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 January 1, 2025

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 January 1, 2025.

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*.

Blue Solutions Administrator ("**BSA**") is the Claims Administrator and offers our participants access to the Blue Card National Provider Network for the medical benefits covered by our Plan. Express Scripts is the Claims Administrator and network provider for the prescription drug benefits covered by our Plan.

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.myhealthtoolkitbsa.com to use the online benefits portal to view medical Claims, Deductible status, explanation of benefits and much more.

Find a Provider

MIT uses Preferred Blue as its Preferred Provider Organization (PPO) in South Carolina for medical benefits. For services rendered outside of South Carolina, MIT utilizes the First Health Network. The medical provider directory is kept up-to-date by our network provider and can be accessed by logging in at: www.myhealthtoolkitbsa.com or by calling BSA at 1-833-644-1296. 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 Express Scripts and its affiliates. You may contact Express Scripts toll free at 1-800-282-2881 (TTY users: 1-800-759-1089), visit the Express Scripts website at www.express-scripts.com, or utilize the Express Scripts 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 by logging into your member account at www.express-scripts.com:

- **Pharmacy Location Services:** Find an in-network pharmacy using the online Find a Pharmacy locator by logging into your member account or contacting Express Scripts at 1-800-282-2881 (TTY users: 1-800-759-1089). 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 register for your member account at www.express-scripts.com, you will need your identifying information 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 803-798-6207.

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).
- 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.

[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 BSA if you believe this applies to you.

- 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-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 (including specified oral and injectable formulations), as well as baseline and monitoring services, 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)*
- Flu (Influenza)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Shingles (Herpes Zoster)
- Tetanus, Diphtheria
- Whooping Cough (Pertussis)

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

COVERED PREVENTIVE SERVICES FOR WOMEN & PREGNANT WOMEN

- Birth control: Food and Drug Administration-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 (including specified oral and injectable formulations), as well as baseline and monitoring services, 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 (including specified oral and injectable formulations), as well as baseline and monitoring services, 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
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 covered 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.

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 outpatient co-payments for Mental Health and Substance Use Treatment.

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.

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 U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, and was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinic trials, in the research, experimental, study of investigational arm of ongoing phase III clinic trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means 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 Food and Drug Administration in general use.

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

In any coverage decisions regarding experimental and/or investigational services as set forth herein, 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 and Complications of Pregnancy with respect to a female employee or a Dependent wife (but not a Dependent child). 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 www.myhealthtoolkitbsa.com or by phone at 1-833-644-1296.

Private Duty Nursing
Skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). 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 Express Scripts.

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 covered 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.

Specialty Non-EHB Drugs
Those prescription drugs that have been designated by our pharmacy benefit provider, Express Scripts, as special pharmacy drugs that are considered to not qualify as essential health benefits ("***EHB***") under our non-HDHP coverages and are therefore covered by the special rules of the SaveOnSP program. The Plan has implemented a specialty pharmacy copay assistance program, known as the SaveOnSP Program, that applies to prescription drug coverage under all coverages except our high deductible health plans (HDHPs). Under the SaveOnSP Program, the cost of Specialty Non-EHB Drugs does not apply toward satisfying your Plan deductible or out-of-pocket maximum, and your copayment for such drugs is intended to be set to the maximum amount that the applicable manufacturer offers in copay assistance. The SaveOnSP Program is designed with the intent that you may apply for reimbursement for your entire copayment cost from the manufacturer, which is expected to result in no net out-of-pocket cost to you. If you choose not to participate in the SaveOnSP Program or fail to submit the necessary manufacturer reimbursement applications, you will bear the full copayment cost for Specialty Non-EHB Drugs. A list of Specialty Non-EHB Drugs can be obtained by contacting MIT directly at MITinfo@scmedical.org or 803-798-6207, or by calling SaveOnSP at 1-800-683-1074.

Step Therapy
Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and progressing to other more costly or risky therapy, only if necessary (i.e., you must try drug "A" before you can get drug "B"). 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 Blue Solutions Administrator (BSA) at 1-833-644-1296 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 Blue Solutions Administrator (BSA) at 1-833-644-1296 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.express-scripts.com or on the Express Scripts mobile app, or by calling Express Scripts toll-free at 1-800-282-2881 (TTY users: 1-800-759-1089). 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
- Growth hormones
- Humira
- Immunoglobulin injection (IVIG)
- Interferon
- Lupon
- Orencia
- Peg Intron
- 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;
- chest wall reconstruction with aesthetic flat closure;
- 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 Payment is for two (2) hearing aids per plan year).

