SOUTH CAROLINA MEDICAL ASSOCIATION VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION WELFARE BENEFIT PLAN AND TRUST
a/k/a SCMA Members' Insurance Trust (MIT)

Summary Plan Description

Effective July 1, 2024

INTRODUCTION

The South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust, also known as the Members' Insurance Trust, ("**MIT**" or the "**Plan**") offers eligible active employees, physicians 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**:
  - Medical (including Prescription Drug) – *See Separate Summary*
  - Dental (Basic and Enhanced) – *See Separate Summary*
- **Embedded Benefits**:
  - Life and Accidental Death & Dismemberment (AD&D) Insurance (Basic and Voluntary) – *See Separate Summary*
  - Short-Term Disability Income benefits – *See Separate Summary*

This booklet contains the general rules that apply to the group benefits that may be offered to eligible active employees, physicians and retirees of our Participating Employers **effective January 1, 2024**. Additional details for each benefit offered under MIT are set forth in the certificate of coverage issued by the insurance company (in the case of Embedded Benefits) or in the benefit Separate Summary (in the case of self-insured medical and dental). These are referred to as the "**Summaries**" and are either attached to the end of this booklet) or are provided as a separate document. Together, this booklet and the individual Summaries for each benefit comprise the Summary Plan Description (**SPD**) for our Plan.

Note, the eligibility requirements for Embedded Benefits may be more restrictive than those for Health and Wellness Benefits (medical and dental). Please consult the Summary for the appropriate Embedded Benefit to determine if you or your spouse or dependents are eligible for the specific Embedded Benefit. If you have any questions regarding eligibility for you or your Dependents in an Embedded Benefit, please contact MIT at MITinfo@scmedical.org or 1-800-327-1021

We file an annual report known as a Form 5500 on behalf of the Plan. Our Plan is considered a "wrap" plan for purposes of legal compliance so that we can file one document for all benefits encompassed through MIT, both (1) Health and Welfare Benefits and (2) Embedded Benefits. However, 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 the Employee Retirement Income Security Act of 1974 (ERISA) law that governs most retirement and health plans. Similarly, while Embedded Benefits are included in our Plan and offered to Participants who elect to participate in the medical coverage offered under our Plan, each such Embedded Benefit is treated as a separate plan for COBRA purposes and is not eligible for COBRA continuation coverage.

This SPD replaces any previously published group benefit plan descriptions you may have in your possession. Your receipt of our SPD does not necessarily mean you are eligible for a benefit under our Plan. This SPD summarizes the Plan and its benefits in plain language so that they will be easier to understand. Our SPD explains the responsibilities of you as an employee or physician eligible to participate in the Plan, of your Participating Employer, and of MIT. However, information contained in our SPD does not cover every possible situation and is not intended to replace or change the meaning of any insurance policy issued by an insurance company who insures the Embedded Benefits offered under our Plan, which shall govern in the event of any conflict. 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 any Plan documents.

Please read our SPD carefully and call MIT if you or your spouse or 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 our SPD do not constitute an employment or service guarantee or contract with any employee or physician, nor do they give any employee, physician, or other person a right to continued employment or service with any Participating Employer.

South Carolina Medical Association (SCMA) is the sponsor of this Plan and reserves the sole right to amend, change, interpret or terminate any of the benefits or the Plan described in our 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 our SPD carefully so you may understand and take full advantage of these benefits. Should you have questions about benefits or our Plan after reading our 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.

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

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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, physicians and retirees (as applicable) 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** (other than the physician-owner);
4. the entity contributes Employer Contributions toward its eligible employees' and physicians' coverage equal to **at least 50%** of the cost of employee-only coverage[1];
5. the entity maintains at least **50% participation** in the medical benefits (or if only dental benefits are offered, 50% in dental benefits) offered under 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); and
6. the entity pays the required Employer Contributions when due.

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

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.

Because MIT is a self-funded trust, Participating Employers pay Employer Contributions to cover the cost of coverage (as opposed to a "premium" paid for an insurance policy). The Employer Contribution consists of two parts, the SCMA MIT Plan Administrator Contribution and the SCMA Plan Sponsor Fee. The SPD and related documents use the term Employer Contribution when talking about payments for your MIT insurance.

A Participating Employer's ability to offer one or more benefits available under the Plan may be subject to additional eligibility requirements as specified in the section of our SPD describing the applicable benefit.

A Participating Employer's annual coverage period will normally be the calendar year beginning each January 1 and ending the following December 31, unless a different annual coverage period (April 1, July 1, or October 1) has been requested by the Participating Employer and has been approved in writing by MIT.

NOTE: It is the responsibility of each Participating Employer to adopt a separate cafeteria plan (as defined under Internal Revenue Code Section 125) if the Participating Employer intends that its employees or physicians qualify to pay for their portion of the cost of the benefits offered under the Plan on a pre-tax basis. If a Participating Employer needs assistance in creating a cafeteria plan, please reach out to MIT at MITinfo@scmedical.org or 1-800-327-1021 and we can refer you to a third party to assist you with

[1] While MIT cannot provide tax advice, it is intended that the Employer Contribution paid to MIT qualify to be reported for tax purposes by Participating Employers as the cost of employer-sponsored health coverage and/or a business deduction. In addition, please note that if the Participating Employer is an LLC or S-corporation, Employer Contributions made on behalf of owners may need to be reported as taxable income on the applicable self-employed owner's Form K-1 or other tax statement and deducted by the owner on his or her personal tax return. Although neither SMCA nor MIT offer tax advice on these subjects, we raise them here to alert Participating Employers to consult their own tax advisors regarding the proper way to reflect such payments.

Termination

A Participating Employer may cancel its participation in MIT, or any benefit offered through 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, not your Fulcrum Risk Solutions broker. The effective date of any voluntary termination of a Participating Employer's participation in MIT, or any benefit offered through 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.

Important: Any termination notice must be delivered to MIT, not to your Fulcrum Risk Solutions broker or other insurance agent or broker.

If a Participating Employer ceases to participate in MIT or any benefit offered through MIT, coverage will automatically cease (a) for employees and physicians of that Participating Employer and their spouse and dependents, (b) for retirees who retired from that Participating Employer on or after January 1, 2020, and (c) for all COBRA qualified beneficiaries who became entitled to continuing group health (medical and/or dental) coverage through that Participating Employer.

MIT reserves the right to routinely audit employer groups to ensure they are compliant with MIT's participation guidelines, including the timely payment of the required Employer Contributions to MIT. Failure of a Participating Employer to comply may result in termination of coverage. MIT reserves the right to refuse to pay and/or reverse payment of any and all claims incurred in a period for which the required Employer Contributions are not timely received by MIT and terminate a Participating Employer's' participation as of the last day of the calendar month through which the required Employer Contributions were paid.

COBRA NOTE: When a Participating Employer ceases to participate in MIT or any benefit offered through MIT that is covered by COBRA, the Participating Employer (not MIT) is responsible for obtaining replacement coverage for its employees, physicians and retirees, as well as its COBRA-qualified beneficiaries who have elected 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, may face penalties under the tax code and ERISA, and will be liable to our Plan for all costs incurred (if any) in paying benefits to such COBRA-qualified beneficiaries and any attorneys' fees or other costs incurred by our Plan or its providers in collecting (or attempting to collect) such amounts from the Participating Employer.

Unless specifically approved in writing by MIT, Participating Employers may not by contract or otherwise agree to offer COBRA continuation coverage through MIT where such continuation coverage is not legally required to be provided pursuant to the COBRA rules.

TERM DATE NOTE: All Participating Employers who terminate participation in our Plan, or any benefit offered through MIT, must pay any/all outstanding balances due within 90 days following the termination date. If full payment is not received within 90 days, MIT reserves the right to reverse any/all claims incurred in the period for which the Employer Contributions were not received.

ELIGIBILITY

This section describes MIT's eligibility rules for employees and physicians, and their Dependents. Additional eligibility requirements, limitations or restrictions may apply under each individual MIT benefit. Be sure to review the applicable Separate Summary for the specific benefit for the eligibility provisions that apply to that separate benefit. In particular, if any of the Embedded Benefits offered by MIT (*e.g.*, life, AD&D, and short-term disability benefits) impose more restrictive eligibility requirements in their Separate Summary document(s) than in this SPD (*e.g.*, exclusion of certain employee classifications or individuals residing outside the U.S., etc.) then the more restrictive eligibility terms in that Separate Summary will control. If you have any questions regarding eligibility for a specific benefit, please contact MIT at MITinfo@scmedical.org or 1-800-327-1021.

Eligibility of Employees

If you are an employee, you are eligible for coverage under our Plan if you are a Full-Time Employee of a Participating Employer (as defined in the INTRODUCTION section), which means you satisfy ALL of the below requirements:

1. 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
2. You are either:
   (a) 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 reasonably determined your Participating Employer; or
   (b) 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 reasonably determines, in accordance with the ACA, 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, worked an average of 30 hours or more per week; and
3. You are a resident of the U.S. (or, if a nonresident working in the U.S. on a visa or other work permit and you hold a South Carolina medical license).

Eligibility for Physicians

If you are a physician, you must satisfy all of the above requirements in paragraphs 1, 2 and 3 above for employees 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, or
2. **Out-Of-State Resident**. You are a non-resident physician, a **member** of the SCMA, and employed through a Participating Employer located in South Carolina (or qualified as having a sufficient connection to the South Carolina medical community, as described earlier).

Retirees

If you are retired, you may continue retiree coverage in our Plan if you had both attained age 55 at the time of your retirement and (i) were continuously covered in active employee or physician coverage through MIT for the five years prior to your retirement, or (ii) were covered in active employee or physician coverage through MIT for at least 20 years (consecutive or nonconsecutive) out of the 30 years preceding your retirement and you are enrolled in active employee or physician coverage through MIT immediately preceding your retirement. To be eligible, you must notify MIT in writing of your election to enroll in retiree coverage prior to your last day of active employee or physician coverage under our Plan and your retiree coverage must commence immediately following the last day of such active coverage (i.e., no gap in coverage may occur). 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. If you cease retiree coverage under our Plan for any reason (whether voluntary or involuntary), you may not later re-enroll. For purposes of determining your eligibility for retiree coverage, continuation coverage under COBRA (or similar state law) does not count as active coverage.

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,
- Individuals participating in a collectively bargained (e.g., union) health and welfare program to which the Participating Employer contributes, and
- Nonresident aliens with no U.S.-source income.

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 spouses and eligible dependent children (collectively, "**Dependents**").

Spouse - Your **spouse** to whom you are legally married is eligible for coverage. This includes your spouse pursuant to a legally recognized marriage (recognized by the state in which you were married). This also includes your legally recognized common law spouse 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).

Dependent Children - The following dependent children may be eligible for coverage until age 26:

- Your **natural children**,
- Your **adopted children**, including those adopted by or placed for adoption with you,
- Your **stepchildren**, and
- 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 an employee or physician, (a) either, but not both, may elect to cover dependent children; and (b) only one will qualify as the "covered employee" or "covered physician" and the other will qualify as the "spouse" for all MIT benefits purposes (e.g., life insurance). If both individuals wish to qualify as the "covered employee" or "covered physician," then they must purchase separate MIT coverage.

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. **If you want to cover your eligible spouse or 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 annual enrollment period, unless another special enrollment event allows earlier enrollment.**

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.

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 also dependent upon you for support. Your handicapped child can continue to be covered as a dependent child 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;
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.

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 both satisfy the *Eligibility* rules set forth above and complete the waiting period designated by your Participating Employer from among the choices offered under the Plan. In all events, the maximum waiting period can be no later than 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 annual enrollment period for your Participating Employer.

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 your eligible spouse or any eligible dependent children, their coverage effective date will be the same as yours.

Rehired employees or physicians who have been absent from employment or service with a Participating Employer in MIT for more than 30 days will be treated as new hires and beginning on their rehire date will be required to satisfy all Plan requirements, including a new waiting period and new deductible and out-of-pocket limits. For purposes of the preceding sentences, any absence that is due to one or more of the permissible leaves of absence described below (e.g., FMLA leave of absence) does not count towards this 30-day threshold. However, if the Participating Employer has notified MIT (and provided any substantiation requested by MIT) that it is an Applicable Large Employer that is subject to the employer shared responsibility requirements of Section 4980H of the Internal Revenue Code (also known as the "**ACA Employer Mandate**"), the foregoing 30-day rule will be extended to 13 consecutive weeks in order to allow the Participating Employer to comply with its obligations to comply with the ACA Employer Mandate.

If you or your spouse or a dependent child 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 or the spouse or dependent child lose that other coverage because you or they are no longer eligible, or a former employer terminates the group coverage, you or the spouse or dependent child (as applicable) 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 written 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 spouse or dependents you wish to cover under each benefit. Only those eligible spouse or 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 have completed 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 annual enrollment period, 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 your spouse or any dependent children to a MIT benefit for the first time, you may receive a request from MIT to provide documentation to verify your spouse or 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 30-90 days prior to the start of your Participating Employer's annual coverage period. During the annual enrollment period, we will provide you information on your benefit choices for the coming 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 (or your Participating Employer's authorized representative) are using our website to enroll, when annual MIT enrollment elections are entered, you (or the authorized representative) will be given the opportunity to confirm the choices. You (or your authorized representative) are responsible for reviewing and ensuring that annual MIT enrollment elections have been correctly entered. If changes are made to elections during the annual enrollment period, the last confirmed annual enrollment will constitute the final election for the upcoming annual coverage period. Remember that you will not be allowed to change your annual MIT enrollment elections until your Participating Employer's 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 a "special enrollment event". 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 your spouse or dependent children:

- Change in your legal marital status;
- Change in the number of your dependent children;
- Change in employment status or work schedule of you, your spouse, or your dependent child;
- Change in your dependent child'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 child.

Important: 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 annual enrollment period for your Participating Employer.

For medical or dental benefits, you may also change your election if:

- Previously Declined Enrollment. You decline enrollment for yourself and/or your spouse or dependent child under any MIT medical or dental benefit because you or your spouse or dependent child (as applicable) had other group medical or dental coverage and either (a) you or your spouse or dependent child later lose eligibility for that coverage, or (b) you marry or gain a new dependent child 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 spouse or dependent child become entitled to or lose eligibility for Medicare or eligibility under a governmental program.

MIT must 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.**

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

An additional special enrollment event occurs if you or your spouse or dependent child lose coverage under a state Medicaid or state Children's Health Insurance Plan ("CHIP") because of loss of eligibility. If this occurs, you may enroll yourself and/or your spouse or dependent children 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 spouse or dependent child's Medicaid or CHIP coverage terminates due to loss of eligibility (as opposed to termination due to failure to pay Employer Contributions). You may also enroll yourself and your eligible spouse or dependent children for a MIT medical benefit if you or your spouse or dependent children become eligible for Medicaid or CHIP premium assistance to help you pay for Plan coverage, provided you enroll yourself and/or your spouse or dependent children within 60 days of the date you or your spouse or 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 Summary for the applicable MIT benefit 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 event. In addition, rules describing additional changes you may make may be included in the for the applicable MIT benefit.

In the case of a special enrollment event that resulted in the loss of your or your covered spouse's or dependent children'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 all MIT benefits for you and your eligible spouse and dependent children.** 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 when 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 you may have no coverage under any MIT benefits. You and your eligible spouse and dependent children will not be permitted to enroll in MIT benefits until your Participating Employer's next annual enrollment period, 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 year:

- Your current elections for medical and dental benefits will remain the same for the next year; and
- The Embedded Benefits offered by MIT will generally continue at the same level so long as you continue to be 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 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 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 and your covered spouse and dependent children 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. You can contact SCMAMIT at: fax 803-731-4021 or MITinfo@scmedical.org.

Medical Leave of Absence

If your Participating Employer provides for a medical leave of absence, you may continue your MIT coverage during the medical leave of absence for a maximum of 12 weeks, whether paid or unpaid (*provided* that any other forms of paid leave available are also exhausted at the end of 12 weeks). A medical leave of absence may run separate from or concurrently with other forms of paid leave pursuant to the Participating Employer's policy.

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

If you are unable to work full-time due to disability, and your Participating Employer has authorized a leave of absence (other than vacation or paid time off (PTO)), you and your covered spouse and dependent children may remain eligible for coverage under our Plan through the last day of the calendar month in which your approved leave of absence ends (but in no event will MIT recognize leaves of absence exceeding 12 weeks during any rolling 12-month period, unless legally required by law) ("**MIT Disability Continuation**"). Thereafter, you and your covered spouse and dependents may be eligible to elect COBRA Continuation Coverage.

During any leave of absence during which MIT coverage continues, you must continue to pay the appropriate amount of Employer Contributions. Employer Contributions must be paid in accordance with the normal deadlines designated by MIT. If your account is delinquent more than 30 days, your coverage under our Plan will terminate.

For Participating Employers eligible for Family and Medical Leave Act (FMLA) Continuation During Participating Employer Certified Leaves of Absence With or Without Pay.

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

Coverage under our Plan due to a FMLA leave of absence may continue until the last day of the calendar month in which your approved FMLA leave of absence ends (but in no event will MIT recognize a leave of absence exceeding 12 weeks during any rolling 12-month period, unless legally required by law). When coverage ends following the end of the FMLA period, you and your covered spouse and dependent children may be eligible to elect COBRA Continuation Coverage.

During any leave of absence during which MIT coverage continues, you must continue to pay the appropriate amount of Employer Contributions. Employer Contributions must be paid in accordance with the normal deadlines designated by MIT. 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 (medical and/or dental) coverage under our Plan as required by the Federal law known as USERRA. If you are eligible under USERRA, you and your covered spouse and dependent children may continue coverage under our Plan until the last day of the calendar month in which occurs the earlier of 24 months beginning with the date your absence from employment begins 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 (subject to eligibility requirements) 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 (other than vacation or paid time off (PTO)) after you have exhausted MIT Disability Continuation, FMLA, USERRA and any normal annual sick leave. If, after normal annual sick leave and any applicable MIT Disability Continuation, FMLA or USERRA leave is exhausted, you are no longer considered a Full-Time Employee (as defined in this SPD) by your Participating Employer, then you and your covered spouse and 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 or physician and his or her spouse and covered dependents. For information about a Participating Employer's cessation of participation in MIT, please see *Participating Employers* above.

General Termination Rules:

Your coverage (including if you are a retiree) and coverage of your spouse and 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, 2020;
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, or end of qualifying leave of absence);
5. the last day of the calendar month for which your last Employer Contribution is paid;
6. the last day of the calendar month in which you first retire if you do not qualify for retiree coverage;
7. the last day of the calendar month in which your spouse or 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 or physician, termination or reduction of hours of a covered employee or physician, or a covered employee or physician 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 spouse or Dependents. Failure of your Participating Employer to timely and properly notify MIT may impair or prohibit you and your covered spouse and dependent children 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 losing Dependent status under the Plan. **Your failure to timely and properly notify MIT may impair or prohibit you or your covered spouse or 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 Employer Contributions are not paid within 31 days of the original due date. If your coverage under our Plan is terminated for non-payment of Employer Contributions, MIT reserves the right to reverse any paid claims incurred after the termination date and request payment for any benefits that were paid but cannot be reversed.

Handicapped Children

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

1. The last day of the calendar month for which your last Employer Contribution 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 application or 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 medical and/or dental coverage through 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, such medical or dental coverage under MIT may be continued by your surviving spouse for your surviving spouse and Dependents until the soonest 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 Employer Contribution 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 Dependents' rights to continued medical and/or dental coverage under MIT, except through COBRA. Refer to the *COBRA Continuation of Medical Care Coverage* section of this booklet for details regarding COBRA rights. Your surviving spouse 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 at:

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 portion of the cost of MIT benefits if you are a W-2 employee. You must pay your share of the cost, as determined by MIT and your Participating Employer, and your Participating Employer will pay the remainder (if any) of the cost. Your share of the cost depends upon the level of coverage you select under each MIT benefit, and whether you choose to cover your eligible spouse and dependent children.

