEDULE OF BENEFITS		
In-Network Deductible	$5,000/person $12,700/family of 3	
Out-of-Network Deductible	$10,000/person $30,000/family of 3	
In-Network Maximum Out-of-Pocket Expense	$6,850/person $13,700/family of 3	
Out-of-Network Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In-Network	Out-of-Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$100 co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

ENHANCEMENT PACKAGE	
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30
In-network Office Visit* Co-pay for Specialists	$50
Prescription Card	$5/35/60
Rx $500-999	$65
Rx $1000-1499	$130
Rx $1500-2000	$200
Rx above $2000	$275

*Excludes any other procedures performed during the visit.

SCMA Members' Insurance Trust

High Deductible Health Plan (HDHP) Options

Please Note for all HDHP Plans

- In-network and out-of-network deductibles and out-of-pocket amounts are separate.
- MIT will pay at in-network benefit levels for covered services rendered by out-of-network radiologist, anesthesiologist, and pathologist when the member/dependent is receiving services from an in-network provider at an in network hospital or emergency department.
- Emergency services are paid at the in-network benefit level, regardless of provider.
- Precertification/prior authorization required for all in-patient admissions and certain out-patient procedures. Penalty for noncompliance is $500 benefit reduction. First penalty waived and written notification issued.
- Specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill. Contact MIT directly for more information.
- Covered preventative benefits are paid at 100% when services are rendered by an in-network provider.
- Step Therapy is required for all plan designs.

HDHP OPTION I SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$1,500/single $3,000/family	
Out-of-Network Aggregate Deductible	$3,000/single $6,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$1,500/single $3,000/family	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	100%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport	100%	

HDHP OPTION II SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$2,500/single $5,000/family	
Out-of-Network Aggregate Deductible	$5,000/single $10,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$2,500/single $5,000/family	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	100%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport	100%	

HDHP OPTION III SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$3,000/single	$6,000/family
Out-of-Network Aggregate Deductible	$6,000/single	$12,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$3,000/single	$6,000/family
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	100%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport	100%	

HDHP OPTION IV SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$3,500/single $7,000/family*	
Out-of-Network Aggregate Deductible	$7,000/single $14,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$3,500/single $7,000/family*	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	100%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport	100%	

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

HDHP OPTION V SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$1,500/single $3,000/family	
Out-of-Network Aggregate Deductible	$3,000/single $6,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$3,000/single $6,000/family	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport	80%	

HDHP OPTION VI SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$2,500/single $5,000/family	
Out-of-Network Aggregate Deductible	$5,000/single $10,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$5,000/single $10,000/family*	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport	80%	

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

SCMA Members' Insurance Trust

Preferred Health Plan Options

Please Note for Premier, Prime & Select Medical Plans

- In-network and out-of-network deductibles and out-of-pocket amounts are separate.
- Prescription fixed dollar co-payments do apply to the out-of-pocket maximum.
- Office visit fixed dollar co-payments do apply to the out-of-pocket maximum.
- Emergency room fixed dollar co-payments do apply to the out-of-pocket maximum.
- Emergency services are paid at the in-network benefit level, regardless of provider.
- MIT will pay at in-network benefit levels for covered services rendered by out-of-network radiologist, anesthesiologist, and pathologist when the member/dependent is receiving services from an in-network provider at an in-network hospital or emergency department.
- Prescription co-payments through mail order pharmacy are two and half (2½) times the retail co-payment for a 90-day supply.
- Precertification/prior authorization required for all in-patient admissions and certain out-patient procedures. Penalty for noncompliance is $500 benefit reduction. First penalty waived and written notification issued.
- Specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill. Contact MIT directly for more information.
- Covered preventative benefits are paid at 100% when services are rendered by an in-network provider.
- Step Therapy is required for all plan designs.
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Please Note for the essential Plan

- In-network and out-of-network deductibles and out-of-pocket amounts are separate.
- MIT will pay at in-network benefit levels for covered services rendered by out-of-network radiologist, anesthesiologist, and pathologist when the member/dependent is receiving services from an in-network provider at an in network hospital or emergency department.
- Precertification/prior authorization required for all in-patient admissions and certain out-patient procedures. Penalty for noncompliance is $500 benefit reduction. First penalty waived and written notification issued.
- Specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill. Contact MIT directly for more information.
- Covered preventative benefits are paid at 100% when services are rendered by an in-network provider.
- Step Therapy is required.

PREMIER OPTION SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$1,200/person	$2,200/family
Out-of-Network Aggregate Deductible	$1,200/person	$2,200/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$4,200/person	$7,800/family*
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum Including Transplants	Unlimited	

Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	100%
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$300 Co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$15
In-network Office Visit** Co-pay for Specialists	$30
Prescription Card	$7/35/100
Specialty Drug Co-pay	$250

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

**Excludes any other procedures performed during the visit.

PRIME OPTION SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$2,000/person	$3,500/family
Out-of-Network Aggregate Deductible	$2,000/person	$3,500/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,300/person	$11,300/family*
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum Including Transplants	Unlimited	

Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	100%
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$200 Co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30
In-network Office Visit** Co-pay for Specialists	$60
Prescription Card	$12/40/100
Specialty Drug Co-pay	$250

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

**Excludes any other procedures performed during the visit.

SELECT OPTION SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$1,750/person	$3,000/family
Out-of-Network Aggregate Deductible	$1,750/person	$3,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,300/person	$11,000/family*
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum Including Transplants	Unlimited	

Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	70%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	100%
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$200 Co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	70%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$25
In-network Office Visit** Co-pay for Specialists	$50
Prescription Card	$12/40/100
Specialty Drug Co-pay	$250

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

**Excludes any other procedures performed during the visit.

ESSENTIAL OPTION SCHEDULE OF BENEFITS (QUALIFIED FOR AN HSA)		
In-Network Aggregate Deductible	$3,000/person	$5,200/family
Out-of-Network Aggregate Deductible	$3,000/person	$5,200/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,350/person	$11,200/family*
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	50%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport		

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

PREMIER PLUS OPTION SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$1,500/person	$3,000/family
Out-of-Network Aggregate Deductible	$3,000/person	$6,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$5,000/person	$10,000/family*
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum Including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	100%
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$500 Co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		

In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$15
In-network Office Visit** Co-pay for Specialists	$30
Prescription Card	$7/35/100
Specialty Drug Co-pay	$250

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

**Excludes any other procedures performed during the visit.

PRIME PLUS OPTION SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$2,500/person $5,000/family	
Out-of-Network Aggregate Deductible	$5,000/person $10,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,850/person $13,700/family*	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum Including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	100%
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$300 Co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$30	
In-network Office Visit** Co-pay for Specialists	$60	
Prescription Card	$12/40/100	
Specialty Drug Co-pay	$250	

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

**Excludes any other procedures performed during the visit.

SELECT PLUS OPTION SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$2,000/person $4,500/family	
Out-of-Network Aggregate Deductible	$4,000/person $9,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,850/person $13,700/family*	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum Including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	70%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	100%	100%
Emergency Room Visits (Co-pay waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a physician)	$300 Co-pay then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	70%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry	$25	
In-network Office Visit** Co-pay for Specialists	$50	
Prescription Card	$12/40/100	
Specialty Drug Co-pay	$250	

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

**Excludes any other procedures performed during the visit.

ESSENTIAL PLUS OPTION SCHEDULE OF BENEFITS (HSA QUALIFIED)		
In-Network Aggregate Deductible	$5,000/person $10,000/family	
Out-of-Network Aggregate Deductible	$10,000/person $20,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,750/person $13,500/family*	
Out-of-Network Aggregate Maximum Out-of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	In Network	Out of Network
Out-patient Surgery, Out-patient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	50%	50%
Assistant Surgeons (limited to 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Out-patient		
Alcohol/Drug Addiction (Hospital & Physician In- or Out-patient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)		
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)		
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Physician Office Visits		
Emergency Room Visits & Emergency Ambulance Transport		

**Individual maximum of $6,850 is embedded for members with dependent coverage.*

UNDERSTANDING HEALTH CARE REFORM AND YOUR PREVENTIVE SERVICES COVERAGE

The healthcare reform law requires health plans to provide coverage to non-grandfathered plans at no cost-sharing for "Recommended Preventive Services" when furnished by an in-network provider. These services are described in the United States Preventive Services Task Force (USPSTF) A and B Recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatric Bright Futures recommendations.

For a complete and detailed list of all Recommended Preventive Services, please visit www.healthcare.gov.

Important to Remember

Recommended Preventive Services may often be furnished as a part of the office visits in which the member receives other health care services. Here's how the rules work relating to cost-sharing requirements for these services:

- If a provider bills a Recommended Preventive Service separately from an office visit, the health plan may require cost-sharing for the office visit (but not the Recommended Preventive Service).
- If a provider does not bill a Recommended Preventive Service separately from an office visit and the primary purpose of the visit is for the patient to get Recommended Preventive Service, the health plan may not require cost-sharing for the office visit or the Recommended Preventive Service.
- If a provider does not bill a Recommended Preventive Service separately from an office visit, and the primary purpose of the office visit is for something other than the Recommended Preventive Service, the health plan may require cost-sharing for the office visit.

Please Note

The preventive benefits described in this booklet are provided for informational purposes only and do not constitute legal advice or legal options. The SCMA/MIT makes no representations regarding the accuracy or legal effect of the information contained herein, and disclaims any warranty of any kind related to it. This document may be based on internal interpretations of healthcare reform legislation, is subject to change without notice, and is not a substitute for legal advice.

PREVENTIVE SERVICES BENEFITS	
Physical Examination In-Network Coverage/One (1) per Calendar Year This coverage is an additional MIT Benefit not required under Healthcare Reform.	
Adults (19+)	Including and limited to urinalysis, CBC, cholesterol, EKG, hemoglobin
Children (0-18)	Including and limited to urinalysis, CBC, hemoglobin
Please Note: In order for benefits to be paid under wellness benefits with no cost share to the member, both the diagnosis code and procedure code submitted by an in-network provider must reflect preventive care.	

COVERED PREVENTIVE SERVICES FOR ADULTS

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages when prescribed by a physician
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

IMMUNIZATION VACCINES FOR ADULTS

Doses, recommended ages, and recommended populations vary.

- Hepatitis A
- Hepatitis B
- Herpes Zoster (Shingles)
- Human Papillomavirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

COVERED PREVENTIVE SERVICES FOR WOMEN & PREGNANT WOMEN

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services for women under 65

COVERED PREVENTIVE SERVICES FOR CHILDREN

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages.
- Blood Pressure screening for children
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

IMMUNIZATION VACCINES FOR CHILDREN FROM BIRTH TO AGE 18

Doses, recommended ages, and recommended populations vary.

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Learn More

For the latest immunizations, vaccine schedules for adults and children, and Affordable Care Act rules on expanding access to preventive services for women, please visit: www.hhs.gov/healthcare.

Please Note

Additional age limits and restrictions may apply. This information is subject to change at any time. Please contact MIT directly at 1-800-327-1021 for the most current information.

SCMA Members' Insurance Trust
Medicare

MEDICARE AND YOU
It is important that you and/or your dependents promptly enroll for Medicare Part A and Part B coverage as soon as you become eligible for such coverage.
There are five times when you and/or your dependents with sufficient work credits will become eligible for Medicare:

1. Anyone age 65;
2. Anyone totally disabled who has been collecting Social Security Benefits for two years;
3. Anyone requiring kidney dialysis;
4. Anyone receiving a disability pension from the Railroad Retirement Fund meeting certain conditions; or
5. Anyone diagnosed with ALS.

PRECERTIFICATION AND PRIOR AUTHORIZATION

Pre-certification or prior authorization is not a guarantee of payment. All applicable plan provisions apply to services rendered. Penalty for noncompliance with pre-certification/prior authorization requirements is a $500 benefit reduction on a payable claim. First penalty can be waived at the discretion of the Plan.

Pre-certification

The process of obtaining all necessary medical information in order to approve a hospital confinement.

