SOUTH CAROLINA MEDICAL ASSOCIATION VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION WELFARE BENEFIT PLAN AND TRUST

Effective January 1, 2020

INTRODUCTION

The South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust ("**MIT**" or the "**Plan**") offers eligible active employees and retirees of our Participating Employers a variety of Benefits designed to promote health, wellness and financial security. Benefits offered under MIT include:

- Health and Wellness Benefits, including:
  - Medical
  - Dental
- Embedded Benefits, which may include one or more of the following:
  - Personal Accident Insurance
  - Life and Accidental Death & Dismemberment (AD&D) Insurance
  - Short-Term Disability Income Benefits
  - Employee Assistance Program (EAP)

This document is a Summary Plan Description ("**SPD**") of the group benefits offered to eligible active employees and retirees of our Participating Employers effective January 1, 2020. We intend, for purposes of the annual report requirement (Form 5500) and for compliance with other laws, that our Plan be considered a "wrap" plan. The terms of the certificates of coverage issued by the insurance companies who insure the Benefits offered under our Plan, as well as the Benefit Summaries for self-insured Benefits (referred to as the "Summaries") are incorporated by reference. The inclusion of any voluntary insurance coverages or ancillary benefits in our Plan is intended solely for consolidation purposes and is not intended to indicate that any such coverage is or is not subject to ERISA. This SPD replaces any previously published group benefit plan descriptions you may have in your possession. Your receipt of this SPD does not necessarily mean you are eligible for a benefit under the Plan.

This SPD summarizes the Plan and its Benefits in plain language so that they will be easier to understand. This SPD explains the responsibilities of you, your Participating Employer, and MIT. However, information contained in this SPD does not cover every possible situation and is not intended to replace or change the meaning of insurance policies issued by insurance companies who insure the Benefits offered under our Plan, as well as the benefit summaries for our self-insured Benefits (the "**Plan Documents**"). In the event this SPD disagrees with any Plan Document, the Plan Document will govern. You can obtain your own copy of the Plan Documents by contacting MIT at MITinfo@scmedical.org or 1-800-327-1021. We may charge you a reasonable fee for a copy of the Plan Documents.

Please read this booklet carefully and call MIT if you or your covered dependents have any questions concerning your coverage before receiving elective procedures. Also note that you will only be allowed to make changes to your coverage 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 Benefits described in this SPD do not constitute an employment guarantee or contract with any employee, nor do they give any employee or other person a right to continued employment with any Participating Employer. The Trustees of MIT reserve the sole right to amend, change, interpret or terminate any of the Benefits or the Plan described in this SPD at any time and for any reason. The terms of any Benefit or the Plan cannot be changed by any oral or written

representation made to you. Because Benefits offered may differ depending upon coverage options elected, we urge you to read this SPD carefully so you may understand and take full advantage of these Benefits. Should you have questions about Benefits or the Plan after reading this SPD, please contact MIT at MITinfo@scmedical.org or 1-800-327-1021.

When used in this booklet (unless otherwise noted), the terms "**you**" and "**your**" mean a person who satisfies the eligibility requirements for the Plan; and "**we**", "**us**" and "**our**" mean MIT.

The following provisions of this booklet contain a summary in English of your rights and benefits under our Plan. If you have questions about your benefits, please contact MIT at MITinfo@scmedical.org or 1-800-327-1021. If needed, simply request a translator and one will be provided to assist you in understanding your benefits.

Atención por favor - Spanish

Este folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al MIT. Solicites implemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

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PARTICIPATING EMPLOYERS

This section explains which employers are eligible to participate in MIT as a Participating Employer and how they terminate their participation in MIT.

Eligibility of Employers

An entity is eligible to enroll as a Participating Employer in MIT and offer Benefits to its eligible employees and retirees only if it satisfies ALL of the following:

1. the entity is a corporation, professional association, limited liability company, partnership, association or other entity engaged in a business or enterprise in or otherwise connected with a medical services-related or health care related field in South Carolina;
2. at least one of the working physicians of the entity is a member of SCMA;
3. the entity has at least 2 employees;
4. the entity contributes employer premiums toward its eligible employees' coverage equal to at least 50% of the cost of employee-only coverage; and
5. the entity maintains 50% participation in the Plan, based on all of its eligible employees and Physicians (for this purpose, any eligible employee or physician who provides a valid waiver of coverage is counted as participating).

In addition to the above, certain entities who otherwise satisfy the above requirements but who are not headquartered in South Carolina may be permitted to enroll in MIT as a Participating Employer if they are determined by MIT to have a sufficient connection to the South Carolina medical community.

In order to become a Participating Employer, an eligible entity must complete and sign a Participating Employer Agreement and any additional documents that we may require from time to time, and we must approve the entity for participation.

SCMA, as an employer itself, also participates as a Participating Employer in the Plan.

Termination

A Participating Employer may cancel its participation in MIT at any time. Requests for termination must be submitted in writing to MIT at MITinfo@scmedical.org or P.O. Box 11188, Columbia, SC 29211. The effective date of any voluntary termination of a Participating Employer's participation in MIT will be the last day of the calendar month in which the Participating Employer's written notice is received by MIT, or the last day of a later calendar month as specified by the Participating Employer in its written notice of cancellation.

Reminder: Any termination notice must be delivered to MIT, not to your insurance agent or broker.

If a Participating Employer ceases to participate in MIT, all coverage will automatically cease for employees of that Participating Employer and for retirees who retired from that Participating Employer on or after January 1, 2020.

NOTE: The Participating Employer (not MIT) is responsible for obtaining replacement coverage for its employees and retirees, as well as its COBRA qualified beneficiaries who elect COBRA continuation coverage. If the Participating Employer fails to obtain replacement COBRA coverage for its COBRA qualified beneficiaries, it may be liable to those qualified beneficiaries for their medical costs and may face penalties under the tax code and ERISA.

NOTE: All Participating Employers whose participation in our Plan terminates must pay any/all outstanding balances due within 90 days of the termination date. If full payment is not received within 90 days, MIT reserves the right to reverse any/all claims incurred in a period for which the premium was not received.

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

ELIGIBILITY

This section describes MIT's eligibility rules for employees and physicians. Additional eligibility requirements, limitations or restrictions may apply under each individual MIT Benefit. Be sure to review the section of this SPD discussing each MIT Benefit and the applicable Plan Document for the eligibility provisions that apply to that separate Benefit.

Eligibility of Employees

If you are an employee, you are eligible for coverage under our Plan if either:

1. **Full-Time Employees.** You are a Full-Time Employee of a Participating Employer (as defined in the INTRODUCTION section above), which means you satisfy ALL of the below requirements:

   (a) You are classified by the Participating Employer as a common law employee of the Participating Employer, or an individual who earns self-employment income with the Participating Employer and is included in the definition of an employee under Internal Revenue Code Section 401(c)(1); and

   (b) You are either:

      (i) if your Participating Employer is not an "applicable large employer" as defined by the ACA (generally, this means an employer with less than 50 full-time equivalent employees), reasonably expected to work 30 hours or more per week, as determined your Participating Employer; or

      (ii) If your Participating Employer is an "applicable large employer" under the ACA (generally, this means an employer with 50 or more full-time equivalent employees), your Participating Employer determines that you (A) are reasonably expected to work an average of 30 hours or more per week, or (B) during the applicable look-back measurement period applied in accordance with the ACA, worked an average of 30 hours or more per week; and

   (c) You are a resident of the U.S.

2. **Retirees.** If you are retired and you had both attained age 55 at the time of your retirement and were continuously covered by MIT for the five years prior to your retirement. Retirees who retire from a Participating Employer on or after January 1, 2020 will only remain eligible for coverage under MIT for so long as their Participating Employer continues its participation in MIT.

Eligibility for Physicians

If you are a Physician, you must satisfy the above requirements AND also satisfy one of the following requirements:

1. **South Carolina Resident**. You are a resident of South Carolina, and a member of the SCMA actively practicing medicine in South Carolina; or

2. **Out-Of-State Resident**. You are a non-resident Physician actively practicing medicine, a member of the SCMA, and employed through a Participating Employer located in South Carolina.

Excluded Individuals

Notwithstanding any other provision of our Plan, the following individuals are NOT eligible to participate in our Plan:

- Leased employees,
- Individuals classified by the Participating Employer as "non-benefit service providers,"
- Independent contractors, and
- Individuals participating in a collectively bargained (e.g., union) health and welfare program to which the Participating Employer contributes.

If you are classified by your Participating Employer in one of the above excluded categories or otherwise as not being a common law employee and such classification is later changed (whether due to governmental or court action, or otherwise), your eligibility for our Plan will be effective only prospectively and will not have any retroactive effect.

Eligibility of Dependents

Certain Benefits offered by MIT allow you to cover eligible dependents. The following dependents may be eligible for coverage until age 26:

1. Your **spouse** to whom you are legally married, including your spouse in a valid common law marriage for which you have provided an affidavit of common law marriage to MIT (note that SC does not recognize common law marriages entered into after July 24, 2019),
2. Your **natural children**,
3. Your **adopted children**, including those adopted by or placed for adoption with you,
4. Your **stepchildren**, and
5. Your 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 child's parents also resides with you).

When both husband and wife are covered by our Plan as employees or Physicians, either, but not both, may elect to cover dependent children.

Dependent children are only eligible for coverage until age 26 (unless they are handicapped and qualify as set forth below under *Handicapped Children*). Refer to the *COBRA Continuation of Medical Care Coverage* section of this booklet for details regarding COBRA rights of your

dependent children who no longer satisfy the eligibility rules described above. You can contact MIT directly at MITinfo@scmedical.org or 1-800-327-1021.

MIT may require proof of dependent status at initial enrollment and from time to time while coverage is in effect.

Under the Employee Assistance Program only, eligible dependents include your spouse and any family members who reside with you and are members of your household, and your otherwise eligible children while they are away to college or the military. Your dependents do not need to be covered by your MIT medical coverage in order to use your Employee Assistance Program benefits.

If you want to cover your eligible dependents, you must enroll them at the time of your initial eligibility for coverage under our Plan. Otherwise, you will not be able to enroll them in our Plan until the next Plan Year, unless another special enrollment event allows earlier enrollment.

Handicapped Children

Special provisions exist for continued coverage of a dependent child over age 26 who is mentally disabled or physically handicapped and unable to earn a living and who is dependent upon you for support. Your handicapped child can continue to be covered as a dependent under MIT, even beyond attaining age 26, if:

1. your child is mentally disabled or physically handicapped and unable to earn a living,
2. your child is dependent upon you for support,
3. your child was continuously covered as your dependent under our Plan prior to attainment of age 26,
4. your child was your dependent and under age 26 at the time he or she became handicapped, and
5. you provide a physician's Certificate of Disability to us at the time you initially enroll your child, and from time to time as requested by MIT; and
6. MIT receives your properly completed application within 31 days after your child attains the age 26 limit.

Reminder: MIT must receive your properly completed enrollment forms within 31 days after your dependent child's 26th birthday to continue coverage as a handicapped child. If you miss this deadline, your handicapped child will lose all eligibility for our Plan, except for any COBRA rights.

Failure to make a properly-filed application and submit a required Certificate of Disability to MIT within 31 days of your handicapped child's 26th birthday will result in your handicapped child's loss of rights to continued coverage under our Plan, except through COBRA. We may require that your Certificate of Disability be submitted using a form provided by MIT. After two years from the date the dependent child attains age 26, we will not require a Certificate of Disability more often than once each calendar year.

When Your Coverage Begins

Initial Enrollment

You may enroll in our Plan effective on the 1st day of the first calendar month after you satisfy the *Eligibility* rules set forth above and you complete the waiting period designated by your Participating Employer (or by the 91st day, as required by the Affordable Care Act). MIT must receive your properly completed enrollment forms within 31 days after the date you become eligible and complete your waiting period. See *How to Enroll in Benefits* below for more information on the enrollment process.