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;
3. benefits will be provided to a non-eligible living transplant donor, provided there is no other insurance (Maximum Payment is $10,000 per transplant for surgical charges); and
4. benefits will be provided for reasonable travel and lodging expenses (Maximum Payment is $10,000 per transplant for travel and lodging expenses).

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 EHB Drugs or Specialty Non-EHB Drugs, which must be obtained through our preferred specialty pharmacy, Express Specialty Pharmacy, or the SaveOnSP 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 is $750 per Illness for the wig/hairpiece).

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 (except for preventive services as described in the *Understanding Your Preventive Services Coverage* section of this SPD).
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.

As a general rule, regardless of the size of your Participating Employer and except to the extent required by federal law, our Plan will not pay for benefits covered by Medicare (this is referred to as paying "secondary" to Medicare). Whenever our Plan pays secondary to Medicare, you (or your covered Dependent(s), where applicable) must enroll in Medicare when eligible, or else you will be responsible for the portion of the cost of the benefits that Medicare would have covered.

Special Medicare Rules
There are three situations where federal law mandates that our Plan pays primary to Medicare:

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.

Active Employment: If you continue to be actively employed by a Participating Employer after you become eligible for Medicare (other than due to disability or End-Stage Renal Disease, as described above), our Plan will be considered the primary payer (and Medicare will be secondary). In cases where our Plan is paying primary, it is up to you whether or not you want to enroll in Medicare and your decision does not impact the portion of the cost of benefits that our Plan will pay. If you or your covered Dependent do choose to enroll in Medicare, Medicare will pay only for those Medicare-eligible expenses that are not eligible for payment by our Plan.

In cases where our Plan is paying primary, if you or your covered Dependent also chooses to enroll in Medicare, Medicare will only pay for those Medicare-eligible expenses that have not been paid by our Plan.

Note: If you choose to enroll in Medicare, (whether original Medicare, a Medicare Advantage plan and/or a Medicare Part D prescription drug plan) and you choose to disenroll from our Plan, coverage for your eligible Dependents will cease (subject to a possible right to continue coverage through COBRA, if they qualify). As the eligible employee or eligible physician, you must continue to enroll in our Plan if you wish to provide active coverage for your eligible Dependents.

Questions about Coordination of Coverage with Medicare

If you have any questions about coordination of your Plan coverage with Medicare, please review MIT's FAQ on Medicare coverage at https://scmamit.com/faq/it or contact MIT at 803-798-6207 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;
- chest wall reconstruction with aesthetic flat closure;
- 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 July 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 July 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 Blue Solutions Administrator (BSA) to process medical (but not prescription drug) Claims on behalf of our Plan. BSA can be contacted at:

Blue Solutions Administrator (BSA)
Attention: Claims
P. O. Box 100121
Columbia, SC 29202-3121
Telephone: 1-833-644-1296

Medical 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 BSA at 1-833-644-1296.

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 not 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.

Medical Appeal Procedures

Appealing an Adverse Benefit Determination

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

All appeals must be submitted in writing to our claims administrator 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.

Blue Solutions Administrator
Columbia Service Center
Attention: Appeals Coordinator, AX-830
P.O. Box 100121
Columbia, SC 29202-3121

The appeal must include:

- the patient's name and address;
- the Claimant's name and address, if different;
- this is an appeal to the MIT 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: 1-833-644-1296. All necessary information, including our Plan's benefit determination on review, will be transmitted between our claims administrator 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
132 Westpark Blvd, Columbia, SC 29210
Phone: 803-798-6207
Fax: 803-731-4021
MITinfo@scmedical.org

Prescription Claims
MIT has hired Express Scripts to process prescription drug Claims on behalf of our Plan. For prescription drugs (other than Specialty EHB Drugs and Specialty Non-EHB 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 Express Scripts Schedule of Benefits for each Medical Benefit Option. 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 Drug Reimbursement Form, which you can obtain by logging into the Express Scripts website or mobile app. For assistance you may contact Express Scripts at 1-800-282-2881.

MIT uses the Express Scripts Premium Formulary. The Express Scripts Premium Formulary is a list of medications that are covered by our Plan and can be found by logging into the Express Scripts website or mobile app, 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 Express Scripts Premium Formulary. The Express Scripts 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 Express Scripts at 1-800-282-2881.