- **All In-patient admissions require pre-certification.**
- **Special Statement Regarding Maternity Admissions:** This Plan may not, under federal law, restrict benefits for any hospital length of stay in connection with the childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, this Plan will not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prior Authorization

Means authorization must be received before receiving specified health services. Prior plan approval helps to control and monitor those health services that are most costly. **This prior authorization list changes periodically. Please call for prior approval before any major elective procedure.**

The following services require prior authorization:

- Air ambulance
- Bone growth stimulator
- Botox injections
- Cardiac transtelephonic monitoring, AICD unit/electrode implantation or replacement, pulse generation unit/electrode implantation or replacement
- CT endoscopy, wireless capsule endoscopy
- Custom made orthopaedic shoes or orthotics
- Durable medical equipment if total purchase or rental charges are greater than $500
- Elective induction of labor before 39 weeks
- ESWT for plantar fasciitis
- Home healthcare
- Home terbutaline pump therapy
- Home uterine monitoring
- Hospice care
- In-patient and out-patient services for mental health
- In-patient and out-patient services for substance abuse
- MRI of breast or heart
- Out-patient rehabilitative therapy (Physical therapy and/or occupational therapy, combined speech, or cardiac/pulmonary rehab) which exceed 8 visits.
- Pain management including epidural steroid injection (ESI)
- Private duty nursing

- Pulse dye laser
- PUVA therapy
- Radiation notification with precertification required for IMRT and proton beam therapy
- RAST
- Remicade injections administered in a physician's office, or out-patient hospital
- Sleep studies
- Spinal cord stimulator
- Tonsillectomy and adnoidectomy (T&A)
- Virtual colonoscopy

Certain surgical procedures

- All potentially cosmetic procedures (e.g. rhinoplasty, septoplasty, blepharoplasty, subcutaneous mastectomy, sclerotherapy, reduction mammoplasty, silicone breast implants, etc.)
- Amnio chorionic villus sampling (CVS)
- Balloon sinuplasty
- Breast implant removal
- Human organ and/or tissue transplants
- Hysterectomy
- In-patient or out-patient back/neck/spine procedures
- Lower extremity venous incompetence/varicose vein surgery
- MOHs Surgery
- Orthognathic surgery including TMJ
- UPP and UPPP

Certain Prescription Drugs

- Avastin
- Avita Crème (over age 29)
- Avonex
- Betaseron
- Capaxone
- Enbrel
- Exubera
- Forteo
- Growth Hormones
- Hormone Pellet Implantation Therapy
- Humira
- Hyaluronic Supplementation for osteoarthritis
- Immunoglobulin Injection (IVIG)
- Interferon
- Lupron
- Orencia
- Peg Intron
- Remicade
- Retin-A (over age 29)
- Rituxan
- Tysabri

The following list includes a list of procedures that may safely be performed in the physician's office. **These procedures need prior authorization if not performed in a physician's office.**

- Acne Surgery
- Anoscopy
- Aspiration and/or Biopsy of Breast Cyst
- Biopsy of: Cervix, Foot Joint Lining, Intranasal, Lip, Mouth Lesion of Floor, Roof, Tongue or Salivary Gland, Testes, Throat, Thyroid, Uterine Lining, Vagina, Vulva
- Cast Application and Changes
- Cervical Cryosurgery (Unless performed with a D&C)
- Cervical Cryotherapy

- Change Bladder Tube
- Circumcision (Up to 3 months)
- Contour of Face Bone Lesion
- Cryosurgery
- Colposcopy
- Culdoscentesis
- Dermabrasion (Potentially Cosmetic: Requires Prior Authorization)
- Destroy Nerve, Facial Muscle
- Destructions of Small Lesions
- Dilation of: Salivary Duct, Urethra
- Drainage: Hematoma, Hydrocele, Joint/Bursa, Mouth Lesion, Pilonidal Cyst, Shoulder Bursa
- Electro, Cryo, Chemical or Other Destruction Of Small Lesions
- Endocervical Curettage
- Endometrial Sampling
- Excision of: Anal Tags, Condyloma, Gum Lesion, Mouth Lesion, Small Lesions
- Excision of or Destruction of: Plantar Warts, Corns, Calluses
- Fracture, Closed Reduction
- Hemorrhoid Ligation
- I & D of Cysts, Abscesses or Hematomas, Perianal Abscess (Simple)
- Incision of: Eardrum, Tendons of the Foot or Toe
- Injection: Cyst, Ligament, Sinus Tract, Tendon
- Injection for Nerve Block
- Insert Nasal Septal Button
- Irrigation of: Bladder, Maxillary Sinus: Sphenoid Sinus
- IUD Removal
- Laryngoscopy, Diagnostic
- Layer Closure of Wounds
- Lumbar Puncture
- Nasal Sinus Therapy (Displacement Tx-Proetz Type)
- Ophthalmology procedures related to: Eyeballs: Removal Ocular Foreign Body, Anterior Segment/Cornea: Removal or Destruction of Lesion, Anterior Iris Ciliary Body, Ocular Adnxa: Orbit such as Retrobul Bar and Periocular Injection, Eyelids: Incision, Excision or Removal of Lesion, Lacrimal System: Incision, Excision, Probing and Related Procedures
- Penile Injection
- Proctoscopy
- Proctosigmoidoscopy
- Release of Foot Contracture, Toe Joint
- Removal of: Cranial Cavity Fluid, Ear Lesion, Extosis: Mandible or Maxilla, Face Bone Lesion, Foreign Bodies of Fingernails or Toenails, Arm, Foot Mouth, Nasal, Subcuta Neous Tissue Simple and/or Complicated, Nasal Polyp, Salivary Stone, Sperm Ducts, Toe Lesions, Toe, Partial
- Repair of Eardrum, Mouth Lesion
- Sigmoidoscopy
- Suture Removal
- Transurethral Collagen Injections
- Treatment of Bladder Lesion
- Treatment of Bone Cyst
- Urethral Dilation
- Vasectomy

ELIGIBILITY

Eligibility for You

You are eligible for coverage under the Plan as an employee if:

1. You are an "Employee" (as defined under the SCMA/MIT) who normally works 30 hours per week; and
2. Your employer maintains 50% participation for all eligible employees; and
3. If you are retired, you retired after being continuously covered by SCMA/MIT the previous five years and have attained the age of 55.

You are eligible for coverage under the Plan as a physician if:

1. You are a resident of South Carolina, a member of the SCMA actively practicing medicine in South Carolina, normally work 30 hours per week, and your employer maintains 50% participation for all eligible employees; or
2. You are a non-resident physician actively practicing medicine, normally work 30 hours per week, employed through an employer located in South Carolina, and your employer maintains 50% participation for all eligible employees; or
3. If you are retired, you retired after being continuously covered by SCMA/MIT the previous five years and have attained the age of 55.

Employee or self-employed physicians may qualify under certain circumstances. Contact SCMA/MIT directly for more information.

SCMA/MIT requires all participating employers to contribute at least 50% of the cost of the employee coverage.

You will become eligible to enroll in this Plan after completing any applicable Probationary/Waiting Period required by the employer as long as any period does not exceed 90 days. Applications for coverage must be received within 31 days from each eligibility date.

Failure to notify the SCMA/MIT within 31 days of a change in eligibility status may result in termination of coverage. SCMA/MIT reserves the right to retroactively terminate coverage back to the ineligibility date.

SCMA/MIT reserves the right to routinely audit employer groups to ensure they are compliant with the Trust's participation guidelines. Failure to comply may result in termination of coverage.

Eligibility for Your Dependents

Dependents eligible for coverage include your:

1. Spouse to whom you are legally married
2. Natural children
3. Adopted children
4. Stepchildren
5. Children for whom you have legal custody and who live with you in a parent-child relationship and who are dependent upon your support and maintenance.

Such parent-child relationship shall not be considered to exist if either of the children's parents also resides with you.

Children listed above must be under the age of 26. When both husband and wife are covered by this Plan as employees, either, but not both may elect to cover dependent children.

Special provisions apply for children who are handicapped and for spouses of a deceased SCMA/MIT covered member. Refer to the "Non-Cobra Continuation of Medical Care Coverage" section for further details.

Effective Dates of Coverage

With respect to an eligible individual who has agreed to make any required contributions and who enrolled within 31 days of first becoming eligible, the effective date will be the date of eligibility. Such individuals will be called Regular Enrollees. Individuals enrolling later than 31 days from first being eligible during a Special Enrollment Period will be called Special Enrollees. Special Enrollees will become effective on the date of the event which makes them a Special Enrollee. Individuals enrolling more than 31 days after becoming eligible will be called Late Enrollees. Late Enrollees will be eligible to enroll in coverage during the annual open enrollment period.

Your newborn child, a child adopted or placed for adoption, or a child for whom you have been awarded legal custody will be covered immediately upon birth, adoption, placement for adoption or award of legal custody provided you are covered for dependent children or family coverage at the time of such acquisition. It will, however be your responsibility to provide us with the name, gender, and date of birth, date of adoption or placement for adoption or date of legal custody of such dependent child.

If you are not covered for dependent children or family coverage when you have a new dependent, you will need to enroll such child within 31 days of acquisition. Otherwise, such child will not be able to enroll as a Regular Enrollee. This Plan does not allow an individual to select which dependent children to cover. An individual must enroll all eligible, dependent children whenever they enroll for dependent children or family coverage.

You should note that if you declined enrollment for yourself, your dependent spouse or your children because of other health insurance coverage at the time you first became eligible, you may in the future be able to enroll yourself and your dependents in this Plan, provided that you request enrollment not more than 31 days after the involuntary loss of the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself and your eligible dependents in this Plan, provided that an enrollment request is made not more than 31 days after the marriage, birth, adoption or placement for adoption.

Please refer to the Definitions section for further details regarding a Special Enrollee, Special Enrollment Period and Late Enrollee.

TERMINATION OF COVERAGE

When Coverage Ends For You and Your Dependents:

Coverage for you and your dependents will cease on the sooner of:

1. the date the Plan ceases;
2. the date the Plan ceases for the class of employees to which you belong;
3. the day of the calendar month during which you are no longer a member of the eligible class;
4. the date ending the period for which your last premium is paid;
5. the day of the month in which you are retired if you have not been continuously covered by MIT for the previous five years and have not attained the age of 55;
6. when a dependent no longer qualifies as eligible under the Plan; or
7. the date of initial coverage (or other applicable date in accordance with Federal law) in the case of fraudulent or intentional misrepresentation of a material fact.

Special provisions exist for continued coverage of handicapped children and spouses of deceased SCMA/MIT covered members.

SCMA/MIT reserves the right to retroactively cancel coverage if premiums are not paid within 31 days of the original due date. If terminated for non-payment of premium, SCMA/MIT will reverse any/all paid claims incurred after the termination date.

All terminated groups must pay any/all outstanding balances due within 90 days of the termination date. If full payment is not received within 90 days, SCMA/MIT reserves the right to reverse any/all claims incurred in a period in which premium was not received.

Employers have an affirmative duty to notify the SCMA/MIT of the date of termination of an employee or dependent within 10 days of termination. Failure to do so may impair or prohibit an employee or dependent from exercising legal rights they may have to continue coverage and subject the employer to legal liability.

Termination of Coverage Due to Medical Leave of Absence
For employers not eligible for Family and Medical Leave Act (FMLA) MIT Disability Continuation During Employer Certified Leaves of Absence Without Pay.

If a covered participant is unable to work full-time due to disability, and his employer has authorized a leave of absence, the participant (and his dependents) may remain eligible for coverage under this Plan during the approved leave of absence for a maximum of twelve (12) weeks ("MIT Disability Continuation"). Thereafter, the participant and his covered dependents may be eligible to elect COBRA Continuation Coverage (for groups of 20 or more employees).

Under COBRA or other continuation of coverage, the participant must continue to pay the appropriate amount of group health coverage premium. Premiums must be paid by the 15th day of each month. If the employee's account is delinquent more than 30 days, his or her group health coverage will terminate.

Failure to notify SCMA/MIT of leave of absence within 31 days may result in retroactive termination. It is the employer's sole responsibility to notify SCMA/MIT of any change in eligibility status.
For employers eligible for Family and Medical Leave Act (FMLA) Continuation During Employer Certified Leaves of Absence Without Pay.

As applicable, this Plan shall at all times comply with the requirements of the Family and Medical Leave Act of 1993, as promulgated in regulations issued by the Department of Labor.

During any leave of absence taken pursuant to the FMLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered employee has been continuously employed during the entire leave period.

At the end of the FMLA period (12 weeks), the participant and his covered dependents may be eligible to elect COBRA Continuation Coverage (for groups of 20 or more employees).

Under COBRA or other continuation of coverage, the participant must continue to pay the appropriate amount of the group health coverage premium. Premiums must be paid by the 15th day of each month. If the employee's account is delinquent more than 30 days, his or her group health coverage may be terminated.

Failure to notify SCMA/MIT of leave of absence within 31 days may result in retroactive termination. It is the employer's sole responsibility to notify SCMA/MIT of any change in eligibility status.