Reminder: MIT must receive your properly completed enrollment forms within 31 days after you first become eligible and complete your waiting period in order for you to enroll. If you do not meet this deadline, you may have to wait to enroll until the next Plan Year.

If you properly enroll as described above, your effective date of coverage will be retroactive to the date you were first eligible for coverage. If you initially elect to cover any eligible dependents, their coverage effective date will be the same as yours.

Rehired employees who previously satisfied the enrollment waiting period described above (regardless of whether they actually enrolled) may enroll in Benefits immediately upon their rehire date provided they satisfy the eligibility requirements (see *Eligibility of Employees* above).

If you or a dependent are covered under another medical or dental plan or under COBRA continuation coverage through another employer when you first become eligible, you may initially choose to decline the corresponding medical or dental Benefits under MIT. If you lose your other coverage because you are no longer eligible, or a former employer terminates the group coverage, you will be entitled to a special enrollment period (see *Changing Your Benefit Elections* below).

Participating Employers are not permitted to waive the waiting periods that apply to Plan coverage, except in very limited circumstances such as the Participating Employer's initial entry into MIT or the Participating Employer's acquisition of another business, which in both cases require MIT consent.

How to Enroll in Benefits

You may enroll in MIT Benefits using our website at www.scmamit.com, unless your Participating Employer has designated a different preferred enrollment method in your enrollment packet. You will receive enrollment information and instructions on how to enroll from your Human Resources department or office manager. If you have questions, you may contact MIT at MITinfo@scmedical.org or 1-800-327-1021.

When enrolling in Benefits, you must select your level of coverage for each Benefit. For medical and dental Benefits, you must indicate any eligible dependents you wish to cover under each Benefit. Only those eligible dependents who you designate for enrollment in a Benefit will be covered under that Benefit. If you qualify for a life or AD&D Benefit, you must also designate your Beneficiary(ies) to receive your benefits in the event of your death.

To ensure your elections are registered on time, your completed enrollment must be received by MIT within 31 days after you are first eligible and you complete your Waiting Period. If you fail to complete your enrollment within this period, you will not be able to enroll in MIT Benefits until the next Plan Year, unless you have a special enrollment event that allows you to enroll mid-year.

Changing Your Benefit Elections

Federal law regulates your ability to change your Benefit elections under our Plan. In general, you may change your elections only under the circumstances described below. All changes to your enrollment elections must be made using our website at www.scmamit.com, unless your Participating Employer has designated a different preferred method in your enrollment materials. If you have questions or any problems changing your elections, you may contact MIT at MITinfo@scmedical.org or 1-800-327-1021.

Please note that when you add any dependent to a MIT Benefit for the first time, you may receive a request from MIT to provide documentation to verify your dependent's eligibility to participate in the Benefit and/or Plan.

Election Changes During Annual Enrollment Period

You are offered an opportunity to change your MIT Benefits during a designated annual enrollment period that usually occurs in December prior to the start of each Plan Year. We will provide you information on your Benefit choices for the coming Plan Year and will announce the dates during which you may make changes to your MIT Benefits. **If you fail to make an election during annual enrollment, you will be subject to default Benefit enrollments as described below.**

If you are using our website, when you enter your annual MIT enrollment elections, you will be given the opportunity to confirm your choices. You are responsible for reviewing and ensuring that your annual MIT enrollment elections have been correctly entered. If you make changes to your elections during the annual enrollment period, your last confirmed annual enrollment will constitute your final election for the new Plan Year. Remember that you will not be allowed to change your annual MIT enrollment elections until the next annual enrollment period (unless you experience a special enrollment event as described below).

Election Changes Due to a Special Enrollment

You may change certain MIT Benefit elections outside of the annual enrollment period when you experience certain "special enrollment events". The following are considered special enrollment events if they affect eligibility for MIT Benefits and result in a gain or loss of MIT Benefit coverage or access to MIT Benefit coverage for you or a dependent:

- Change in your legal marital status,
- Change in the number of your dependents,
- Change in employment status or work schedule of you, your spouse or your dependent,
- Change in your dependent's eligibility to participate in a MIT Benefit due to attainment of age or change in full-time student status, or
- Change in place of residence for you, your spouse or dependent.

Regardless of whether you are enrolled in family coverage, be sure to enroll your new dependent within 31 days, or else the child will not be able to enroll until the next Plan Year.

For medical or dental Benefits, you may also change your election if you or a covered dependent:

- Previously Declined Enrollment. You decline enrollment for yourself and/or any of your dependents under any MIT medical or dental Benefit because you or your dependents have other group medical or dental coverage and either (a) you or your dependents later lose eligibility for that coverage, or (b) you marry or gain a new dependent through birth, adoption or placement for adoption. You must request enrollment within 31 days after the date upon which the other coverage is lost.
- Entitlement or Loss of Medicare or Governmental Program. You or your dependent become entitled to or lose eligibility for Medicare or eligibility under a governmental program.

MIT make receive your request to make the corresponding change to your MIT Benefit enrollment within 31 days of any of the above special enrollment events. Election changes and corresponding required contribution increases or refunds are retroactive to the date of the event. **Failure to notify MIT within 31 days of the above special enrollment events may result in your inability to make changes to your MIT coverage.**

To request a change to your MIT Benefits coverage due to a special enrollment event, you must fax or email SCMA/MIT at:
Fax 803-731-4021
Email:
MITinfo@scmedical.org.

An additional special enrollment event occurs if you or your dependent lose coverage under a state Medicaid or state Children's Health Insurance Plan ("**CHIP**") because of loss of eligibility, you may enroll yourself and your dependents in a MIT medical Benefit, *provided* you request enrollment within 60 days of the date upon which you lose the Medicaid or CHIP coverage. This special enrollment eligibility only applies if you or your eligible dependent's Medicaid or CHIP coverage terminates due to loss of eligibility (as opposed to termination due to failure to pay premiums). You may also enroll yourself and your dependents for a MIT medical Benefit if you or your dependents become eligible for Medicaid or CHIP premium assistance to help you pay for Plan coverage, *provided* you enroll yourself and/or your dependents within 60 days of the date you or your dependent is determined to be eligible for such premium assistance.

Federal regulations require that election changes made because of a special enrollment event must be consistent with the type of change you have experienced. We will determine if a requested change in coverage is consistent with your corresponding special enrollment event.

Besides legal requirements discussed above, the Plan Documents for certain MIT Benefits or your Participating Employer's cafeteria plan may further restrict changes you may make to your Benefit elections, including changes due to a special enrollment events. In addition, rules describing additional changes you may make may be included in the Plan Documents for the applicable Benefit.

In the case of a special enrollment event that resulted in the loss of your or your covered dependent's eligibility for MIT Benefit coverage, **your failure to timely notify MIT of the event may result in the permanent loss of your eligibility to participate in <u>all</u> MIT Benefits for you and your covered dependents.** MIT reserves the right to retroactively terminate coverage back to the earliest date that an individual becomes ineligible for a MIT Benefit and to seek repayment of all amounts paid by MIT for ineligible expenses (except where limited by law).

Changing Your Health Savings Account Contributions

If you make voluntary contributions to a Health Savings Account ("**HSA**") in conjunction with participation in one of the MIT medical Benefits, you may change your HSA contribution at any time, regardless of whether you experience a special enrollment event.

Default Coverage for Elective Benefit Options

Default Coverage for Initial Eligibility - If MIT does not receive your MIT Benefit elections on our website (or using your Participating Employer's other designated enrollment method) within 31 days of the date you are first eligible and complete your waiting period, we will consider you to have elected no participation, and therefore no coverage under all MIT Benefits. You and your dependents will not be permitted to enroll in MIT Benefits for the remainder of the Plan Year, unless you have a special enrollment event as described above.

Default Coverage for Annual Enrollment Period - If you fail to submit enrollment elections for MIT Benefits during an annual enrollment period occurring after your initial enrollment, the following default coverage will apply for the next Plan Year:

- Your current elections for medical and dental Benefits will remain the same for the next Plan Year
- The Embedded Benefits offered by MIT will generally continue so long as you are covered by a MIT medical Benefit, unless you are otherwise notified by MIT.

If you are enrolled in any Benefit that is discontinued for the coming Plan Year, we will designate the default replacement Benefit in the annual enrollment materials sent to you. If no replacement Benefit has been designated by us, you will be deemed to have elected no participation in that Benefit. This default provision will apply only if no replacement benefit plan is specifically designated in annual enrollment materials.

WHEN YOU TAKE A LEAVE OF ABSENCE

NOTE: Failure to notify MIT of a leave of absence within 31 days may result in retroactive termination of coverage under our Plan. It is the Participating Employer's sole responsibility to notify MIT of any change in eligibility status. Failure of your Participating Employer to timely and properly notify MIT may impair or prohibit you or your covered dependent from exercising legal rights you or they may have to continue coverage during a leave of absence under our Plan and subject the Participating Employer to legal liability. We recommend that you take it upon yourself to also provide notice to MIT of your leave of absence to avoid premature loss of coverage.

Medical Leave of Absence

For Participating Employers <u>not eligible</u> for Family and Medical Leave Act (FMLA) - MIT Disability Continuation During Participating Employer Certified Leaves of Absence Without Pay.

If you are unable to work full-time due to disability, and your Participating Employer has authorized a leave of absence, you and your covered dependents may remain eligible for coverage under our Plan during the approved leave of absence for a maximum of twelve (12) weeks ("**MIT Disability Continuation**"). Thereafter, you and your covered dependents may be eligible to elect COBRA Continuation Coverage.

During any leave of absence, you must continue to pay the appropriate amount of premium. Premiums must be paid by the 15th day of each calendar month. If your account is delinquent more than 30 days, your coverage under our Plan will terminate.

For Participating Employers <u>eligible</u> for Family and Medical Leave Act (FMLA) Continuation During Participating Employer Certified Leaves of Absence Without Pay.

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

At the end of the FMLA period (12 weeks), the covered employee and his or her covered dependents may be eligible to elect COBRA Continuation Coverage.

Under any leave of absence, you must continue to pay the appropriate amount of the premium. Premiums must be paid by the 15th day of each calendar month. If your account is delinquent more than 30 days, your coverage under our Plan may be terminated.

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 our Plan as required by the Federal law known as USERRA. If you are eligible under USERRA, 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 you fail to apply for or return to active employment with the Participating Employer as required by USERRA.

If you qualify for re-employment with your Participating Employer under the provisions of USERRA, you will be eligible for reinstatement of coverage under our Plan upon re-employment without being subjected to a waiting period or pre-existing 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 our Plan.

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

Additional Participating Employer Leave Not Recognized

In terms of eligibility for coverage, MIT does not recognize additional paid or unpaid leave of any kind after you have exhausted MIT Disability Continuation, FMLA, USERRA and any normal annual or sick leave. If after normal annual and sick leave and any applicable MIT Disability Continuation, FMLA or USERRA leave is exhausted you are no longer considered a Full-Time Employee by your Participating Employer, then you and your covered dependents may be eligible to elect COBRA Continuation Coverage (*provided, however*, if your Participating Employer is an "applicable large employer" under the ACA, any termination of your coverage will comply with the ACA).

WHEN YOUR COVERAGE ENDS

This section discusses when coverage ends for the covered employee and covered dependents. For information about a Participating Employer's cessation of participation in MIT, please see *Participating Employers* above.