- 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 the basic life and disability benefits. They are automatically included when you enroll in eligible MIT medical benefits. If you elect to purchase the voluntary supplemental life insurance coverage offered by MIT, you are responsible for the full cost of Employer Contributions.

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

Your share of Employer Contributions is usually deducted by your Participating Employer from your pay each pay period and is 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 Employer 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 your share of Employer Contributions 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 covered spouse or dependent children participate in the program or satisfy certain health standards. If you or your covered spouse or dependent children 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.

CLAIMS AND APPEALS

The claims and appeals procedures that apply to each benefit offered under our Plan are included in the Separate Summary for the specific benefit. Please consult the appropriate Separate Summary for those procedures. MIT may be available to assist you with the claims and appeals process for any of the benefits offered under our Plan. If you need assistance, please contact:

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

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 (see the COBRA section of this booklet for information on lawsuits regarding COBRA benefits).

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 one (1) year 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.

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

SCMA, known as the Plan Sponsor, reserves the right to terminate, suspend, withdraw, amend, or modify the Plan at any time. Any such change or termination in benefits will be based solely on the decision and sole discretion of the Plan Sponsor and may apply to active employees, active physicians, 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 (as determined by MIT) 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; and
3. 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:

1. 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 the United States Department of Labor, Internal Revenue Service, or other applicable governmental agencies, departments and instrumentalities;
2. any and all disclosures required to be made to such Participating Employer's employees, physicians and other applicable individuals as required under ERISA, the Code or other applicable law;
3. any and all notices, documents and other writings required to be issued to such Participating Employer's employees, physicians and other applicable individuals pursuant to ERISA, the Code or other applicable law;
4. 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, 1095-C, 1094-B and 1095-B);
5. any and all required compliance testing required under the Code; and
6. the adoption of a separate "cafeteria plan" described in Section 125 of the Code if the Participating Employer's intention is that the benefits available under the Plan be offered to employees or physicians on a pre-tax basis.

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, state or local income or payroll taxes from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional taxes (plus any penalties) that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, less any such additional taxes actually paid by you.

Severability

If any provision of our 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 medical 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 or physician 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 and the Separate Summary for each benefit offered under our Plan, comprises the SPD under ERISA:

Plan Name:

South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust

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 upon written request to MIT and is available for examination, to the extent required by law.

Employer Identification Number (EIN): 91-1839164

Plan Number: # 501

Type of Plan: Comprehensive Major Medical

Name of Plan Administrator

The Trustees of South Carolina Medical Association Members' Insurance Trust ("SCMA/MIT" or "MIT")
P.O. Box 11188, Columbia, SC 29211
803-798-6207 (in Columbia) or 1-800-327-1021 (statewide)

The names and addresses of individuals currently serving as Trustees are on file at MIT's office and are available upon request.

Type of Administration

This Plan is administered by the Plan Administrator. All benefits are provided in accordance with the provisions as outlined in this booklet.

Service of Legal Process

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

Plan Trustees

The Trustees of the South Carolina Medical Association Members' Insurance Trust. The names and addresses of the current Trustees are on file at MIT's office and are available upon request, to the extent required by law.

Termination of Plan

The right is reserved for SCMA 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 to which Participating Employers contribute Employer Contributions. The Trust pays the cost of self-insured benefits as they become due. Embedded Benefits are fully insured through third-party insurance policies, the premiums for which are paid from Employer Contributions made to the 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 medical and dental benefit Deductibles and out-of-pocket maximum (as referenced in the applicable Separate Summary) apply based on the Participating Employer's annual coverage period (See the PARTICIPATING EMPLOYERS section above). Each Participating Employer's annual enrollment period is conducted prior to the start of its annual coverage period (usually during the prior 30 to 90 days).

Provider Network

A copy of the applicable provider network listing is available, free of charge, upon request or can be accessed at the websites listed in the *Important Contact Information* section of our SPD.

STATEMENT OF RIGHTS UNDER ERISA

Plan participants, eligible employees and physicians, 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 physicians, 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 dependent 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.

IMPORTANT CONTACT INFORMATION

Your Question/Need	Who To Contact	Contact Information
General		
For questions about enrollment applications, eligibility, or Employer Contributions:	MIT	P.O. Box 11188, Columbia, SC 29211 Phone: 803-798-6207 or 1-800-327-1021 Fax: 803-731-4021 Email[2]: MITinfo@scmedical.org
HIPAA complaints or questions	MIT Privacy Officer: Chief Legal Officer	P.O. Box 11188, Columbia, SC 29221 Phone: 803-798-6207 or 1-800-327-1021 Fax: 803-731-4021 Email: MITinfo@scmedical.org
Medical		
For questions regarding Claims and verification of benefits:	Planned Administrators, Inc.	www.paisc.com Phone: 800-768-4375
Submit all medical Claims to: **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"*	Planned Administrators, Inc.	P.O. Box 6927, Columbia, SC 29260 Fax: 803-870-8012 (specify "Attention: Claims") Phone: 800-652-3076
For Pre-Certification/Prior Approval:	Planned Administrators, Inc. Utilization Review	Phone: 800-652-3076
For questions regarding Mental Health/Substance Use benefits:	Planned Administrators, Inc.	Phone: 800-868-1032
Provider Network Listing	Planned Administrators, Inc.	www.paisc.com (under the 'Members' tab)
Dental		
Customer Service	Sun Life Financial	P.O. Box 981624, El Paso, TX 79998 Phone: 800-733-7879
Provider Network Listing	Sun Life Financial	www.sunlife.com/findadentist or 1-800-733-7879
Submit all dental Claims to:	Sun Life Financial	P.O. Box 2940, Clinton, IA 52733 Phone: 800-442-7742 Electronic Claims: Payor 70408
Prescription Drug		
For questions regarding pharmacy benefits or drug card related issues:	OptumRx	Phone: 1-844-538-1209 www.Optumrx.com
Submit all pharmacy Claims to:	OptumRx	Log into to www.Optumrx.com to reach the MIT portal
Provider Network Listing	OptumRx	www.Optumrx.com
COBRA		
COBRA Notices	MIT	P.O. Box 11188, Columbia, SC 29211 Fax: 803-731-4021 Email: MITinfo@scmedical.org
Embedded Benefits		
Life/AD&D and Disability	The Hartford	See separate Life/AD&D Addendum

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

PROVISIONS APPLICABLE TO MEDICAL AND DENTAL BENEFITS

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 medical or dental benefits under our Plan.

To be considered a Qualified Medical Child Support Order, the 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 or physician 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 (medical or dental) 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 or physician.

Note: An employee or physician not covered prior to issuance of a QMCSO will be subjected to the eligibility and enrollment provisions described earlier in our 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

Note: The term "covered employee" as used in this COBRA discussion includes any individual (employee or physician) 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.

Application of COBRA for Medical & Dental

If coverage for you or your eligible family members under the medical or dental benefits offered by MIT ceases because of certain "COBRA 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-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

While Embedded Benefits are included in our Plan and offered to Participants who elect to participate in the medical coverage offered under our Plan, each such Embedded Benefit is treated as a separate plan and is not eligible for COBRA continuation coverage.

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 "**COBRA Enrollment Event**"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the COBRA 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 COBRA Enrollment Event (in other words, similarly-situated non-COBRA beneficiaries).

Important: Unless specifically approved in writing by MIT, Participating Employers may not by contract or otherwise agree to offer COBRA continuation coverage through MIT where such continuation coverage is not legally required to be provided pursuant to the COBRA rules.

Qualified Beneficiaries

In general, a Qualified Beneficiary can be:

- Any individual who, on the day before a COBRA 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 dependent 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 COBRA Enrollment Event.
- Any dependent 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 COBRA Enrollment Event.

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.

COBRA Enrollment Events

A COBRA 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 COBRA Enrollment Event) under the applicable MIT medical or dental benefit in the absence of COBRA continuation coverage:

- The death of a covered employee.
- The termination (other than by reason of the covered employee's gross misconduct), or reduction of hours, of a covered employee's employment or service with the Participating Employer.
- The divorce or legal separation of a covered employee from the covered employee's spouse. If the covered employee reduces or eliminates the covered 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 COBRA Enrollment Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
- A covered spouse or dependent child's ceasing to satisfy the Plan's requirements for eligibility for the benefit (for example, child's attainment of the maximum age for coverage).
- If the COBRA Enrollment Event causes the covered employee or his or her covered spouse or Dependent to cease to be covered under the benefit under the same terms and conditions as in effect immediately before the COBRA 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 spouse or Dependents 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 COBRA Enrollment Event. A COBRA Enrollment Event will occur, however, if a covered employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a COBRA 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 covered spouse and Dependents will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of Employer Contributions 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 Employer Contributions 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 COBRA 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 no later than the date the Qualified Beneficiary would lose coverage on account of the COBRA Enrollment Event and ends 60 days after the later of the date the Qualified Beneficiary would lose

coverage on account of the COBRA 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 (or the extended deadline, as applicable), all rights to elect COBRA continuation coverage are forfeited.

Responsibility for Informing MIT of the Occurrence of a COBRA Enrollment Event

We will offer COBRA continuation coverage to Qualified Beneficiaries only after MIT has been timely notified that a COBRA Enrollment Event has occurred. Your Participating Employer will notify MIT of the COBRA Enrollment Event within 30 days following the date coverage ends when the COBRA Enrollment Event is: (1) the end of employment with the Participating Employer; (2) reduction of hours of employment below the defined Full Time Employee hours; or (3) death of the covered employee. There are qualifying events that may occur and not be known by your employer, such as legal separation or divorce, discussed in the box below. Either you should tell your employer of these events and make sure that it notifies MIT, or you must notify MIT of these events.

IMPORTANT: For the other COBRA Enrollment Events (divorce or legal separation of the covered employee and spouse or an eligible Dependent's losing eligibility for coverage as an eligible Dependent), you or someone on your behalf must notify MIT in writing within 60 days after the COBRA 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 Dependent 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 covered employee under the MIT benefit,
- The name(s) and address(es) of the Qualified Beneficiary(ies), and
- The COBRA Enrollment Event and the date it happened.

If the COBRA 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 COBRA 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 or legal guardians may elect COBRA continuation coverage on behalf of their Dependents. 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 Dependents do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.**

1. **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.
2. **COBRA When 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). See the ***COBRA and Medicare Coordination*** section below for more information.

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 COBRA 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 the applicable type of group health plan (e.g., medical or dental) 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 COBRA 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.

If a Participating Employer ceases to participate in MIT or any benefit offered through MIT, coverage will automatically cease for all COBRA qualified beneficiaries.

Maximum Coverage Periods

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

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

   See the ***COBRA and Medicare Coordination*** section below for examples.
3. In the case of a Qualified Beneficiary who is a dependent 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 COBRA Enrollment Event giving rise to the period of COBRA continuation coverage during which the dependent child was born or placed for adoption.
4. In the case of any other COBRA Enrollment Event than that described above, the maximum coverage period ends 36 months after the COBRA Enrollment Event.

5. If a COBRA 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 COBRA 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 COBRA Enrollment Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first COBRA Enrollment Event. **MIT must be notified by the Qualified Beneficiary of the second COBRA Enrollment Event within 60 days of the second COBRA 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 COBRA 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 Employer Contribution and 150% of the applicable Employer Contribution 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.

Alternative to COBRA

You may be able to get medical 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 Employer Contributions and cost-sharing reductions (amounts that lower the out-of-pocket costs for deductibles, coinsurance, and copayments) right away. The Marketplace shows what the Employer Contribution, 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 **COBRA Enrollment Event**, you (or your spouse or dependent children) 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.

COBRA and Medicare Coordination

A complicated set of rules applies if you experience a COBRA Enrollment Event and have recently or will become entitled to Medicare. The questions and answers below are intended to help you understand these special rules.

1. **Can I keep MIT coverage when I become entitled to Medicare?** Yes. If you are still employed by a Participating Employer when you become entitled to Medicare and if you decide to enroll, you won't automatically lose coverage under our Plan. You can continue your Plan coverage for yourself and your eligible spouse and dependent children. If you have both Medicare and coverage under our Plan while you are employed, Medicare usually pays secondary to Plan coverage. This means that your medical expenses must first be submitted to this Plan for payment and then, to the extent not covered by our Plan, the expenses may be eligible for payment through Medicare. So long as you are an active employee or physician, MIT pays first.

   If you retire and are enrolled in MIT coverage (if you are eligible), Medicare will pay first, and then the Plan coverage pays as secondary.

2. **Can I drop Plan coverage if I enroll in Medicare?** Yes. However, if you drop coverage under our Plan because you enroll in Medicare, this is not a COBRA Enrollment Event so neither you nor your Qualified Beneficiaries will have the right to elect COBRA continuation coverage through our Plan. The only way to keep your Qualified Beneficiaries on coverage under our Plan when you enroll in Medicare is to keep our Plan coverage for yourself.

3. **What happens if I decide to keep Plan coverage and not enroll in Medicare?** If you don't enroll in Medicare when you are first eligible because you are still employed, you will have a special enrollment period to sign up for Medicare, generally beginning on the earlier of the month after your employment ends, or the month after your Plan coverage ends. If you don't enroll in Medicare after the end of this special enrollment period and decide to elect COBRA continuation coverage instead, you should know that Medicare late enrollment penalties could apply. While we cannot advise you as to your Medicare rights, we urge you to consult your advisors to determine when you must enroll in Medicare. For purposes of your analysis, it should be noted that because we are an association-sponsored health plan that covers one or more employers who have 20 or more employees or physicians, the medical coverage obtained through our Plan is subject to the Medicare secondary payor rules, regardless of whether the participating employer has 20 or more employees or physicians (which is normally the threshold for an employer to become subject to the Medicare secondary payor rules). Our Plan has not elected out of these Medicare secondary payor rules.

4. **What happens if I terminate employment, elect COBRA continuation coverage, and then become entitled to Medicare?** If you terminate employment and elect COBRA continuation coverage through our Plan for yourself and one or more of your other Qualified Beneficiaries, your later entitlement to Medicare will trigger a loss of COBRA continuation coverage for yourself, but not your other Qualified Beneficiaries. However, as discussed in the ***Maximum Coverage Periods*** section above, if your qualifying event is a termination of employment or a reduction in hours of employment, COBRA continuation coverage for your Qualified Beneficiaries may be extended.

5. **Below are some examples to help understand these COBRA and Medicare coordination rules:**

   Example 1 – Active Employment and Medicare Entitlement

   Jim, an employee of a Participating Employer in our Plan, becomes eligible for Medicare on June 1, 2024. Jim may elect to continue Plan coverage for himself and his spouse and eligible dependents. However, if Jim decides to drop Plan coverage and enroll in Medicare on August 1, 2024, while still employed by a Participating Employer of our Plan, this is not a COBRA qualifying event so Jim's Qualified Beneficiaries will not be able to elect COBRA continuation coverage.

   Example 2 – COBRA Enrollment and Subsequent Entitlement to Medicare

   Megan terminates employment with a Participating Employer in our Plan on December 1, 2024, and elects COBRA continuation coverage for herself and her Qualified Beneficiaries. On February 1, 2025, Megan becomes entitled to Medicare. Entitlement to Medicare triggers a loss of COBRA continuation coverage for Megan but not for her Qualified Beneficiaries. Megan's Qualified Beneficiaries are still entitled to 18 months of COBRA continuation coverage.

Example 3 – Retirement Less Than 18 Months After Medicare Entitlement.

Fritz, an employee of a Participating Employer in our Plan, became entitled to Medicare on May 1, 2024. Fritz retires on May 1, 2025. Fritz elects COBRA continuation coverage for himself and his spouse Margie under our Plan. Fritz is entitled to up to 18 months of COBRA continuation coverage from the date he retired. Margie is entitled to up to 24 months of COBRA continuation coverage from the date Fritz retired (24 months from Fritz's termination date is the same as 36 months from Fritz's Medicare entitlement date). Margie is entitled to COBRA through April 30, 2027.

Example 4 – Retirement More Than 18 Months After Medicare Entitlement.

Assume the same facts as in Example 3, except that Fritz retires on May 1, 2026. Margie is entitled only up to 18 months of COBRA coverage from the date that Fritz retired, because Fritz's Medicare entitlement occurred more than 18 months before the qualifying event (termination of employment).

Example 5 – Retirement Same Day as Medicare Entitlement.

Assume the same facts as in Example 3, except that Fritz retires on May 1, 2024. Margie is entitled only up to 18 months of COBRA coverage from the date that Fritz retired; no extension is available, because the extension is available only if a qualifying event occurs less than 18 months after the covered employee's Medicare entitlement.

Example 6 – Retirement Before Medicare Entitlement.

Assume the same facts as in Example 3, except that Fritz retires on April 30, 2024. Margie is entitled only up to 18 months of COBRA coverage from the date that Fritz retired; no extension is available because the extension is available only if a qualifying event occurs less than 18 months after the covered employee's Medicare entitlement.

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.

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 that represent 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).

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 Employer Contribution 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 Employer Contributions 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, Employer Contribution 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 Administrator. To the extent that PHI is disclosed to MIT, 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 Executive Director
- MIT Sr. Director of Operations
- MIT Director of Operations
- MIT Chief Medical Officer
- MIT Insurance Coordinator
- MIT Marketing Services Manager
- MIT /Customer Representative
- MIT Trustees
- SCMA Vice President of Information Technology
- SCMA CEO, CFO, and staff as needed

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© 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© 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.

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

MEDICAL AND PRESCRIPTION DRUG BENEFIT SUMMARY

(this document is part of the Summary Plan Description for MIT)

Effective July 1, 2024

INTRODUCTION

This Benefit Summary is part of the Summary Plan Description ("**SPD**") for the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust known as the SCMA Members' Insurance Trust ("**MIT**" or the "**Plan**") and describes the medical and prescription drug benefit coverage options offered under MIT. This Benefit Summary is effective as of July 1, 2024.

The medical benefits offered under MIT are not a contract of insurance and the *Participating Employers* do not assume the obligations of an insurer under the *Plan*.

Planned Administrators, Inc. ("**PAI**") is the Claims Service/Advice Only Administrator for the medical benefits and OptumRx ("**Optum**") is the Claims administrator and network provider for the prescription drug benefits.

The Schedules of Benefits describing the Deductible, Maximum Out-of-Pocket Expense, co-payment, and coinsurance requirements for each medical and prescription drug coverage option offered by MIT are included at the end of this Summary or provided separately to you. Capitalized terms have the meaning set forth under the *Definitions* heading later in this Summary. Capitalized terms that are not defined in this Summary shall have the meaning provided in the main SPD for the Plan.

Benefit levels for most mental health and substance use disorders are not separately stated. Please refer to the appropriate subsections below that relate to the services or supplies you receive, such as inpatient Hospital benefits, outpatient Hospital benefits, etc.

ELIGIBILITY TO OFFER MEDICAL AND PRESCRIPTION DRUG COVERAGE

For a Participating Employer to offer one or more of MIT's medical and prescription drug coverage options to its eligible employees and Physicians through MIT, the Participating Employer must maintain 50% participation in MIT's medical and prescription drug benefits coverage options, 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). See the Main Portion of the SPD for additional rules on eligibility.

GENERAL INFORMATION

Online benefits portal

Visit www.paisc.com/members 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, MIT utilizes the First Health Network. The medical provider directory is kept up-to-date by our network provider (who reviews it for accuracy no less than once every 90 days, with removal of unverified providers) and can be accessed by logging in at: www.paisc.com/members or by calling PAI at 1-800-652-3076. In accordance with applicable law, your inquiry as to whether a provider is in-network should be answered within one (1) business day of receipt.

Prescription drug contact

The prescription drug program through MIT is administered by OptumRX and its affiliates. You may contact OptumRX toll free at 1-844-538-1209, visit the MIT OptumRx website at Optumrx.com, or utilize the OptumRx mobile app for more details about the applicable copays and drug coverages under your Plan benefits. Additional plan tools such as those listed below are also accessible on the SCMA MIT portal at Optumrx.com:

- **Pharmacy Location Services:** Find an in-network pharmacy using the online pharmacy locator or contacting OptumRX at 1-844-538-1209. In accordance with applicable law, your inquiry as to whether a provider is in-network should be answered within one (1) business day of receipt.
- **Drug Price Check:** Identify which drugs are covered by our Plan, get an estimated cost before filing a prescription, and compare estimated costs between generic and brand-name drugs.
- **Tracking Out-Of-Pocket Expenses:** See current remaining Plan balances, up-to-date out-of-pocket expenses and Maximum Out-of-Pocket Expense limits. This information is updated daily.