Additional Employer Leave Not Recognized
In terms of eligibility for coverage, SCMA/MIT does not recognize additional paid or unpaid leave of any kind after the covered participant has exhausted MIT Disability Continuation or FMLA and any normal annual or sick leave. If after normal annual and sick leave and any applicable MIT Disability Continuation or FMLA is exhausted the covered participant is not normally working 30 hours a week, or the minimum number of hours required by the employer, if such minimum exceeds 30 hours per week, then the participant and his covered dependents may be eligible to elect COBRA Continuation Coverage (for groups of 20 or more employees).

CERTIFICATES OF PRIOR COVERAGE

The Plan will provide a Certificate of Prior Coverage free of cost upon request.

To request a certificate of prior coverage contact us:

Phone: 803-798-6207 (Columbia)
1-800-327-1021 (Statewide)

Mail: SCMA/MIT
P.O. Box 11188
Columbia, SC 29211

Email: MITinfo@scmedical.org

NON-COBRA CONTINUATION OF COVERAGE

Handicapped Children

Medical care benefits may be continued beyond age 26 for a dependent child who is mentally disabled or physically handicapped and unable to earn a living and who is dependent upon you for support. You must furnish proof of the dependent's handicap and agree to make any required contribution within 31 days after the dependent attains the age limit.

Any coverage continued for such dependent child will end on the sooner of:

1. the date ending the period for which your last premium is paid;
2. the date your coverage ceases;
3. when the handicap ceases; or
4. at the end of the 31-day period after any required proof is not furnished. *(After two years from the date the dependent attains the age limit, proof may not be required more often than once each calendar year.*)

Surviving Spouse

If an SCMA/MIT covered member dies, and has been covered by SCMA/MIT continuously for the previous three (3) years, and you agree to make any required contribution within 31 days of the covered member's death, all medical care coverage may be continued on the member's spouse (if covered), until the sooner of:

1. the surviving spouse becomes eligible for other group medical care benefits;
2. the surviving spouse remarries;
3. the plan ceases; or
4. the last premium is paid.

Failure to make an application within 31 days of the applicable circumstances described under the "Handicapped Children," or "Surviving Spouse" immediately above, will result in loss of rights to continued coverage.

Uniformed Services Employment and Re-Employment Rights Act (USERRA)

If you are called to military service in The United States Armed Forces for a period of more than 31 days, you may continue health coverage under this plan per the provisions of the Federal law known as USERRA. Under such provisions, you and your covered dependents may continue coverage until the earlier of 24 months beginning with the date your absence from employment begins (or 18 months if the individual elected to continue coverage prior to December 10, 2004,) or the day after the date on which the employee fails to apply for or return to active employment with the Employer as otherwise required by USERRA.

If you qualify for re-employment under the provisions of USERRA, you will be eligible for reinstatement of coverage upon re-employment without being subjected to a waiting period or pre-exisiting condition limitations and exclusions. However, illnesses or injuries determined by the Secretary of Veteran's Affairs to have been incurred or aggravated during military service will not be covered by this plan.

It is the intent of SCMA/MIT to be fully compliant with USERRA, and any difference between this language and USERRA will be implemented in accordance with USERRA.

COBRA CONTINUATION OF COVERAGE RIGHTS

Neither the SCMA nor MIT assumes or otherwise has the Employer's sole responsibility for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA Continuation of Coverage), or any other legal or other obligations of the Employer. This section is included to give an over-view of the rights extended by the federal law known as COBRA Continuation of Coverage and to describe how a SCMA/MIT-funded Group Health Care Plan is available for individuals to exercise their rights to continued coverage in accordance with this federal law.

As required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA Continuation of Coverage), an employer who during the preceding Plan Year typically employs twenty (20) or more employees is subject to COBRA and must allow an individual who is eligible to participate in the SCMA/MIT plan the right to continue up to the extent called for under this law. As defined by COBRA, those individuals who lose coverage are called "Qualified Beneficiaries" and the event which causes those individuals to lose coverage is called a "Qualifying Event." Individuals eligible for such COBRA continued coverage must pay the full cost and make timely payments as defined by this law for this continued coverage. Such costs are subject to be re-determined periodically by the SCMA/MIT plan. Such individuals who elect COBRA continued coverage will be eligible for the benefits that they had at the time of the Qualifying Event; in addition, they will retain the same rights to change to a different benefit plan during the plan's Open Enrollment Period each year.

The Qualifying Events *which result in loss of coverage* and maximum coverage periods for these events are as follows:

Qualifying Event	**Maximum Months Available**
Voluntary or involuntary termination of employment (for reasons other than "gross misconduct"), or reduction of work hours	18 months for the employee and dependents who were covered at the time of the qualifying event
Death of the employee	36 months for dependents who were covered at the time of the employee's death
Divorce or legal separation	36 months for the dependents who were covered at the time of the divorce or legal separation
Dependent ceasing to be eligible due to no longer meeting the definition of an eligible dependent as defined by the plan	36 months from the date the dependent no longer meets the definition of an eligible dependent
Employee's entitlement to Medicare	36 months for dependents who were covered at the time of the employee's entitlement

Special Rights for an SSA Disabled Qualified Beneficiary

In the case of a covered person (employee or dependent) who is deemed disabled by the Social Security Administration (SSA) before or within the first 60 days of COBRA continued coverage, coverage may be extended for up to a total of 29 months instead of 18, for not only the disabled person, but for any other members of the family who have elected COBRA continued coverage.

It is the responsibility of the Qualified Beneficiary to notify the Employer of the SSA determination of disability within 60 days of such determination, and prior to the expiration of the 18 month period of continued coverage. **Failure to notify within this time-frame will result in loss of rights to any additional months of continued coverage.**

It is also the responsibility of the Qualified Beneficiary who had been deemed disabled by SSA to notify the Employer within 60 days of being notified that SSA no longer considers him disabled.

Cost of COBRA Continued Coverage

Each year, the cost for COBRA continued coverage is re-determined and the individuals continuing their coverage for 18 or 36 months will pay 102% of that actual cost. For individuals deemed disabled by SSA and eligible for additional months of coverage up to a total of 29 months, the cost will be 102% for the first 18 months and 150% for months thereafter. The individual will begin paying for the COBRA continued coverage retro-active to the date that coverage otherwise would have ended. The SCMA/ MIT office should be consulted for the current rates.

Employer's Responsibilities for Extending Rights to COBRA Continued Coverage

In the event of a termination of employment, reduction of hours, death of the employee or Medicare entitlement of the employee, the Employer has the responsibility of extending rights to continued coverage to any Qualified Beneficiaries in accordance with the provisions in the COBRA regulations. A Model Notice can be found at: http://www.dol.gov/cobra/

Employee's Responsibilities for Notifying Employer of a Qualifying Event

In the event of a dependent who no longer meets the definition of an eligible dependent as defined by this plan, or of a divorce or legal separation, the employee **or** the dependent affected by the Qualifying Event has the responsibility to notify the Employer **within 60 days** of such event. Upon notification, the Employer must extend rights to continued coverage in accordance with the provisions in the COBRA regulations. **Failure to notify the Employer within 60 days will result in dependents losing rights to continued coverage.**

Qualified Beneficiary's Responsibilities in Electing and Paying For COBRA Continued Coverage

The Qualified Beneficiary must make an election for continued coverage within 60 days of the date of the notice or the Qualifying Event date, *whichever is later*, in order to remain entitled to COBRA continued coverage. COBRA provisions spell out that the post-marked date of the envelope containing the signed election form is

considered to *be the date of the election*. **Failure to make an election within this time-frame will result in loss of rights to COBRA continued coverage.**

The first payment which is due within 45 days of the date of the election must be in an amount that pays for coverage retro-active to the Qualifying Event date. The second and subsequent payments are due the first of each month and must be post-marked within 30 days of the due date in order to be considered "timely'. **Failure to remit in accordance with these time-frames will cause loss of rights to COBRA continued coverage or coverage to be terminated retro-active to the date in which the last valid, timely payment was made.**

COBRA Continued Coverage May Be Cut Short

COBRA Continuation of Coverage will end on the **Earliest** of the following:

1. The date the maximum number of months are exhausted;
2. The date the SCMA/MIT-funded plan under which you are covered ceases to be in existence;
3. The last date for which a timely, valid payment has been made;
4. The date *following the date that COBRA continued coverage has been elected* that an individual becomes covered by Medicare, either Part A, B, or both, or another group health care plan.
5. The month that begins more than 30 days after a final determination by SSA that the individual is no longer disabled. Such determination will cause coverage to be terminated for the disabled person and any other family members who were extended additional months of COBRA continued coverage due to the disabled individual's status.

Qualified Beneficiaries Covered by Medicare or another Group Health Care Plan

A Qualified Beneficiary who is covered by Medicare or another group health care program ***prior*** to electing COBRA Continued Coverage may have both Medicare and COBRA continued coverage under this plan, or coverage under another group health care plan and COBRA continued coverage under this plan. However, obtainment of Medicare ***after*** electing this COBRA continued coverage will cause this COBRA continued coverage to cease as of the date of Medicare entitlement. In addition, obtainment of other group health care coverage (which does not subject the individual to any preexisting condition exclusion periods) after electing COBRA continued coverage will also cause COBRA continued coverage under this plan to cease as of the date of obtainment of the other coverage.

Continuation Coverage for Employees in the Uniformed Services As Required By USERRA

For purposes of this section, an Employee who is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services experiences a qualifying event as of the first day of the Employee's absence for such duty. Such an individual and any of the individuals Covered Dependents shall be treated as any other Qualified Beneficiary hereunder for all purposes of COBRA. The Employer shall furnish the Employee and the Employee's Covered Dependents a notice of the right to elect COBRA continuation coverage and shall afford the Employee the opportunity to elect such coverage. However, the maximum period of coverage available to the Employee and the Employee's Dependents is the lesser of (a) 24 months beginning

on the date of the Employee's absence, (or 18 months, if individual elected to continue coverage **prior** to December 10, 2004), or (b) the day after the date on which the Employee fails to apply for or return to active employment with the Employer. All privileges granted and limitations imposed under the Consolidated Omnibus Budget Reconciliation Act of 1985 and subsequent amendments thereto shall apply in matters not specifically addressed above.

COVERAGE PURSUANT TO MEDICAL CHILD SUPPORT ORDERS

A "Qualified Medical Child Support Order" (QMCSO) means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction. A QMSCO is a court order that creates or recognizes the right of your child (called an "Alternate Recipient" in the law) to receive benefits under this plan.

To be considered a "Qualified Medical Child Support Order," the medical support order must clearly specify the following information:

1. The name of an issuing agency.
2. The name and last known mailing address of the Employee who is a Participant under the Plan.
3. The name and mailing address of one or more Alternate Recipients or the name and mailing address of an official or agency which has been substituted on behalf of the Alternate Recipient.
4. That group health coverage is desired and that it be identified and available.

Coverage for an Alternate Recipient under a "Qualified Medical Child Support Order" (QMCSO) will become effective the later of:

1. The date the court decrees or the date the order is signed by the judge, whichever is earlier; or
2. The date coverage becomes effective for the Employee.

Note: An Employee not covered prior to issuance of a "Qualified Medical Child Support Order" (QMCSO) will be subjected to the Eligibility and Enrollment Provisions pertaining to a Special Enrollee.

The court order may not require this Plan to provide any type of form of benefit, or any option, not otherwise provided under this Plan.

No item of expense incurred prior to the effective date or after the termination date of the Alternate Recipient's coverage shall be payable under this Plan. If a state has paid for medical services for the children under Medicaid for which the plan was liable, the state may seek to recover those paid amounts from this Plan.

Participants and beneficiaries may obtain, without charge, a copy of the Plan's Procedures for Determining Status of Medical Child Support Orders from the Plan Administrator.

DEFINITIONS

The following terms apply to all medical care benefits.

Air Ambulance
Must be a specifically designed and equipped aircraft for transporting the sick or injured. Must have a crew of at least two (2) members.

Allowable Amounts
For out-of-network providers
For any service or supply, the Allowable Amount will not exceed the lesser of:
1. the amount customarily charged by the provider; or
2. the charge for the service or supply made by providers of comparable services or supplies in the same locality where services are rendered; or
3. if a Member receives Emergency Services outside the area where they reside, the charges will be covered only to the extent that they do not exceed usual and customary charges generally made in the same area under similar conditions; or
4. for elective services rendered outside of the area where the patient generally resides charges will be covered only to the extent that they do not exceed the South Carolina usual and customary rates.