Employee and Dependents:

Your coverage (including if you are a retiree) and coverage of your spouse and other dependents will cease on the sooner of:

1. the date our Plan ceases;
2. the date your Participating Employer ceases to participate in our Plan, unless you are a retiree who retired from a Participating Employer prior to January 1, 2010;
3. the last day of the calendar month in which coverage under our Plan ceases for the class to which you belong;
4. the last day of the calendar month during which you no longer satisfy the eligibility requirements (such as a Full-Time Employee moving to part-time status);
5. the last day of the calendar month for which your last premium is paid;
6. the last day of the calendar month in which you are retired if you retire without being continuously covered by MIT for the previous five years or before you attain the age of 55;
7. the last day of the calendar month in which a dependent no longer qualifies as eligible under our Plan; or
8. 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.

NOTE: A Participating Employer has an affirmative duty to notify MIT within 31 days of the death of a covered employee, termination or reduction of hours of a covered employee, or a covered employee who becomes entitled to Medicare (regardless of whether he/she enrolls), in each case which results in the termination of your coverage or the coverage of your covered dependent. Failure of your Participating Employer to timely and properly notify MIT may impair or prohibit you or your covered dependent from exercising legal rights you or they may have to continue coverage under our Plan and subject the Participating Employer to legal liability. **If you want to preserve your COBRA rights under MIT, we recommend that you (or in the event of your death, your survivors) also take it upon yourself to notify MIT if you have one of these events occur.**

In addition, you are responsible for notifying MIT of your divorce or legal separation or your dependent child's losing dependent status under the Plan. **Your failure to timely and properly notify MIT may impair or prohibit you or your covered dependent from exercising legal rights you or they may have to continue coverage under our Plan.**

You can contact MIT directly at MITinfo@scmedical.org or 1-800-327-1021. Refer to the *COBRA Continuation of Medical Care Coverage* section of this booklet for further details.

MIT reserves the right to retroactively cancel coverage if premiums are not paid within 31 days of the original due date. If your coverage under our Plan is terminated for non-payment of premium, MIT reserves the right to reverse any paid claims incurred after the termination date.

Handicapped Children

Coverage for your handicapped children over the age of 26 will end on the sooner of:

1. the last day of the calendar month for which your last premium is paid;
2. the date your coverage ceases;
3. the last day of the calendar month in which the handicap ceases; or
4. if any required Certificate of Disability is not furnished by the 31st day after it is requested, the last day of the calendar month in which such deadline expires.

Surviving Spouse

If you die and your surviving spouse was covered by MIT continuously for the previous three (3) years, and your surviving spouse files an application and agrees to make any required contribution within 31 days of your death, coverage under MIT may be continued by your spouse for your spouse and your dependent children until the sooner of:

1. the surviving spouse becomes eligible for other group medical care benefits;
2. the surviving spouse remarries;
3. your Participating Employer ceases participation in MIT;
4. our Plan ceases; or
5. the last premium is paid.

Your surviving spouse's failure to make an application within 31 days of your death will result in loss of your surviving spouse's and any other covered dependent's rights to continued coverage, except through COBRA.

Refer to the *COBRA Continuation of Medical Care Coverage* section of this booklet for details regarding COBRA rights. You can contact MIT directly at MITinfo@scmedical.org or 1-800-327-1021.

Certificates of Prior Coverage

This Plan will provide a Certificate of Prior Coverage for MIT medical or dental Benefits 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:	MIT P.O. Box 11188, Columbia, SC 29211
Fax:	803-731-4021
Email:	MITinfo@scmedical.org

YOUR BENEFIT COSTS

Your Participating Employer funds a large part of the cost of MIT Benefits. You must pay your share of the cost, as determined by MIT and your Participating Employer from time to time, and your Participating Employer will pay the remainder (if any) of the cost. Your share depends upon the level of coverage you select under each MIT Benefit, and whether you choose to cover eligible dependents.

- For medical and dental Benefits, MIT will designate your share of the cost in the enrollment materials provided to you during your initial enrollment period or the annual open enrollment period. Any Participating Employer costs have already been taken into account in the Benefit costs you see. If you enroll in a medical Benefit that qualifies as a high-deductible health plan (see *Medical Benefits* below), you may also elect to contribute to a Health Savings Account that you will establish with a provider of your choosing.
- For our Embedded Benefits, there is generally no additional cost to you for your participation in these Benefits. They are automatically included when you enroll in eligible MIT medical Benefits. At times, MIT may offer you the opportunity to elect an enhanced level of Embedded Benefits, in which case we will notify you of the cost to you of such enhancements.

Any designation of your Participating Employer's premium amounts in open enrollment or other communications is intended as an estimate, not a fixed dollar amount, of its contributions.

Benefit contributions are usually deducted by your Participating Employer from your pay each pay period. Payroll deductions for MIT Benefits are normally taken by your Participating Employer before taxes. This means you do not pay federal or Social Security (and in most cases, state or local) taxes on these contributions. Such pre-tax treatment is conditioned upon you satisfying the requirements of your Participating Employer's cafeteria plan, which is a separate plan established by your Participating Employer. In some cases where you are not eligible for your Participating Employer's cafeteria plan, or where persons covered under a MIT Benefit selected by you do not qualify for pre-tax benefits under the tax code, your Participating Employer, in its sole discretion, may allow you to pay all or part of the cost on an after-tax basis outside of its cafeteria plan (in some limited situations described in the cafeteria plan, after-tax payments may be made through the cafeteria plan).

Wellness Discounts

MIT may, from time to time, implement or adopt one or more wellness programs or disease management programs that offer you the opportunity to qualify for discounts on the cost of medical or dental Benefits or other financial incentives if you or your dependents participate in the program or satisfy certain health standards. If you or your dependents choose to participate, or stop or otherwise fail to qualify in such a program, any adjustments will be automatically applied to the cost of your medical or dental Benefits and to your salary reductions.

MEDICAL BENEFITS

This section describes the medical Benefits offered by MIT. The Schedules of Benefits describing the deductible, out-of-pocket maximums, co-payment and coinsurance requirements for each medical coverage option offered by MIT are included at the end of this SPD or provided separately to you. Capitalized terms have the meaning set forth under the *Definitions* heading later in this section.

Online benefits portal

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

Find a Provider

MIT uses Preferred Blue as its Preferred Provider Organization (PPO) in South Carolina for medical Benefits. For services rendered outside of South Carolina we will utilize the First Health Network.

Visit www.paisc.com/members/scmamembers.aspx to view the provider directory.

Summary of Benefits

In accordance with the Patient Protection and Affordable Care Act ("**ACA**"), SCMA/ MIT has developed a Summary of Benefits and Coverage (SBC) for each medical Benefit coverage option offered under our Plan. Copies of these SBCs can be accessed by visiting www.scmamit.com or a paper copy can be requested by calling 1-800-327-1021.

Understanding Your Preventive Services Coverage

Current law requires our Plan to provide coverage 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.

Please Note
The preventive benefits described in this booklet are provided for informational purposes only and do not constitute legal advice or legal options. 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 law, is subject to change without notice, and is not a substitute for legal advice. Covered preventive services are subject to change from time to time by the federal government.

Important to Remember

Recommended Preventive Services may often be furnished as a part of the office visits in which you receive 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, our 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 you to get Recommended Preventive Service, our 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, our Plan may require cost-sharing for the office visit.

PREVENTIVE SERVICES BENEFITS	
Physical Examination In-Network Coverage/One (1) per Calendar Year This coverage is an additional MIT Benefit not required under the Affordable Care Act.	
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 with no cost share to you, both the diagnosis code and procedure code submitted by an in-network provider must reflect preventive care.	

EXAMPLES OF 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
- Die 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 woman
- 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 dugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid Supplement for women who may become pregnant
- Gestation diabetes screening for women 24-28 weeks pregnant and those at high risk of developing gestation diabetes
- Gonorrhea screening all women at high risk
- Hepatitis B screening for pregnant women at their first prenatal visits
- 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 woman at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco user
- 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 MITinfo@scmedical.org or 1-800-327-1021 for the most current information.

Pre-Certification and Prior Authorization

Pre-certification or prior authorization is not a guarantee of payment. All Plan provisions apply to services rendered. The penalty for noncompliance with pre-certification/prior authorization requirements is a $500 benefit reduction on a Covered Expense. The first penalty that would otherwise be owed by you as a result of any noncompliance by either you or your covered dependents will be waived and a written notification will be issued (only one such waiver applies to your covered family group).

Pre-Certification

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

- **All In-patient admissions require pre-certification.** Please call Planned Administrators, Inc. Utilization Review at 1-800-652-3076 for 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, our Plan will not, under federal law, require that a provider obtain pre-certification or prior authorization from our 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 Planned Administrators, Inc. Utilization Review at 1-800-652-3076 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 outpatient services for mental health

- In-patient and outpatient services for substance abuse
- MRI of breast or heart
- Outpatient 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 pre-certification required for IMRT and proton beam therapy
- RAST
- Remicade injections administered in a physician's office, or outpatient 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 outpatient 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
- Lupon
- 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, Root 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

Definitions

The following terms apply to all medical Benefits offered under our Plan.

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 an individual receives Emergency Services outside the area where he or she resides, 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 individual 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, 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.

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 outpatient 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 our Plan will pay in a calendar year on any individual, regardless of which Plan coverage option or combination of Plan coverage 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 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, our 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:

1. Evaluation and assistance for the individual, his or her Physician, and his or her family to help develop a plan of services to meet specific needs;
2. Assistance with obtaining unusual equipment or supply needs;
3. Assistance in home care planning and implementation;
4. Arrangements for needed nursing/caregiver services;
5. Providing help with assessment of rehabilitation needs and provider arrangements;
6. 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;
7. Monitoring and assuring treatment programs and interventions for Mental and Nervous Treatment and/or treatment for Substance Abuse; and

8. 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, MIT shall have the right to alter or waive the normal provisions of our Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Benefits provided under this section are subject to all other Plan provisions. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that individual or any other individual covered by our Plan. Nothing contained in our Plan shall obligate MIT 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 an individual 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 individual prior to benefits being payable under our Plan.

The Deductible is shown in the Schedule of Benefits. The Deductible applies separately to each covered individual 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 outpatient 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 layperson who possesses an average knowledge of health and medicine to reasonably expect the absence of immediate medical attention to result in:

1. 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
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part, or
4. 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.

MIT will make an independent evaluation of the experimental/non-experimental standings of specific technologies. 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. 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.

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, MIT will fully comply with Section 2709 of the Public Health Service Act, as added by Section 1201 of the ACA , 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 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.

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

Maximum Out-of-Pocket Expense
The amount required to be paid by a covered individual prior to benefits being payable by our Plan 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 individual covered under our Plan 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 health coverage providing benefits. However, if our Plan is secondary to another group health plan, the payment percentage may increase to 100%.

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 designated by MIT (usually in the month of December) during which you can make changes to your Benefits under our 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.

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.

Specialty Non-EHB Drugs
Those prescription drugs that have been designated by our Pharmacy Benefit Provider, ExpressScripts, as "Specialty Non-EHB Drugs" and are therefore covered by the special rules of the SaveOnSP program (the "**Program**"). The Plan has implemented a specialty pharmacy copay assistance program that applies to prescription drug coverage under all coverages except our high deductible health plans (HDHPs). Certain special pharmacy drugs are considered non-essential health benefits under our non-HDHP coverages and the cost of such drugs does not apply toward satisfying your Plan deductible or out-of-pocket maximum for those coverages. In addition, your copayment for such drugs is intended to be set to the maximum amount that the applicable manufacturer offers in copay assistance. The Program is designed with the intent that you may apply for reimbursement for your entire copayment cost from the manufacturer, which is expected to result in no cost to you. If you choose not to participate in the Program and submit the necessary manufacturer reimbursement applications, you will bear the full copayment cost for such drugs. A list of Specialty Non-EHB Drugs can be obtained by contacting MIT directly at MITinfo@scmedical.org or 1-800-327-1021, or by calling SaveOnSP at 1-800-683-1074.