To log into the portal at Optumrx.com, you will need your "Member ID," which is the "Medical/Pharmacy ID#" on your benefits card, and your personal identifying information.

Summary of Benefits

In accordance with the Patient Protection and Affordable Care Act ("**ACA**"), 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 MIT at 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.[1] These services are described in the United States Preventive Services Task Force (USPSTF) A and B Recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and Health Resources and Services Administration (HRSA) guidelines, including the American Academy of Pediatric Bright Futures recommendations. For a complete and detailed list of all Recommended Preventive Services, please visit www.healthcare.gov.

Important to Remember

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

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.

- 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).

[1] Note that if there is no in-network provider that provides the preventive service, coverage may be available for such services to be provided by an out-of-network provider. Please contact PAI if you believe this applies to you.

- 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.
- Items and services that are integral to the furnishing of a recommended preventive service (such as anesthesia or collection of a specimen) are covered, regardless of whether the item or service is billed separately.

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, vitamin D levels
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 to prevent cardiovascular disease and colorectal cancer for certain ages with a high cardiovascular risk, with a valid prescription
- blood pressure screening
- cholesterol screening for certain ages or at higher risk
- colorectal cancer screening for ages 45 to 75
- contraception: Food and Drug Administration ("**FDA**")-approved contraceptive methods and patient screening, education and counseling for men, including condoms with a valid prescription
- COVID-19: items and services intended to prevent or mitigate coronavirus disease 2019 (COVID-19) if recommended by ACIP or rated "A" or "B" in the current USPSTF recommendations
- depression screening
- type 2 diabetes screening for ages 40 to 70 who are overweight or obese
- diet counseling for adults at higher risk for chronic disease
- falls prevention (with exercise or physical therapy and vitamin D use) for ages 65 or older, living in a community setting
- hepatitis B screening for people at high risk, including people from countries with 2% or more hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more hepatitis B prevalance
- hepatitis C screening for ages 18 to 79
- HIV screening for ages 15 to 65, and others at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- lung cancer screening for ages 50 to 80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- obesity screening and counseling
- sexually transmitted infection (STI) prevention counseling for adults at higher risk
- statin preventive medication for ages 40 to 75 at high risk
- syphilis screening for adults at higher risk
- tobacco use screening for all adults and cessation interventions for tobacco users
- tuberculosis screening for certain adults without symptoms at high risk

IMMUNIZATION VACCINES FOR ADULTS

Doses, recommended ages, and recommended populations vary.

- chickenpox (varicella)
- coronavirus (COVID-19)
- diphtheria
- flu (influenza)
- hepatitis A
- hepatitis B
- human papillomavirus (HPV)
- measles, mumps, rubella
- meningococcal
- pneumococcal
- shingles (herpes zoster)
- tetanus
- whooping cough (pertussis)

COVERED PREVENTIVE SERVICES FOR WOMEN & PREGNANT WOMEN

- birth control: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a provider for women with reproductive capacity (not including abortifacient drugs), including over-the-counter contraceptives with a valid prescription
- bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- breast cancer screening mammogram with or without clinical breast examination, every 1-2 years for women age 40 and over
- breast cancer chemoprevention counseling for women at higher risk
- breast cancer genetic test counseling (BRCA) for women at higher risk
- breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- cervical cancer screening (pap test/smear) for women ages 21 to 65
- chlamydia infection screening for younger women and other women at higher risk
- diabetes screening for women with history of gestational diabetes who are not currently pregnant and who have not been diagnosed with type 2 diabetes before
- domestic and interpersonal violence screening and counseling for all women
- folic acid supplement for women who may become pregnant
- gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
- gonorrhea screening for all women at higher risk
- hepatitis B screening for pregnant women at their first prenatal visit
- human immunodeficiency virus (HIV) screening and counseling for everyone ages 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use
- maternal depression screening for mothers at well-baby visits
- preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh incompatibility screening for all pregnant women and follow up testing for women at higher risk
- tobacco use screening and interventions for all women, and expanded tobacco intervention and counseling for pregnant tobacco users
- sexually transmitted infections (STI) counseling for sexually active women
- syphilis screening
- urinary incontinence screening for women yearly
- urinary tract and other infection screening
- well-woman visits to get recommended preventive services for all women

COVERED PREVENTIVE SERVICES FOR CHILDREN

- alcohol, tobacco and drug use assessments for adolescents
- autism screening for children at 18 and 24 months
- behavioral assessments
- bilirubin concentration screening for newborns
- blood pressure screening
- blood screening for newborns
- depression screening for adolescents beginning routinely at age 12
- developmental screening for children under age 3
- dyslipidemia screening for all children once between ages 9 and 11 and once between ages 17 and 21, and for children at higher risk of lipid disorders
- fluoride supplements for children without fluoride in their water source

- fluoride varnish for all infants and children as soon as teeth are present
- gonorrhea preventive medication for the eyes of all newborns
- hearing screening for all newborns, and regular screenings for children and adolescents as recommended by their provider
- height, weight and body mass index (BMI) measurements taken regularly
- hematocrit or hemoglobin screening
- hemoglobinopathies or sickle cell screening for newborns
- hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- hypothyroidism screening for newborns
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- lead screening for children at risk of exposure
- obesity screening and counseling
- oral health risk assessment for young children from ages 6 months to 6 years
- phenylketonuria (PKU) screening for 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
- well-baby and well-child visits

IMMUNIZATION VACCINES FOR CHILDREN FROM BIRTH TO AGE 18

Doses, recommended ages, and recommended populations vary.

- chickenpox (varicella)
- coronavirus (COVID-19)*
- diphtheria, tetanus, pertussis (DTAP)
- haemophilus influenzae type B
- hepatitis A
- hepatitis B
- human papillomavirus (HPV)
- inactivated poliovirus
- influenza (flu shot)
- measles
- meningococcal
- mumps
- pneumococcal
- rotavirus
- rubella

**Coverage for COVID-19 vaccinations is mandated by the FFCRA and CARES Act.*

Learn More

For the latest immunizations, vaccine schedules for adults and children, and Affordable Care Act rules on expanding access to preventive services, please visit: www.hhs.gov/programs/prevention-and-wellness/index.html.

DEFINITIONS

The following terms apply to all medical and pharmacy benefits offered under our Plan.

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; and
- a decision that denies a benefit based on a determination that a Claimant is not eligible to participate in the medical 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 not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by 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.

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. (*See 'Ambulance' under Covered Expenses below for more detail*)

Allowable Charge
The amount that MIT agrees to pay a provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment, unless otherwise required by applicable law.

2. The Allowable Charge for Emergency Services (including Air Ambulance services) provided by out-of-network providers, as well as non-Emergency Services from an out-of-network provider at an in-network Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, will be covered in accordance with applicable federal law. In such cases, the Allowable Charge will be the Recognized Amount (less any applicable Deductible, copayment or coinsurance), unless otherwise prescribed under applicable law. If the out-of-network provider disputes such Allowable Charge and initiates a 30-day open negotiation and/or independent dispute resolution process in accordance with applicable federal law, MIT will administer such processes. The covered individual's responsibility for Deductibles, copayments, and/or coinsurance for Covered Expenses provided by out-of-network providers as described in this paragraph will be calculated as if the item or service was furnished by an in-network provider, and based on the Recognized Amount (which may differ from the Allowable Charge).

3. In addition to the covered individual's liability for Deductibles, copayments and/or coinsurance, the covered individual may be balance-billed by the out-of-network provider for any difference between the Allowable Charge and the billed charge, except when prohibited by applicable law (certain advance patient notice and consent requirements may be required) and except for those services described in paragraph 2 above.

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

Ambulatory Surgical Center
A licensed facility that:
1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
2. provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the covered individual is in the facility;
3. does not provide inpatient accommodations; and
4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

An Ambulatory Surgical Center includes any licensed facility described in section 1833(i)(1)(A) of the Social Security Act.

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.

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 using the form approved by MIT (which may be obtained from the applicable claims administrator) to the applicable claims administrator designating such an individual. The applicable claims administrator 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 the Claims and Appeals Procedures to the "Claimant" or "you," include (where appropriate) an Authorized Representative.

Case Management - Alternative Treatment Plan
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.

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 provider 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 in the Appeals section.

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

Complications of Pregnancy[2]
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,
2. 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
3. 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.

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

Continuation of Care
The payment of the in-network provider level of benefits for services rendered by certain out-of-network providers for a definite period of time in order to ensure the continuity of care for covered individuals for a Serious Medical Condition. See the CONTINUATION OF CARE section of this SPD for more information.

Continuing Care Patient
A covered individual who, with respect to a provider or facility, is either:
1. undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. undergoing a course of institutional or inpatient care from the provider or facility;
3. scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care;
4. pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. receiving treatment for a terminal illness from the provider or facility.

[2] NTD: Not Used Anywhere.

For this purpose, a serious and complex condition means a condition that, in the case of an acute Illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or in the case of a chronic Illness or condition, is life-threatening, degenerative, potentially disability, or congenital and requires specialized medical care over a prolonged period of time.

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

Critical Access Hospital
A facility that is designated by the state in which it is located and certified by the United States Department of Health and Human Services as a critical access hospital.

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[3] outpatient co-payments.

The Deductible amount includes out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network facilities.

Emergency Medical Condition
A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the Claimant, or with respect to a pregnant Claimant, the health of the Claimant and her unborn child, in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part; or
4. other serious medical consequences.

The below examples combined 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 is not considered an emergency.

[3] NTD: Should this refer instead to mental health and substance use disorders?

Emergency Services
An appropriate medical screening examination, services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital emergency room or department or an independent freestanding emergency department, as well as post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished.

Emergency Services are only covered to treat services provided on an outpatient basis at a Hospital emergency room or department and only for as long as the condition continues to be considered an Emergency Medical Condition, unless otherwise required by applicable law. Under the Plan's current criteria used to process Emergency Services Claims, the following Claims are generally treated as Emergency Services:

- any services provided with an emergency CPT code (Specifically, 99281-99285 and 99288);
- claims with a place of service code indicating the services were rendered in an emergency room (HIPAA place of service 23); or
- any treatment filed with an emergency services revenue code (specifically 0450. 0451, 0452, 0456, 0459, and 0981).

All other (non-emergency) charges in a Hospital during an Admission (including, for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and X-ray services) are paid as inpatient benefit and not Emergency Services.

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

Experimental and/or Investigational Services or Experimental
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 and its claims administrators will make an independent evaluation of the experimental/non-experimental standings of specific technologies. They 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 and its claims administrators will be guided by the following principles:

- if the drug or device cannot be lawfully marketed without approval of the FDA 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 of 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 FDA 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, the Plan 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.

Genetic Testing
A type of medical test that identifies changes in genes, chromosomes, or proteins, the results of which can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder.

Hospice Care Plan

A plan, in writing, by the attending Physician for home or inpatient hospice care which treats the special needs of the Terminally Ill Person and his or her family. The Hospice Care Plan must be approved by the Plan 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 inpatient 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 a 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 the Plan coverage option or combination of Plan coverage options under which the individual is covered.

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 Expense is comprised of the Deductible plus the co-insurance and applicable co-payments. When these items reach the Maximum Out-of-Pocket Expense 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.

Maximum Out-of-Pocket Expense 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%.

Maximum Payment. The maximum amount the Plan will pay (as determined by MIT or its designee) for a particular benefit. The Maximum Payment will not be affected by any credit. The Maximum Payment will be one of the following, as determined by MIT or its designee in its discretion, subject to any different amount that may be required under applicable law:

1. the actual charge submitted to the plan for the service, supply, or equipment by a provider;
2. an amount based upon reimbursement rates established by the Plan;
3. an amount that has been agreed upon in writing by a provider and the Plan;
4. an amount established by the plan, based upon factors including, but not limited to:

a. governmental reimbursement rates applicable to the service, procedure, supply or equipment; or
b. reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location, and circumstances giving rise to the need for the service, procedure, supply or equipment; or

5. the lowest amount of reimbursement the Plan allows for the same or similar service, procedure, supply, or equipment when provided by an in-network provider.

In addition, the Maximum Payment for Emergency Services or Air Ambulance services by an out-of-network provider, or non-Emergency Services by an out-of-network provider at an in-network Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, will be the Recognized Amount, unless a different Maximum Payment amount is permitted or required under applicable law.

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, 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 during which you can make changes to your benefits under our Plan (usually commencing 90 days and ending 30 days prior to the start of the applicable Participating Employer's renewal date).

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.

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

Pre-Certification
The process of obtaining all necessary medical information in order to approve an inpatient hospital stay.

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.

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

For prescriptions, the Prior Authorization program is used to validate diagnosis or other treatment information to assure the prescription is being prescribed appropriately. Often times this requires additional information from the prescriber for approval. A prescriber can submit information by electronic means at go.covermymeds.com/OptumRx; by phone at 1-800-880-1188; or by fax at 1-844-403-1029.

Private Duty Nursing

Skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse (RN), or licensed practical nurse (LPN). Private duty nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private duty nursing service does not include custodial care service.

Quantity Limitations
There may be quantity limitations on certain prescription drug medicines. Quantity limitations are based on the FDA's recommended dosing guidelines for each medication and are reviewed regularly by the Plan to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions. Requests for prescription drug quantities above the Plan's Quantity Limitations require review and authorization by OptumRx.

Recognized Amount
The lesser of the non-participating/non-contracting provider's billed charges or the Plan's median contracted rate for participating/contracting providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with Air Ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

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 the applicable claims 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.

Residential Treatment Center (RTC)
A licensed institution, other than a Hospital, which meets all six (6) of the following requirements:

1. maintains permanent and full-time facilities for bed care of resident patients;
2. has the services of a psychiatrist (addictionologist, when applicable) or Physician extender available at all times who is responsible for the diagnostic evaluation and provides face-to-face evaluation services with documentation a minimum of once per week and as needed as indicated;
3. has a registered nurse (RN) present onsite who is in charge of patient care along with one (1) or more RNs or licensed practical nurses (LPNs) onsite at all times twenty-four (24) hours per day and seven (7) days per week;
4. keeps a daily medical record for each patient;
5. is primarily providing a continuous structured therapeutic program specifically designated to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp, or any other facility that provides Custodial Care; and
6. is operating lawfully as a residential treatment center in the area where it is located.

Serious Medical Condition
A health condition or Illness that requires medical attention and for which failure to provide the current course of treatment through the current provider would place the Claimant's health in serious jeopardy. This includes cancer, acute myocardial infarction, and pregnancy.

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

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

Step Therapy
Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and progressing to other more costly or risky therapy, only if necessary (i.e., you must try drug "A" before you can get drug "B"). You must try one or more prerequisite drugs before the Step Therapy drug will be covered by the Plan. This is designed for people who regularly take prescription drugs to manage ongoing medical conditions. 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.

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 the applicable claims administrator 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.

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.

CASE MANAGEMENT

Case Management - Comprehensive
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 as determined by medical care review;
7. monitoring and assuring treatment programs and interventions; and
8. functioning as an effective resource for information on treatment facilities and available care for serious or catastrophic Illness or Injuries, including for mental health or substance use disorders.

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). In no event shall the penalty apply in the case of claims for mental health or substance abuse disorder benefits.

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

- **All inpatient 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 orthopedic 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 Health Care
- home terbutaline pump therapy
- home uterine monitoring
- Hospice Care
- MRI of breast or heart
- outpatient rehabilitative therapy (physical therapy and/or occupational therapy, combined speech, or cardiac/pulmonary rehab) which exceeds 8 visits.
- pain management including epidural steroid injection (ESI)
- 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 adenoidectomy (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 transplants and/or tissue transplants
- hysterectomy
- inpatient or outpatient back/neck/spine procedures
- lower extremity venous incompetence/varicose vein surgery
- MOHs Surgery
- UPP and UPPP

Certain Prescription Drugs
Some drugs require Prior Authorizations and/or have Quantity Limits. Please review the most up-to-date information by logging into your account at www.Optumrx.com. Below is a sample list of commonly requested drugs that require a Prior Authorization. Some may also have Quantity Limitations.

- Avastin
- Avonex
- Betaseron
- Copaxone
- Enbrel
- immunoglobulin injection (IVIG)
- Interferon
- Lupon
- Orencia
- Peg Intron

- growth hormones
- Humira
- Rituxan
- Tysabri

These procedures need prior authorization if not performed in a Physician's office:

- acne surgery
- anoscopy
- cast application and changes
- change bladder tube
- circumcision (up to 3 months)
- contour of face bone lesion
- colposcopy
- 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
- 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, subcutaneous 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

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 Charge.

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 covered 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 Payment.

If MIT requests that you or your covered Dependent participate in case management and you or your covered Dependent refuse such services, MIT reserves the right to deny payment of subsequent treatment related to that condition.

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 and can only be to the nearest facility able to provide the required Medically Necessary treatment or care. Medical Necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Care to repatriate, either domestically within the 50 U.S. states or from a foreign country, the patient nearer to their home, or nearer to the home of a relative or acquaintance, is not eligible for coverage. It is very strongly suggested that you and your covered Dependents consider acquiring travel insurance for any domestic or foreign travel more than 20 miles from your or their residence. 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 (6) 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 the Maximum Out-of-Pocket Expense.

Genetic Testing

Genetic Testing is covered if it is performed by Greenwood Genetic Center and is used for diagnoses related to high-risk pregnancies or if it is indicated by an abnormal prenatal screening. Covered Genetic Tests are limited to the following:

- chromosomal microarray
- fragile x
- whole exome sequencing (wes) – consisting of exome sequence analysis for the pregnant woman and spouse covered by our Plan
- chromosome analysis, short study - consisting of tissue culture lymphocyte, chromosome analysis 5, and cyto/molecular report.
- chromosome analysis, routine – consisting of tissue culture lymphocyte, chromosome analysis 15-20, and cyto/molecular report.
- chromosome analysis, high resolution - consisting of tissue culture lymphocyte, chromosome analysis 15-20, chromosome study additional hi-res, and cyto/molecular report.
- maternal cell contamination (mcc) – when performed prior to one or more of the tests above, if done prenatally.

Breast cancer genetic test counseling (BRCA) for women at higher risk is also covered by our Plan as a Recommended Preventive Service. See *Understanding Your Preventive Services Coverage* earlier in this SPD.

Hearing Aids

Allowable Charges for hearing aids will only be covered when purchased for a hearing loss which was caused by a specific medical condition diagnosed by a Physician or audiologist. (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 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 Care benefits will be paid for Allowable Charges for hospice care incurred by you or your covered Dependent up to 180 days during your or their lifetime, including both inpatient and outpatient hospice care services. The charges must be made by a hospice care team under a hospice care plan for a terminally ill person. Allowable Charges for hospice care 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 Covered Expense listed below:

1. Allowable Charges for room and board and general nursing care for a Terminally Ill Person in a freestanding hospice; and
2. Allowable 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

Allowable 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 under our Plan.
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; and

3. benefits will be provided to a non-eligible living transplant donor, provided there is no other insurance, Maximum Payment is $10,000 for surgical charges.

Licensed Personnel
Allowable Charges by licensed 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; and
4. speech therapy limited to 30 visits per year, to restore or correct impaired function that is due to:
    a. accidental injury;
    b. surgical operation;
    c. cerebrovascular accident ("stroke"); or
    d. congenital defects and birth abnormalities in a child.

Medical Supplies
Allowable 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; and
10. catheters.