For in-network providers
For any service or supply, the Allowable Amount will not exceed the PPO allowable amount.
A special provision will apply when there are no providers of comparable services or supplies in the same locality, or in the event of an unusual type of service or supply. When this happens, the SCMA/MIT will decide whether the charge is appropriate, based on:
1. the complexity involved;
2. the degree of professional skill required;
3. the cost of supplies; and
4. other pertinent factors.

The SCMA/MIT may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized.

Ambulatory Surgical Center
A center approved and licensed as such by the state. If the state does not have license requirements, the center must meet all of the following criteria:

It must have Out-patient facilities for diagnosis or treatment of an injury or surgery;
1. it must be supervised by a staff of physicians;
2. it must provide nursing services by registered graduate nurses
3. it must maintain medical records on all patients;
4. it must have emergency equipment and supplies with medical personnel trained in the use of the equipment; and
5. it must have a contract with a hospital for admission in the case of an emergency.

Annual Maximum
The maximum amount this Plan will pay in a calendar year on any participant, regardless of which plan option or combination of plan options the individual is covered under.

Approved Treatment Facility

An institution that does not qualify as a hospital but that does provide a program of effective medical and therapeutic treatment of alcoholism or drug abuse, or mental/nervous disorders; and

1. has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law; and
2. the center meets all of the following requirements:
    a. is established and operated in accordance with the applicable laws of the jurisdiction in which it is located;
    b. provides a program of treatment approved by the physician and the SCMA/MIT;
    c. has or maintains a written, specific and detailed regiment requiring full-time residence and full-time participation by the patient; and
    d. provides at least the following basic services:
        (i.) room and board;
        (ii.) evaluation and diagnosis;
        (iii.) counseling; and
        (iv.) referral and orientation to specialized community resources.

Complications of Pregnancy

1. Conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Comprehensive Case Management

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

a. Evaluation and assistance for the Employee, their Physician, and family to help develop a plan of services to meet specific needs;
b. Assistance with obtaining unusual equipment or supply needs;
c. Assistance in home care planning and implementation;
d. Arrangements for needed nursing/caregiver services;
e. Providing help with assessment of rehabilitation needs and Provider arrangements;
f. Offering appropriate and effective alternative care/therapy suggestions for Mental and Nervous Treatment and/or treatment for Substance Abuse as determined by medical care review;
g. Monitoring and assuring treatment programs and interventions for Mental and Nervous Treatment and/or treatment for Substance Abuse; and

h. Functioning as an effective resource for information on treatment facilities and available care for Mental and Nervous Treatment and/or treatment for Substance Abuse.

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

Covered Expenses
The items of expense for which comprehensive medical benefits may be paid. The full list of Covered Expenses is included in this booklet.

Custodial Care
Services, including room and board, or supplies provided to a person that consists primarily of that basic care given to maintain life and/or comfort with no reasonable expectation of cure or improvement of the Injury or Illness.

Deductible

The amount required to be paid by the covered person prior to benefits being payable under this plan.

The Deductible is shown in the Schedule of Benefits. The Deductible applies separately to each covered person once each calendar year; except as provided under "Family Deductible" shown in the Schedule of Benefits.

The Deductible amount excludes physician visit co-payments, emergency room co-payments, pharmacy co-payments and mental/nervous out-patient co-payments.

Emergency Services
Emergency services are those health care services provided to evaluate and treat medical conditions of rapid onset and severity that would lead a prudent lay person 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 individual or with respect to a pregnant woman, the health of a woman and her unborn child in serious jeopardy; or
b. serious impairment to bodily functions; or
c. serious dysfunction of any bodily organ or part, or
d. other serious medical consequences.

The following examples in conjunction with the above definition would demonstrate the need for immediate or urgent medical care:

- Acute severe pain (chest discomfort, abdominal)
- Acute injury (i.e., Burns, lacerations, fractures)
- Sepsis or severe infection
- Obstetrical crisis

- Sudden onset of bleeding
- Acute illness or injury that would cause loss or impairment of body systems
- Unconsciousness
- Convulsions
- Respiratory distress
- Acute condition resulting in admission of the patient to a hospital
- Severe emotional distress or suspected mental illness requiring prompt medical attention to prevent possible deterioration, disability, or death
- Sudden dehydration
- Sudden onset blurred vision, difficulty speaking, walking and/or numbness of extremities

Effective ongoing care of minor Illness or Injury which could reasonably have been provided by a physician in his/her office setting in not considered an emergency.

Emotional Support Services

A program for meeting the special physical, psychological, spiritual and social needs of a person.

Experimental and/or Investigational Services

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

The SCMA/MIT will make an independent evaluation of the experimental/non-experimental standings of specific technologies. The SCMA/MIT will be guided by reasonable interpretations of plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The SCMA/MIT will be guided by the following principles:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, and was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinic trials, in the research, experimental, study of investigational arm of ongoing phase III clinic trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means treatment or diagnosis; or
- If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for

purchase and/or they are not approved by the Food and Drug Administration in general use.

The SCMA/MIT reserves the right to make the final determination in the case if a dispute should arise, subject to appeal and grievance procedures

In any coverage decisions regarding experimental and/or investigational services as set forth herein, the SCMA/MIT will fully comply with Section 2709 of the Public Health Service Act, as added by Section 1201 of the Patient Protection and Affordable Care Act, as modified by Section 10103.

Hospice Care Plan
A plan, in writing, by the attending physician for home or In-patient hospice care which treats the special needs of the terminally ill person and his or her family. The Hospice Care Plan must be approved by the SCMA/MIT as meeting established standards, including any legal licensing requirements of the state or locality in which it operates.

Hospice Care Team
A group of trained medical personnel, homemakers and counselors that provides care for a terminally ill person and his or her family.

Hospital
An institution legally operating as a hospital that:
1. is mainly engaged in providing In-patient medical care for diagnosis and treatment of an injury or illness, and routinely makes a charge for such care;
2. is supervised by a staff of physicians on the premises;
3. provides 24 hour nursing services on the premises by graduate registered nurses; and
4. is licensed by the state as an acute care hospital.

In no event will "Hospital" include any institution that:
1. is run mainly as rest, nursing or convalescent home or residential treatment center;
2. is engaged in the schooling of its patients;
3. is not licensed as an acute care facility; or
4. for which any part is mainly for the care of the aged.

Illness
Sickness or disease, including mental disease, that requires treatment by a physician. Illness includes pregnancy with respect to a female employee and a dependent wife. However, elective abortions are not included unless the life of the mother would be in danger if pregnancy continued, or if the medical condition of the fetus makes it incompatible with life and there is medical documentation of the incompatibility.

Injury
Accidental bodily injury that requires treatment by a physician.

Intensive Care Unit
A unit that is reserved for seriously ill patients who need constant observation as prescribed by the attending physician. The unit must provide room and board, nursing care by nurses assigned only to the unit, and special equipment or supplies on an immediate standby basis for the unit only.

Late Enrollee
The term "Late Enrollee" means an individual who completes the required forms for

coverage more than 31 days after becoming eligible for coverage or one who does not enroll during a 31 day Special Enrollment Period.

Lifetime Maximum
The maximum amount this Plan will pay in a lifetime on any participant, regardless of which plan option or combination of plan options the individual is covered under.

Maximum Out-of-Pocket Expense
The amount required to be paid by a covered person prior to benefits being payable at 100%.

The maximum Out-of-Pocket Expense is shown in the Schedule of Benefits. The maximum Out-of-Pocket is comprised of the Deductible plus the co-insurance and applicable co-payments. When these items reach the maximum out-of-pocket amount, benefits will be paid at 100%.

The Maximum Out-of-Pocket Expense applies separately to each Covered Person each calendar year, except as provided under "Family Out-of-Pocket Expense," shown in the Schedule of Benefits.

Out-of-Pocket maximums do not apply if there is other group coverage providing benefits. However, if this plan is secondary to another group plan, the payment percentage may increase to 100%.

Medically Necessary
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:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. 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 the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors

Medicare
Title XVIII of the Social Security Act (Federal Health Insurance for the Aged & Disabled) as it is now or as it may be amended.

Open Enrollment Period
The annual period from December 1 through December 31 in which an individual can make changes to his/her plan.

Physician
A person, other than an intern, resident, or house physician who is duly licensed as a medical doctor, dentist, oral surgeon, osteopath, or podiatrist legally entitled to practice medicine, surgery, or dentistry within the scope of his or her license, and who customarily bills for his or her services.

Pre-certification
The process of obtaining all necessary medical information in order to approve an In-patient hospital stay.

Prior Authorization
The process of obtaining all necessary medical information in order to approve certain health services prior to the service being performed or received.

Probationary/Waiting Period
The term "Waiting Period" means the period of continuous, full-time employment, as described in the "Eligibility for You" section which is required before an individual becomes eligible for coverage under this plan. This period cannot exceed 90 days.

Regular Enrollee
The term "Regular Enrollee" means an individual who has completed and filed the necessary enrollment forms within thirty-one (31) days of completing any required Waiting Period

Special Enrollee
The term "Special Enrollee" means an individual:
1. who did not enroll for coverage under this Plan due to being covered under another plan who later experiences a loss of eligibility for the other coverage; or
2. who may or may not be enrolled who experiences a family status change.

Such events will give rise to a Special Enrollment Period.

Special Enrollment Period
The term "Special Enrollment Period" means the period of thirty-one (31) days during which an individual can enroll in this Plan. This Special Enrollment Period is triggered by an event such as:
1. Acquisition of a new dependent as a result of marriage, birth of a child, adoption or placement for adoption of a child.
2. Failure to meet the other plan's definition of an eligible participant due to events such as, legal separation, divorce, a child ceasing to be an eligible dependent, termination or reduction in hours of employment, or death of an employee.
3. Termination of contributions toward the employee's or dependent's coverage by the employer sponsoring the other plan.
4. Meeting the other plan's lifetime limit for benefits.
5. Cessation of coverage for a certain group of employees, such as, part-time workers, or cessation of benefits for individuals who no longer reside, live or work in an HMO's service area.
6. Loss of eligibility for coverage under another plan due to an involuntary event which is not caused by:
    a. Failure of the participant to make timely contributions
    b. Requested cancellation of the other coverage by the participant
    c. Termination of the other coverage due to cause, or
    d. Failure to exhaust the maximum length of time as extended by COBRA Continuation of Coverage provisions.

The term "Special Enrollment Period" also means the period of 60 days during which an individual can enroll in this plan if the event is triggered by the following:
    a. termination of Medicaid or SCHIP; or
    b. upon becoming eligible for premium assistance in the employer's group health plan.

In these events, you must request coverage within sixty (60) days of termination or

the date they are determined entitled to premium assistance.

Skilled Nursing Facility

A legally operating institution or a distinct part of one that:

1. is supervised by a resident Physician or a resident registered graduate nurse;
2. requires that the health care of each patient be under the supervision of a physician;
3. requires that a Physician be available to furnish necessary medical care in emergencies;
4. provides 24 hour nursing care;
5. provides facilities for the full-time care of five or more patients; and
6. keeps clinical records on all patients.

Step Therapy

Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and progressing to other more costly or risky therapy, only if necessary (i.e., you must try drug "A" before you can get drug "B"). The goal is to control costs and minimize risks

Terminally Ill Person

A person diagnosed by a Physician as having six months or less to live.

COVERED EXPENSES

Covered Expenses are charges for the services and supplies listed below. The services or supplies must be both Medically Necessary for treatment or diagnosis of Injury or Illness and ordered or prescribed by a Physician. Charges will be covered in accordance with the applicable Allowable Amounts.

The charges must be incurred while you or your dependent are covered under the Plan. Benefits are paid for charges for services or supplies you are required to pay.

Benefit Provision

A charge will be considered incurred as of the date on which the service or supply for the charge made is provided. This means that if you incur expenses after the date the coverage under this Plan ceases for you or your dependents for any reason, such expenses will not be covered. This is true even though the expenses relate to a condition which began while you or your dependent were covered.

Benefits will be paid for Covered Expenses incurred by you or your dependent for care of any Injury or Illness as shown in the Schedule of Benefits. In no event will benefits paid for any Covered Person exceed the maximum benefit.

If the SCMA/MIT Administrator requests that a Covered Person participate in case management and the Covered Person refuses such services, the SCMA/MIT reserves the right to deny payment of subsequent treatment related to that condition.

Alcohol and Drug Abuse

Charges made by an approved treatment facility will be covered, including professional fees for alcoholism and drug abuse subject to the coverage limitations outlined in the Schedule of Benefits.