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.

Waiting Period
The period of continuous, full-time employment, as described in the *Eligibility* section which is required before an individual becomes eligible for coverage under our Plan. This period cannot exceed 90 days.

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 the individual is covered under our Plan. Benefits are paid for charges for services or supplies you or your covered dependent are required to pay.

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 our 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 individual exceed the maximum benefit.

If MIT requests that you or your dependent participate in case management and you or your dependent refuse such services, 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.

Breast Reconstructive Surgery Benefit (WHCRA)
In connection with the Women's Health and Cancer Rights Act of 1998 ("**WHCRA**"), any individual covered by our Plan who elects breast reconstruction in connection with a mastectomy will be covered by our Plan 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.

This coverage will be provided in a manner determined in consultation with the covered individual and her attending Physician. Deductibles and coinsurance established for medical Benefits under our Plan also apply to these reconstructive surgery benefits.

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 our 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 individual in the individual'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 an individual 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 our 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 Outpatient.

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 by our Plan, benefits will be provided for both.
2. When the transplant recipient is not covered by our Plan, and the donor is covered by our Plan, 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. Special rules apply to those drugs and medications categorized as Specialty Non-EHB Drugs (see *Definitions* above), which must be obtained through the SaveOnSP program in order for you to avoid having to pay their higher copayment cost.

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 you or your covered dependent are 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.)

Limitations And Exclusions

Benefits will <u>not</u> be paid for:

1. Expenses for any accidental bodily injury or sickness for which the covered individual 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 outpatient facility that could have been performed in a less expensive setting as determined by 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 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 the individual 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. MIT 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 our 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 by:
    a. the covered individual or his/her spouse; or
    b. the parent, sister, brother, or child of the covered individual or his/her spouse.
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 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 individual committing or attempting to commit an assault, a felony, or any other illegal act.
26. Expenses for a covered individual 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 pre-certification/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 you or your covered dependents 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 you or your covered dependents 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.

Medicare

Medicare and You

You or your covered dependent must notify MIT when you or your covered dependent becomes eligible for Medicare. Except where otherwise required by Federal law, our Plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage. This Plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage even if you fail to enroll in Medicare when eligible. For more information about how our Plan coordinates with Medicare, please read the section entitled *Coordination of Benefits*.

If you continue to be actively employed when you are age 65 or older, you and your covered dependents will continue to be covered for the same benefits available to employees under age 65. In this case, our Plan will pay all eligible expenses primary to Medicare. In this case, if you are enrolled in Medicare, Medicare will pay for Medicare-eligible expenses, if any, not paid by our Plan.

If both you and your spouse are over age 65, you and your spouse may elect to enroll in Original Medicare or a Medicare Advantage plan and/or a Medicare Part D prescription drug plan and disenroll completely from our Plan. This means that neither you nor your eligible dependents will have any benefits under our Plan.

If you or your spouse is enrolled in Original Medicare, you or your spouse may also purchase a Medicare Supplement contract suited for the parts of Medicare in which either of you have enrolled. Note that MIT is prohibited by law from purchasing the Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.

If you or your spouse is enrolled in a Medicare Advantage plan, neither of you may purchase a Medicare Supplement contract.

If you are age 65 or older, considering retirement, or have another Special Enrollment Event under COBRA and think you may need to buy COBRA coverage after the Special Enrollment Event, you should read the *COBRA* section below.

Special Medicare Rules

Disabled Individuals: If you or your dependent is eligible for Medicare due to disability and is also covered under our Plan by virtue of current employment status with MIT, our Plan will be considered the primary payer (and Medicare will be secondary).

End-Stage Renal Disease: If you or your dependent is eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), our Plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility or entitlement. Thereafter, Medicare will be primary and our Plan will be secondary.

Questions about Coordination of Coverage with Medicare

If you have any questions about coordination of your coverage with Medicare, please contact MIT at 1-800-327-1021 for further information. You may also find additional information about Medicare at www.medicare.gov.

Legal Notices

Newborns' Act
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from our Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health Coverage
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("**WHCRA**"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physician complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

Michelle's Law
Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under our Plan if the child loses eligibility because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under the group health coverages offered under our Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue group health coverage under our Plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under the group health coverage offered under our Plan and was enrolled as a student at a post-secondary educational institution.

A "**medically necessary leave of absence**" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under the group health coverages offered under our Plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage

continuation may end before the end of one year if your child would otherwise lose eligibility under the group health coverage or our Plan – for example, by reaching age 26.

CHIPRA Notice

If you live in one of the following States, you may be eligible for assistance paying your health plan premiums. The following list of States is current as of January 31, 2019. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

DENTAL BENEFITS

This section describes the dental Benefits offered by MIT. The Schedules of Benefits describing the deductible, out-of-pocket maximums, co-payment and coinsurance requirements for each dental coverage option offered by MIT are included at the end of this SPD or provided separately to you. Capitalized terms have the meaning set forth later in this section.

General Description

Good dental care is important to maintaining overall good health. Regular check-ups and cleanings can resolve small problems before they become expensive procedures. MIT offers comprehensive dental coverage to meet the needs of you and your family. Under this dental Benefit, you are free to go to the dentist of your choice. The MIT dental Benefit covers diagnostic, preventive, basic and major dental services for you, your spouse, and your eligible Dependents (if elected) as well as orthodontic services for dependent children under age 19.

Online benefits portal

To assure the professional handling of your dental claims, we have engaged Planned Administrators, Inc. (PAI) as our claim administrator. Visit www.paisc.com to use the online benefits portal to view dental claims, deductible status, Explanation of Benefits and much more.

What You Pay For Benefits

Depending on the type of dental services, you pay:

- Deductibles,
- Coinsurance,
- Fees in excess of the coverage limits and maximum plan allowances, and/or
- Fees for services not covered by this dental Benefit.

Deductible

For some services, you and each covered dependent must pay an amount each calendar year toward Covered Dental Expenses before this dental Benefit begins to pay benefits. This is called a deductible. Once you reach your annual deductible, this dental Benefit pays a percentage of Covered Dental Expenses, subject to certain limits. A new deductible applies each calendar year.

Where the Schedule of Benefits indicates that a Covered Dental Expense does not apply toward satisfying a deductible under this dental Benefit, the cost of that Covered Dental Expense will not reduce the amount of deductible that you must meet in order to have your Covered Dental Expenses paid under this dental Benefit.

Coinsurance

The percentage of charges for Covered Dental Expenses you pay under this dental Benefit. For example, if this dental Benefit covers the service you receive at 80% of the allowed charge for the Covered Dental Expense, you pay the remaining 20% coinsurance. You also pay any amounts above the maximum coverage limit.

Coverage Limits
The maximum coverage limit per participant is set forth in the Schedule of Benefits included at the end of this SPD or provided separately to you. After this maximum coverage limit is reached, you will be responsible for all Covered Dental Expenses received by you or your covered Spouse or Dependents.

In addition, note that Covered Dental Expenses are limited to only Type A and Type B expenses during the first 12 months of your coverage, unless you enroll in MIT's dental Benefits when you first become eligible.

Dental Care Benefits

Covered Dental Expenses are those Reasonable and Customary charges made by your Dentist for services or procedures recognized by the current edition of The American Dental Association's *Current Dental Terminology* manual. These expenses must be incurred after you become covered under MIT's dental Benefit and not be listed in the Dental Exclusions and Limitations section of this SPD.

Examples of Covered Dental Expenses:

Preventive Care Expenses – Type A Benefits
These procedures consist of Diagnostic and/or Preventive services, such as:
- Periodic Oral Examinations
- Dental Prophylaxis
- Periodontal Maintenance
- Fluoride Treatment
- Bitewing X-Rays
- Sealants
- Space Maintenance
- Panoramic X-Rays
- Full Mouth X-Rays

Routine Restorative Expenses – Type B Benefits
These procedures consist of minor routine repair and maintenance services such as:
- Amalgam Fillings
- Denture Relining
- Surgical Extractions
- Repairs to Dentures
- Simple Extractions
- Anesthesia

Major Restorative Expenses – Type C, D, E Benefits
Type C procedures consist of Endodontic services such as:
- Pulp Capping
- Root Canal Therapy

Type D procedures consist of Periodontic services such as:
- Gingivectomy
- Periodontal Scaling and Root Planing

Type E procedures consist of Major Restorative and Prosthodontics, such as:

Dentures	Pontics
Crowns	Gold Inlays

Orthodontic Care Expenses – Type F Benefits
Type F procedures consist of Orthodontic services (only for covered dependent children under age 19).

Dental Exclusions and Limitations

MIT's dental Benefit does not cover, and Covered Dental Expenses do not include, charges incurred for:

1. Dental expenses incurred prior to the date you or the covered dependent (as applicable) were covered by this dental Benefit, or after coverage is terminated;

2. Illness or injury which result from service in the military, navy or air force of any country, combination of countries or international organization, or in any civilian non-combatant unit service with such forces;

3. Injury sustained in the commission of or the attempt to commit a felony;

4. Expenses to the extent that you or your covered dependent is reimbursed, entitled to reimbursement, or is in any way indemnified for such expenses by or through any public program, State or Federal, or any program of medical benefits sponsored and paid for by the Federal government or any agency thereof;

5. Services provided through a medical department, clinic, or similar facility provided by your or your covered dependent's employer, labor union, or mutual benefit association, or other similar group;

6. Expenses for any accidental bodily injury or sickness for which you or your covered dependent would be entitled to benefits under any worker's compensation or occupational disease policy (whether or not such policy is actually in force);

7. Services for which you or your covered dependent is not obligated to make payments;

8. Services and supplies primarily for cosmetic or aesthetic purposes;

9. The replacement of lost or stolen dentures or appliances or for any duplicate dentures or appliances;

10. All charges in connection with any services, treatment, or drugs prescribed, ordered or performed by you, your spouse or your covered dependent, or the parent, sister, brother, or child of you, your spouse, or your covered dependent;

11. Treatment other than by a physician or dentist, except for treatment performed under the supervision and direction of a dentist or physician by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations;

12. Any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five (5) years of the date previously placed;

13. Charges for replacement of tooth unless you or your covered dependent who incurred the charge was covered under this MIT dental Benefit when the tooth was extracted;

14. Charges for services for treatment of Temporomandibular Joint Dysfunction (TMJ);

15. Charges for myofunctional therapy or correction of harmful habits including, but not limited to, occlusal guards to minimize the effects of bruxism (grinding) and other occlusal factors or fixed or removable appliance therapy (Note: appliance therapy for thumb sucking or occlusal guards for periodontal disease are covered expenses);

16. Expenses incurred for intentionally self-inflicted injury or illness, unless due to a medical condition (either physical or mental) or domestic violence;

17. Any service which is covered under the Covered Medical Expenses of MIT's medical Benefits;

18. Denture replacement during the first 12 month period that you or your covered dependent receiving the replacement is covered under MIT's dental Benefit, unless the replacement is required because of the initial placement of an opposing full denture.

EMBEDDED BENEFITS

MIT provides you certain Embedded Benefits when you enroll in MIT medical Benefit coverage. These Embedded Benefits are listed at the end of this SPD and are described in the separate Certificates of Coverage or other summary documents that MIT will separately make available to you. You can access these documents on our website at www.scmamit.com.

If you have questions regarding the Embedded Benefits offered by MIT for any Plan Year, you can contact MIT directly at MITinfo@scmedical.org or 1-800-327-1021.

Coverage Pursuant To Medical Child Support Orders

A "**Qualified Medical Child Support Order**" or **"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 our 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 our 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; and
4. That group health coverage is desired and that it be identified and available.

Coverage for an Alternate Recipient under a 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 QMCSO will be subjected to the eligibility and enrollment provisions described earlier in this SPD.