Mental Health and Substance Use Treatment
Allowable Charges by an approved provider or for drugs prescribed by an approved provider will be covered, including professional fees, for the treatment and diagnostic services for mental health and substance use disorders.
1. Allowable Charges made by a Residential Treatment Center, psychologists, social workers, licensed counselors, or for psychiatric services will be covered, including professional fees for the treatment and diagnostic services for, and drugs prescribed by approved providers to treat, mental/nervous conditions, including, but not limited to Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).
2. Allowable Charges for substance use disorders include treatment of the uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals, and the resultant physiological and/or psychological dependency that develops with continuous use.

Physicians' Fees
Allowable Charge 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; and
9. initial pediatric examination (other than the delivering Physician), provided you are covered for Dependent children

Prescription Drugs
Drugs and medications that (1) can be 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) are purchased within the United States. Special rules apply to those drugs and medications categorized as specialty drugs which must be obtained through the specialty drug program in order for you to avoid having to pay their higher copayment cost.

Skilled Nursing Facility Care
Patient must be admitted to the facility within 14 days following confinement in a Hospital for at least three (3) consecutive days. Coverage is provided for a maximum of 60 calendar days per year for:

1. room and board; and
2. Allowable 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.

Wigs
Allowable Charges for the initial wig/hairpiece will be covered when purchased for hair loss caused by chemotherapy administered for cancer. (Maximum Payment amount for the wig/hairpiece: $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 inpatient or in an outpatient facility that could have been performed in a less expensive setting as determined by the Plan, except to the extent required by law.
3. educational, occupational, recreational, and 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 (1) year of the accident of an injury to natural teeth other than by eating or chewing (including their replacement);
      (iii) Physician service for excision or extraction of impacted teeth, when supported by dental x-rays; or
      (iv) Hospital services for excision or extraction of three or more bony impacted teeth, when supported by dental x-rays, and in connection with dental services if the procedure is of such complexity as to require hospitalization or if hospitalization is required to ensure proper medical management, control or treatment of a non-dental physical condition, when advance approval of coverage has been obtained from the Plan.
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 a short-term basis on business or for pleasure.
9. experimental and/or Investigational Services, including surgery, medical procedures, devices, or drugs. We reserve 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. services or supplies not specifically listed under Covered Expenses.
11. 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.
12. blood or blood plasma (that is replaced by a blood bank).
13. expenses related to obesity, weight reduction or weight control, except obesity screening and counseling covered as a preventive service (See *Preventive Services Benefits* earlier in this SPD).
14. acupuncture.
15. treatment or surgery to change gender or to improve or restore sexual function or to reverse sterilization.
16. 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.
17. services for which no charge is made, such as VA hospitals or similar hospitals or agencies.
18. charges for chiropractic services regardless of who renders the service.
19. usual and normal home medical supplies or first aid items.
20. nutritional counseling, over-the-counter vitamins, over-the-counter food supplements and other dietary supplies.

21. more than $25,000 per lifetime for any treatment (including prescription medications) of infertility.
22. charges for an egg or sperm donor if the donor is not covered by our Plan.
23. speech therapy, except as specifically provided under Covered Expenses.
24. 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.
25. expenses for a covered individual engaging in an illegal occupation or employment.
26. any and all charges related to surrogate parenting.
27. removal of breast implants that were initially placed for cosmetic, non-reconstructive purposes.
28. expenses incurred as a result of a Dependent child's pregnancy.
29. services, procedures, or drugs not meeting Medical Necessity criteria or pre-certification/prior authorization criteria.
30. reduction mammoplasty under the age of 16.
31. prescription drugs purchased outside the United States (drug re-importation).
32. combined occupational/physical therapy visits in excess of 30 visits per calendar year.
33. speech therapy in excess of 30 visits per calendar year.
34. Genetic Testing, except to the extent specifically provided in the *Covered Services* or *Understanding Your Preventive Services Coverage* sections of this SPD.
35. all expenses, accommodations, materials, services, and care related to non-Covered Services.
36. all expenses provided or ordered to treat complications of a non-covered Illness, Injury, condition, situation, procedure, or treatment.
37. all charges, services, treatments, or drugs prescribed for autism and/or autism spectrum disorder except what is allowed in the *Preventive Services* section of this SPD.
38. hospice charges in excess of the 180-day lifetime limitation.
39. Home Health Care in excess of 60 visits per calendar year. Benefits for Home Health Care do not include non-treatment services or: (a) routine transportation; (b) homemaker or housekeeping services; (c) behavioral counseling (d) supportive environmental equipment; (e) maintenance care or Custodial Care; (f) social casework; (g) meal delivery; (h) personal hygiene; and/ or (i) convenience items.
40. Private Duty Nursing.
41. admissions or portions thereof for custodial care or long-term care, including:
    a. rest cares;
    b. 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);
    c. Custodial Care or long-term care; or
    d. psychiatric or substance use residential treatment when provided at therapeutic schools, wilderness/bootcamps, therapeutic boarding homes, halfway houses, and therapeutic group homes, except where required by law.
42. court-ordered drug testing.
43. relationship counseling, including marriage counseling, for the treatment of premarital, marital or relationship dysfunction.
44. orthognathic surgery including Temporomandibular Joint Syndrome (TMJ).

CONTINUATION OF CARE

If an in-network provider's contract ends or is not renewed for any reason other than fraud or a failure to meet applicable quality standards and the covered individual is a Continuing Care Patient, the covered individual may be eligible to continue to receive in-network benefits from that provider with respect to the course of treatment relating to the covered individual's status as a Continuing Care Patient.

In order to receive this Continuation of Care, the covered individual must submit a request to the Plan on the appropriate form. Upon receipt of the request, the Plan will notify the covered individual and the provider of the last date the provider is part of the network and a summary of Continuation of Care requirements. The Plan will review the request to determine qualification for the Continuation of Care. If additional information is necessary to make a determination, the Plan may contact the covered individual or the provider for such information. If the Plan approves the request, in-network benefits for that provider will be provided, with respect to the course of treatment relating to the covered individual's status as a Continuing Care Patient, for ninety (90) days or until the date the covered individual is no longer a Continuing Care Patient for the provider. During this time, the provider will accept the in-network allowance as payment in full. Continuation of Care is subject to all other terms and conditions of this Plan, including regular benefit limits.

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 by our Plan for the same benefits available to employees under age 65. In this case, our Plan will pay all Covered 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. If you disenroll, this means that neither you nor your eligible Dependents will be eligible for 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 our Plan 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 covered Dependent is eligible for Medicare due to disability and is also covered under our Plan by virtue of current employment status with MIT or a Participating Employer, our Plan will be considered the primary payer (and Medicare will be secondary).

End-Stage Renal Disease: If you or your covered 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 Plan coverage with Medicare, please contact MIT at 1-800-327-1021 for further information. You may also find additional information about Medicare and supplemental Medicare plans 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, our Plan may not, under Federal law, require that a provider obtain authorization from our Plan 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 by our Plan, 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 medical or dental coverage (as applicable) 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.

For this purpose, 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 medically necessary leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the medical or dental coverage (as applicable) or our Plan – for example, by reaching age 26.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your Participating Employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your Dependent children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under our Plan, your Participating Employer must allow you to enroll in our Plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage under our Plan within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in our Plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your Plan premiums. The following list of states is current as of January 31, 2024. Contact your state for more information on eligibility –

ALABAMA – Medicaid	ALASKA– Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website :https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website:https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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, Menu Option 4, Ext. 61565

CLAIMS AND APPEALS

General

Claims for Physician's Employees
If Claims are submitted for treatment provided by a Participating Employer for its employees or Physicians (as defined in our main SPD) 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 or Physicians 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.

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).

No Assignment
Most providers 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 from 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.

Medical Claims
MIT has hired Planned Administrators, Inc. (PAI) to process medical (but not prescription drug) 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: 1-800-768-4375
> 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 Claims
MIT has hired OptumRx to process prescription drug Claims on behalf of our Plan. For non-specialty prescription drugs obtained at an in-network retail pharmacy, MIT will provide coverage for up to a 90-day supply per dispensing (standard supply), subject to the cost share listed in the OptumRx online "pricing and coverage" tool. You should present your prescription drug identification 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 Prescription Reimbursement Request Form located on the MIT website. For assistance you may contact MIT at MITinfo@scmedical.org or 1-800-327-1021.

MIT uses the OptumRx Premium Formulary. The OptumRX Premium Formulary is a list of medications that are covered by our Plan and can be found at: https://professionals.optumrx.com/resources/formulary-drug-lists.html or on the MIT website. However, specific coverage and/or utilization limitations may apply. Covered individuals may have specific benefit exclusions, copayments or coverage considerations that are not reflected specifically in the OptumRx Premium Formulary. The OptumRX Premium Formulary applies only to outpatient drugs prescribed to covered individuals and does not apply to medications used in an inpatient setting. If you have specific questions regarding your coverage, please contact OptumRx at 1-844-538-1209.

General Covered Drugs

- federal legend drugs
- state restricted drugs
- antihaemophilia agents
- diabetic supplies

- needles and syringes
- specialty pharmacy drugs
- compounded medications of which all ingredients are covered by the Plan
- ACA preventative medication drug list (covered at 100%)

General Excluded Drugs

- over-the-counter (OTC) medications or their equivalents, unless the individual's pharmacy benefit offers coverage of OTC medications
- drugs specifically listed as not covered
- any drug products used for cosmetic purposes
- Experimental drug products or any drug product used in an Experimental manner
- non-self-administered injectable drug products unless otherwise specified in the OptumRx Premium Formulary listing
- foreign-sourced drugs or drugs not approved by the FDA, except in certain cases of drug shortage, when allowed under the individual's pharmacy benefit
- vitamins and nutritional products or supplements
- dietary management
- homeopathics

Our Plan offers a Home Delivery Pharmacy Benefit program through OptumRx, which allows you to order non-specialty prescription drugs with coverage for up to a 90-day supply per dispensing (standard supply), subject to the cost share listed in the OptumRx online "pricing and coverage" tool. You can log in to the portal at Optumrx.com to see if you have eligible prescriptions for this program. Ordering through the Home Delivery Pharmacy Benefit program will provide you with a savings if a pharmacy copayment would otherwise apply. You may enroll in the program and receive automatic refills from OptumRx Home Delivery using a credit card on file. You can opt-out of the program at any time.

Our Plan utilizes Optum Specialty Pharmacy as the specialty pharmacy. You can set up specialty services when you log into your account at Optumrx.com or call OptumRx at 1-844-538-1209. Specialty medications are limited to a 30-day supply.

Claims Procedures

The following medical Claims procedure and prescription drug Claims procedure apply to Claims.

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 PAIs 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 the applicable claims administrator 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 medical services or prescription drugs. Pre-Service Claims for Prior Authorization of these services and prescription drugs must be submitted by calling the applicable claims administrator.

Initial Benefit Notification - A Pre-Service Claim is considered to have been filed upon receipt of the Claim by the applicable claims administrator. For Pre-Service Claims filed in accordance with these Claim Procedures, you will be notified of an Initial Benefit Determination within 15 days of receipt of the Claim by the applicable claims administrator. 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 by the claims administrator of the circumstances requiring the extension of time and the date by which an Initial Benefit Decision is expected to be rendered.

In the event additional information is needed from you to process your Claim, you will receive a Request for Additional Information before the end of the initial 15-day period, which specifies the information needed. You will have 45 days from receipt of the Request for Additional Information to supply the information requested. If you do not provide the information within the specified time frame, your Claim will be denied. During the period in which you may supply additional information, the normal deadline for making the Initial Benefit Determination will be suspended. The deadline is suspended from the date of the Request for Additional Information

until either 45 days or the date you respond to the request (whichever is earlier). The claims administrator 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.

Urgent Claims
A Pre-Service Claim that is also an Urgent Claim will be treated as an Urgent Claim. Urgent Claims, which may include Pre-Certifications of Hospital admissions and Prior Authorizations of various services and prescription drugs, must be submitted by calling the applicable claims administrator. An Urgent Claim is considered to have been filed upon receipt of the Claim by the applicable claims administrator.

For properly filed Urgent Claims, you will be notified of an Initial Benefit Determination by telephone as soon as possible, considering 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 will specify the specific information necessary to complete the Claim. You must provide the specified information to the claims administrator 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 deciding 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 (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 the applicable claims administrator's Utilization Review. A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made by the claims administrator 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 Claim, the applicable claims administrator will respond to your request within 24 hours of receipt of the Claim, provided that the Claim is received by the claims administrator 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 the applicable claims administrator 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 the applicable claims administrator 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 the claims administrator 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 the applicable claims administrator. Ordinarily, Claimants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the claims administrator. The claims administrator 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 the claims administrator expects to render a decision.

If an extension is required because the claims administrator needs additional information from you, the claims administrator 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 deciding on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until either 45 days or until the date you respond to the request, whichever is earlier. The claims administrator then has 15 days to decide on the Claim and provide you with the Initial Benefit Determination.

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

Notice of Initial Benefit Determination

The applicable claims administrator 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

Medical Appeals

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 NIT 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 the Plan.
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 the Plan.
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 the Plan.

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 is 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; and
- 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 ACA. 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.

External Appeals

After you have completed the appeals process, you may be entitled to an additional, external review of your medical Claim at no cost to you. An external review may be used to reconsider your medical Claims if our Plan has denied, either in whole or in part, your medical Claim. In order to qualify for external review, your medical Claim must have been denied, reduced, or terminated. In addition, our Plan will apply these external review procedures to any Adverse Benefit Determination as to any surprise billing protections, as required by applicable law.

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, our Plan 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 our Plan. 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 our Plan's denial of benefits if our denial of benefits involved Emergency Services 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 claims process for any of the benefits offered under our Plan:

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

Pharmacy Appeals

Appeals of Adverse Benefit Determinations

If an Adverse Benefit Determination is rendered, in whole or in part, or a benefit denial is rendered on your prescription drug Claim, you may file an appeal of that determination. Your appeal of the Adverse Benefit Determination can either be verbal or written and submitted to OptumRx within 180 days after you receive notice of the Adverse Benefit Determination.

If the Adverse Benefit Determination is rendered with respect to an urgent Prior Authorization (PA) request, a healthcare professional with knowledge of your condition is always deemed to act as your representative. If you do not object to representation by a healthcare professional or authorize the healthcare professional or another party to represent you to the conclusion of the appeal process, you will have exhausted your opportunity to appeal the Adverse Benefit Determination or benefit denial in the future. However, if you do not authorize the healthcare professional to request an appeal on your behalf, you may reject the representation and withdraw the appeal request.

Your representatives must be identified, and their authority verified in accordance with OptumRX policy and procedures. There are no fees or costs charged to you for any level of appeal conducted by OptumRX on behalf of our Plan.

Your appeal should include the following information:

- name of the person filing the appeal,
- pharmacy benefit identification number,
- date of birth,
- written statement of the issue(s) being appealed,
- drug name(s) being requested, and
- written comments, documents, records or other information relating to the Claim.

Your appeal and supporting documentation may be mailed or faxed to:

OptumRx
Attn: Appeals Coordinator
P.O. Box 25184
Santa Ana, CA

OR

PA (Clinical) Appeal Phone # 888-403-3398
PA (Clinical) Appeal Fax # 844-403-1029

OptumRx's Review

The review of your claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the guidelines under our Plan's pharmacy benefit coverage option, the requirements of ERISA and any related laws. You will be accorded all rights granted to you under ERISA, if applicable.

Review of Adverse Benefit Determinations of Pre-Service Clinical Prior Authorizations

OptumRx will provide the first-level review of appeals of Adverse Benefit Determination for pre-service clinical Prior Authorizations (PA). Such Claims will be reviewed against pre-determined clinical criteria relevant to the drug or benefit being requested under our pharmacy benefit plan. If your first-level appeal is denied, you may appeal the decision and request an additional second-level review. The second-level review will be conducted by an Independent Review Organization (IRO).

Review of Administrative Denials

OptumRx provides a single level of appeal for administrative denials. Upon receipt of such an appeal, OptumRx will review your request for a particular drug or benefit against the terms of our Plan, including preferred drug lists or formularies selected by our Plan.

Timing of Review

- Pre-Service Clinical Prior Authorization Appeal – OptumRx will decide on a first-level appeal of an Adverse Benefit Determination rendered on a pre-service clinical Prior Authorization Claim within 15 days after it receives your appeal. If OptumRx renders an Adverse Benefit Determination on the first-level appeal of the pre-service clinical Prior Authorization Claim, you may appeal that decision by providing the information described above. A decision on your second-level appeal of the Adverse Benefit Determination will be made (by the IRO) 45 days after the new appeal is received.

- Urgent Care Claim Appeal - If you appeal an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the appeal request is received.
- Administrative Denial Appeal – OptumRx will decide on an appeal of an Adverse Benefit Determination rendered on an administrative denial within 15 days after it receives such appeal.
- Post Service Claim Appeal – OptumRx will decide on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 30 days after it receives such appeal.

Scope of Review

During its pre-authorization review, first-level review of the appeal of a pre-service clinical Prior Authorization Claim, or review of a Post-Service Claim or administrative denial, OptumRx shall:

- take into account all comments, documents, records and other information submitted by you relating to the Claim, without regard to whether such information was submitted or considered in the Initial Benefit Determination on the Claim;
- follow reasonable procedures to verify the benefits determination is made in accordance with applicable Plan documents;
- follow reasonable procedures to ensure that the applicable Plan provisions are applied to you in a manner consistent with how such provisions have been applied to other similarly-situated covered individuals, and
- provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If you appeal OptumRx's denial of a pre-service clinical claim and request an additional second-level review by an IRO, the IRO shall:

- consult with an appropriate healthcare professional who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- identify the healthcare professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, and
- provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination

Following the review of your Claim, OptumRx will notify you of any Adverse Benefit Determination in writing (decisions on Urgent Care Claims will also be communicated by telephone). This notice will include:

- the specific reason(s) for the Adverse Benefit Determination;
- references to pertinent Plan provisions on which the Adverse Benefit Determination was based
- a statement that you are entitled to receive, upon written request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Claim;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion will be provided free of charge upon written request, and
- if the Adverse Benefit Determination is upheld by the IRO, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of our Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

COORDINATION OF BENEFITS

Our Plan includes a Coordination of Benefits (COB) provision to eliminate duplicate payment of medical or prescription drug 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 spouse or dependent child 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; and
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 dependent 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 during which benefits are actually paid or provided before the entity has the actual knowledge, and
   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 Charge for in-network providers, for:
1. a medical or prescription drug 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. Our Plan has the right to decide which facts are needed. We may receive needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming medical or dental benefits under our Plan must give us any facts needed to pay the claim. We 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, our Plan 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. We 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 our Plan is more than should have been paid under this COB provision, the excess may be recovered from one or more of the persons we have paid or for whom we have 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.

MEDICAL BENEFIT OPTIONS

All Plan Medical Benefit Options include the following:

- Emergency Services are paid at the in-network benefit level, regardless of provider.
- Ambulance Services are paid at the in-network benefit level, regardless of provider, to the extent required by applicable federal law and provided that our Plan's requirements are satisfied.
- our Plan will pay at in-network benefit levels for covered services rendered by out-of-network providers when you or your covered Dependent are receiving non-Emergency Services at certain in-network facilities (unless the provider satisfies advance patient notice and consent requirements).
- specialty prescriptions must be processed through our preferred specialty pharmacy after one retail fill. Contact MIT directly for more information.
- covered Preventive Service Benefits are paid at 100% when services are rendered by an in-network provider or, in the case of prescription drugs when issued pursuant to a valid prescription
- Step Therapy is required.
- all mental health treatment and substance use services are covered with the same cost sharing (coinsurance and/or copayment) limitations, and requirements as the corresponding medical/surgical benefits.
- inpatient benefits includes all other (non-emergency) benefits in a Hospital during an admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and x-ray services).