Ambulance Service

Local, professional ambulance service for Emergency Services to or from the nearest hospital where Medically Necessary treatment can be given.

Non-emergency ambulance services may be covered to a Skilled Nursing Facility or Hospital if the patient's condition is such that any other method or transportation is inadvisable. All non-emergency ambulance use will be individually considered for Medical Necessity and Prior Authorization should be obtained if possible.

In some cases, emergency transportation by an Air Ambulance may qualify as ambulance service. Air Ambulance service must be Medically Necessary. Medical Necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. All Air Ambulance services will be individually considered for Medical Necessity and Prior Authorization should be obtained if possible.

Artificial Limbs, Eye and Breast Prosthesis

The purchase of artificial limbs, eyes, or breast prosthesis.

Breast Implant Removal

The removal of breast implants that were placed post mastectomy, regardless of when the cancer occurred.

Durable Medical Equipment

Rental fees (but not to exceed the purchase price) for:

1. Hospital bed or manually operated wheelchair

2. Kidney dialysis equipment
3. Other durable therapeutic medical equipment made and used only for treatment of injury or illness
4. Oxygen and rental of equipment to administer oxygen.
5. Sleep apnea monitors
6. Custom made orthopedic shoes or orthotics, required by a specific diagnosis (limited to one pair at six month intervals)

Eyeglasses
The first pair of eyeglasses or contact lenses prescribed due to a cataract operation performed while covered under this plan (Maximum payable is $150.00). This is not subject to deductible, coinsurance or maximum out of pocket.

Hearing Aids
Charges for hearing aids will only be covered when purchased for a hearing loss which was caused by treatment of a medical condition. (Maximum amount payable is $1,000 per hearing aid)

Home Health Care
Home Health Care benefits subject to limitations and exclusions will be paid for Home Health Care expenses for up to sixty (60) visits per calendar year when rendered to a homebound Participant in the Participant's place of residence. Home Health Care must be rendered by or through a community Home Health agency, must be provided on a part-time visiting basis and must be provided according to a Physician-prescribed course of treatment. Pre-Service Authorization must be obtained before a Participant is eligible for Home Health Care benefits. Benefits for Home Health Care includes those services and supplies that are usually provided by a Hospital or Skilled Nursing Facility to an inpatient by a registered or licensed practical nurse.

Hospice Care
Hospice benefits will be paid for hospice care expense charges incurred by you or your dependent up to sixty (60) days lifetime including both inpatient and outpatient hospice services. The charges must be made by a hospice care team under a hospice care plan for a terminally ill person. Hospice care expense benefits will be paid in addition to benefits that are provided under the medical care benefits of this plan. Payment will be made as provided in the Schedule of Benefits for the items of expense listed below:
1. charges for room and board and general nursing care for a Terminally Ill Person in a freestanding hospice; and
2. charges for Emotional Support Services provided in the counseling sessions with the patient and with the family to assist in coping with the death of the Terminally Ill Person, and charges for homemaker services. Counseling sessions with the family prior to and within six months after the death of the Terminally Ill Person, not to exceed $200 for all sessions.

Hospital and Ambulatory Surgical Center
Charges for services and supplies required for treatment that are provided by the Hospital or Ambulatory Surgical Center and used while at the Hospital as an Out-patient.

Hospital Care for:
1. Room and board including charges for the nursery care of a newborn child provided you have dependent coverage for the child.

2. Intensive care while confined in an intensive care unit.
3. Charges for other Hospital services and supplies required for treatment, except those by outside agencies and supplies not used while confined in the hospital as a bed-patient.

Human Organ Transplants

Benefits will be provided for you or a covered dependent when hospitalized for cornea, bone marrow, kidney, heart, heart-lung, liver and pancreas/kidney transplants subject to the following conditions:

1. When both the transplant recipient and the donor are Covered Persons, benefits will be provided for both.
2. When the transplant recipient is not a Covered Person and the donor is a Covered Person, the donor will receive benefits to the extent that such benefits are not provided by any hospitalization coverage available to the recipient of the organ or tissue transplant procedure.
3. Benefits will be provided to a non-eligible transplant donor, provided there is no other insurance, maximum payable $10,000 for surgical charges.

Licensed Medical Personnel

Charges by licensed medical personnel, operating within the scope of their license, for:

1. Diagnostic x-ray and laboratory services required for investigation of specific symptoms and/or complaints.
2. Physiotherapy.
3. Use of x-ray, radium and other radioactive substances for treatment.
4. Speech therapy limited to 30 visits per year, to restore or correct impaired function which is due to:
    a. accidental injury;
    b. surgical operation;
    c. cerebrovascular accident (“stroke”)
    d. congenital defects and birth abnormalities in a child.

Medical Supplies

Charges for medical supplies made and used only for treatment of Injury or Illness, including:

1. Orthopedic braces and the lifts attached to the braces
2. Splints or casts for treatment of any part of the legs, arms, shoulders, hips or back
3. Insulin and other supplies, including syringes, used only for care of monitoring of diabetic patients
4. Colostomy sets
5. Specialized surgical dressings or bandages
6. Crutches
7. Trusses
8. Surgical trays
9. Test tape
10. Catheters

Mental/Nervous Treatment

Charges made by an approved treatment facility or for psychiatric services will be covered including professional fees for the treatment and diagnostic services for mental/nervous conditions.

Physicians Fees
Allowable Amounts for the following:
1. Surgical operations
2. Assistance at surgery, when Medically Necessary
3. Administration of general anesthetic, other than by the operating surgeon
4. Radiology and pathology
5. Medical visits in a Hospital or Skilled Nursing Facility
6. Intensive medical care
7. Consultation
8. Office and home visits
9. Initial pediatric examination (other than the delivering physician), provided you are covered for dependent children

Prescription Drugs
Drugs and medications that can be (1) legally obtained only by the written prescription of a physician (2) are approved by the U.S. Food and Drug Administration for general use by humans, and (3) which are purchased within the United States.

Private Duty Nursing
Charges for skilled, private duty nursing care in the home, by a graduate registered nurse, licensed vocational nurse or licensed practical nurse. Proof of Medical Necessity for the skilled private duty nursing care must be certified by the attending physician. Coverage is provided up to 16 hours per day for up to 30 days per calendar year when the member is transitioned from an inpatient setting to the home.

Skilled Nursing Facility Care
Patient must be admitted to the facility within 14 days following confinement in a hospital for at least three consecutive days. Coverage is provided for a maximum for sixty (60) calendar days per year for:
1. Room and board
2. Charges for medical services and supplies required for treatment which are provided by the facility and used while in the facility as a bed-patient

TMJ and Related Care
Certain care connected with the detection or correction of jaw joint problems, including Temporomandibular Joint Syndrome (TMJ) and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint. This care is covered only if performed by a licensed oral surgeon or by a dentist when there is a second opinion by an oral surgeon that the dentist should perform the service. Pre-authorization is required.

Wigs
Charges for the initial wig/hairpiece will be covered when purchased for hair loss caused by chemotherapy administered for cancer. (Maximum amount allowable for the wig/hairpiece will be $750.)

Women's Health and Cancer Rights Act of 1998
On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and cancer Rights Act of 1998, an SCMA/MIT Plan Participant or Beneficiary who elects breast reconstruction in connection with a mastectomy also will be covered for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The coverage will be provided in a manner determined in consultation with the attending Physician and patient. Deductibles and coinsurance established for other benefits under this plan also apply to these reconstructive surgery benefits.

This Plan is in compliance with The Women's Health and Cancer Rights Act of 1998.

LIMITATIONS AND EXCLUSIONS

Benefits will not be paid for:

1. Expenses for any accidental bodily injury or sickness for which the Covered Person would be entitled to benefits under any Worker's Compensation or Occupational Disease policy whether or not such policy is actually in force.
2. Treatment or tests as an in-patient or in an out-patient facility that could have been performed in a less expensive setting as determined by the SCMA/MIT.
3. Educational, occupational, recreational, rehabilitative therapy; unless specifically listed under "Covered Expenses."
4. Routine eye or hearing exams or treatment including radial keratotomy, excimer laser technology, etc., eye refractions, eyeglasses, contact lenses, hearing aids or any type of external appliances used to improve visual or hearing acuity and their fittings; except as specifically provided under "Covered Expenses."
5. Cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance but do not restore or improve impaired physical function except as follows:
    a. repair, within one year of the accident, of defects resulting from an accident;
    b. treatment of a birth defect in a child; and
    c. medical care and treatment of a cleft lip and palate.
6. Dental work or treatment that includes hospital and/or professional charges in connection with:
    a. operation or treatment in connection with the fittings or wearing of dentures or dental implants;
    b. orthodontic or prosthodontic care or treatment of malocclusion; or
    c. dental care for any operation on or treatment to the teeth or the supporting tissues of the teeth except for the following covered dental expenses:
        (i) removal of tumors;
        (ii) treatment within one year of the accident of an injury to natural teeth other than by eating or chewing (including their replacement)
        (iii) Physician service for excision or extraction of impacted teeth, when supported by dental x-rays; or
        (iv) Hospital services for excision or extraction of three or more bony impacted teeth, when supported by dental x-rays, and in connection with dental services if the procedure is of such complexity as to require hospitalization or if hospitalization is required to ensure proper medical management, control or treatment of a non-dental physical condition, when advance approval of coverage has been obtained from the SCMA/MIT.
7. Expenses resulting from war, whether declared or undeclared, hostilities, invasion, civil war or while serving in the military.
8. Expenses incurred outside the United States or Canada, unless you or your dependent is a resident of one or the other and the charges are incurred while traveling on business or for pleasure.
9. Experimental and/or investigational services, including surgery, medical procedures, devices or drugs. The Plan reserves the right to approve, upon medical review, non-labeled or off-labeled use of chemotherapy agents that have been approved by the FDA for cancer. All other non-labeled or off-labeled use of drugs are not covered by the plan.
10. Custodial care, sanitarium care or rest cures.

11. Services or supplies not specifically listed under "Covered Expenses."
12. Elective abortions unless the life of the mother would be in danger if pregnancy continued, or if the medical condition of the fetus makes it incompatible with life and there is medical documentation of the incompatibility.
13. Blood or blood plasma (that is replaced by a blood bank).
14. Expenses related to obesity, weight reduction or weight control.
15. Acupuncture.
16. Treatment or surgery to change gender or to improve or restore sexual function or to reverse sterilization.
17. All charges in connection with any services, treatment, or drugs prescribed, ordered or performed for:
    a. you or your spouse; or
    b. your or your spouse's parent, sister, brother, or child.
18. Services for which no charge is made, such as VA hospitals or similar hospitals or agencies.
19. Charges for chiropractic services regardless of who renders the service.
20. Usual and normal home medical supplies or first aid items.
21. Nutritional counseling, over-the-counter vitamins, over-the-counter food supplements and other dietary supplies.
22. More than $25,000 per lifetime for any treatment (including prescription medications) of infertility.
23. Charges for an egg or sperm donor if the donor is not covered by SCMA/MIT.
24. Speech therapy, except as specifically provided under Covered Expenses.
25. Expenses for any bodily injury, illness or other condition that was the result of the covered person or covered dependent committing or attempting to commit an assault, a felony, or any other illegal act.
26. Expenses for a covered person or covered dependent engaging in an illegal occupation or employment.
27. Expenses incurred as a result of attempted suicide, suicide or self-inflicted injuries provided that such injuries do not result from a medical condition or domestic violence.
28. Any and all charges related to surrogate parenting.
29. Removal of breast implants that were initially placed for cosmetic, non-reconstructive purposes.
30. Charges from psychologists, social workers, counselors, or Doctors of Divinity.
31. Expenses incurred as a result of a dependent child's pregnancy.
32. Services, procedures, or drugs not meeting Medical Necessity criteria or Precertification/Prior Authorization criteria.
33. Reduction Mammoplasty under the age of 16.
34. Prescription drugs purchased outside the United States (drug re-importation).
35. Combined Occupational/Physical Therapy visits in excess of 30 visits per calendar year.
36. Speech Therapy in excess of 30 visits per calendar year.
37. Genetic Testing.
38. All expenses, accommodations, materials, services, and care related to Non-Covered services.
39. All expenses provided or ordered to treat complications of a non-covered illness, injury, condition, situation, procedure, or treatment.
40. Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) medications for covered persons age 25 and older when prescribed for a diagnosis of ADD and/or ADHD.