The court order may not require our Plan to provide any type of form of benefit, or any option, not otherwise provided under our 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 our Plan. If a state has paid for medical services for the children under Medicaid for which our Plan was liable, the state may seek to recover those paid amounts from our Plan.

Participants and beneficiaries may obtain, without charge, a copy of our Plan's Procedures for Determining Status of Medical Child Support Orders by contacting MIT at MITinfo@scmedical.org or 1-800-327-1021 or visiting our website at www.scmamit.com.

COBRA CONTINUATION OF COVERAGE RIGHTS

Application of COBRA

If coverage for you or your eligible family members under the medical or dental Benefits offered by MIT ceases because of certain "special enrollment events" (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of an eligible dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1996 ("**COBRA**").

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

COBRA Notice

This notice is intended to inform you and your beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA. This notice is intended to reflect the law and does not grant or take away any rights under the law.

MIT is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by MIT to participants who become Qualified Beneficiaries under COBRA (as defined below).

COBRA Continuation Coverage

COBRA continuation coverage is the temporary extension of group health plan coverage (e.g. medical, dental) under MIT that must be offered to certain participants and their eligible family members (called "**Qualified Beneficiaries**") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the Plan (the "**Special Enrollment Event**"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Special Enrollment Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly-situated active employees who have not experienced a Special Enrollment Event (in other words, similarly-situated non-COBRA beneficiaries).

Qualified Beneficiaries

In general, a Qualified Beneficiary can be:

- any individual who, on the day before a Special Enrollment Event, is covered under the MIT Benefit by virtue of being on that day either a covered employee, the spouse of a covered employee (as recognized under federal law), or an eligible child of a covered employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the MIT Benefit under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will

be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Special Enrollment Event.

- Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and any individual who is covered by the MIT Benefit as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the MIT Benefit under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Special Enrollment Event.

The term "**covered employee**" includes any individual who is provided coverage under the MIT Benefit due to his or her performance of services for a Participating Employer and who participates in our Plan. However, this provision does not establish eligibility of these individuals. Eligibility for coverage under the MIT Benefit shall be determined in accordance with our Plan's eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Participating Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

A Qualified Beneficiary would not include a domestic or civil union partner or a grandchild of a covered employee although these individuals may be able to obtain continued coverage through the covered employee's COBRA election.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Special Enrollment Events

A Special Enrollment Event is any of the following if the Plan provides that the individual would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Special Enrollment Event) under the applicable MIT Benefit in the absence of COBRA continuation coverage:

- The death of a covered employee.

- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment with the Participating Employer.

- The divorce or legal separation of a covered employee from the employee's spouse. If the employee reduces or eliminates the employee's spouse's coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce

or legal separation may be considered a Special Enrollment Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

- A covered employee's enrollment in any part of the Medicare program.

- A dependent's or child's ceasing to satisfy the Plan's requirements for eligibility for the Benefit (for example, attainment of the maximum age for coverage).

- If the Special Enrollment Event causes the covered employee or his or her covered dependent to cease to be covered under the Benefit under the same terms and conditions as in effect immediately before the Special Enrollment Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered employee or his or her covered dependent for coverage under the Benefit that results from the occurrence of one of the events listed above is a loss of coverage.

- The taking of leave under the Family and Medical Leave Act of 1993 ("**FMLA**") does not constitute a Special Enrollment Event. A Special Enrollment Event will occur, however, if an employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Special Enrollment Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered employee and his or her dependents will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the MIT Benefit during the FMLA leave.

Factors To Be Considered

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy. Also, you should take into account that you have special enrollment rights under federal law (HIPAA). You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days (or longer, if permitted by that plan) after coverage ends under MIT due to a Special Enrollment Event listed above. You may also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Procedure for Obtaining COBRA Coverage

MIT conditions the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period. The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under our Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Special Enrollment Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Special Enrollment

Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

1. **Responsibility for Informing MIT of the Occurrence of a Special Enrollment Event**. We will offer COBRA continuation coverage to Qualified Beneficiaries only after MIT has been timely notified that a Special Enrollment Event has occurred. Your Participating Employer will notify MIT of the Special Enrollment Event within 30 days following the date coverage ends when the Special Enrollment Event is:

    - the end of employment with the Participating Employer or reduction of hours of employment;
    - death of the employee; or
    - enrollment of the employee in any part of Medicare.

    IMPORTANT: For the other Special Enrollment Events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify MIT in writing within 60 days after the Special Enrollment Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to MIT during the 60-day notice period, any spouse or child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to MIT using one of the methods listed below.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax, or email your notice to MIT at the address listed below:

Mail: MIT
P.O. Box 11188
Columbia, SC 29211
Fax: 803-731-4021
Email: MITinfo@scmedical.org

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the MIT Benefit under which you lost or are losing coverage,
- the name and address of the employee covered under the MIT Benefit,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Special Enrollment Event and the date it happened.

If the Special Enrollment Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once we receive *timely notice* that a Special Enrollment Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Benefit coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

2. **Effect of a Waiver**. If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to MIT, as applicable.

3. **COBRA Where Other Coverage or Medicare Available**. Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When COBRA Coverage May Be Terminated

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Special Enrollment Event and ending not before the earliest of the following dates:

- The last day of the applicable maximum coverage period;

- The first day for which Timely Payment is not made to MIT with respect to the Qualified Beneficiary;

- The date upon which your Participating Employer ceases to provide any group health plan to any employee (if your Participating Employer ceases to participate in MIT, your right to COBRA coverage through MIT will cease and your Participating Employer will be

responsible for providing a successor plan through which you may continue your COBRA coverage);

- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary;

- The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier);

- In the case of a Qualified Beneficiary entitled to a disability extension, the later of: (a) 29 months after the date of the Special Enrollment Event, or (b) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

- The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

MIT can terminate for cause the coverage of a Qualified Beneficiary on the same basis that MIT terminates for cause the coverage of similarly-situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

Maximum Coverage Periods

The maximum coverage periods are based on the type of Special Enrollment Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Special Enrollment Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Special Enrollment Event if there is not a disability extension and 29 months after the Special Enrollment Event if there is a disability extension.

2. In the case of a covered employee's enrollment in the Medicare program before experiencing a Special Enrollment Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered employee ends on the later of:

    - 36 months after the date the covered employee becomes enrolled in the Medicare program; or

- 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.

3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Special Enrollment Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

4. In the case of any other Special Enrollment Event than that described above, the maximum coverage period ends 36 months after the Special Enrollment Event.

5. If a Special Enrollment Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Special Enrollment Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Special Enrollment Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Special Enrollment Event. **MIT must be notified by the Qualified Beneficiary of the second special enrollment event within 60 days of the second special enrollment event.** This notice must be sent to MIT in accordance with the procedures above.

6. A disability extension will be granted if an individual (whether or not the covered employee) who is a Qualified Beneficiary in connection with the Special Enrollment Event that is a termination or reduction of hours of a covered employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. **To qualify for the disability extension, the Qualified Beneficiary must also provide MIT with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.** This notice must be sent to MIT in accordance with the procedures above.

Payment for COBRA Coverage

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage are required to pay 102% of the applicable premium and 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. MIT will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Payment for COBRA continuation coverage may be made in monthly or other installments, as approved by MIT.

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. However, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. In addition, if Timely

Payment is made in an amount that is not significantly less than the amount required to be paid for a period of coverage, MIT will notify you of the amount of the deficiency and grant a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount. Payment is considered made on the date on which it is postmarked to MIT.

Availability of Conversion Health Plan at End of COBRA

If a Qualified Beneficiary's COBRA continuation coverage ends as a result of the expiration of the applicable maximum coverage period, MIT will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly-situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Alternative to COBRA

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

1. **Health Insurance Marketplace**: The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you (or your dependent) could be eligible for a new kind of tax credit that lowers any monthly premiums and cost-sharing reductions (amounts that lower the out-of-pocket costs for deductibles, coinsurance, and copayments) right away. The Marketplace shows what the premium, deductibles, and out-of-pocket costs will be before you (or your dependent) must make a decision to enroll. The Marketplace also provides the qualifications for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). The Marketplace can be accessed for each state at www.HealthCare.gov.

   Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit eligibility for coverage or for a tax credit through the Marketplace.

2. **Marketplace enrollment**: Upon a special enrollment event, you (or your dependent) will have a 60-day special enrollment period in which to enroll in the Marketplace. After 60 days the special enrollment period will end and the next available time to enroll in the Marketplace is during what is called an "open enrollment" period when anyone can enroll in Marketplace coverage.

   To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and special enrollment events and special enrollment periods, visit www.HealthCare.gov.

3. **Coordination Between COBRA Continuation Coverage and Marketplace Coverage**: A switch to coverage under the Marketplace after COBRA continuation coverage has been selected may occur during a Marketplace open enrollment period. Otherwise, COBRA continuation coverage can be ended early and a switch made to a Marketplace plan if and

only if there is another special enrollment event such as marriage or birth of a child through something called a "special enrollment period." Without another special enrollment event, eligibility to enroll in the Marketplace coverage will not be available until the next open enrollment period.

Additionally, once the maximum COBRA continuation coverage period available to you has expired (and you have paid the cost of coverage until such date), a special enrollment period allows enrollment in the Marketplace, even if Marketplace open enrollment has ended.

A switch to coverage under COBRA continuation coverage after Marketplace coverage has been selected is not allowed under any circumstances.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact MIT directly at MITinfo@scmedical.org or 1-800-327-1021. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("**HIPAA**"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("**EBSA**"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Update Your Address

In order to protect your family's rights, you should keep MIT informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to MIT.

CLAIMS AND APPEALS

The following claims procedures apply to all claims for medical and dental Benefits offered under our Plan. The claims procedures for Embedded Benefits are included in the Certificate of Coverage or summary that will be provided to you.

General Claims Information

Medical/Dental. MIT has hired Planned Administrators, Inc. to process medical (but not prescription drug) and dental Claims on behalf of our Plan. Planned Administrators can be contacted at:

> **Planned Administrators, Inc.**
> Attention: Claims
> P. O. Box 6927, Columbia, SC 29260
> Telephone: 1-800-652-3076
> Fax: 803-870-8012 (specify "Attention: Claims")
>
> For prompt processing, if you are submitting an in-state claim, please designate "Payor Code 886"; if you are submitting an out-of-state claim, please designate "Payor Code 37287"

Prescription Drugs. MIT has hired Express Scripts to process prescription drug Claims on behalf of our Plan. You should present your prescription drug ID card at the participating retail pharmacy. If you have paid full price at a retail pharmacy or need to submit Claims, you must complete the Express Scripts Prescription Drug Reimbursement Form, which can be obtained on our website at www.scmamit.com or by contacting MIT at MITinfo@scmedical.org or 1-800-327-1021. You must submit your completed Prescription Drug Reimbursement Form to Express Scripts at:

> **Express Scripts**
> ATTN: Commercial Claims
> P.O. Box 14711
> Lexington, KY 40512-4711

If your pharmacy needs to contact Express Scripts, please have them call 800-922-1557.

Claims for Physician's Employees
If claims are submitted for treatment provided by a Participating Employer for its employees who are covered by our Plan, such claims must be submitted with payment assigned to the Participating Employer. This Plan will not reimburse a Participating Employer's employees directly for care provided by their Participating Employer. MIT believes this to be a prudent fiscal policy that is in line with its goal of assuring sound financial management of our Plan.