Please also note the below additions for Major Medical Options:

- in-network and out-of-network deductibles and out-of-pocket amounts are separate (except for special situations, such as certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network facilities).
- prescription fixed dollar copayments 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.
- emergency room fixed dollar copayments do apply to the out-of-pocket maximum
- prescription copayments for a 90-day supply through mail order pharmacy are two and half (2½) times the retail copayment for a 30-day supply. In contrast, prescription copayments for a 90-day supply through a retail pharmacy are three (3) times the retail copayment for a 30-day supply.
- prescriptions drug supplies covering a period of longer than 90 days require Plan approval and will generally only be approved if the covered individual is expected to have an extended absence from the available network area resulting from a leave of absence or other extenuating circumstances and provided that the covered individual's Plan coverage is expected to remain in place and the cost to our Plan is insignificant.
- Pre-Certification/Prior Authorization is required for all inpatient admissions and certain outpatient procedures. Except as otherwise provided in this SPD, 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.

Please also note the below additions for Premier Plus, Prime Plus, Select Plus, and Value Plus Options:

- prescription fixed dollar copayments do apply to the out-of-pocket maximum.
- office visit fixed dollar copayments do apply to the out-of-pocket maximum.
- emergency room fixed dollar copayments do apply to the out-of-pocket maximum.
- prescription copayments 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 inpatient admissions and certain outpatient procedures. Except as otherwise provided in this SPD, 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.

Please also note the below additions 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.

Major Medical Choice Plus

SCHEDULE OF BENEFITS		
In-Network Embedded Deductible[4]	$500/person	$1,500/family
Out-of-Network Embedded Deductible[5]	$1,000/person	$3,000/family
In-Network Embedded Maximum Out-of-Pocket Expense[6]	$2,500/person	$7,500/family
Out-of-Network Embedded Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[7]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	80%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%	50%
Alcohol/Drug Addiction (Hospital & Physician In-patient or Outpatient)	80%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$100 Fee 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 (including Urgent Care)		
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	80% (30 day) 50% (90 day)	Not Applicable (0%)

[4] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family deductible applies to 3 or more persons.

[5] Family deductible applies to 3 or more persons.

[6] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family limit applies to 3 or more persons.

[7] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

Major Medical HD 1000

SCHEDULE OF BENEFITS		
In-Network Embedded Deductible[8]	$1,000/person	$3,000/family
Out-of-Network Embedded Deductible[9]	$2,000/person	$6,000/family
In-Network Embedded Maximum Out-of-Pocket Expense[10]	$3,000/person	$9,000/family
Out-of-Network Embedded Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[11]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	80%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	80%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits & Emergency Ambulance Transport	$100 Fee 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 (including Urgent Care)		
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	80% (30 day) 50% (90 day)	Not Applicable (0%)

[8] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family deductible applies to 3 or more persons.

[9] Family deductible applies to 3 or more persons.

[10] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family limit applies to 3 or more persons.

[11] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

Major Medical HD 2000 Enhanced

SCHEDULE OF BENEFITS		
In-Network Embedded Deductible[12]	$2,000/person	$6,000/family
Out-of-Network Embedded Deductible[13]	$4,000/person	$12,000/family
In-Network Embedded Maximum Out-of-Pocket Expense[14]	$4,000/person	$12,000/family*
Out-of-Network Embedded Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[15]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	80%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$100 Fee 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[16]**	**Out-of-Network**
Office Visit Co-pay (including Urgent Care) for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$50	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$5/$35/$60 (30 day) $12.50/$87.50/$150 (90 day-mail) $15/$105/$180 (90 day-retail)	Not Applicable (0%)
Prescription Drug Coverage ($500-$999)	$65 copay (30 day) $162.50 (90 day)	
Prescription Drug Coverage ($1000-$1499)	$130 copay (30 day) $325 (90 day)	
Prescription Drug Coverage ($1500-$2000)	$200 copay (30 day) $500 (90 day)	
Prescription Drug Coverage (above $2000)	$275 copay (30 day) $687.50 (90 day)	
Prescription Drug Coverage (specialty)	$275 copay	Not Applicable (0%)

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit.*

[12] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family deductible applies to 3 or more persons.
[13] Family deductible applies to 3 or more persons.
[14] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family limit applies to 3 or more persons.
[15] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).
[16] Office visits exclude any other procedures performed during the visit.

Major Medical HD 5000

SCHEDULE OF BENEFITS		
In-Network Embedded Deductible[17]	$5,000/person $12,700/family	
Out-of-Network Embedded Deductible[18]	$10,000/person $30,000/family	
In-Network Embedded Maximum Out-of-Pocket Expense[19]	$9,100/person $18,200/family	
Out-of-Network Embedded Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[20]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	80%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	80%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$100 Fee 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 (including Urgent Care)		
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	80% (30 day), 50% (90 day)	Not Applicable (0%)

[17] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family deductible applies to 3 or more persons.

[18] Family deductible applies to 3 or more persons.

[19] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. Family limit applies to 3 or more persons.

[20] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

HDHP Option I

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[21]	$1,600/single	$3,200/family
Out-of-Network Aggregate Deductible	$3,200/single	$6,400/family
In-Network Aggregate Maximum Out-of-Pocket Expense[22]	$1,600/single	$3,200/family
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[23]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	100%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	100%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	100%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	100%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	100%	50%
Hospice (Maximum 180 days/lifetime)	100%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	100%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	100%	50%
All Other Covered Expenses (including Urgent Care)	100%	50%
Physician Office Visits	100%	50%
Emergency Room Visits & Emergency Ambulance Transport	100%	100%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	100 %	Not Applicable (0%)

[21] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities. .

[22] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[23] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

HDHP Option II

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[24]	$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[25]	$3,750/single	$7,500/family
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[26]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	90%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day) 75% (90 day)	Not Applicable (0%)

[24] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[25] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[26] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

HDHP Option III

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[27]	$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[28]	$4,500/single	$9,000/family
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[29]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	90%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day) 75% (90 day)	Not Applicable (0%)

[27] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[28] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[29] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

HDHP Option IV

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[30]	$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[31]	$5,250/single	$10,500/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[32]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	90%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day) 75% (90 day)	Not Applicable (0%)

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

[30] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[31] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[32] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

HDHP Option VI

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[33]	$3,500/single	$7,000/family
Out-of-Network Aggregate Deductible	$5,000/single	$10,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[34]	$7,000/single	$12,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[35]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	70%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	70%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	70%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	70%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	70%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	70%	50%
All Other Covered Expenses (including Urgent Care)	70%	50%
Physician Office Visits	70%	50%
Emergency Room Visits & Emergency Ambulance Transport	70%	70%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	70% (30 day) 50% (90 day)	Not Applicable (0%)

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

[33] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[34] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[35] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

HDHP Option VII

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[36]	$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[37]	$7,500/single	$15,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[38]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	90%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day) 75% (90 day)	Not Applicable (0%)

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

[36] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[37] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[38] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

HDHP Option VIII

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[39]	$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[40]	$7,500/person	$15,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[41]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	90%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	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 (including Urgent Care)		
Physician Office Visits	90% (30 day) 75% (90 day)	Not Applicable (0%)

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit*

[39] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[40] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[41] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

Premier Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[42]	$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[43]	$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[44]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	70%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	70%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	70%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee 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		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay (including Urgent Care) for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day) $30/$200/$500 (90 day-mail) $36/$240/$600 (90 day-retail)	Not Applicable (0%)
Prescription Drug Coverage (specialty)	$250	

** Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

*** Excludes any other procedures performed during the visit.*

[42] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[43] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[44] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

Prime Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[45]	$3,000/person $6,000/family	
Out-of-Network Aggregate Deductible	$5,000/person $10,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense[46]	$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[47]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	70%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	70%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	70%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee 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		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay (including Urgent Care) for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day) $30/$200/$500 (90 day-mail) $36/$240/$600 (90 day-retail)	Not Applicable (0%)
Prescription Drug Coverage (specialty)	$250	

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit.*

[45] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[46] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[47] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies the advance patient notice and consent requirements).

Select Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[48]	$3,500/person	$7,000/family
Out-of-Network Aggregate Deductible	$6,500/person	$13,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[49]	$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[50]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	70%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	70%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	70%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee 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		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay (including Urgent Care) for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day) $30/$200/$500 (90 day-mail) $36/$240/$600 (90 day-retail)	Not Applicable (0%)
Prescription Drug Coverage (specialty)	$250	

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

*** Excludes any other procedures performed during the visit.*

[48] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[49] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[50] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

Value Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[51]	$9,100/person	$18,200/family*
Out-of-Network Aggregate Deductible	$10,000/person	$30,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[52]	$9,100/person	$18,200/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[53]**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA), Laboratory, X-ray	100%	50%
Assistant Surgeons (limit of 25% of primary surgeon's allowable fee)	100%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	100%	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	100%	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	100%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee 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		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay (including Urgent Care) for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day) $30/$200/$500 (90 day-mail) $36/$240/$600 (90 day-retail)	Not Applicable (0%)
Prescription Drug Coverage (specialty)	$250	

** Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

*** Excludes any other procedures performed during the visit.*

[51] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[52] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[53] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

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

Basic Dental Benefit Summary

(this document is part of the Summary Plan Description for MIT)

Effective January 1, 2024

INTRODUCTION

This Benefit Summary is part of the Summary Plan Description ("SPD") for the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust ("MIT").

As used in this Benefit Summary, the *Plan* refers to the basic dental plan coverage option offered under MIT. This Benefit Summary is effective as of January 1, 2024.

The purpose of this dental benefit offered by our *Plan* is to provide reimbursement for eligible expenses incurred as a result of *dentally necessary treatment* for *injury* or sickness for the *Adopting Employer's* eligible *employees* and their eligible spouse and dependents.

The *Plan* is not a contract of insurance and the *Participating Employers* do not assume the obligations of an insurer under the *Plan*.

Sun Life Assurance Company of Canada/Sun Life and Health Insurance Company (U.S.) is the Claims Service/Advice Only Administrator for the dental benefits offered by our Plan.

ELIGIBILITY TO OFFER DENTAL COVERAGE

For a Participating Employer to offer dental benefits to its eligible employees and Physicians through MIT, the Participating Employer must maintain 50% participation in dental benefits, 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).

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EMPLOYEE AND DEPENDENT DENTAL COVERAGE INFORMATION

(Dependent coverage applies only if elected)

Participant's effective date on file with Plan Administrator

SCHEDULE OF BENEFITS
Basic Plan

Deductible Amount Per Benefit Year:

	Network Plan	**Out-of-Network Plan**
Individual Deductible Amount:		
for Class II and III Dental Services:	$50	$50
Maximum Family Deductible:	3 persons individually	3 persons individually

The individual deductible does not apply to Class I Network or Out-of-Network Dental Services.

Covered dental expenses incurred toward the deductible amount apply to both the Network and Out-of-Network Plans.

Coinsurance Percentages

	Network Plan	**Out-of-Network Plan**
Class I Preventive Services:	100%	100%
Class II Basic Services:	75%	75%
Class III Major Services:	45%	45%

Benefit Maximums:

Benefit Maximums	**Network Plan**	**Out-of-Network Plan**
Benefit Year Maximum:	$1,000	$1,000

Amounts applied to the benefit maximums will apply to both the Network Plan and Out-of-Network Plan maximums.

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

ARTICLE ONE

DEFINITIONS

The below terms have the meanings shown here when *italicized*. All other capitalized terms have the meaning set forth in our main SPD.

Active work means the expenditure of time and energy for the *participating employer* or an *associated company* at your usual place of business on a *full-time* basis

Allowable charge means:

- For a covered dental service rendered by a *network provider*, the *allowable charge* is based on an amount that the *network provider* has agreed to accept.

- For a covered dental service rendered by an *out-of-network provider*, the *allowable charge* is the reasonable charge. The reasonable charge is the charge made by other providers in the area for like *treatment*. A determination by the *Dental Claims Administrator* of what is an *allowable charge* or reasonable charge is final for the purposes of determining benefits payable under the *Plan*.

A determination by the *Dental Claims Administrator* of what is an *allowable charge* is final for the purpose of determining benefits payable under the *Plan*.

Allowable expense means any *dentally necessary*, *usual and customary charge*, at least a portion of which is covered under 1 or more of the *programs* which cover the person:

- for whom claim is made, and

- on whose account payment is legally required.

When a *program* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a *program*, the amount of the reduction will not be considered an *allowable expense*. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense*.

Benefit year normally means a calendar year beginning on January 1 of any year and ending on December 31 of that year, unless a different benefit year has been requested by the Participating Employer and has been approved in writing by MIT.

Claim period means a calendar year. A *claim period* will not start before a person's effective date of participation under this *Plan* nor extend beyond the last day the person is covered under this *Plan*.

Claimant means an individual who has submitted an application for benefits under the *Plan*.

Contributory means the *Participant* pays part or all of the *Plan* costs and/or benefits through contributions from the *Participant*.

Covered dependent means an *eligible dependent* who is covered under the *Plan*.

Dental Claims Administrator means Sun Life Assurance Company of Canada/Sun Life and Health Insurance Company (U.S.), which has accepted appointment by the *Plan Administrator* to provide certain administrative services with respect to the *Plan*.

Dental coverage means the group dental coverage under the *Plan*.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

Dentally necessary and dental necessity mean a *treatment* appropriate for the diagnosis and in accordance with accepted dental standards. The *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;
- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Eligible class means class of persons eligible to participate under the *Plan*.

Emergency dental care means any *dentally necessary treatment* rendered or received as the direct result of unforeseen events or circumstances which require prompt attention.

Employer means and includes the *Participating Employers*.

Employee means any person employed by an *Employer*. An *Employee* may or may not be a *Participant*.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the regulations and rulings in effect thereunder from time to time.

Family unit means a *Participant* and his *covered dependents*.

Full-Time has the meaning set forth in the main SPD.

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Immediate family member means a person who is related to the *Participant* in one of the following ways: parent, Spouse, *domestic partner*, child, brother, sister, grandparent or grandchild.

Medicaid means the Title XIX of the Social Security Act of 1965 as amended.

Natural tooth means any tooth or part of a tooth that is formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Network provider means a *dentist* who is a participant in the *network provider plan*.

Network provider plan means the dental care delivery system in which *network providers* participate and under which we provide certain dental benefits.

Noncontributory means the Trust pays for the entire *Plan* costs and benefits.

Orthodontic treatment means the procedures which provide the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food). Determination of the severity of the malocclusion will be made by the *Dental Claims Administrator*.

Other group dental expense coverage means:

- any other group plan providing benefits for dental expenses; or
- any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Out-of-network provider means a *dentist* who is not a participant in the *network provider plan* at the time covered dental services are provided.

Out-of-network provider plan means the plan under which we provide certain dental benefits for services received from an *out-of-network provider*.

Participant means an eligible e*mployee or Physician* who participates in the *Plan*.

Participating Employer has the meaning set forth in the main SPD.

Periodontal maintenance procedures mean recall procedures for patients who have undergone either surgical or non-surgical *treatment* for periodontal disease. The procedures include examination, periodontal evaluation and any further scaling and root planing that is *dentally necessary*.

Plan means the group dental plan established by the *Participating Employer* that describes benefits for *Participants* and their *covered dependents*.

Plan Administrator shall have the same meaning as provided in *ERISA*.

Pre-estimate review means review of a *dentist's* statement, including diagnostic X-rays, describing the planned *treatment* and expected charges.

Primary program means a *program* whose benefits for health care coverage must be determined without considering the existence of any other *program*. A *program* is *primary* if:

- the *program* has no order of benefit determination rules, or it has rules which differ from *this provision*; or
- under the order of benefit determination rules, this *Plan* determines its benefits first.

Prior plan means the Employer's plan of group dental coverage or insurance that was replaced by the Plan.

Program means any program which provides benefits or services for medical or dental care or treatment through:

- group, blanket, or franchise insurance coverage;
- group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);
- a labor-management trusteed plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;
- coverage under government programs or coverage required or provided by any statute, except *Medicaid*. Benefits and services provided by Part A and Part B of *Medicare* are included. If the *Participant* or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if the *Participant* or the *covered dependent* had been covered, will be included, unless prohibited by state law or regulation; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by state law or regulation.

Program does not include any of the following:

- school accident coverage;
- the first $30 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;
- Medicaid; and does not include a law or program when, by law, its benefits are in excess of those of any private or other non-governmental plan; or

- no-fault motor vehicle coverage or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of this Plan have been determined, or any optional no-fault motor vehicle coverage.

The term *program* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

- that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other programs in determining its benefits; and

- that part which does not.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

Secondary program is not a *primary program* and may consider the benefits of the *primary program* and the benefits of any other *program* which, under the rules of *this provision*, has its benefits determined before those of that *secondary program*.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Trust means the *Trust* established under the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan *Trust Agreement*.

ARTICLE TWO

DENTAL PLAN BENEFITS

Benefits Provided

The *Plan* will provide benefits for covered dental expenses identified in this Summary when incurred by the *Participant* or a *covered dependent*, while participating under the *Plan*. The *Plan* will pay at the co-insurance percentage shown in the Schedule after the *Participant* or a *covered dependent* have satisfied any deductible required for the *benefit year*, subject to all the terms and conditions of the *Plan*.

Covered dental expenses will only include *treatment* provided to the *Participant* or a *covered dependent* for which, as outlined in the Covered Dental Expenses section, the date started, and the date completed occur while the person is participating in the *Plan*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's participation in the *Plan*, except as stated in the Continuity of Coverage provision, if any. No payment will be made for dental *treatment* completed after the *Participant's* or a *covered dependent's* participation under the *Plan* ends.

Network Provider Plan

Benefits of the *network provider plan will* be provided, as shown in the Schedule, for covered expenses incurred by the *Participant* or a *covered dependent* if the *treatment* is provided by a *network provider*. The *Participant* or a *covered dependent* must be identified as being covered under the *network provider plan each* time *treatment* is received, to obtain the benefits of the *network provider plan*. Benefits will be provided under the *out-of-network provider plan*, as shown in the Schedule, for covered dental expenses incurred by the *Participant* or a *covered dependent* if the *treatment* is provided by a dental care provider who is not a participant in the *network provider plan*.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each class of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that the *Participant* and each *covered dependent* must incur in a *benefit year* before benefits will be paid. When covered dental expenses equal to the deductible amount have been incurred and submitted, the deductible will be satisfied. Benefits will not be paid for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *benefit year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *benefit year*.

The deductible will apply to the *Participant* and each *covered dependent* separately each *benefit year* except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

The family deductible is shown in the Schedule. It indicates the number of persons in the *Participant's family unit* who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *benefit year*, the deductible will be considered satisfied for each person in the *Participant's family unit* for that *benefit year*. Benefits will be paid for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount.

Benefit Year Maximum

The maximum benefit payable during a *benefit year* is shown in the Schedule. This maximum will apply even if coverage for the *Participant* or a *covered dependent* ends and starts again within the same *benefit year* or if the *Participant* or a *covered dependent* have been covered both as a *Participant* and a dependent.

Date Started and Date Completed

If the *Plan* includes any of the following listed services, dental *treatment* is considered to be started as follows:

- for a full or partial denture, on the date the first impression is taken,
- for a fixed bridge, crown, inlay and onlay, on the date the teeth are first prepared,

- for root canal therapy, on the date the pulp chamber is first opened,
- for periodontal surgery, on the date the surgery is performed, and
- for all other *treatment*, on the date *treatment* is rendered;

and dental *treatment* is considered to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth,
- for a fixed bridge, crown, inlay and onlay, the date an appliance is cemented in place, and
- for root canal therapy, the date a canal is permanently filled.

Covered Dental Expenses

Covered dental expenses include only the lesser of the discounted amount agreed upon by the *network provider* under the *network provider plan*, the *dentist's* actual charge, or the *allowable charge* for expenses incurred by the *Participant* or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist,*
- *dentally necessary,* and
- *started* and completed while a *covered person* is insured, except as otherwise provided in the Extension of Benefits provisions and Continuity of Coverage, if any.

Expenses submitted must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. The Plan reserves the right to request X-rays, narratives and other diagnostic information, as seen fit, to determine benefits.

Benefits will only be paid for covered dental expenses incurred for *treatment* which, was determined to have a reasonably favorable prognosis for the patient.

A temporary *treatment* will be considered to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are *usual and customary*.

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

The following is a complete list of covered dental expenses. Benefits will not be paid for expenses incurred for any service not listed in the *Plan*.