41. All charges, services, treatments, or drugs prescribed for Autism and/or Autism Spectrum Disorder except what is allowed in Covered Preventive Services section.
42. Hospice charges in excess of the 60 day lifetime limitation.
43. Home Health Care in excess of 60 visits per calendar year. Benefits for Home Health Care do not include non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) Maintenance Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and/or (9) convenience items.
44. Charges for Private Duty Nursing in excess of 16 hours per day up to 30 days per calendar year.
45. Admissions or portions thereof for custodial care or long-term care including:
    a. Rest cares;
    b. Long-term acute or chronic psychiatric care;
    c. Care to assist a Participant in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
    d. Care in a sanitarium;
    e. Custodial or long-term care; or
    f. Psychiatric or Substance Abuse residential treatment when provided at therapeutic schools; wilderness/bootcamps; therapeutic boarding homes; halfway houses; and therapeutic group homes.
46. Court ordered drug testing.

COORDINATION OF MEDICAL BENEFITS

The SCMA/MIT Plan includes a Coordination of Benefits (COB) provision to eliminate duplicate payment of benefits when a Covered Person individual's expenses are covered by more than one plan.

1. COB provision applies to:

(a) group insurance plan if not individually underwritten;
(b) health maintenance organization or hospital or medical service pre- payment plan available through an employer, union or association;
(c) trusted plan, union welfare plan, multiple employer plan, or employee benefit plan; and
(d) governmental program or a plan required by a statute, except Medicaid.

2. Primary Plan

The plan, that pays its benefits first, without regard to any other coverages. If a plan does not have a COB provision, that plan is primary. If the other plan also includes a COB provision, the plan covering the person the longest is primary, with the following exceptions:

(a) the plan covering a person as an employee rather than as a dependent is primary; and
(b) the plan covering a person as an actively employed person is primary rather than a plan covering the person other than as an actively employed person.
(c) the rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:
    1. the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
    2. if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
    3. the word "birthday" only refers to month and day of a calendar year, not the year in which the person was born;
    4. if the other plan does not have the rule described in 1, 2, and 3 above, but instead has a rule based upon the gender of the parent; and as a result the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
(d) if two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined as follows:
    1. the plan of the parent with custody of the child;
    2. the plan of the spouse of the parent with the custody of the child;
    3. the plan of the parent not having custody of the child;
    4. if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which benefits are actually paid or provided before the entity has the actual knowledge.
    5. if the specific terms of a court decree state that parents shall share joint

custody, without stating that one of the parents is responsible for the healthcare expenses of the child the plans covering the child shall follow the order of benefit determination rules outlined in Section 5B of South Carolina law.

3. Allowable Expense

Any Usual and Customary Charge for out of network provider, or the PPO Allowable Amount for in network providers:

(a) a medical service or supply which is covered, at least in part, under either plan; or
(b) a dental service or supply which is listed as a covered expense under this medical plan.

With respect to coverage provided under Medicare, allowable expenses will include only the types of expenses covered under this plan.

4. Benefit Determination Period

A calendar year (January 1 through December 31), but excluding any portion occurring prior to the effective date of a person's coverage or after the termination date of a person's coverage under this plan.

When this plan is not primary, benefits during any one benefit determination period will be the lesser of:

(a) benefits otherwise payable under this plan; or
(b) the difference between allowable expense and the benefits paid or payable by other plans for these same expenses.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Administrator has the right to decide which facts are needed. The Administrator may receive needed facts from or give them to any other organization or person. The Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Administrator any facts needed to pay the claim. The SCMA/MIT may exchange information with, receive information from, or may payment to, other persons or organizations as needed to enforce this provision.

6. Facility of Payment

A payment made under another plan may include an amount which should have been paid under this plan. If it does, the Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by the Administrator is more than should have been paid under this COB provision, the excess may be recovered from one or more of the persons it has paid or for whom it has paid insurance companies or other organizations.

The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

ACTS OF THIRD PARTIES

Medical care benefits are not payable to or for a person covered under this plan when the Injury or Illness to the Covered Person occurs through the act or omission of another person. However, the SCMA/MIT may elect to advance payment for medical care expenses incurred for an Injury or Illness in which a third party may be liable. For this to happen, the Covered Person must sign an agreement with the SCMA/MIT to pay the SCMA/MIT in full any sums advanced to cover such medical expenses from the judgement or settlement he or she receives.

When this provision applies: You may incur medical or dental charges due to injuries you sustain which may be caused by the act or omission of a third party or for which a third party may be responsible. In such circumstances, you may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this plan for those incurred medical or dental expenses automatically assigns to this plan any rights you may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim that you may have against any third party or insurer whether or not the Covered Person chooses to pursue that claim. This Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by you whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

You agree that you will:
1. Automatically assign to the Plan your rights against any third party or insurer when this provision applies; and
2. Repay the Plan any benefits paid on your behalf out of the recovery made from the third party or insurer.

Amount subject to subrogation or refund: You agree to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to you relative to the injury or sickness, including a priority over any claim for nonmedical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the plan's subrogation and reimbursement rights, as well as the rights assigned to it, are limited to the extent to which the SCMA/MIT has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. However, the Plan's right to subrogation still applies if the recovery received by you is less that the claimed damage, and as a result, you are not made whole.

When a right of recovery exists, you will execute and deliver all required instruments and papers as well as doing whatever else is necessary to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, you agree to do nothing to prejudice the right of the Plan to subrogate.

Defined terms:
"Recovery" means monies Paid to you by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or sickness whether or not said

losses reflect medical or dental charges covered by the plan.

"Subrogation" means the Plan's right to pursue your claims for medical or dental charges against another third party.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the injury or sickness.

Recovery from another plan under which you are covered: This right of refund also applies when you recover under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

CLAIM PAYMENTS

Notice of Claim
Written notice of claim must be given within 20 days after the loss, or as soon as possible. The notice must be given to the SCMA/MIT with information identifying you.

Proof of Loss
Except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than 12 months after the date the expense was incurred.

Time of Payment of Claims
All benefits provided by this plan will be paid upon receipt of proof of loss.

Physical Examination and Autopsy
The SCMA/MIT reserves the right to examine any person as often as it may require and to perform an autopsy where not forbidden by law. This will be at the expense of the SCMA/MIT.

Legal Actions
No action may be brought to recover under this plan until 60 days after proof of loss has been given. No action can be brought after three years from the date written proof of loss was required to be furnished.

Claims for Physician's Employees
If claims are submitted for treatment provided by a Physician for his/her employees who are covered by the SCMA/MIT, such claims must be submitted with payment assigned to the Physician. The SCMA/MIT will not reimburse a physician's employees directly for care provided by their employer. The Board of Trustees believes this to be a prudent fiscal policy that is in line with its goal of assuring sound financial management of your health plan.

When a Physician believes it necessary and appropriate to submit charges for care of an covered employee, we require that the claim be submitted on an assigned basis.

Right to Recovery
If the amount of payment for claims by the Administrator is more than should have been paid under the plan, the excess may be recovered from one or more of the persons it has paid or for whom it has paid insurance companies or other organizations.

PROVISIONS APPLICABLE TO ALL COVERAGE

Any representations or statement made to a covered person by the SCMA/MIT, its representatives or agent, about being covered for benefits under this plan, which disagree with the provisions of this plan shall not:

1. Be considered as representations or statements made by, or on behalf of, the Plan Administrator;
2. Bind the Plan Administrator or the SCMA/MIT for coverage, benefits, or otherwise under this plan; or
3. Be enforceable or valid.

The SCMA/MIT reserves the right to terminate, suspend, withdraw, amend or modify this plan at any time. Any such change or termination in benefits will be based solely on the decision and sole discretion of the SCMA/MIT and may apply to active employees, future retirees, and current retirees as either separate groups or as one group.

Notwithstanding anything to the contrary in the SCMA/MIT, this plan, other plan(s) of benefits, any other employee benefit plan or similar arrangement relating to the SCMA/MIT, or any other document, writing or communication (verbal or written):

1. The Plan Administrator shall have sole authority with respect to and sole responsibility for determining the existence, non-existence, nature and amount of the rights and interests of all persons in, and in respect of, this plan;
2. The Plan Administrator shall have sole authority with respect to and sole responsibility for the interpretation and other construction of, shall have sole and the broadest discretion with respect to such interpretation and construction of, and shall have sole and the broadest discretion in all other matters relating to the operation and administration of, this plan;
3. Except as may be otherwise provided in provision "4," immediately below, to the extent the SCMA/MIT sets forth provisions, terms, conditions or requirements which are in addition to, or greater or more stringent than, any of those in this plan, or which impose more limitations or restrictions than any of those is this plan, then such applicable provision, term, condition or requirement of the SCMA/MIT shall absolutely control, govern and supersede; and
4. Without limiting any other provision of this plan or the SCMA/MIT as to each Employer's responsibility and obligation in connection with this plan and the SCMA/MIT, each Employer, in relation to this plan as sponsored by such Employer, shall be solely and exclusively responsible for the following obligations, including, without limitation, those of, and such Employer shall serve as, the Plan Administrator (solely for the purposes and requirements of this provision "4") in relation to this plan as sponsored by such Employer:

    (a) Any and all requirements under one or more of the Employee Retirement Security Act of 1974, as amended (the "Act"), Internal Revenue Code of 1986, as amended (the "Code"), and other applicable law in connection with any and all required reporting (and/or issuance of any and all information required to be provided) to one or more of the United States Department of Labor, Internal Revenue Service, and all other applicable governmental agencies, departments and instrumentalities,

(b) Any and all disclosure required to be made to such Employer's Employees and other applicable individuals as required under one or more of the Act, the Code and other applicable law,

(c) Any and all notices, documents and other writings required to be issued to such Employer's Employees and other applicable individuals pursuant to one or more of the Act, the Code and other applicable law,

(d) Each Employer shall have sole and exclusive responsibility to determine whether or not such Employer is subject to one or more of Code Section 4980B and Act Sections 601, et seq. (collectively, "COBRA") with respect to this plan as sponsored for such Employer's respective Employees and other applicable individuals, and to determine whether or not such Employer is in compliance with the applicable continuation of health coverage or other similar requirements which may be or are imposed under applicable state law (collectively, "Mini-COBRA"), and if an Employer is subject to COBRA or Mini-COBRA, then it shall be such Employer's sole and exclusive responsibility to maintain compliance with all applicable aspects of COBRA and Mini-COBRA, as applicable, including making certain that COBRA and Mini-COBRA beneficiaries and other applicable individuals are timely given all required COBRA and Mini-COBRA notices and other information, are timely given all appropriate COBRA and Mini-COBRA forms and information to elect COBRA and Mini-COBRA, and are timely paying all applicable COBRA and Mini-COBRA premium amounts, and

(e) Any and all other similar (to subprovision "(a)," "(b)," "(c)," or "(d)," immediately above) applicable requirements under the Act, the Code and other applicable law.

ERISA Information

If you participate in the SCMA/MIT plan as an employee of a participating employer, certain additional information must be supplied to you under the Employee Retirement Income Security Act of 1974 (ERISA). The following information, together with the other information contained in this group booklet, comprises the SUMMARY PLAN DESCRIPTION under ERISA:

Plan Name:
South Carolina Medical Association Members' Insurance Trust (SCMA/MIT)

Name and Address:
South Carolina Medical Association
Members' Insurance Trust
132 Westpark Boulevard
Columbia, SC 29210
P.O. Box 11188
Columbia, SC 29211
803-798-6207 (in Columbia) or 1-800-327-1021 (statewide)

NOTE: A complete list of the employers sponsoring this plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries as required by law.

Employer Identification Number (EIN)
91-1839164

Plan Number
501

Type of Plan
Comprehensive Major Medical

Name of Plan Administrator
South Carolina Medical Association Members' Insurance Trust
132 Westpark Blvd. P.O. Box 11188
Columbia, SC 29210 Columbia, SC 29211

803-798-6207 (in Columbia)
1-800-327-1021 (statewide)

Type of Administration
The plan is administered by the Plan Administrator. All benefits are provided in accordance with the provisions as outlined in this booklet.

Service of Legal Process
Service of legal process may be made upon a Plan Trustee or the Plan Administrator at the address listed above.

Plan Trustees
The names and addresses of the current trustees are on file at the Plan Administrator's office and are available on request.

Termination of Plan
The right is reserved for the Plan Administrator to terminate, suspend, withdraw, amend, or modify this plan, in whole or in part, at any time.

Contributions
Contributions are made by member employers and employees. Contributions are calculated and based upon the estimated cost of operating the plan.

Plan Funding Medium
Benefits are provided under a Trust.

Plan Year
The financial records of this plan are kept on a plan year basis ending June 30th.