No Assignment
Most providers are will file claims for you. If your provider does not file your claim for you, you should call MIT or the Customer Service phone number on your benefit ID card and ask for a

claim form. However, regardless of who files a claim for benefits under our Plan, our Plan will not honor an assignment by you of payment of your claim to anyone. What this means is that our Plan will only pay covered benefits to you or your in-network provider (as may be required by our or our network providers' contract with your in-network provider) – even if you have assigned payment of your claim to someone else. If you or the provider owes our Plan money, we may deduct the amount owed by the benefit paid, to the maximum extent permitted by law. When our Plan pays you or the provider (subject to the aforementioned deductions), this completes our obligation to you under our Plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our Plan obligation to you. Special rules apply to treatment provided by a Physician for his/her employees, as described under *Claims for Physician's Employees* above.

Definitions

The following defined terms used within these Claims and Appeals Procedures have the following meanings:

Adverse Benefit Determination or Adverse Appeal Determination - Any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under our Plan. 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 our 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 medical or dental Benefit offered under our 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. A "rescission" is a cancellation or discontinuance of coverage that has retroactive effect; provided, however, a cancellation or discontinuance shall not be a "rescission" if (1) the cancellation or discontinuance of coverage has only prospective effect, or (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless you pay the entire cost, is <u>not</u> 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 our Plan). Similarly, if a network 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 our Plan) such a decision is not considered an Adverse Benefit Determination.

Authorized Representative - 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 (which may be obtained from Planned Administrators or MIT) to Planned Administrators designating such an individual. Planned Administrators may request additional information to verify that the designated person is authorized to act on your behalf. 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. References in these Claims and Appeals Procedures to the "Claimant" or "you," include (where appropriate) an Authorized Representative.

Claimant - Any individual covered by our Plan or his or her Authorized Representative who files a Claim with our Plan.

Claim - A request for Plan benefits or payment made by a Claimant in accordance with our 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 our 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 our 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 our Plan. Similarly, interactions between a covered individual and network providers do not constitute Claims in cases where the providers exercise no discretion on behalf of our 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 these Claim Procedures.

A request for Pre-certification or Prior Authorization of a benefit that does not require Pre-certification or Prior Authorization by our Plan is not considered a Claim. However, requests for Pre-certification or Prior Authorization of a benefit where our 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.

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

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

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

Relevant Documents - Includes documents pertaining to a Claim if they were relied upon in making the Adverse Benefit Determination, were submitted, considered or generated in the course of making the Adverse Benefit Determination, demonstrate compliance with MIT's or Planned Administrator's administrative processes or safeguards, or constitute our Plan's policy or guidance with respect to the denied treatment option or benefit, whether or not relied upon. Relevant

Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that our Plan's rules were appropriately applied to a Claim.

Urgent Claim - 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. This 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 Planned Administrators of such, it will be treated as an Urgent Claim.

Utilization Review Decision - Any decision based on the medical necessity or medical appropriateness of a requested medical care or treatment or benefit payment.

Claims Procedures
(Medical (including Prescription Drug) & Dental Only)

Pre-Service Claims

Pre-certification - A Pre-Service Claim is a Claim for a benefit for which our 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. This 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.

Prior Authorization - Like Pre-certification, Prior Authorization is a Pre-Service Claim for a benefit for which our 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.

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 Determination within 15 days of Planned Administrators' receipt of the Claim. If additional time is needed due to matters beyond the control of our 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). Planned Administrators will then notify you of our Plan's Initial Benefit Determination within 15 days.

In the case of a failure by you to follow our Plan's procedures for filing a Pre-Service Claim, you will be notified of the failure and the proper procedures to be followed in filing a Claim for benefits. This notification will be provided to you 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. 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.

A Pre-Service Claim that is also an Urgent Claim will be treated as an Urgent Claim and handled as described below.

Urgent Claims

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

For properly filed Urgent Claims, you will be notified of an 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 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 must provide the specified information to Planned Administrators within 48 hours. If the information is not provided within that time, the Claim will be denied.

During the period in which you 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 respond to the request, whichever is earlier. You 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 to provide this information, whichever is earlier.

If you improperly file an Urgent Claim with MIT or our Plan (and your Claim names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested), we will notify you 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 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.

Concurrent Claims

If you have been notified by our 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 Planned Administrators 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 an Urgent Care, Planned Administrators will respond to your request within 24 hours of receipt of the Claim, provided that the Claim is received by Planned Administrators at least 24 hours prior to the expiration or reduction of the applicable treatment.

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.

Post-Service Claims

A Post-Service Claim, or Claim made after medical service is received, must be submitted to Planned Administrators in writing at the above address, using the appropriate Claim form, within **180 days** after expenses are incurred.

If you do not submit your Claim by this deadline, you will <u>not</u> be eligible to receive payment or reimbursement for the expenses incurred and you will be responsible for payment of such expenses (unless MIT determines that it was not reasonably possible to file the Claim within such time and the Claim was submitted as soon as reasonably possible, but subject to the Plan's overall deadline as described under *Proof of Loss* below). 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 at the above address.

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 Planned Administrators. Ordinarily, Claimants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by Planned Administrators. Planned Administrators may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of our 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 Planned Administrators expects to render a decision.

If an extension is required because Planned Administrators needs additional information from you, Planned Administrators 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. Planned Administrators then has 15 days to make a decision on the Claim and provide you with the Initial Benefit Determination.

If Planned Administrators 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 Planned Administrators' 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.

Authorized Representatives

Your Authorized Representative may submit a Claim or Appeal on your behalf if you have previously designated the individual to act on your behalf (see Definitions above).

Notice of Initial Benefit Determination

Planned Administrators 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 our Plan's appeal procedures, available external review process, 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); and
- A statement of your right to request the diagnosis and treatment codes (and their meanings) related to the determination.

Appeal Procedures

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 MIT within 180 days after receipt of the Notice of Adverse Benefit Determination. If you fail to timely submit an appeal, you will not be eligible to receive payment or reimbursement for the expenses incurred and you will be responsible for payment of such expenses.

MIT Appeals
P. O. Box 11188
Columbia, SC 29211
Fax: 803-731-4021
MITinfo@scmedical.org

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

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 Relevant Documents that are in the Plan's possession. 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 will 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 our 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.

Timeframes for Sending Notices of Appeal Determinations

1. **Pre-Service Claims or Concurrent Claims that are not Urgent Claims**. Notice of the appeal determination for Pre-Service Claims will be sent no later than 30 days after receipt of the appeal by MIT.
2. **Urgent Claims or Concurrent Claims that are Urgent Claims.** Notice of the appeal determination for Urgent Claims will be sent no later than within 72 hours after receipt of the appeal by MIT.
3. **Post-Service Claims.** Decisions on appeals involving Post-Service Claims will be made no later than 60 days following receipt of the appeal by MIT.

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 Appeal Determination is based;
- A statement that you or your covered dependent are entitled to receive reasonable access to and copies of all Relevant Documents, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an Adverse Appeal Determination;
- 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.

Continued Coverage During Appeal.

You will be entitled to continued coverage pending the outcome of your appeal to the extent mandated by the Patient Protection and Affordable Care Act. For this purpose, the Plan will comply with the requirements of ERISA Section 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. If you are receiving Urgent Care or an ongoing course of treatment, you may be allowed to proceed with an expedited external review at the same time as the Plan's appeals process, under either a state external review process or the federal external review process, in accordance with the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners, as applicable.

When a Lawsuit May Be Filed

You may not file a lawsuit to recover benefits under our 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.

External Appeals

After you have completed the appeals process, you may be entitled to an additional, external review of your Claim at no cost to you. An external review may be used to reconsider your Claims if MIT has denied, either in whole or in part, your Claim. In order to qualify for external review, your Claim must have been denied, reduced, or terminated.

After you have completed the appeal process (and an Adverse Benefit Determination has been made), you will be notified in writing of your right to request an external review. You should file a request for external review within four (4) months of receiving the notice of the decision on your appeal. In order to receive an external review, you will be required to authorize the release of your medical records (if needed in the review for the purpose of reaching a decision on your claims).

Within six (6) business days of the date of receipt of your request for an external review, MIT will respond by either:

1. Assigning your request for an external review to an independent review organization and forwarding your records to such organization; or,
2. Notifying you in writing that your request does not meet the requirements for an external review and the reasons for the decision.

The external review organization will take action on your request for an external review within forty-five (45) days after it receives the request for external review from MIT. Expedited external reviews are available if your physician certifies that you have 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 your health in serious jeopardy. If you may be held financially responsible for the treatment, you may request an expedited review of MIT's denial of benefits if MIT's denial of benefits involved emergency medical care and you have not been discharged from the treating facility.

Assistance with Internal Claims and Appeals and External Review Process

MIT 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
1-800-327-1021
Fax: 803-731-4021
MITinfo@scmedical.org

Legal Actions

No action may be brought to recover under our Plan until 60 days after proof of loss has been given. No action can be brought after 3 years from the date written proof of loss was required to be furnished.

Right to Recovery

If the amount of payment for claims by our Plan is more than should have been paid under our 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.

Proof of Loss

Notwithstanding any other provision in our Plan to the contrary, in no event will an expense be considered for payment under our Plan if proof for that expense is furnished more than 12 months after the date the expense was incurred.

Physical Examination and Autopsy

MIT or its delegate 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 MIT.

COORDINATION OF BENEFITS

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

The COB provision applies to a:

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

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:

1. the plan covering a person as an employee rather than as a dependent is primary; and
2. 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.
3. the rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:
   a) 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;
   b) 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;
   c) the word "birthday" only refers to month and day of a calendar year, not the year in which the person was born;
   d) if the other plan does not have the rule described in a, b, and c 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.
4. if two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
   a) the plan of the parent with custody of the child;
   b) the plan of the spouse of the parent with the custody of the child;
   c) the plan of the parent not having custody of the child;
   d) 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.
   e) 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.

Allowable Expense

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

1. a medical service or supply which is covered, at least in part, under either plan; or
2. a dental service or supply which is listed as a covered expense under our Plan.

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

Benefit Determination Period

A calendar year (January 1 through December 31), but excluding any portion occurring prior to the effective date of an individual's coverage or after the termination date of an individual's coverage under our Plan.

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

1. benefits otherwise payable under our Plan; or
2. the difference between allowable expense and the benefits paid or payable by other plans for these same expenses.

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another plan may include an amount which should have been paid under our Plan. If it does, MIT may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under our Plan. MIT 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.

Right of Recovery

If the amount of the payments made by MIT 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/SUBROGATION

Benefits are not payable to or for an individual covered under the medical or dental Benefits offered under our Plan when the Injury or Illness to the covered individual occurs through the act or omission of another person. However, MIT may elect to advance payment for eligible expenses incurred for an Injury or Illness in which a third party may be liable. For this to happen, the covered individual must sign an agreement with MIT to pay MIT in full any sums advanced to cover such 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 our Plan for those incurred medical or dental expenses automatically assigns to our Plan any rights you may have to recover payments from any third party or insurer. This subrogation right allows our Plan to pursue any claim that you may have against any third party or insurer whether or not you choose to pursue that claim. This Plan may make a claim directly against the third party or insurer, but in any event, our 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 our Plan is repaid in full.

As a covered individual in our Plan, you agree that you will:

1. automatically assign to our Plan your rights against any third party or insurer when this provision applies; and
2. repay to our 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 our Plan's right to subrogation and reimbursement. These rights provide our 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, our Plan's subrogation and reimbursement rights, as well as the rights assigned to it, are limited to the extent to which our Plan 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 our Plan. However, our Plan's right to subrogation still applies if the recovery received by you or your covered dependent is less that the claimed damage, and as a result, you or your covered dependent 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 our Plan's right of subrogation as a condition to having our Plan make payments. In addition, you agree to do nothing to prejudice the right of our Plan to subrogate.

Defined Terms

The following defined terms apply to these COB provisions:

Recovery - 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 our Plan.

Subrogation - This Plan's right to pursue your claims for medical or dental charges against another third party.

Refund - Repayment to our Plan for medical or dental benefits that we have 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.