Class I: Preventive Dental Services

- All oral evaluations, limited to 2 times per calendar year
- Intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to 1 time in any 36-month period
- Bitewing X-rays (four films), limited to 1 time in any 12-month period
- Dental prophylaxis, limited to 2 times per calendar year
- Genetic test for susceptibility to oral diseases, limited as follows:
    - Limited to 1 test per lifetime; and

- Limited to persons over age 18

- Topical fluoride *treatment*, limited to:
  - 1 time in any 6-month period; and
  - Covered dependent children less than age 19;

- Sealants, limited to:
  - 1 time per tooth in any 36-month period;
  - Applications made to the occlusal surface of permanent molar teeth; and
  - Covered dependent children less than age 16.

Diagnostic Services

- Intraoral periapical X-rays
- Intraoral occlusal x-rays, limited to 2 films in any 12-month period
- Extraoral x-rays, limited to 1 film in any 6-month period
- Accession and examination of tissue

Class II: Basic Dental Services

Other Basic Services

- Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other *treatment* (except X-rays) is rendered during the visit
- Consultation, including specialist consultations, limited as follows:
  - Considered for payment only if billed by a *dentist* who is not providing operative *treatment*
  - Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration
- Therapeutic drug injections

Restorative Services (Fillings)

- Amalgam restorations, limited as follows:
  - Multiple restorations on one surface will be considered a single filling
  - Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least 24 months have passed since the existing amalgam restoration was placed
  - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations will be considered single surface restorations
  - Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration
- Composite restorations, limited as follows:
  - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations will be considered single surface restorations

- Benefits for the replacement of an existing composite restoration will only be considered for payment if at least 24 months have passed since the existing composite restoration was placed

- Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration

- Pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to 1 time per tooth.

- Silicate restorations (fillings)

- Space maintainers, including all adjustments made within 6 months of installation, limited to *covered dependent* children less than age 19 and to one appliance per child.

Class III: Major Dental Services

Endodontic Services

- Pulpotomy, limited to covered dependent children less than age 19

- Root canal therapy, including all pre-operative, operative and post-operative X-rays, canal preparation and fitting of preformed dowel or post, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24 month period (including teeth treated prior to the date the coverage takes effect under the *Plan*)

- Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care

- Retrograde filling--per root

- Root amputation--per root

- Hemisection, including any root removal and an allowance for local anesthesia and routine postoperative care, does not include a benefit for root canal therapy

Periodontal Non-Surgical Services

- Periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24 month period. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the *allowable charge* for a prophylaxis. Benefits for scaling and root planing and *periodontal maintenance procedures*, performed during the same appointment, will be based on the *allowable charge* for *periodontal maintenance procedures*.

- *Periodontal maintenance procedure* (following active *treatment*), limited to 1 dental prophylaxis or 1 *periodontal maintenance procedure* in any 12-month period

- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth by report, limited to 1 application per tooth in any 12-month period

Periodontal Surgical Services

- Periodontal related services as listed below, limited to:

    - 1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period

        – Gingivectomy

        – Osseous surgery

- Osseous grafts, limited to *treatment* when periodontal disease is present, excludes grafting after extractions

- Guided tissue regeneration
- Pedicle grafts
- Tissue grafts

Oral Surgery Services

- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care
    - Surgical extractions (including extraction of wisdom teeth)
    - Alveoloplasty
    - Vestibuloplasty
    - Removal of lateral exostosis—maxilla or mandible
    - Frenulectomy (frenectomy or frenotomy)
    - Excision of hyperplastic tissue—per arch
    - Orantral fistula closure

    If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.
- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Biopsy
- Incision and drainage only if not performed on the same day as an extraction

Inlay, Onlay, and Crown Restorations

- Inlays and onlays
    - Covered only when there is extensive decay or fracture and the tooth cannot be restored by an amalgam or composite filling,
    - Covered only if more than 10 years have elapsed since last placement, and
    - Limited to persons over age 16.
- Crowns, including porcelain crowns on anterior teeth only (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care)
    - Covered only when there is extensive decay or fracture and the tooth cannot be restored by an amalgam or composite filling,
    - Covered only if more than 10 years have elapsed since last placement, and
    - Limited to persons over age 16.
- Labial veneers (only for anterior teeth)
    - Covered only if more than 10 years have elapsed since last placement, and

- Limited to persons over age 16.

- Crown build-up, including pins and prefabricated posts
- Post and core, covered only for endodontically treated teeth requiring crowns
- Stainless steel crowns, limited to:
  - 1 time in any 36-month period,
  - Teeth not restorable by an amalgam or composite filling, and
  - *Covered dependent* children less than age 19.

Full and Partial Dentures (Removable)

- Full dentures (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care), limited as follows:
  - Limited to 1 time per arch, unless
    - 10 years have elapsed since last replacement, and
    - the denture cannot be made serviceable.
  - The Plan will not pay additional benefits for personalized dentures or overdentures or associated *treatment*
- Partial dentures, including any clasps and rests and teeth (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care), limited as follows:
  - Limited to 1 partial denture per arch, unless
    - 10 years have elapsed since last replacement, unless there is a *dentally necessary* extraction of an additional *functioning natural tooth,* and
    - the partial denture cannot be made serviceable.
  - There are no benefits for precision or semi-precision attachments
- Each additional clasp and rest
- Denture adjustments, limited to:
  - 1 time in any 12-month period, and
  - Adjustments made more than 12 months after the insertion of the denture.
- Relining or rebasing dentures, limited to:
  - 1 time in any 36-month period, and
  - Relining or rebasing done more than 12 months after the insertion of the denture.
- Tissue conditioning performed more than 12 months after the initial insertion of the denture.

Fixed Partial Dentures (Bridges)

- Fixed bridges, limited as follows (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care)

- Limited to persons over age 16,
- Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge
  - is more than 10 years old, and
  - cannot be made serviceable.

    unless there is a *dentally necessary* extraction of an additional *functioning natural tooth* and the extracted tooth was not an abutment to an existing bridge
- A fixed bridge replacing the extracted portion of a hemisected tooth is not covered

Other Major Services

- Repairs to or recementing of full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion
- General anesthesia and intravenous sedation for the first 30 minutes and one additional 15 minute unit, limited as follows:
  - Considered for payment as a separate benefit only with surgical extractions and when administered in the *dentist's* office or outpatient surgical center in conjunction with oral surgery services which are listed as covered services under the *policy*
  - Benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation

Pre-estimate

If the charge for any *treatment* is expected to exceed $300, a *dental treatment plan* is recommended to be submitted for review before *treatment* begins. An estimate of the benefits payable will be sent to the *Participant* and the *dentist*.

In estimating the amount of benefits payable, the *Plan* will consider whether or not an alternate *treatment* may accomplish a professionally satisfactory result. If the *Participant* or a *covered dependent* and the *dentist* agree to a more expensive *treatment* than that pre-estimated under the *Plan*, the excess amount will not be paid.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets the *Participant* or a *covered dependent* know in advance approximately what portion of the expenses will be considered covered dental expenses under the *Plan*.

Alternate Treatment

If an alternate *treatment* can be performed to correct a dental condition, the maximum covered dental expense consider for payment under the *Plan* will be the most economical *treatment* which will, as determined by the *Dental Claims Administrator*, produce a professionally satisfactory result. The *Plan* will not provide a full payment, a partial payment, or an alternate *treatment* payment for any service that is not a covered dental expense.

Special Limitations

Late Entrant Limitation

If an *employee* applies for *dental coverage* more than 31 days after the *employee* or any eligible dependents first become eligible or after participation in the *Plan* ended because a required contribution was not paid, the *employee* and any eligible dependents are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

Time Insured Continuously Under the Policy	Benefits Provided for Only These Services
Less than 6 months	Class I Dental Services
At least 6 months but less than 12 months	Class I & Class II Restorative Services
At least 12 months but less than 24 months	Class I & all Class II Dental Services

The *Plan* will not pay for any *treatment* that is started or completed during the late entrant limitation period.

Missing Teeth Limitation

Benefits will not be paid for replacement of teeth missing on the *Participant's* or a *covered dependent's* effective date of participation under the *Plan* for the purpose of the initial placement of a prosthetic device to replace a missing tooth. However, expenses for the replacement of teeth missing on the effective date of participation will be considered for payment as follows:

- The initial placement of full or partial dentures will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan.

- The initial placement of a fixed bridge will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan. However, the following restrictions will apply:

    - The replacement of an extracted tooth will not be considered a covered dental expense if it was an abutment to an existing prosthesis

    - Benefits will only be paid for the replacement of the teeth extracted while the *Participant or covered dependent* are participating under the Plan

    - Benefits will not be paid for the replacement of other teeth which were missing on the *Participant's* or *covered dependent's* effective date of participation under the *Plan*

General Exclusions

Benefits will not be paid for expenses incurred for any of the following:

- *Treatment* or an appliance which

    - Is not included in the list of covered dental expenses

    - Is not *dentally necessary*

    - Is experimental in nature

    - Is temporary in nature

    - Does not have uniform professional endorsement

- *Treatment* related to procedures that are:

    - Part of a service but are not reported as separate services

    - Reported in a *treatment* sequence that is not appropriate

    - Misreported or that represent a procedure other than the one reported

- Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting

- Any *treatment* or appliance, the sole or primary purpose of which relates to

    - The change or maintenance of vertical dimension

    - The alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder

    - Bite registration

    - Bite analysis

- Attrition or abrasion

- Replacement of a lost or stolen appliance or prosthesis

- Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions

- Completion of claim forms or missed dental appointments

- Personal supplies or equipment, including but not limited to water piks, toothbrushes, floss holders, or athletic mouthguards, except supplies prescribed and dispensed by a *dentist* related to the bleaching of teeth (subject to the 36-month frequency limitation for the bleaching of teeth)

- Administration of nitrous oxide or any other agent to control anxiety

- *Treatment* for a jaw fracture

- *Treatment* provided by a *dentist*, *dental hygienist*, or *denturist* who is

  - An *immediate family member* or a person who ordinarily resides with a Participant or *covered dependent*

  - An *employee or Physician* employed by or performing services for the *Participating Employer*

  - A *Participating Employer*

- Hospital or facility charges for room, supplies or emergency room expenses or routine chest x-rays and medical exams prior to oral surgery

- *Treatment* provided primarily for cosmetic purposes

- *Treatment* which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years as determined by the *Dental Claims Administrator*

- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which do not have extensive decay or fracture and can be restored with an amalgam or composite resin filling

- *Treatment* for the prevention of bruxism (grinding of teeth)

- *Treatment* performed outside the United States, except for *emergency dental treatment*. The maximum benefit payable to any person during a *benefit year* for covered dental expenses related to *emergency dental treatment* performed outside the United States is $100.

- *Treatment* or appliances which are covered under any workers' compensation law, employer's liability law or similar law. A *Participant* must promptly claim and notify MIT of all such benefits.

- *Treatment* for which a charge would not have been made in the absence of insurance or Plan coverage

- *Treatment* for which a *Participant* or *covered dependent* does not have to pay, except when payment of such benefits is required by law and only to the extent required by law

- Orthodontic treatment

- Any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures

Continuity of Coverage

This provision applies only to *Participants* and their *covered dependents* who elect to participate on the effective date of the *Plan*, unless otherwise specified below.

Continuity of Coverage for Participants

The *Plan* will provide continuity of coverage if the *Participant* was covered under the *prior plan* on the day before coverage was replaced by the *Plan*.

If the *Participant*

- is at *active work* on the Effective Date of the *Plan,* and
- applies for coverage before or within 31 days of the Effective Date of the *Plan*, the *Participant* will be covered under the *Plan*.

Continuity of Coverage for Eligible Dependents

We will provide continuity of coverage for the *Participant's eligible dependents*, if any, who were covered under the *prior plan* on the day before coverage was replaced by the *Plan,*

- If the dependent is not in a hospital or similar facility on the Effective Date of the *Plan*, and
- the *Participant* applies for dependent coverage before or within 31 days of the Effective Date of the *Plan.*

Prior Extractions

If *treatment* is *dentally necessary* due to an extraction which occurred before the Effective Date of this *Plan* but while the *Participant* or *covered dependent* were covered under the *prior plan* and *treatment* would have been covered under the *Employer's prior plan*, the Coverage for Treatment in Progress provision will be applied as stated below and expenses will be considered as follows:

- the replacement of the extracted tooth must take place within 12 months of extraction; and
- expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Late Entrant Limitations

If the *Participant* or a *covered dependent*:

- was eligible but not covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*;
- is eligible to participate on the effective date of this *Plan*; and
- the *Participant* elects participation under this *Plan* before or within 31 days of the Effective Date of this *Plan*,

then the *Participant* and any *covered dependents* will be subject to the Late Entrant Limitation in the Special Limitations section.

Coverage for Treatment in Progress

If the *Participant* or a *covered dependent* was covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*, benefits will be paid for any program of dental *treatment* already in progress on the Effective Date of this *Plan* as stated below. However, the expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Extension of Benefits under Prior Plan

This *Plan* will not pay benefits for *treatment* if:

- the *prior plan* has an extension of benefits provision;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was completed during the *prior plan's* extension of benefits.

No Extension of Benefits under Prior Plan

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* if:

- the *prior plan* has no extension of benefits when that plan terminates;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was completed while participating under this *Plan*.

Treatment Not Completed during Extension of Benefits

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* and during the extension if:

- the *prior plan* has an extension of benefits;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was not completed during the *prior plan*'s extension of benefits.

This *Plan* will consider only the percentage of *treatment* completed beyond the extension period to determine any benefits payable under this *Plan*.

ARTICLE THREE

COORDINATION OF BENEFITS

Applicability

All of the benefits provided under this Summary are subject to *this provision.*

This provision means the provision for coordination between the benefits of this *Plan* and other *programs*.

Order of Benefit Determination

The rules to establish the order of benefit determination for each *program* are as follows:

- A program which covers the claimant as an employee, member or subscriber (that is, other than as a dependent) will determine its benefits before a program which covers the claimant as a dependent. However, if the claimant is also a Medicare beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,
    - the *program* covering the *claimant* as a dependent will determine its benefits before *Medicare*; and
    - *Medicare* will determine its benefits before the *program* covering the *claimant* as other than a dependent (e.g. a retired employee). Then the *program* covering the *claimant* as a dependent will determine its benefits before the *program* covering the *claimant* as other than a dependent.
- In the event that the *claimant* is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:
    - first, the *program* which covers the *claimant* as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and
    - second, the *program* which covers the *claimant* as a dependent child of the parent whose birthdate occurs later in the calendar year.
    - If both parents have the same birthdate, benefits for the child are determined in this order:
    - first the *program* which covered the parent longer; and
    - second, the *program* which covered the other parent for a shorter period of time.

If the other *program* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *program* will determine the order of benefits.

- In the event that the *claimant* is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:
    - When the parent with custody of the child has not remarried,
        - first, the *program* which covers the child as a dependent of the parent with custody; and
        - second, the *program* which covers the child as a dependent of the parent without custody; or
    - When the parent with custody of the child has remarried,
        - first, the *program* which covers the child as a dependent of the parent with custody; and
        - second, the *program* which covers that child as a dependent of the stepparent; and
        - finally, the *program* which covers that child as a dependent of the parent without custody; or

- When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.

- If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the *program* of that parent has actual knowledge of these terms, then

  – first, the *program* of parent with financial responsibility; and

  – second, the *program* of the other parent.

  This does not apply to any *claim period* during which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.

- A *program* which covers the *claimant* as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *program* covering such *claimant* as an employee, other than a laid-off or retired employee, or as a dependent of that person.

  If a *program* does not have a provision regarding laid-off or retired employees, which results in each *program* determining its benefits after the other, then this rule will not apply.

- When the *claimant* whose coverage is provided under a federal or state continuation law is also covered under another *program*, benefits are determined in this order:

  - first, the *program* which covers the *claimant* as an employee; and

  - second, the *program* which covers the *claimant* under a continuation law.

  If the other *program* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.

- When none the rules described above establish an Order of Benefit Determination, a *program* which has covered the *claimant* longer will determine its benefits before a *program* which has covered that *claimant* for a shorter period of time.

Effect on Benefits

A *primary program's* benefits are not reduced because of the existence of another *program*.

When there are more than two *programs*, this *Plan* may be a *primary program* to one or more other *programs* and may be a *secondary program* to a different *program(s)*.

When this *Plan* is a *secondary program*, benefits payable under this *Plan* will be reduced so that when they are added to the benefits payable under all other *programs*, they will not exceed the total *allowable expenses* incurred by the *Participant* or a *covered dependent* during the *claim period*. Benefits payable under any other *program* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part

B of *Medicare*, the *Participant* or *covered dependent* must actually be covered by the other *programs*.

The *Plan* will exclude the benefits payable under any *program* in determining the above reduction if:

- that other *program* contains a provision which requires it to determine its benefits after the benefits of this *Plan*, and

- the rules set forth in the Order of Benefit Determination require this *Plan* to decide the benefits of this *Plan* before the other *program*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which the *Dental Claims Administrator* considers fair. The reduced amount will be charged against any benefit limit of this *Plan* that may apply.

Right to Receive and Release Necessary Information

A *claimant* will furnish any information necessary to implement *this provision*. The *Dental Claims Administrator* may release or obtain any information, with respect to the *claimant*, which it deems necessary. This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the *claimant*. In so acting, the *Dental Claims Administrator* and *Plan* will be free from any liability.

Facility of Payment

When payments which should have been made under this *Plan*, by the terms of *this provision*, have been made under any other *programs*, the *Dental Claims Administrator* has the right to pay to any organization making the other payments any amounts it determines are due to satisfy the intent of *this provision*. Any amount paid in good faith will release the *Plan* from further liability for that amount.

Recovery of Payment

If the *Dental Claims Administrator* pays more than the maximum amount required to satisfy the intent of *this provision* at that time, the *Dental Claims Administrator* has the right to recover the excess paid. Recovery may be made from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

ARTICLE FOUR

CLAIM PROVISIONS FOR DENTAL

Filing of Claim

As a condition to the receipt of benefits, a *Participant* covered by the *Plan* who has a claim for benefits under the *Plan* must give written notice of such claim to the *Plan Administrator* on the application form specified by the *Plan Administrator* for that purpose. As a further condition to the receipt of benefits, a *Participant* must submit such notice of claim at any time before the end of 30 days after the date after any covered loss occurs, or within a reasonable time thereafter. The time limit for submitting a notice of claim is 90 days after the date of the loss. All applications for benefits under the *Plan* shall be submitted, with such information as the application shall require, to the *Dental Claims Administrator*. The application form must be completed by the *Participating Employer*, *claimant* and the *dentist* providing *dental treatment* to the *claimant*. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider option*.

Time of Payment of Claim

After the *Dental Claims Administrator* has reviewed the claim form and obtained any other information deemed necessary to render a decision on the claim, the *Dental Claims Administrator* shall notify the *claimant* within 30 days after receipt of all data necessary to recommend the acceptance or denial of the *claimant*'s claim. Unless circumstances beyond the control of the *Plan* require an extension of time for processing the claim such recommendation shall be made within 30 days after receipt of the claim form. Such an extension of time may not exceed 15 additional days and notice of the extension shall be provided to the *claimant* prior to the termination of the initial 30 day period indicating the special circumstances requiring the extension and the date by which a final decision on the claim is expected.

To decide the *Plan's* liability, the *Dental Claims Administrator* may require additional information, including, but not limited to:

- itemized bills,
- proof of benefits from other sources,
- proof that the *claimant* has applied for all benefits from other sources, and that the *claimant* has furnished any proof required to get them,
- a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
- preoperative x-rays, study models, laboratory and/or hospital reports.

To Whom Payable

If the *Participant* or *covered dependent* assigns dental benefits to the provider of the dental *treatment*, any benefits payable under the *Plan* will be paid directly to the provider. Otherwise, any benefits payable under the *Plan* will be paid to the *Participant*. After the *Participant's* death, the *Dental Claims Administrator* has the option to pay any benefits payable under the *Plan* to the *Participant's* Spouse; to the providers of the *treatment*; or to the *Participant's* estate.