Provider Network
A complimentary copy of the applicable provider network is available upon request.

STATEMENT OF RIGHTS UNDER ERISA

If this plan is being provided to you by your employer, you, as a participant in the plan, are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the United States Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual fiscal report. The Plan Administrator is required by law to make available to each participant a copy of this annual report at the principal office of the Administrator and other places.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above right. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the material and pay you up to $100 per day until you receive the materials, unless the materials were not sent to you because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court. The court will decide who should pay the costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these fees, for example, if it finds your claim frivolous. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the United States Labor-Management Services Administration, Department of Labor.

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

CLAIMS AND APPEALS PROCEDURES

Section 1 Definitions

Section 1.1 Adverse Benefit Determination

An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the plan. An "Adverse Benefit Determination" also includes a rescission of coverage whether or not the rescission has an adverse effect on any particular benefit at that time. Each of the following is an example of an Adverse Benefit Determination:

- A payment of less than 100% of a Claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible);
- A denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any Utilization Review Decision;
- A failure to cover any services or supplies because the plan considers it to be experimental, investigational, not medically necessary or not medically appropriate;
- A restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and
- A decision that denies a benefit based on a determination that a claimant is not eligible to participate in the plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless You pay the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the plan). Similarly, if a Preferred Blue Provider declines to render services to You unless You pay the entire cost (and the provider's decision for declining to render the services is based on coverage rules predetermined by the plan) such a decision is not considered an Adverse Benefit Determination.

Section 1.2 Authorized Representative

An "Authorized Representative" is any individual, including Your spouse, adult child or physician, who has been designated by You to act on Your behalf. You must submit an Appointment of Authorized Representative form to the SCMA/MIT designating such an individual. A health care professional with knowledge of Your medical condition may act as an Authorized Representative in connection with an Urgent Claim without You having to complete the Appointment of Authorized Representative Form.

Section 1.3 Claimant

A "Claimant" is any plan participant, beneficiary or Authorized Representative on behalf of a plan participant or beneficiary who files a Claim with the Plan.

Section 1.4 Claim

A "Claim" is a request for plan benefits or payment made by a Claimant in accordance with the plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. A request for a determination of whether an individual is eligible for benefits under the plan also is not considered a Claim.

However, if a Claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the plan, the coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the plan. Similarly, interactions between participants and Preferred Blue Providers do not constitute Claims in cases where the Providers exercise no discretion on behalf of the plan. If a physician, hospital or pharmacy declines to render services or refuses to fill a prescription unless You pay the entire cost, You should submit a Post-Service Claim for the services or prescription, as described under the Claim Procedures, below.

A request for Pre-certification or Prior Authorization of a benefit that does not require Pre-certification or Prior Authorization by the plan is not considered a Claim. However, requests for Pre-certification or Prior Authorization of a benefit where the plan does require Pre-certification or Prior Authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under the Claim Procedures, below.

Section 1.5 Concurrent Claim

A "Concurrent Claim" is a Claim that is reconsidered after an initial approval is made that results in reducing or terminating a benefit.

Section 1.6 Post-Service Claim

A "Post-Service Claim" is a Claim for benefits after services have been rendered that is not a Pre-Service, Urgent or Concurrent Claim.

Section 1.7 Pre-Service Claim

A "Pre-Service Claim" is a Claim for benefits for which the plan requires, in order to receive the benefit, Pre-certification or Prior Authorization before medical care is received.

Section 1.8 Relevant Documents

"Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the plan's rules were appropriately applied to a Claim.

Section 1.9 Urgent Claim

An "Urgent Claim" is a Claim for medical care or treatment that, if normal Pre-Service Claim standards were applied, could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

Section 1.10 Utilization Review Decision

A "Utilization Review Decision" is any decision based on the medical necessity or medical appropriateness of a requested medical care or treatment or benefit payment.

Section 2 Claim Procedures

Section 2.1 Pre-Service Claims

Section 2.1.1 Pre-certification

A Pre-Service Claim is a Claim for a benefit for which the plan requires Pre-certification or Prior Authorization before medical care is obtained. Pre-certification involves a Utilization Review Decision and is the process of obtaining all necessary medical information in order to approve a hospital confinement. The plan requires that all Hospital admissions be pre-certified, thus, Pre-certification of a Hospital admission is treated as a Pre-Service Claim. Pre-Service Claims for the Pre-certification of Hospital admissions must be submitted by calling Planned Administrators Utilization Review at 1-800-652-3076.

Section 2.1.2 Prior Authorization

Like Pre-certification, Prior Authorization is a Pre-Service Claim for a benefit for which the plan requires prior approval from Planned Administrators before receiving specified health services, including, various services and prescription drugs, as described in this booklet. Prior Authorization involves a Utilization Review Decision and is the process of obtaining all necessary medical information in order to approve certain health services and prescription drugs. Pre-Service Claims for Prior Authorization of these services and prescription drugs must be submitted by calling Planned Administrators Utilization Review at 1-800-652-3076.

Section 2.1.3 Initial Benefit Notification

A Pre-Service Claim is considered to have been filed upon receipt of the Claim by Planned Administrators Utilization Review. For Pre-Service Claims filed in accordance with these Claim procedures, You will be notified of an Initial Benefit Decision within 15 days of the plan's receipt of the Claim. If additional time is needed due to matters beyond the control of the plan, the time for response may be extended up to 15 days. In that event, You will be notified of the circumstances requiring the extension of time and the date by which an Initial Benefit Decision is expected to be rendered.

In the event additional information is needed from You to process Your Claim, You will receive a Request for Additional Information before the end of the initial 15-day period, which specifies the information needed. You will have 45 days from receipt of the Request for Additional Information to supply the information requested. If You do not provide the information within the specified time frame, Your Claim will be denied. During the period in which You may supply additional information, the normal deadline for making the Initial Benefit Determination will be suspended. The deadline is suspended from the date of the Request for Additional Information until either 45 days or the date You respond to the request (whichever is earlier). The plan will then notify You of its Initial Benefit Determination within 15 days.

In the case of a failure by You or Your Authorized Representative to follow the Plan's procedures for filing a pre-service claim, You or Your Authorized Representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to You or Your Authorized Representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by You or Your Authorized Representative. You only will receive notice of an improperly filed Pre-Service Claim if the Claim includes (i) the patient's name, (ii) the patient's specific medical condition or symptom, and (iii) the specific treatment, service or product for which approval is requested. Unless refiled properly, it will not constitute a Claim.

Section 2.2 Urgent Claims

An Urgent Claim is a Claim for a benefit for which the plan requires Pre-certification or Prior Authorization before medical care is obtained and whereby application of the Pre-Service Claims procedures described in Section 2.1 above could seriously jeopardize Your life or health.

The plan will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if your attending physician with knowledge of Your medical condition determines that the Claim is an Urgent Claim, and notifies the plan of such, it will be treated as an Urgent Claim.

Urgent Claims, which may include Pre-certifications of Hospital admissions and Prior Authorizations of various services and prescription drugs, must be submitted in the same manner as Pre-Service Claims by calling Planned Administrators Utilization Review at 1-800- 652-3076. A Post-Service Claim is considered to have been filed upon receipt of the Claim by Planned Administrators Utilization Review.

For properly filed Urgent Claims, the plan will notify You or Your Authorized Representative of its Initial Benefit Determination by telephone as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt of the Claim. The Determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, You or Your Authorized Representative will receive a Request for Additional Information as soon as possible, but not later than 24 hours after receipt of the Claim, which specifies the specific information necessary to complete the Claim. You or Your Authorized Representative must provide the specified information within 48 hours. If the information is not provided within that time, the Claim will be denied.

During the period in which You or Your Authorized Representative may supply additional information, the normal deadline for making a decision on the Urgent Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until either 48 hours or the date You or Your Authorized Representative responds to the request, whichever is earlier. You or Your Authorized Representative will be provided the Initial Benefit Determination no later than 48 hours after receipt of the specified information or the end of the 48-hour period given for You or Your Authorized Representative to provide this information, whichever is earlier.

If You or Your Authorized Representative improperly file an Urgent Claim to the SCMA/MIT or to Planned Administrators, Inc., the plan will notify You or Your Authorized Representative as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing an Urgent Claim. You or Your Authorized Representative will only receive notice of an improperly filed Urgent Claim if the claim includes (i) the patient's name, (ii) the patient's specific medical condition or symptom, and (iii) the specific treatment, service or product for which approval is requested. Unless refiled properly, it will not constitute a Claim.

Section 2.3 Concurrent Claims

If You have been notified by the plan that an ongoing course of treatment must be reduced or terminated, You may file a concurrent claim to request an extension of the benefit by calling Planned Administrators Utilization Review at 1-800-652-3076. A reconsideration of a benefit with respect to a Concurrent Claim that involves

the termination or reduction of a previously-approved benefit (other than by plan amendment or termination) will be made by the plan as soon as possible. In any event, You will be given enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

If Your request for an extension involves the need for urgent care, the plan will respond to Your request within 24 hours of receipt of the Claim, provided that the Claim is received at least 24 hours prior to the expiration or reduction of the urgent care. A request to extend approved treatment that does not involve an Urgent Claim will be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable.

Section 2.4 Post-Service Claims

A Post-Service Claim, or Claim made after medical service is received, must be submitted to Planned Administrators in writing, using the appropriate claim form, within 180 days after expenses are incurred. Generally, Post-Service Claims will be filed with Planned Administrators on Your behalf by Your Provider. In the event that Your Provider will not submit a claim on your behalf, a claim form may be obtained by contacting Planned Administrators or the SCMA/MIT. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim within such time. However, in that case, the Claim must be submitted as soon as reasonably possible from the date the charges were incurred.

The claim form must be completed in full and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. The claim form and/or itemized bill(s) must include the following information for the request to be considered a Claim:

- Patient's name;
- Date of service;
- Type of service or CPT-4 code (the code for physician services and other healthcare services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
- Diagnosis or ICD-9 code (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of units (for anesthesia and certain other claims);
- Provider's federal taxpayer identification number (TIN); and
- Provider's billing name and address.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by SCMA/MIT.

Claims should be submitted to SCMA/MIT at the following address:

Planned Administrators, Inc.
P.O. Box 6927, Columbia, SC 29260

Ordinarily, Claimants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by SCMA/MIT. The plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the plan. If an extension is necessary, You will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the plan expects to render a decision.

If an extension is required because the plan needs additional information from You, the plan will issue a Request for Additional Information that specifies the information needed. You will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which You may supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until either 45 days or until the date You respond to the request, whichever is earlier. The plan then has 15 days to make a decision on the Claim and provide you with the Initial Benefit Determination.

If the plan determines that additional information is required from You, it may issue a combined Request for Additional Information and Notice of Adverse Benefit Determination. The Notice of Adverse Benefit Determination would only be applicable if You fail to provide any information within 45 days. In this case, You would not receive a separate Notice of Adverse Benefit Determination. The combined Notice will clearly state that the Claim will be denied if You fail to submit any information in response to the plan's Request for Additional Information, and will satisfy the content requirements of both the Request for Additional Information and the Notice of Adverse Benefit Determination. When the combined Notice is used, the time frame for appealing the Adverse Benefit Determination begins to run at the end of the 45-day period prescribed in the combined Notice for submitting the requested information.

Section 2.6 Authorized Representatives

An authorized representative, such as a physician, spouse or an adult child, may submit a Claim or Appeal on Your behalf if You have previously designated the individual to act on Your behalf. An Appointment of Authorized Representative form, which may be obtained from the SCMA/MIT, must be used to designate an Authorized Representative. The SCMA/MIT may request additional information to verify that the designated person is authorized to act on Your behalf.
A healthcare professional with knowledge of Your medical condition may act as an Authorized Representative in connection with an Urgent Claim without You having to complete the Appointment of Authorized Representative form.

Section 2.7 Notice of Initial Benefit Determination

The plan will provide You with written notice of the Initial Benefit Determination. If the determination is an Adverse Benefit Determination, the notice will include:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
- A description of the plan's appeal procedures and applicable time limits;
- A statement of Your right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;
- If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
- For Urgent Claims, a description of the expedited review process applicable

to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification);
- A statement of Your right to request the diagnosis and treatment codes (and their meanings) related to the determination.

Section 3 Appeal Procedures

Section 3.1 Appealing an Adverse Benefit Determination

If a Claim is denied in whole or in part, or if You disagree with the decision made on a Claim, You may file a written Appeal appealing the decision.