Constructive Trust and Lien Right

By accepting benefits from our Plan, you agree to serve as a constructive trustee and to hold in constructive trust such money or property resulting from any payments from a responsible party. Further, you agree not to dissipate any such money or property without prior written consent of MIT, regardless of how such money or property is classified or characterized. Failure to hold such funds in trust will be deemed a breach of our Plan.

This Plan and MIT will automatically have a lien to the extent of benefits paid by our Plan for illness, injury, condition, or losses for which the responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgement or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by our Plan including, but not limited to, you, your representative or agent, a responsible party, a responsible party's insurer, a responsible party's representative or agent, and any/or any source possessing funds representing the amount of benefit paid by our Plan.

Cooperation

By participating in our Plan, you automatically agree to (i) promptly assign all subrogation rights to our Plan and MIT for full or partial reimbursement without reduction for attorneys' fees, expenses, or costs; (ii) promptly execute any documents and instruments, including a reimbursement and subrogation agreement, and take any action that MIT considers necessary to protect its rights; (iii) not take any actions (or non-actions) that could jeopardize or prejudice our Plan's or MIT's position or rights (including refraining from making any settlement or recovery that attempts to reduce or recover or exclude the full cost of all benefits provided by our Plan); (iv) notify MIT in writing within thirty (30) days following the date any notice is given to any party of your intention to pursue or investigate a claim due to injury, illness, condition, or other loss covered under our Plan; and (v) refrain from releasing any responsible party or funds that may be liable for or obligated to you for the illness, injury or conditions covered under our Plan without obtaining MIT's written approval.

If you fail to comply with the provisions of this subrogation and reimbursement section, our Plan may suspend payments of further benefits in connection with an illness, injury, or condition covered under our Plan, remove you from coverage under our Plan, or offset benefits already paid against future benefits for you under our Plan. If you fail to reimburse our Plan or MIT out of any

recovery or reimbursement received as a result of a covered illness, injury or condition, you will be liable for any and all expenses (whether fees or costs) associated with our Plan's or MIT's attempt to recover such money from you.

Interpretation

The provisions of this COB section shall apply regardless of whether liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by you identifies the benefits our Plan provided or purports to allocate any portion of such recovery to payment of expenses other than expenses paid by our Plan. MIT is entitled to recover from any and all settlements, judgments, or other recoveries, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Except as specifically delegated in the *Claims and Appeals Procedures* section, MIT retains sole and final discretion for interpreting the terms and conditions of our Plan, as well as making all necessary factual determinations with respect to our Plan and our Plan document. MIT shall not recognize the "made whole doctrine" or the "full compensation doctrine" in interpreting the terms and conditions of our Plan. The rights described in this section shall bind you, your guardian, your estate, your executor, your personal representatives, and your heir(s).

PROVISIONS APPLICABLE TO ALL MIT BENEFITS

No Reliance

Any representations or statement made to you by MIT or its representatives or agents about being covered for benefits under our Plan but which disagree with the provisions of our Plan shall not:

1. Be considered as representations or statements made by, or on behalf of, our Plan;
2. Bind our Plan for coverage, benefits, or otherwise under our Plan; or
3. Be enforceable or valid.

Amendment or Termination

MIT reserves the right to terminate, suspend, withdraw, amend or modify our Plan at any time. Any such change or termination in benefits will be based solely on the decision and sole discretion of MIT and may apply to active employees, future retirees, and current retirees as either separate groups or as one group. If the Plan or any coverage option terminates or changes, any claims for eligible expenses incurred while the Plan or coverage option was in effect will continue to be processed under the Plan's standard claim payment rules. Any claims incurred by you or a covered dependent after the termination of the Plan or coverage option will not be considered an eligible expense under the Plan or coverage option regardless of when the expense is submitted. In the event the Plan is amended to materially reduce a covered service or benefit, you will be notified of the reduction no later than 60 days after the amendment is adopted.

Interpretation of Plan

Notwithstanding anything to the contrary in our Plan or any other document, writing or communication (verbal or written):

1. MIT 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, our Plan;
2. MIT 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, our Plan;
3. Except as may be otherwise provided in paragraph 4 immediately below, to the extent MIT or any network provider or other delegate of MIT sets forth provisions, terms, conditions or requirements which are in addition to, or greater or more stringent than, any of those in our Plan, or which impose more limitations or restrictions than any of those in our Plan, then such applicable provision, term, condition or requirement of MIT, such network provider, or such delegate shall absolutely control, govern and supersede.

Participating Employer Responsibilities

Without limiting any other provision of our Plan or MIT as to each Participating Employer's responsibility and obligation in connection with our Plan and to MIT, each Participating Employer shall be solely and exclusively responsible for the following obligations in relation to our Plan as to that portion sponsored by such Participating Employer, as plan sponsor:

a. Any and all required reporting under the Employee Retirement Security Act of 1974, as amended ("**ERISA**"), Internal Revenue Code of 1986, as amended (the "**Code**"), or other applicable law to one or more of the United States Department of Labor, Internal Revenue Service, or other applicable governmental agencies, departments and instrumentalities,
b. Any and all disclosures required to be made to such Participating Employer's employees and other applicable individuals as required under one or more of ERISA, the Code and other applicable law,
c. Any and all notices, documents and other writings required to be issued to such Participating Employer's employees and other applicable individuals pursuant to one or more of ERISA, the Code and other applicable law, and
d. Any and all compliance obligations under the employer shared responsibility requirements of the ACA, including determination as to whether such Participating Employer is an "applicable large employer" under such Act; determination of the look-back period for identifying full-time employees and tracking their hours and determining their eligibility for participation in accordance with the ACA; and preparation and delivery of statements and reporting (including on Forms 1094-C and 1095-C).

Electronic Forms

To facilitate efficient operation of the Plan, MIT may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

Nondiscrimination Requirement

It is the intent of our Plan not to discriminate in violation of the Internal Revenue Code, ERISA or applicable law. If MIT deems it necessary to avoid discrimination under the Internal Revenue Code, ERISA or applicable law, it may, but shall not be required to, either aggregate or separate any coverage options included within our Plan or limit the participation by any Participating Employer or the benefits of any participant, as it determines in its sole discretion is necessary or advisable in order to comply with such laws. Any act taken by MIT under this section will be carried out in a uniform and nondiscriminatory manner.

No Guarantee of Tax Consequences

Neither MIT nor any Participating Employer makes any commitment or guarantee that any amounts paid to or for your benefit under the Plan will be excludable from your gross income for federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to you. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for Federal and state income tax purposes, and to notify MIT if you have reason to believe that any such payment is not so excludable.

Indemnification of Plan by Participants.

If you receive one or more payments or reimbursements under the Plan that are not for a permitted benefit under the Plan, you must indemnify and reimburse the Plan, MIT and your Participating Employer for any liability that any of them may incur for failure to withhold Federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and state income tax (plus any penalties) that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any

Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by you.

Severability.

If any provision of this SPD is held illegal or invalid for any reason, the remaining provisions are to remain in full force and effect and to be construed and enforced in accordance with the purposes of the Plan as if the illegal or invalid provision did not exist.

Facility of Payment.

If at any time you are, in the judgment of MIT, legally, physically or mentally incapable of receiving any distribution or benefits due to you, the distribution or benefit may, if MIT so directs and the law allows, be made to your guardian or legal representative, or, if none exists, to any other person or institution that, in MIT's judgment, will apply the distribution in your best interests.

Prohibition on Rescissions.

The Plan will not rescind coverage with respect to any individual once the individual is covered under the Plan, except where the individual has committed an act of fraud, intentional misrepresentation of material fact, or other permitted circumstances, all as described in the ACA. Where coverage is permitted to be cancelled, MIT or its delegate will provide prior notice of cancellation to the individual as required by the ACA.

ERISA INFORMATION

If you participate in our 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 booklet, comprises the SUMMARY PLAN DESCRIPTION under ERISA:

Plan Name:
South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust (MIT)

Sponsor Name and Address:
South Carolina Medical Association
P.O. Box 11188
Columbia, SC 29211
803-798-6207 (in Columbia) or 1-800-327-1021 (statewide)

NOTE: A complete list of the Participating Employers sponsoring our Plan may be obtained by participants and beneficiaries upon written request to MIT, 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 (SCMA/MIT)
P.O. Box 11188
Columbia, SC 29211
803-798-6207 (in Columbia)
1-800-327-1021 (statewide)

Type of Administration

This Plan is administered by MIT, as 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 MIT at the address listed above.

Plan Trustees
The Board of Trustees of the South Carolina Medical Association Members' Insurance Trust. The names and addresses of the current individual members of the Board of Trustees are on file at MIT's office and are available on request.

Termination of Plan
The right is reserved for MIT to terminate, suspend, withdraw, amend, or modify our Plan, in whole or in part, at any time.

Contributions
Contributions are made by Participating Employers and participants. Contributions are calculated and based upon the estimated cost of operating our Plan.

Plan Funding Medium
Benefits are provided under a Trust.

Plan Year
The financial records of our Plan are kept on a Plan Year basis commencing each July 1 and ending June 30th. However, all Deductibles and out-of-pocket maximum apply on a calendar year basis, and annual open enrollment is conducted annually with a January 1 effective date.

Provider Network
A copy of the applicable provider network listing is available, free of charge, upon request or can be accessed at the paisc.com website under the 'Members' tab. For pharmacy network information, please visit Express Scripts' website at www.express-scripts.com.

STATEMENT OF RIGHTS UNDER ERISA

Plan participants, eligible employees and all other employees of each Participating Employer may be entitled to certain rights and protections under ERISA and the Code. These laws provide that participants, eligible employees and all other employees are entitled to:

Receive Information About Your Plan and Benefits.

- Examine, without charge, at MIT's offices, all Plan documents, including insurance contracts, collective bargaining agreements (if any), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to MIT. MIT may charge a reasonable fee for the copies.

COBRA and HIPAA Rights.

- Continue health coverage for a participant or covered dependents if there is a loss of coverage under the Plan as a result of a special enrollment event. Participants or covered dependents may have to pay for such coverage. Review the section entitled *COBRA Continuation of Coverage* for the rules governing COBRA continuation rights.

Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

Enforcement.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request MIT to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons

beyond the control of MIT. 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 Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court 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 costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions.

If you have any questions about the Plan, you should contact MIT at 1-800-327-1021 or at the address in the General Information Section at the beginning of this booklet. If you have any questions about this statement, or about your rights under ERISA or HIPAA or if you need assistance in obtaining documents from MIT, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PRIVACY STATEMENT: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

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 Participating 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.

This Plan's 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, our 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 our 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, our Plan may share information about you with your separate dental Benefit 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 your 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 your (and your 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 our 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 our Plan, 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 or Participating Employers; and
    - 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 our Plan includes a description of such additional uses/disclosures in its Notice of Privacy Practice. The following are examples of such uses/disclosures for our Plan to consider including:

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

- *Public Health and Health Oversight Activities*. This 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. This 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*. This Plan may disclose your PHI in response to a court order or an administrative order. This 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, our Plan is required to make sure you or your covered dependent are aware of the request or obtain an assurance that your PHI will be used appropriately.
- *Law Enforcement*. This 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*. This 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*. This 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*. This Plan may be required to disclose limited PHI to the extent our 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*. This Plan may be required to disclose your PHI to the United States or a State government if you or your covered dependent are an active or veteran member of the military, seeking a government security clearance or permission to travel abroad, if you or your covered dependent are in lawful custody, or if the government requires such information to conduct lawful national security activities.
- *Worker's Compensation*. This Plan may disclose your PHI as authorized by the state's workers' compensation laws.

No Disclosures Other Than As Permitted by Law. This Plan will use and disclose PHI as required by law and as permitted by your written authorization. Only with your written authorization will our Plan disclose PHI to pension plans, disability plans, workers' compensation insurers, etc.) for purposes related to administration of these plans.