Claim Denials

In the event any claim for benefits is denied, in whole or in part, the *Dental Claims Administrator* shall notify the *claimant* of such denial in writing and shall advise the *claimant* of the *Plan's* review and appeal procedure. The notice shall be written in a manner calculated to be understood by the *claimant* and shall contain:

- specific reasons for the denial;
- specific references to the *Plan* provisions on which the denial is based;
- a description of any information or material necessary for the *claimant* to perfect the claim;
- an explanation of why such information or material is necessary; and

- an explanation of the *Plan's* review and appeal procedure.

Discretion of Plan Administrator

The discretionary responsibility and authority to determine eligibility for participation in the *Plan* and to interpret *Plan* provisions and to determine whether a claim will be paid or denied rests solely with the *Plan Administrator*.

Appeal Procedure

If a claim is denied in whole or in part as recommended by the *Dental Claims Administrator* the following claims appeal procedure shall be observed:

- The *claimant*, or the *claimant*'s duly authorized representative, may appeal the denial by submitting to the *Plan Administrator* a written request for review of the claim within 180 days after receiving written notice of such denial from the *Dental Claims Administrator*. Failure by the *claimant* to submit a request for review within 180 days after receiving the denial of benefits shall constitute a waiver by the *claimant* of the right to appeal the decision. The *Plan Administrator* shall, upon the *claimant*'s request, give the *claimant* an opportunity to review relevant documents, other than legally privileged documents, in preparing such request for review.

- The request for review must be in writing and shall be addressed as follows:

  Sun Life Financial
  P.O. Box 2940
  Clinton, IA 52733-2940

- The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the *claimant* deems pertinent. The *Plan Administrator* or the *Dental Claims Administrator* may require the *claimant* to submit, at the expense of the *claimant*, such additional facts, documents or other material as are necessary or advisable in conducting the review.

- The *Plan Administrator* shall act upon each request for review within 60 days after the *Plan Administrator* receives the request for review.

- In the event the *Plan Administrator* confirms the denial of the claim for benefits in whole or in part, written notice of the *Plan Administrator's* decision shall be given to the *claimant*. Such notice shall be written in a manner calculated to be understood by the *claimant* and shall contain the specific reasons for the denial.

Exhaustion of Administrative Remedies

No legal action for benefits under the *Plan* shall be brought unless and until the following has occurred:

- The *claimant* has submitted a proper written claim for benefits;

- The *claimant* has been notified by the *Dental Claims Administrator* that the claim is denied.

- The *claimant* has filed a written appeal with the *Plan Administrator* for review of the denied claim as recommended by the *Dental Claims Administrator*.

- The *claimant* has been twice notified in writing of the *Plan Administrator's* decision to uphold the denial or the *Plan Administrator* has failed to take any action on the second request for review within the time prescribed by the terms of the *Plan*.

Required Physician Examination

The *Dental Claims Administrator* or *Plan Administrator* may require the *claimant* to submit to a medical examination, to be paid for by the *Plan*, by a *doctor or dentist* selected by the *Dental Claims Administrator* and *Plan Administrator* upon submission of a claim for benefits or appeal thereof under the *Plan*.

General Right to Receive and Release Necessary Information

Subject to federal and state law requirements, the *Dental Claims Administrator* and *Plan Administrator* may, for the purpose of determining a *claimant*'s qualification for an amount of benefits, and without the specific consent of any person, release to, or obtain from, any person, any information with respect to any person which the *Dental Claims Administrator* or *Plan Administrator* reasonably deems to be necessary for such purpose. Any *employee* shall furnish such information as the *Dental Claims Administrator* or *Plan Administrator* reasonably deems to be necessary to administer the *Plan*.

Overpayment and Subrogation Rights

The overpayment and subrogation provisions of the main SPD apply to dental benefits.

B.2 – ENHANCED DENTAL BENEFIT

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

Enhanced Dental Benefit Summary

(this document is part of the Summary Plan Description for MIT)

Effective January 1, 2024

INTRODUCTION

This Benefit Summary is part of the Summary Plan Description ("SPD") for the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust ("MIT").

As used in this Benefit Summary, the *Plan* refers to the enhanced dental plan coverage option offered under MIT. This Benefit Summary is effective as of January 1, 2024.

The purpose of this dental benefit offered by our *Plan* is to provide reimbursement for eligible expenses incurred as a result of *dentally necessary treatment* for *injury* or sickness for the *Adopting Employer's* eligible *employees* and their eligible spouse and dependents.

The *Plan* is not a contract of insurance and the *Participating Employers* do not assume the obligations of an insurer under the *Plan*.

Sun Life Assurance Company of Canada/Sun Life and Health Insurance Company (U.S.) is the Claims Service/Advice Only Administrator for the dental benefits offered by our Plan.

ELIGIBILITY TO OFFER DENTAL COVERAGE

For a Participating Employer to offer dental benefits to its eligible employees and Physicians through MIT, the Participating Employer must maintain 50% participation in dental benefits, 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).

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EMPLOYEE AND DEPENDENT DENTAL COVERAGE INFORMATION

(Dependent coverage applies only if elected)

Participant's effective date on file with Plan Administrator

SCHEDULE

Enhanced Plan

Deductible Amount Per Benefit Year

	Network Plan	**Out-of-Network Plan**
Individual Deductible Amount: for Class II and III Dental Services:	$50	$50
Individual Deductible Amount for Class IV Services:	$0	$0
Maximum Family Deductible:	3 persons individually	3 persons individually

The individual deductible does not apply to Class I Network or Out-of-Network Dental Services.

Covered dental expenses incurred toward the deductible amount apply to both the Network and Out-of-Network Plans.

Coinsurance Percentages

	Network Plan	**Out-of-Network Plan**
Class I Preventive Services:	100%	100%
Class II Basic Services:	80%	80%
Class III Major Services:	50%	50%
Class IV Orthodontic Services:	50%	50%

Benefit Maximums	Network Plan	Out-of-Network Plan
Benefit Year Maximum:	$1,000	$1,000
Class IV Orthodontic Services:	$1,000	$1,000

Amounts applied to the benefit maximums will apply to both the Network Plan and Out-of-Network Plan maximums.

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

ARTICLE ONE

DEFINITIONS

The below terms have the meanings shown here when *italicized*. All other capitalized terms have the meanings set forth in our main SPD.

Active work means the expenditure of time and energy for the *participating employer* or an *associated company* at your usual place of business on a *full-time* basis

Allowable charge means:

- For a covered dental service rendered by a *network provider*, the *allowable charge* is based on an amount that the *network provider* has agreed to accept.

- For a covered dental service rendered by an *out-of-network provider*, the *allowable charge* is the reasonable charge. The reasonable charge is the charge made by other providers in the area for like *treatment*. A determination by the *Dental Claims Administrator* of what is an *allowable charge* or reasonable charge is final for the purposes of determining benefits payable under the *Plan*.

A determination by the *Dental Claims Administrator* of what is an *allowable charge* is final for the purpose of determining benefits payable under the *Plan*.

Allowable expense means any *dentally necessary*, *usual, and customary charge*, at least a portion of which is covered under 1 or more of the *programs* which cover the person:

- for whom claim is made, and

- on whose account payment is legally required.

When a *program* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a *program*, the amount of the reduction will not be considered an *allowable expense*. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense*.

Benefit year normally means a calendar year beginning on January 1 of any year and ending on December 31 of that year unless a different benefit year has been requested by the Participating Employer and has been approved in writing by MIT.

Claim period means a calendar year or such other annual coverage period as elected by the *Participating Employer* as described in the main SPD. A *claim period* will not start before a person's effective date of participation under this *Plan* nor extend beyond the last day the person is covered under this *Plan*, except where special credits are approved by MIT in special circumstances, such as an acquisition by the *Participating Employer*.

Claimant means an individual who has submitted an application for benefits under the *Plan*.

Contributory means the *Participant* pays part or all of the *Plan* costs and/or benefits through contributions from the *Participant*.

Covered dependent means an *eligible dependent* who is covered under the *Plan*.

Dental Claims Administrator means Sun Life Assurance Company of Canada/Sun Life and Health Insurance Company (U.S.), which has accepted appointment by the *Plan Administrator* to provide certain administrative services with respect to the *Plan*.

Dental coverage means the group dental coverage under the *Plan*.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

Dentally necessary and dental necessity mean a *treatment* appropriate for the diagnosis and in accordance with accepted dental standards. The *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;
- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Eligible class means class of persons eligible to participate under the *Plan*.

Emergency dental care means any *dentally necessary treatment* rendered or received as the direct result of unforeseen events or circumstances which require prompt attention.

Employer means and includes the *Participating Employers*.

Employee means any person employed by an *Employer*. An *Employee* may or may not be a *Participant*.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the regulations and rulings in effect thereunder from time to time.

Family unit means a *Participant* and his *covered dependents*.

Full-Time has the meaning set forth in the main SPD.

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Immediate family member means a person who is related to the *Participant* in one of the following ways: parent, Spouse, child, brother, sister, grandparent, or grandchild.

Medicaid means the Title XIX of the Social Security Act of 1965 as amended.

Natural tooth means any tooth or part of a tooth that is formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Network provider means a *dentist* who is a participant in the *network provider plan*.

Network provider plan means the dental care delivery system in which *network providers* participate and under which we provide certain dental benefits.

Noncontributory means the Trust pays for the entire *Plan* costs and benefits.

Orthodontic treatment means the procedures which provide the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food). Determination of the severity of the malocclusion will be made by the *Dental Claims Administrator*.

Other group dental expense coverage means:

- any other group plan providing benefits for dental expenses; or
- any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid

health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Out-of-network provider means a *dentist* who is not a participant in the *network provider plan* at the time covered dental services are provided.

Out-of-network provider plan means the plan under which we provide certain dental benefits for services received from an *out-of-network provider*.

Participant means an eligible *employee* or Physician who participates in the *Plan*.

Participating Employer has the meaning set forth in the main SPD.

Periodontal maintenance procedures mean recall procedures for patients who have undergone either surgical or non-surgical *treatment* for periodontal disease. The procedures include examination, periodontal evaluation and any further scaling and root planing that is *dentally necessary*.

Plan means the group dental plan established by the *Participating Employer* that describes benefits for *Participants* and their *covered dependents*.

Plan Administrator shall have the same meaning as provided in *ERISA*.

Pre-estimate review means review of a *dentist's* statement, including diagnostic X-rays, describing the planned *treatment,* and expected charges.

Primary program means a *program* whose benefits for health care coverage must be determined without considering the existence of any other *program*. A *program* is *primary* if:

- the *program* has no order of benefit determination rules, or it has rules which differ from *this provision*; or
- under the order of benefit determination rules, this *Plan* determines its benefits first.

Prior plan means the *Employer's* plan of group dental coverage or insurance that was replaced by the *Plan*.

Program means any program which provides benefits or services for medical or dental care or treatment through:

- group, blanket, or franchise insurance coverage;
- group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);
- a labor-management trusteed plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;
- coverage under government programs or coverage required or provided by any statute, except *Medicaid*. Benefits and services provided by Part A and Part B of *Medicare* are included. If the *Participant* or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if the *Participant* or the *covered dependent* had been covered, will be included, unless prohibited by federal or state law or regulation; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by federal or state law or regulation.

Program does not include any of the following:

- school accident coverage;
- the first $30 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;

- Medicaid; and does not include a law or program when, by law, its benefits are in excess of those of any private or other non-governmental plan; or

- no-fault motor vehicle coverage or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of this Plan have been determined, or any optional no-fault motor vehicle coverage.

The term *program* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

- that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other programs in determining its benefits; and

- that part which does not.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from School" basis.

Secondary program is not a *primary program* and may consider the benefits of the *primary program* and the benefits of any other *program* which, under the rules of *this provision*, has its benefits determined before those of that *secondary program*.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Trust means the *Trust* established under the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan *Trust Agreement*.

ARTICLE TWO

DENTAL PLAN BENEFITS

Benefits Provided

The *Plan* will provide benefits for covered dental expenses identified in this Summary when incurred by the *Participant* or a *covered dependent*, while participating under the *Plan*. The *Plan* will pay at the co-insurance percentage shown in the Schedule after the *Participant* or a *covered dependent* have satisfied any deductible required for the *benefit year*, subject to all the terms and conditions of the *Plan*.

Covered dental expenses will only include *treatment* provided to the *Participant* or a *covered dependent* for which, as outlined in the Covered Dental Expenses section, the date started, and the date completed occur while the person is participating in the *Plan*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's participation in the *Plan*, except as stated in the Continuity of Coverage provision, if any. No payment will be made for dental *treatment* completed after the *Participant's* or a *covered dependent's* participation under the *Plan* ends.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each class of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that the *Participant* and each *covered dependent* must incur in a *benefit year* before benefits will be paid. When covered dental expenses equal to the deductible amount have been incurred and submitted, the deductible will be satisfied. Benefits will not be paid for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *benefit year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *benefit year*.

The deductible will apply to the *Participant* and each *covered dependent* separately each *benefit year* except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

The family deductible is shown in the Schedule. It indicates the number of persons in the *Participant's family unit* who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *benefit year*, the deductible will be considered satisfied for each person in the *Participant's family unit* for that *benefit year*. Benefits will be paid for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount. Expenses incurred for Class IV: Orthodontic Dental Services will not be applied to the family deductible.

Date Started and Date Completed

If the *Plan* includes any of the following listed services, dental *treatment* is considered to be started as follows:

- for a full or partial denture, on the date the first impression is taken,
- for a fixed bridge, crown, inlay and onlay, on the date the teeth are first prepared,
- for root canal therapy, on the date the pulp chamber is first opened,
- for periodontal surgery, on the date the surgery is performed, and
- for all other *treatment*, on the date *treatment* is rendered;

and dental *treatment* is considered to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth,
- for a fixed bridge, crown, inlay and onlay, the date an appliance is cemented in place, and
- for root canal therapy, the date a canal is permanently filled.

See Class IV: Orthodontic Dental Services for start and completion dates for *orthodontic treatment*.

Covered Dental Expenses

Covered dental expenses include only the lesser of the discounted amount agreed upon by the *network provider* under the *network provider plan*, the *dentist's* actual charge, or the *allowable charge* for expenses incurred by the *Participant* or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist,*
- *dentally necessary,* and
- started and completed while a *covered person* is insured, except as otherwise provided in the Extension of Benefits provisions and Continuity of Coverage, if any.

Expenses submitted must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. The Plan reserves the right to request X-rays, narratives, and other diagnostic information, as seen fit, to determine benefits.

Benefits will only be paid for covered dental expenses incurred for *treatment* which, was determined to have a reasonably favorable prognosis for the patient.

A temporary *treatment* will be considered to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are *usual and customary*.

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

The following is a complete list of covered dental expenses. Benefits will not be paid for expenses incurred for any service not listed in the *Plan*.

Class I: Preventive Dental Services

- All oral evaluations, limited to 2 times in a calendar year
- Intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to 1 time in any 36-month period
- Bitewing X-rays (four films), limited to 1 time in any 12-month period
- Dental prophylaxis, limited to 2 times in a calendar year
- Genetic test for susceptibility to oral diseases, limited as follows:
    - Limited to 1 test per lifetime; and
    - Limited to persons over age 18
- Topical fluoride *treatment*, limited to:
    - 1 time in any 6-month period; and
    - Covered dependent children less than age 19;
- Sealants, limited to:
    - 1 time per tooth in any 36-month period;

- Applications made to the occlusal surface of permanent molar teeth; and
- Covered dependent children less than age 16.

- Intraoral periapical X-rays
- Intraoral occlusal x-rays, limited to 2 films in any 12-month period
- Extraoral x-rays, limited to 1 film in any 6-month period

Class II: Basic Dental Services

Diagnostic Services

- Accession and examination of tissue

Endodontic Services

- Pulpotomy, limited to covered dependent children less than age 19
- Root canal therapy, including all pre-operative, operative and post-operative X-rays, canal preparation and fitting of preformed dowel or post, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24 month period (including teeth treated prior to the date the coverage takes effect under the *Plan*)
- Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia, and routine follow-up care
- Retrograde filling--per root
- Root amputation--per root
- Hemisection, including any root removal and an allowance for local anesthesia and routine postoperative care, does not include a benefit for root canal therapy

Periodontal Surgical Services

- Periodontal related services as listed below, limited to:
  - 1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period
    - Gingivectomy
    - Osseous surgery
- Osseous grafts, limited to *treatment* when periodontal disease is present, excludes grafting after extractions
- Guided tissue regeneration
- Pedicle grafts
- Tissue grafts

Periodontal Non-Surgical Services

- Periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the *allowable charge* for a prophylaxis. Benefits for scaling and root planing and *periodontal maintenance procedures*, performed during the same appointment, will be based on the *allowable charge* for *periodontal maintenance procedures*.

- *Periodontal maintenance procedure* (following active *treatment*), limited to 1 dental prophylaxis or 1 *periodontal maintenance procedure* in any 12-month period

- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth by report, limited to 1 application per tooth in any 12-month period

- Biopsy

- Incision and drainage only if not performed on the same day as an extraction

- General anesthesia and intravenous sedation for the first 30 minutes and one additional 15-minute unit, limited as follows:

    - Considered for payment as a separate benefit only with surgical extractions and when administered in the *dentist's* office or outpatient surgical center in conjunction with oral surgery services which are listed as covered services under the *policy*

    - Benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation

Other Basic Services

- Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other *treatment* (except X-rays) is rendered during the visit

- Consultation, including specialist consultations, limited as follows:

    - Considered for payment only if billed by a *dentist* who is not providing operative *treatment*

    - Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration

- Therapeutic drug injections

- Space maintainers, including all adjustments made within 6 months of installation, limited to *covered dependent* children less than age 19 and to one appliance per child.

- Repairs to or recementing of full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion

Restorative Services (Fillings)

- Amalgam restorations, limited as follows:

    - Multiple restorations on one surface will be considered a single filling

    - Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least 24 months have passed since the existing amalgam restoration was placed

    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations will be considered single surface restorations

    - Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration

- Composite restorations, limited as follows:

    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations will be considered single surface restorations

    - Benefits for the replacement of an existing composite restoration will only be considered for payment if at least 24 months have passed since the existing composite restoration was placed

- Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration

- Pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to 1 time per tooth.

- Silicate restorations (fillings)

- Repairs to or recementing of full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion

Class III: Major Dental Services

Oral Surgery Services

- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care

  - Surgical extractions (including extraction of wisdom teeth)

  - Alveoloplasty

  - Vestibuloplasty

  - Removal of lateral exostosis—maxilla or mandible

  - Frenulectomy (frenectomy or frenotomy)

  - Excision of hyperplastic tissue—per arch

  - Orantral fistula closure

    If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.

- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus

- Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Inlay, Onlay, and Crown Restorations

- Inlays and onlays

  - Covered only when there is extensive decay or fracture and the tooth cannot be restored by an amalgam or composite filling,

  - Covered only if more than 10 years have elapsed since last placement, and

  - Limited to persons over age 16.

- Crowns, including porcelain crowns on anterior teeth only (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care)

  - Covered only when there is extensive decay or fracture and the tooth cannot be restored by an amalgam or composite filling,

  - Covered only if more than 10 years have elapsed since last placement, and

  - Limited to persons over age 16.