All Appeals must be submitted in writing to the SCMA/MIT within 180 days after receipt of the Notice of Adverse Benefit Determination:

SCMA/MIT Appeals
P. O. Box 11188
Columbia, SC 29211 or by fax: 803-731-4021

The Appeal must include:
- the patient's name and address;
- the Claimant's name and address, if different;
- this is an Appeal to the Board of Trustees of a decision by the plan;
- the date of the Adverse Benefit Determination; and
- the basis of the Appeal, i.e., the reason(s) why the Claim should not be denied.

If You are filing an Appeal of an Adverse Benefit Determination regarding an Urgent Claim, including a Concurrent Claim that involves urgent care, you may file your appeal either orally or in writing, within 180 days after receipt of the Notice of Adverse Benefit Determination. Oral appeal may use the following phone number: 1-800-327-1021. All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and you by telephone, facsimile, or other available similarly expeditious method.

Section 3.2 The Appeal Process

You have the opportunity to submit written comments, documents, records, and other information relating to your appeal without regard to whether such information was submitted or considered in the initial benefit determination. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal. The review of the appeal will be conducted by an appropriate person pursuant to applicable law and regulation.

The review of the appeal will not afford deference to the initial adverse benefit determination and will be conducted by a person who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the person conducting the review of the appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, will be made available to you upon request. Any health care

professional engaged for purposes of such a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Section 3.3 Timeframes for Sending Notices of Appeal Determinations

(a) Pre-Service Claims or Concurrent Claims not involving Urgent Care. Notice of the Appeal determination for Pre-Service Claims will be sent no later than within 30 days of receipt of the Appeal by the plan.

(b) Urgent Claims or Concurrent Claims involving Urgent care. Notice of the appeal determination for Urgent Claims will be sent no later than within 72 hours of receipt of the Appeal by the plan.

(c) Post-Service Claims. Decisions on appeals involving Post-Service Claims will be made no later than 60 days following receipt of the Appeal by the plan.

Section 3.4 Content of Appeal Determination Notices

You will receive a Notice of Appeal Determination in writing. In the event that the decision is an Adverse Appeal Determination, this Notice will contain:

- The specific reason(s) for the adverse determination;
- Reference to the specific plan provision(s) on which the adverse determination is based;
- A statement that You are entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
- A statement of Your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
- If an internal rule, guideline or protocol was relied upon, a statement that a copy is available to You upon request at no charge; and
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available to You upon request at no charge;
- A statement of Your right to request the diagnosis and treatment codes (and their meanings) related to the determination.

Section 3.5 When a Lawsuit May Be Filed

You may not file a lawsuit to recover benefits under the plan until after You have requested an Appeal and a final decision has been reached, or until the appropriate timeframe described above has elapsed since You filed a request for review and You have not received a final decision or notice that an extension was needed.

Section 4 External Appeals

1. After a Participant has completed the appeals process, a Participant may be entitled to an additional, external review of the Participant's claim at no cost to the Participant. An external review may be used to reconsider the Participant's claims if MIT has denied, either in whole or in part, the Participant's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated.
2. After a Participant has completed the appeal process (and an Adverse Benefit Determination has been made), such Participant will be notified in writing of such Participant's right to request an external review. The Participant should file a request for external review within four (4) months of receiving the notice of the decision on the Participant's appeal. In order to

receive an external review, the Participant will be required to authorize the release of such Participant's medical records (if needed in the review for the purpose of reaching a decision on Participant's claims).

3. Within six (6) business days of the date of receipt of a Participant's request for an external review, MIT will respond by either:
   a) Assigning the Participant's request for an external review to an independent review organization and forwarding the Participant's records to such organization; or,
   b) Notifying the Participant in writing that the Participant's request does not meet the requirements for an external review and the reasons for the decision.
4. The external review organization will take action on the Participant's request for an external review within forty-five (45) days after it receives the request for external review from MIT.
5. Expedited external reviews are available if the Participant's physician certifies that the Participant has a serious medical condition. A serious medical condition means one that requires immediate attention to avoid serious impairment to bodily functions, serious harm to an organ or body part, or that would place the Participant's health in serious jeopardy. If the Participant may be held financially responsible for the treatment, a Participant may request an expedited review of MIT's denial of benefits if MIT's denial of benefits involved emergency medical care and the Participant has not been discharged from the treating facility.

Section 5 Assistance with Internal Claims and Appeals and External Review Process

The following office may be available to assist you with the Internal Claims and Appeals and External review process:

South Carolina Medical Association Members' Insurance Trust
P.O. Box 11188
Columbia, SC 29211
803-798-6207

PRIVACY STATEMENT: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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.

A. Use and disclosure of Protected Health Information (PHI).

PHI is any individually identifiable health information that is transmitted or maintained by electronic media, or in any other form or medium. It is information that is created or received by your health care provider, health plan, or employer which relates to your past, present, or future (1) physical or mental health or condition; (2) receipt of health care; or (3) payment for health care and which identifies you as an individual or creates a reasonable basis to believe the information can be used to identify you.

The Plan will use PHI only to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premium payments or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, plan maximums, and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives) inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;
- Disclosure of consumer reporting agencies related to collection of premiums

or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan);
- Reimbursement to the plan.

"Health Care Operations" consist of activities necessary to run our organization. For example, we may use health information about you to develop better services for you. Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment.
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of healthcare providers and patients with information about treatment alternatives; and related functions.
- Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities.
- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract of reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development ad administrations, development or improvement of methods of payment or coverage policies.
- Business management and general administrative activities of the entity, including, but not limited to:
- Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
- Customer service, including the provision of data analyses for policyholders, Plan Sponsors or other customers.
- Resolution of internal grievances.
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

HIPAA allows a Plan to disclose for certain purposes other than payment, health care operations and those required by law if the Plan includes a description of such additional uses/disclosures in its Notice of Privacy Practice. The following are examples of such uses/disclosures for the Plan to consider including:

Other Disclosures.

- Public Health and Health Oversight Activities. The Plan may disclose your PHI to public health authorities that are authorized by state, federal or local law to collect information for purposes such as preventing or controlling disease, injury or disability or notification of exposure to communicable diseases. The Plan may also disclose your PHI to a federal, state or local agency required by law to oversee, license, inspect or investigate programs where health related information is collected or used.
- Lawsuits or Similar Proceedings. The Plan may disclose your PHI in

response to a court order or an administrative order. The Plan may also disclose your PHI in response to a subpoena or other type of lawful request from an attorney involved in a lawsuit, or from a government agency or investigator involved in an administrative proceeding. In the case of a subpoena or other lawful request, the Plan is required to make sure you are aware of the request or obtain an assurance that your PHI will be used appropriately.

- Law Enforcement. The Plan may disclose your relevant PHI in response to a court ordered warrant, subpoena or summons; a grand jury subpoena; or a civil investigative demand made by an agency or officer for legitimate law enforcement purpose.
- Coroners, Medical Examiners, and Funeral Directors. The Plan may disclose your PHI to a coroner or medical examiner for purposes of identifying a deceased person or determining the cause of death, or to a funeral director.
- Organ, Eye or Tissue Donation. The Plan may disclose your PHI to facilitate organ, eye or tissue donation or transplantation as allowed by the state's organ procurement laws.
- Threats to Public Health. The Plan may be required to disclose limited PHI to the extent the Plan in good faith determines such disclosure is necessary to prevent or lessen a serious and imminent threat to public health or safety, or to the health or safety of a specific individual.
- Specialized Government Functions. The Plan may be required to disclose your PHI to the United States or a State government if you are an active or veteran member of the military, seeking a government security clearance or permission to travel abroad, if you are in lawful custody, or if the government requires such information to conduct lawful national security activities.
- Worker's Compensation. The Plan may disclose your PHI as authorized by the state's workers' compensation laws.

B. The Plan will use and disclose PHI as required by law and as permitted by written authorization of a Plan Participant or Beneficiary. Only with an authorization, will the plan disclose PHI to pension plans, disability plans, workers' compensation insurers, etc.) for purposes related to administration of these plans.

C. The Plan will never sell your PHI or use your PHI for marketing purposes without your prior, written permission.

D. For purposes of this section, the SCMA is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Summary Plan Description ("SPD") has been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the "SPD" or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and

decisions unless authorized by the individual in writing;
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual in writing;
- Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the plan that the Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

E. Adequate separation between the plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI.

- The Plan Administrator
- Staff Designated by the Plan Administrator
- MIT Vice President
- MIT Director of Operations
- MIT Insurance Coordinator
- MIT Marketing Services Manager
- MIT Board of Trustees
- SCMA Vice President of Information Technology
- CEO

F. The persons described in section E may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

G. If the persons described in section E do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

H. For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

I. Your Rights. You may make a written request to the Plan to do one or more of the following concerning your PHI that the Plan maintains:

- To put additional restrictions on the Plan's use and disclosure of your PHI for payment, health care operations, or to someone who is involved in your care or the payment for it. Except in limited circumstances, the Plan does not have to agree to your request.
- To ask the Plan to communicate with you in confidence about your PHI by a different means or at a different location than the Plan is currently

using. The Plan will consider and accommodate reasonable requests. Your request must specify the alternative means or location to communicate with you in confidence.

- To see and get copies of your PHI that is created or maintained by the Plan or its business associates. For any portion of your health record maintained in an electronic health record, you may request we provide that information to you in an electronic format. If you make that request, we are required to provide that information to you electronically. In limited cases, the Plan does not have to agree to your request.
- To correct your PHI that is created or maintained by the Plan. In some cases, the Plan does not have to agree to your request but will respond in writing within 60 days.
- To receive a list of disclosures of your PHI that the Plan and its business associates made for the last 6 years (but not for disclosures made before April 14, 2004, and subject to Section 13405(c) of the HITECH Act). The Plan is not required to list disclosures made for treatment, payment or health care operations (except when required by, and upon the effective date of, Section 13405(c) of the HITECH Act), or disclosures made with your authorization. We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To send you a paper copy of this notice even if you have previously agreed to receive this notice by e-mail or on the internet.
- To be notified if there is a breach to the security or privacy of your PHI due to your information being unsecured. We are required to notify you within 60 days of discovery of a breach.

If you want to exercise any of these rights described in this Notice, please contact the designated Plan Contact at the address provided below. The Plan Contact will give you the necessary information and forms for you to complete and return. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

J. Complaints. If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan Contact designated below, or ask for the address of the appropriate regional office of the Secretary of the USDHHS. Neither the Plan nor the Company will retaliate against you if you choose to file a complaint.

K. Contact Office. To request additional copies of this notice or to receive more information about our privacy practices or to exercise any of your rights, including your right to file a complaint, please contact us at the following Contact Office:

Contact Office: SCMA Members' Insurance Trust
Privacy Officer: J.C. Nicholson III
Telephone: 803-798-6207
Fax: 803-731-4021
E-mail: JCNicholson@scmedical.org
Address: P.O. Box 11188, Columbia, SC 29221

L. THE EFFECTIVE DATE OF THIS AMENDED NOTICE IS SEPTEMBER 23, 2013. The Plan is required to follow the terms of this notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time. If the Plan

makes significant changes to this Notice, the Plan will revise it and send a new notice at that time. The Plan reserves the right to make the new changes apply to all your PHI maintained by or for the Plan before and after the effective date of the new notice

M. Effective April 21, 2005, the Plan Sponsor:

1. Implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan.
2. Ensured that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensured that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Reports to the Plan an security incident of which it becomes aware concerning electronic PHI.

Important Contact Information

Claims

For questions regarding claims and verification of benefits:
Planned Administrators, Inc.
www.paisc.com or 1-800-768-4375

Submit all claims to:
Planned Administrators, Inc.
P.O. Box 6927
Columbia, SC 29260

Benefits

For pre-certification/prior approval:
Planned Administrators, Inc Utilization Review
1-800-652-3076

For questions regarding Mental Health/Substance Abuse benefits:
1-800-868-1032

For questions regarding pharmacy benefits or drug card related issues:
Express Scripts
1-855-686-9785 or www.express-scripts.com

Enrollment

For questions about enrollment applications, eligibility or premium:
SCMA Members' Insurance Trust

Phone:	Mail:	Email*:
803-798-6207 or 1-800-327-1021	P.O. Box 11188 Columbia, SC 29211	MITinfo@scmedical.org

*All emails containing protected health information (PHI) must be submitted via encrypted email.

SCMA Members' Insurance Trust
P.O. Box 11188
Columbia, SC 9211

1-800-327-1021

MITinfo@scmedical.org

www.scmaMIT.com

SCMA
MEMBERS' INSURANCE TRUST