No Sale or Marketing. This Plan will never sell your PHI or use your PHI for marketing purposes without your prior, written permission.

Disclosures to MIT. For purposes of this section, MIT is the Plan Sponsor. To the extent that PHI is disclosed to MIT, SCMA, MIT has agreed 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 MIT provides PHI received from our Plan agree to the same restrictions and conditions that apply to MIT 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 MIT unless authorized by the individual in writing;
- Report to our Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which MIT 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 our Plan available to the Secretary of HHS for the purposes of determining our Plan's compliance with HIPAA. If feasible, return or destroy all PHI received from our Plan that MIT 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.

Disclosures to Participating Employers. Under no circumstances will your PHI be shared with your Participating Employer, except where you have specifically authorized such release in writing or where such information has been de-identified in accordance with HIPAA so that your information is no longer capable of being attributed to you.

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

- SCMA or MIT staff designated by MIT
- 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
- SCMA Executive Director

The persons described above may only have access to and use and disclose PHI for Plan administration functions that MIT performs for our Plan. If the persons described above do not comply with our Plan document, MIT shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Hybrid Entity Designation. For purposes of complying with the HIPAA privacy rules, our Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. This Plan

designates that its health care components that are covered by the privacy rules include only health benefits and no other plan functions or benefits.

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

- To put additional restrictions on our 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, our Plan does not have to agree to your request.
- To ask our Plan to communicate with you in confidence about your PHI by a different means or at a different location than our Plan is currently using. This 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 our 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, our Plan does not have to agree to your request.
- To correct your PHI that is created or maintained by our Plan. In some cases, our 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 our 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). This 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 MIT Contact at the address provided below. He or she will give you the necessary information and forms for you to complete and return. In some cases, our Plan may charge you a nominal, cost-based fee to carry out your request.

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

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 our Plan at the following Contact Office:

Contact Office:	SCMA Members' Insurance Trust
Privacy Officer:	Chief Legal Officer
Telephone:	803-798-6207
Fax:	803-731-4021
Email:	MITinfo@scmedical.org
Address:	P.O. Box 11188, Columbia, SC 29221

Security Protections. MIT has taken the following steps to protect your PHI:

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 as discussed 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 our Plan a 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 premiums:

MIT

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.

MEDICAL BENEFIT OPTIONS

ALL MEDICAL BENEFIT OPTIONS

- Emergency services are paid at the in-network benefit level, regardless of provider.
- This Plan will pay at in-network benefit levels for covered services rendered by out-of-network radiologist, anesthesiologist, and pathologist when you or your covered dependent are receiving services from an in-network provider at an in-network hospital or emergency department.
- Specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill. Contact MIT directly for more information.
- Covered preventive benefits are paid at 100% when services are rendered by an in-network provider.
- Step Therapy is required.

Please Also Note for all Major Medical Options

- 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
- Prescription co-payments for a 90-day supply through mail order pharmacy are two and half (2½) times the retail co-payment for a 30-day supply.
- Pre-certification/prior authorization is required for all in-patient admissions and certain outpatient procedures. The penalty for noncompliance is a $500 benefit reduction. The first penalty that would otherwise be owed by you as a result of any noncompliance by you or your covered dependents will be waived and a written notification will be issued.
- Certain Specialty Non-EHB Drugs are classified as non-essential health benefits under Major Medical Plans and have a significantly higher co-payment, and the cost of these drugs does not apply to the deductible and out-of-pocket maximum. You will, however, be able to participate in the SaveOnSP program in order to obtain these drugs at no cost to you.

Please Also Note for Premier Plus, Prime Plus, Select Plus, Value, and Value Plus Options:

- 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.
- Prescription co-payments for a 90-day supply through mail order pharmacy are two and half (2½) times the retail co-payment for a 30-day supply. Pre-certification/prior authorization is required for all in-patient admissions and certain outpatient procedures.

The penalty for noncompliance is a $500 benefit reduction. The first penalty that would otherwise be owed by you as a result of any noncompliance by you or your covered dependents will be waived and a written notification is issued.

- Certain Specialty Non-EHB Drugs are classified as non-essential health benefits under Premier, Prime and Select Plans and have a significantly higher co-payment, and the cost of these drugs does not apply to the deductible and out-of-pocket maximum. You will, however, be able to participate in the SaveOnSP program in order to obtain these drugs at no cost to you.

Please Also Note for all HDHP Options:

- Our HDHPs are designed to permit you to contribute to a health savings account (HSA), which can be established through any bank or financial institution that you choose. You can find a link or contact information for common HSA providers on our website at www.scmamit.com.

Plan 1 – Major Medical Choice Plus

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, Outpatient 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 of 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 Outpatient)		
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		
Prescription Drugs, except Specialty Non-EHB Drugs	80%	50%
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation*	

** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 2 – Major Medical HD 1000

SCHEDULE OF BENFITS		
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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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		
Prescription Drugs, except Specialty Non-EHB Drugs	80%	50%
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation*	

** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 3 – 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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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%	
Prescription Drugs	100%	50%

Plan 4 – Premier Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$1,750/person	$3,500/family
Out-of-Network Aggregate Deductible	$3,500/person	$7,000/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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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	$30
In-network Office Visit** Co-pay for Specialist	$60
Prescription Card	$12/40/100
Specialty Drug Co-pay (except Non-EHB)	$250
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation***

** Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit.*
**** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 5 – Major Medical HD 2000 Enhanced

SCHEDULE OF BENFITS		
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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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 Specialist	$50
Prescription Card	$5/35/60
Rx $500-999	$65
Rx $1000-1499	$130
Rx $1500-2000	$200
Rx above $2000	$275
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation**

**Excludes any other procedures performed during the visit.*
*** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 6 – 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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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%	
Prescription Drugs	80%	50%

**Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*

Plan 7 – 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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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%	
Prescription Drugs	100%	50%

Plan 8 – Prime Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$2,750/person	$5,500/family
Out-of-Network Aggregate Deductible	$5,000/person	$10,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$7,900/person	$15,800/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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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	$30
In-network Office Visit** Co-pay for Specialist	$60
Prescription Card	$12/40/100
Specialty Drug Co-pay (except Non-EHB)	$250
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation***

**Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit.*
**** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 9 – 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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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%	
Prescription Drugs	100%	50%

Plan 10 – Select Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$3,250/person	$6,500/family
Out-of-Network Aggregate Deductible	$6,500/person	$13,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$7,900/person	$15,800/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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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	$30
In-network Office Visit** Co-pay for Specialist	$60
Prescription Card	$12/40/100
Specialty Drug Co-pay (except Non-EHB)	$250
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation***

**Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit.*
**** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 11 – 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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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%	
Prescription Drugs	100%	50%

Plan 12 – Value

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$4,500/person	$9,000/family
Out-of-Network Aggregate Deductible	$9,000/person	$18,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$7,900/person	$15,800/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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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 Specialist	$60
Prescription Card	$12/40/100
Specialty Drug Co-pay (except Non-EHB)	$250
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation***

** Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit.*
**** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 13 – Major Medical HD 5000

SCHEDULE OF BENFITS		
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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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		
Prescription Drugs, except Specialty Non-EHB Drugs	80%	50%
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation*	

** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 14 – Value Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$7,900/person	$15,800/family
Out-of-Network Aggregate Deductible	$10,000/person	$30,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$7,900/person	$15,800/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
Outpatient Surgery, Outpatient 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 of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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)	100%	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 Specialist	$60
Prescription Card	$12/40/100
Specialty Drug Co-pay (except Non-EHB)	$250
Specialty Non-EHB Drugs	When implemented, 0% but 100% coverage is available at no cost to you through SaveOnSP Program participation***

** Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit.*
**** Until the SaveOnSP Program is implemented, Specialty Non-EHB Drugs will be covered as Prescription Drugs.*

Plan 15 – HDHP Option VII

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$5,000/single	$10,000/family
Out-of-Network Aggregate Deductible	$10,000/single	$30,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,900/single	$13,800/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
Outpatient Surgery, Outpatient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	90%	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
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	90%	
Prescription Drugs	90%	50%

**Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*

Plan 16 – HDHP Option VIII

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible	$6,000/person	$12,000/family
Out-of-Network Aggregate Deductible	$10,000/person	$30,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense	$6,900/person	$13,800/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
Outpatient Surgery, Outpatient Hospital, In-patient Hospital (room & board, ICU & ancillary charges) In-patient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	90%	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)		
Mental/Nervous Treatment In-patient (Hospitals & Physicians)		
Mental/Nervous Treatment Outpatient		
Alcohol/Drug Addiction (Hospital & Physician In- or Outpatient)		
Skilled Nursing Facility (Maximum 60 days/calendar year)		
Hospice (Maximum 60 days/lifetime)	90%	50%
Emergency Room Visits	90%	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses		
Prescription Drugs	90%	50%

**Individual maximum of $8,150 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit*

Members' Insurance Trust

Dental Benefits

DENTAL BENEFIT OPTIONS

Coverages

Benefit **Type**	**Coverage** Description	Calendar Year Deductible	Payment Percentage
Type A	Preventive	None	100%
Type B	Routine Restorative	$50 (Individual) $150 (Family) For Type B, C, D, E, and F Expenses Combined	80%
Type C*	Endodontic		80%
Type D*	Periodontic		80%
Type E*	Major Restorative		50%
Type F*	Orthodontics		50%

*Benefits are limited to Type A and Type B expenses only during the first 12 months of coverage, unless you enroll in MIT's dental Benefits when you first become eligible.

Maximum Benefits

Type A through Type E Expenses $1,000 per calendar year/per person

Type A Preventive Care Limitations:
Exams, Cleanings, X-rays - 2 per calendar year
Fluoride Treatment - 1 per calendar year up to age 19
Sealants - up to age 17
Space Maintenance - up to age 14
Panoramic - 1 in 36 months
Full Mouth X-rays - 1 in 36 months

Type F Expenses $1,000 per lifetime *(dependent children only)*

Rates

Coverage Type	Rate per Month
Single	$40.00
Employee/Spouse	$80.00
Employee/Children	$95.55
Family	$136.66

Please note: changes to dental coverage elections can only be made at open enrollment unless you have a special enrollment event.

Covered Dental Expenses

Covered Dental Expenses are those Reasonable and Customary charges made by your Dentist for services or procedures recognized by the current edition of The American Dental Association's *Current Dental Terminology* manual. These expenses must be incurred after you become covered under MIT's dental Benefits and not be specifically excluded in the Dental Exclusions and Limitations section of this MIT SPD. Examples of covered dental expenses:

Type A Benefits
Preventive Care Expenses

These procedures consist of Diagnostic and/or Preventive services, such as:

- Periodic Oral Examinations
- Dental Prophylaxis
- Periodontal Maintenance
- Fluoride Treatment
- Bitewing X-Rays
- Sealants
- Space Maintenance
- Panoramic X-Rays
- Full Mouth X-Rays

Type B Benefits
Routine Restorative Expenses

These procedures consist of minor routine repair and maintenance services such as:

- Amalgam Fillings
- Repairs to Dentures
- Denture Relining
- Simple Extractions
- Surgical Extractions
- Anesthesia

Type C, D, E Benefits
Major Restorative Expenses

Type C procedures consist of Endodontic services such as:

- Pulp Capping
- Root Canal Therapy

Type D procedures consist of Periodontic services such as:

- Gingivectomy
- Periodontal Scaling and Root Planing

Type E procedures consist of Major Restorative and Prosthodontics, such as:

- Dentures
- Pontics
- Crowns
- Gold Inlays

Type F Benefits
Orthodontic Care Expenses

Type F procedures consist of Orthodontic services

- Only for covered dependent children under age 19

Contact us today

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