- Labial veneers (only for anterior teeth)
    - Covered only if more than 10 years have elapsed since last placement, and
    - Limited to persons over age 16.
- Crown build-up, including pins and prefabricated posts
- Post and core, covered only for endodontically treated teeth requiring crowns

Full and Partial Dentures (Removable)

- Full dentures (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care), limited as follows:
    - Limited to 1 time per arch, unless
        - 10 years have elapsed since last replacement, and
        - the denture cannot be made serviceable.
    - The Plan will not pay additional benefits for personalized dentures or overdentures or associated *treatment*
- Partial dentures, including any clasps and rests and teeth (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care), limited as follows:
- Partial dentures, including any clasps and rests and teeth (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care), limited as follows:
    - Limited to 1 partial denture per arch, unless
        - 10 years have elapsed since last replacement, unless there is a *dentally necessary* extraction of an additional *functioning natural tooth,* and
        - the partial denture cannot be made serviceable.
    - There are no benefits for precision or semi-precision attachments
- Each additional clasp and rest
- Denture adjustments, limited to:
    - 1 time in any 12-month period, and
    - Adjustments made more than 12 months after the insertion of the denture.
- Relining or rebasing dentures, limited to:
    - 1 time in any 36-month period, and
    - Relining or rebasing done more than 12 months after the insertion of the denture.
- Tissue conditioning performed more than 12 months after the initial insertion of the denture

Fixed Partial Dentures (Bridges)

- Fixed bridges, limited as follows (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care)

- Limited to persons over age 16,
- Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge
  - is more than 10 years old, and
  - cannot be made serviceable.

    unless there is a *dentally necessary* extraction of an additional *functioning natural tooth* and the extracted tooth was not an abutment to an existing bridge
- A fixed bridge replacing the extracted portion of a hemisected tooth is not covered

Other Major Services

- Stainless steel crowns, limited to:
  - 1 time in any 36-month period,
  - Teeth not restorable by an amalgam or composite filling, and
  - *Covered dependent* children less than age 19.

Class IV: Orthodontic Dental Services

- Diagnostic X-ray, limited to x-rays for orthodontic purposes;
- Diagnostic casts, limited to casts made for orthodontic purposes;
- Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes;
- Orthodontic appliances for tooth guidance; and
- Fixed or removable appliances to correct harmful habits.

Benefits for *orthodontic treatment* will be provided to *Participants* and their *covered dependents*.

Benefits for *orthodontic treatment* are not payable for expenses incurred for retention of orthodontic relationships. Benefits for *orthodontic treatment* are payable only for active *orthodontic treatment* for the services listed above.

The coinsurance percentage amount shown in the Schedule will be paid after any required deductible for orthodontic services has been satisfied for the *benefit year*. The maximum benefit payable to each *Participant* and *covered dependent*, while covered under the *Plan*, for orthodontic services is shown in the Schedule. The maximum benefit will apply even if Plan coverage ceases and recommences or is otherwise interrupted and regardless of what network provider, claims administrator or insurance company is used by the Plan. Benefits paid for orthodontic services will not be applied to the Benefit Year Maximum shown in the Schedule.

Pre-estimate

If the charge for any *treatment* is expected to exceed $300, a *dental treatment plan* is recommended to be submitted for review before *treatment* begins. An estimate of the benefits payable will be sent to the *Participant* and the *dentist*.

In estimating the amount of benefits payable, the *Plan* will consider whether or not an alternate *treatment* may accomplish a professionally satisfactory result. If the *Participant* or a *covered dependent* and the *dentist* agree to a more expensive *treatment* than that pre-estimated under the *Plan*, the excess amount will not be paid.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets the *Participant* or a *covered dependent* know in advance approximately what portion of the expenses will be considered covered dental expenses under the *Plan*.

Alternate Treatment

If an alternate *treatment* can be performed to correct a dental condition, the maximum covered dental expense consider for payment under the *Plan* will be the most economical *treatment* which will, as determined by the *Dental Claims Administrator*, produce a professionally satisfactory result. The *Plan* will not provide a full payment, a partial payment, or an alternate *treatment* payment for any service that is not a covered dental expense.

Special Limitations

Late Entrant Limitation

If an *employee* applies for *dental coverage* more than 31 days after the *employee* or any eligible dependents first become eligible or after participation in the *Plan* ended because a required contribution was not paid, the *employee* and any eligible dependents are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

Time Insured Continuously Under the Policy	Benefits Provided for Only These Services
Less than 6 months	Class I Dental Services
At least 6 months but less than 12 months	Class I & Class II Restorative Services
At least 12 months but less than 24 months	Class I & all Class II Dental Services

The *Plan* will not pay for any *treatment* that is started or completed during the late entrant limitation period.

Missing Teeth Limitation

Benefits will not be paid for replacement of teeth missing on the *Participant's* or a *covered dependent's* effective date of participation under the *Plan* for the purpose of the initial placement of a prosthetic device to replace a missing tooth. However, expenses for the replacement of teeth missing on the effective date of participation will be considered for payment as follows:

- The initial placement of full or partial dentures will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan.

- The initial placement of a fixed bridge will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan. However, the following restrictions will apply:

    - The replacement of an extracted tooth will not be considered a covered dental expense if it was an abutment to an existing prosthesis

    - Benefits will only be paid for the replacement of the teeth extracted while the *Participant or covered dependent* are participating under the Plan

    - Benefits will not be paid for the replacement of other teeth which were missing on the *Participant's* or *covered dependent's* effective date of participation under the *Plan*

General Exclusions

Benefits will not be paid for expenses incurred for any of the following:

- *Treatment* or an appliance which

    - Is not included in the list of covered dental expenses

    - Is not *dentally necessary*

    - Is experimental in nature

    - Is temporary in nature

    - Does not have uniform professional endorsement

- *Treatment* related to procedures that are:

- Part of a service but are not reported as separate services
- Reported in a *treatment* sequence that is not appropriate
- Misreported or that represent a procedure other than the one reported

- Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting
- Any *treatment* or appliance, the sole or primary purpose of which relates to
  - The change or maintenance of vertical dimension
  - The alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder
  - Bite registration
  - Bite analysis
  - Attrition or abrasion
- Replacement of a lost or stolen appliance or prosthesis
- Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions
- Completion of claim forms or missed dental appointments
- Personal supplies or equipment, including but not limited to water piks, toothbrushes, floss holders, or athletic mouthguards, except supplies prescribed and dispensed by a *dentist* related to the bleaching of teeth (subject to the 36-month frequency limitation for the bleaching of teeth)
- Administration of nitrous oxide or any other agent to control anxiety
- *Treatment* for a jaw fracture
- *Treatment* provided by a *dentist*, *dental hygienist*, or *denturist* who is
  - An *immediate family member* or a person who ordinarily resides with a Participant or *covered dependent*
  - An *employee* or Physician employed by or performing services for the *Participating Employer*
  - A *Participating Employer*
- Hospital or facility charges for room, supplies or emergency room expenses or routine chest x-rays and medical exams prior to oral surgery
- *Treatment* provided primarily for cosmetic purposes, except for the bleaching of teeth
- *Treatment* which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years as determined by the *Dental Claims Administrator*
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which do not have extensive decay or fracture and can be restored with an amalgam or composite resin filling
- *Treatment* for implants, implant abutments, implant supported prosthetics (crown, fixed partial denture, dentures) or any other services related to the care and *treatment* of the implant
- *Treatment* for the prevention of bruxism (grinding of teeth)

- *Treatment* performed outside the United States, except for *emergency dental treatment*. The maximum benefit payable to any person during a *benefit year* for covered dental expenses related to *emergency dental treatment* performed outside the United States is $100.

- *Treatment* or appliances which are covered under any workers' compensation law, employer's liability law or similar law. A *Participant* must promptly claim and notify MIT of all such benefits.

- *Treatment* for which a charge would not have been made in the absence of insurance or Plan coverage

- *Treatment* for which a *Participant* or *covered dependent* does not have to pay, except when payment of such benefits is required by law and only to the extent required by law

- Any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures

Continuity of Coverage

This provision applies only to *Participants* and their *covered dependents* who elect to participate on the effective date of the *Plan*, unless otherwise specified below.

Continuity of Coverage for Participants

The *Plan* will provide continuity of coverage if the *Participant* was covered under the *prior plan* on the day before coverage was replaced by the *Plan*.

If the *Participant*

- is at *active work* on the Effective Date of the *Plan* and

- applies for coverage before or within 31 days of the Effective Date of the *Plan*, the *Participant* will be covered under the *Plan*.

Continuity of Coverage for Eligible Dependents

We will provide continuity of coverage for the *Participant's eligible dependents*, if any, who were covered under the *prior plan* on the day before coverage was replaced by the *Plan,*

- If the dependent is not in a hospital or similar facility on the Effective Date of the *Plan*, and

- the *Participant* applies for dependent coverage before or within 31 days of the Effective Date of the *Plan*.

Prior Extractions

If *treatment* is *dentally necessary* due to an extraction which occurred before the Effective Date of this *Plan* but while the *Participant* or *covered dependent* were covered under the *prior plan* and *treatment* would have been covered under the *Employer's prior plan*, the Coverage for Treatment in Progress provision will be applied as stated below and expenses will be considered as follows:

- the replacement of the extracted tooth must take place within 12 months of extraction; and

- expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Late Entrant Limitations

If the *Participant* or a *covered dependent*:

- was eligible but not covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*;

- is eligible to participate on the effective date of this *Plan*; and

- the *Participant* elects participation under this *Plan* before or within 31 days of the Effective Date of this *Plan*,

then the *Participant* and any *covered dependents* will be subject to the Late Entrant Limitation in the Special Limitations section.

Coverage for Treatment in Progress

If the *Participant* or a *covered dependent* was covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*, benefits will be paid for any program of dental *treatment* already in progress on the Effective Date of this *Plan* as stated below. However, the expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Extension of Benefits under Prior Plan

This *Plan* will not pay benefits for *treatment* if:

- the *prior plan* has an extension of benefits provision;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was completed during the *prior plan's* extension of benefits.

No Extension of Benefits under Prior Plan

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* if:

- the *prior plan* has no extension of benefits when that plan terminates;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was completed while participating under this *Plan*.

Treatment Not Completed during Extension of Benefits

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* and during the extension if:

- the *prior plan* has an extension of benefits;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was not completed during the *prior plan*'s extension of benefits.

This *Plan* will consider only the percentage of *treatment* completed beyond the extension period to determine any benefits payable under this *Plan*.

ARTICLE THREE

COORDINATION OF BENEFITS

Applicability

All of the benefits provided under this Summary are subject to *this provision.*

This provision means the provision for coordination between the benefits of this *Plan* and other *programs*.

Order of Benefit Determination

The rules to establish the order of benefit determination for each *program* are as follows:

- A program which covers the claimant as an employee, member, or subscriber (that is, other than as a dependent) will determine its benefits before a program which covers the claimant as a dependent. However, if the claimant is also a Medicare beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,
    - the *program* covering the *claimant* as a dependent will determine its benefits before *Medicare*; and
    - *Medicare* will determine its benefits before the *program* covering the *claimant* as other than a dependent (e.g. a retired employee). Then the *program* covering the *claimant* as a dependent will determine its benefits before the *program* covering the *claimant* as other than a dependent.
- In the event that the *claimant* is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:
    - first, the *program* which covers the *claimant* as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and
    - second, the *program* which covers the *claimant* as a dependent child of the parent whose birthdate occurs later in the calendar year.
    - If both parents have the same birthdate, benefits for the child are determined in this order:
        - first the *program* which covered the parent longer; and
        - second, the *program* which covered the other parent for a shorter period of time.

If the other *program* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *program* will determine the order of benefits.

- In the event that the *claimant* is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:
    - When the parent with custody of the child has not remarried:
        - first, the *program* which covers the child as a dependent of the parent with custody; and
        - second, the *program* which covers the child as a dependent of the parent without custody; or
    - When the parent with custody of the child has remarried:
        - first, the *program* which covers the child as a dependent of the parent with custody; and
        - second, the *program* which covers that child as a dependent of the stepparent; and
        - finally, the *program* which covers that child as a dependent of the parent without custody; or

- When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.

- If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the *program* of that parent has actual knowledge of these terms, then

  – first, the *program* of parent with financial responsibility; and

  – second, the *program* of the other parent.

  This does not apply to any *claim period* during which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.

- A *program* which covers the *claimant* as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *program* covering such *claimant* as an employee, other than a laid-off or retired employee, or as a dependent of that person.

  If a *program* does not have a provision regarding laid-off or retired employees, which results in each *program* determining its benefits after the other, then this rule will not apply.

- When the *claimant* whose coverage is provided under a federal or state continuation law is also covered under another *program*, benefits are determined in this order:

  - first, the *program* which covers the *claimant* as an employee; and

  - second, the *program* which covers the *claimant* under a continuation law.

  If the other *program* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.

- When none the rules described above establish an Order of Benefit Determination, a *program* which has covered the *claimant* longer will determine its benefits before a *program* which has covered that *claimant* for a shorter period of time.

Effect on Benefits

A *primary program's* benefits are not reduced because of the existence of another *program*.

When there are more than two *programs*, this *Plan* may be a *primary program* to one or more other *programs* and may be a *secondary program* to a different *program(s)*.

When this *Plan* is a *secondary program*, benefits payable under this *Plan* will be reduced so that when they are added to the benefits payable under all other *programs*, they will not exceed the total *allowable expenses* incurred by the *Participant* or a *covered dependent* during the *claim period*. Benefits payable under any other *program* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part

B of *Medicare*, the *Participant* or *covered dependent* must actually be covered by the other *programs*.

The *Plan* will exclude the benefits payable under any *program* in determining the above reduction if:

- that other *program* contains a provision which requires it to determine its benefits after the benefits of this *Plan*, and

- the rules set forth in the Order of Benefit Determination require this *Plan* to decide the benefits of this *Plan* before the other *program*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which the *Dental Claims Administrator* considers fair. The reduced amount will be charged against any benefit limit of this *Plan* that may apply.

Right to Receive and Release Necessary Information

A *claimant* will furnish any information necessary to implement *this provision*. The *Dental Claims Administrator* may release or obtain any information, with respect to the *claimant*, which it deems necessary. This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the *claimant*. In so acting, the *Dental Claims Administrator* and *Plan* will be free from any liability.

Facility of Payment

When payments which should have been made under this *Plan*, by the terms of *this provision*, have been made under any other *programs*, the *Dental Claims Administrator* has the right to pay to any organization making the other payments any amounts it determines are due to satisfy the intent of *this provision*. Any amount paid in good faith will release the *Plan* from further liability for that amount.

Recovery of Payment

If the *Dental Claims Administrator* pays more than the maximum amount required to satisfy the intent of *this provision* at that time, the *Dental Claims Administrator* has the right to recover the excess paid. Recovery may be made from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

ARTICLE FOUR

CLAIM PROVISIONS FOR DENTAL

Filing of Claim

As a condition to the receipt of benefits, a *Participant* covered by the *Plan* who has a claim for benefits under the *Plan* must give written notice of such claim to the *Plan Administrator* on the application form specified by the *Plan Administrator* for that purpose. As a further condition to the receipt of benefits, a *Participant* must submit such notice of claim at any time before the end of 30 days after the date after any covered loss occurs, or within a reasonable time thereafter. The time limit for submitting a notice of claim is 90 days after the date of the loss. All applications for benefits under the *Plan* shall be submitted, with such information as the application shall require, to the *Dental Claims Administrator*. The application form must be completed by the *Participating Employer*, *claimant* and the *dentist* providing *dental treatment* to the *claimant*. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider option*.

Time of Payment of Claim

After the *Dental Claims Administrator* has reviewed the claim form and obtained any other information deemed necessary to render a decision on the claim, the *Dental Claims Administrator* shall notify the *claimant* within 30 days after receipt of all data necessary to recommend the acceptance or denial of the *claimant*'s claim. Unless circumstances beyond the control of the *Plan* require an extension of time for processing the claim such recommendation shall be made within 30 days after receipt of the claim form. Such an extension of time may not exceed 15 additional days and notice of the extension shall be provided to the *claimant* prior to the termination of the initial 30 day period indicating the special circumstances requiring the extension and the date by which a final decision on the claim is expected.

To decide the *Plan's* liability, the *Dental Claims Administrator* may require additional information, including, but not limited to:

- itemized bills,
- proof of benefits from other sources,
- proof that the *claimant* has applied for all benefits from other sources, and that the *claimant* has furnished any proof required to get them,
- a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
- preoperative x-rays, study models, laboratory and/or hospital reports.

To Whom Payable

If the *Participant* or *covered dependent* assigns dental benefits to the provider of the dental *treatment*, any benefits payable under the *Plan* will be paid directly to the provider. Otherwise, any benefits payable under the *Plan* will be paid to the *Participant*. After the *Participant's* death, the *Dental Claims Administrator* has the option to pay any benefits payable under the *Plan* to the *Participant's* Spouse; to the providers of the *treatment*; or to the *Participant's* estate.

Claim Denials

In the event any claim for benefits is denied, in whole or in part, the *Dental Claims Administrator* shall notify the *claimant* of such denial in writing and shall advise the *claimant* of the *Plan's* review and appeal procedure. The notice shall be written in a manner calculated to be understood by the *claimant* and shall contain:

- specific reasons for the denial;
- specific references to the *Plan* provisions on which the denial is based;
- a description of any information or material necessary for the *claimant* to perfect the claim;
- an explanation of why such information or material is necessary; and

- an explanation of the *Plan's* review and appeal procedure.

Discretion of Plan Administrator

The discretionary responsibility and authority to determine eligibility for participation in the *Plan* and to interpret *Plan* provisions and to determine whether a claim will be paid or denied rests solely with the *Plan Administrator*.

Appeal Procedure

If a claim is denied in whole or in part as recommended by the *Dental Claims Administrator* the following claims appeal procedure shall be observed:

- The *claimant*, or the *claimant*'s duly authorized representative, may appeal the denial by submitting to the *Plan Administrator* a written request for review of the claim within 180 days after receiving written notice of such denial from the *Dental Claims Administrator*. Failure by the *claimant* to submit a request for review within 180 days after receiving the denial of benefits shall constitute a waiver by the *claimant* of the right to appeal the decision. The *Plan Administrator* shall, upon the *claimant*'s request, give the *claimant* an opportunity to review relevant documents, other than legally privileged documents, in preparing such request for review.

- The request for review must be in writing and shall be addressed as follows:

  Sun Life Financial
  P.O. Box 2940
  Clinton, IA 52733-2940

- The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the *claimant* deems pertinent. The *Plan Administrator* or the *Dental Claims Administrator* may require the *claimant* to submit, at the expense of the *claimant*, such additional facts, documents, or other material as are necessary or advisable in conducting the review.

- The *Plan Administrator* shall act upon each request for review within 60 days after the *Plan Administrator* receives the request for review.

- In the event the *Plan Administrator* confirms the denial of the claim for benefits in whole or in part, written notice of the *Plan Administrator's* decision shall be given to the *claimant*. Such notice shall be written in a manner calculated to be understood by the *claimant* and shall contain the specific reasons for the denial.

Exhaustion of Administrative Remedies

No legal action for benefits under the *Plan* shall be brought unless and until the following has occurred:

- The *claimant* has submitted a proper written claim for benefits;

- The *claimant* has been notified by the *Dental Claims Administrator* that the claim is denied.

- The *claimant* has filed a written appeal with the *Plan Administrator* for review of the denied claim as recommended by the *Dental Claims Administrator*.

- The *claimant* has been twice notified in writing of the *Plan Administrator's* decision to uphold the denial or the *Plan Administrator* has failed to take any action on the second request for review within the time prescribed by the terms of the *Plan*.

Required Physician Examination

The *Dental Claims Administrator* or *Plan Administrator* may require the *claimant* to submit to a medical examination, to be paid for by the *Plan*, by a *doctor or dentist* selected by the *Dental Claims Administrator* or *Plan Administrator* upon submission of a claim for benefits or appeal thereof under the *Plan*.

General Right to Receive and Release Necessary Information

Subject to federal and state law requirements, the *Dental Claims Administrator* and *Plan Administrator* may, for the purpose of determining a *claimant*'s qualification for an amount of benefits, and without the specific consent of any person, release to, or obtain from, any person, any information with respect to any person which the *Dental Claims Administrator* or *Plan Administrator* reasonably deems to be necessary for such purpose. Any *employee* shall furnish such information as the *Dental Claims Administrator* or *Plan Administrator* reasonably deems to be necessary to administer the *Plan*.

Overpayment and Subrogation Rights

The overpayment and subrogation provisions of the main SPD apply to dental benefits.