General Covered Drugs
- federal legend drugs
- state restricted drugs
- antihaemophilia agents
- diabetic supplies
- needles and Syringes
- Specialty EHB Drugs and Specialty Non-EHB 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 Express Scripts 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 Express Scripts Pharmacy, which allows you to order prescription drugs (other than Specialty EHB Drugs and Specialty Non-EHB Drugs) with coverage for up to a 90-day supply per dispensing (standard supply), subject to the cost share listed in the Schedule of Benefits for the applicable Medical Benefit Option. You can log into the Express Scripts website or mobile app to see if you have eligible prescriptions for this program. Ordering through the Express Scripts website or mobile app will provide you with a savings if a pharmacy copayment would otherwise apply. You may enroll in the program and receive automatic refills from Express Scripts Pharmacy using a credit card on file. You can opt-out of the program at any time.

Our Plan utilizes Express Specialty Pharmacy as our preferred specialty pharmacy for Specialty EHB Drugs and Specialty Non-EHB Drugs. You can set up specialty drug services by logging into the Express Scripts website or mobile app or call Express Scripts at 1-800-282-2881. Specialty prescription drugs (whether Specialty EHB Drugs or Specialty Non-EHB Drugs) are limited to a 30-day supply.

Prescription 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 Express Scripts 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 Express Scripts policy and procedures. There are no fees or costs charged to you for any level of appeal conducted by Express Scripts 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:

Express Scripts - Attn: Appeals Department
P.O. Box 66588, St. Louis, MO
Phone: 800-753-2851
Fax: 877-852-4070

Express Scripts' 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

Express Scripts 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

Express Scripts provides a single level of appeal for administrative denials. Upon receipt of such an appeal, Express Scripts 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 – Express Scripts 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 Express Scripts 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 – Express Scripts 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 – Express Scripts 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, Express Scripts 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 Express Scripts' 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, Express Scripts 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 EHB Drug and Specialty Non-EHB Drug prescriptions must be processed through our preferred specialty pharmacy, Express 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.
- Certain Specialty Non-EHB Drugs are classified as non-essential health benefits under Premier, Prime and Select Plans and have a significantly higher co-payment, and the cost of these drugs does not apply to the deductible and out-of-pocket maximum. You will, however, be able to participate in the SaveOnSP Program in order to obtain full reimbursement for the cost of these drugs, resulting in no net cost to you.

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

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

SCHEDULE OF BENEFITS		
In-Network Embedded Deductible[2]	$500/person	$1,500/family
Out-of-Network Embedded Deductible[3]	$1,000/person	$3,000/family
In-Network Embedded Maximum Out-of-Pocket Expense[4]	$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[5]**	**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	**In-Network**	**Out-of-Network**
Generic, Preferred, Non-Preferred	80% (30 day) 50% (90 day mail) 50% (90 day retail)	N/A (0%)
Specialty EHB Drug	80%	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

[2] 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.

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

[4] 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.

[5] "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 2000 Enhanced

SCHEDULE OF BENEFITS		
In-Network Embedded Deductible[6]	$2,000/person	$6,000/family
Out-of-Network Embedded Deductible[7]	$4,000/person	$12,000/family
In-Network Embedded Maximum Out-of-Pocket Expense[8]	$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[9]**	**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[10]**	**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	**In-Network**	**Out-of-Network**
Generic Preferred Non-Preferred	$5/$35/$60 (30 day) $12.50/$87.50/$150 (90 day mail) $15.00/$105/$180 (90 day retail)	N/A (0%)
Specialty EHB Drug	$500-$999: $65 copay (30 day) $1000-$1499: $130 copay (30 day) $1500-$2000: $200 copay (30 day) above $2000: $275 copay (30 day)	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

**Individual maximum of $9,200 is embedded for covered individuals with Dependent coverage.*
*** Excludes any other procedures performed during the visit.*

[6] 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.
[7] Family deductible applies to 3 or more persons.
[8] 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.
[9] "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).
[10] Office visits exclude any other procedures performed during the visit.

HDHP Option I

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[11]	$1,650/single	$3,300/family
Out-of-Network Aggregate Deductible	$3,300/single	$6,600/family
In-Network Aggregate Maximum Out-of-Pocket Expense[12]	$1,650/single	$3,300/family
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[13]**	**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	**In-Network**	**Out-of-Network**
Generic, Preferred, Non-Preferred	100 %	N/A (0%)
Specialty EHB Drug	100%	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

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

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

[13] "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[14]	$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[15]	$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[16]**	**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	**In-Network**	**Out-of-Network**
Generic, Preferred, Non-Preferred	90% (30 day) 75% (90 day mail) 75% (90 day retail)	N/A (0%)
Specialty EHB Drug	90%	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

[14] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[15] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[16] "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[17]	$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[18]	$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[19]**	**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	**In-Network**	**Out-of-Network**
Generic, Preferred, Non-Preferred	70% (30 day) 50% (90 day mail) 50% (90 day retail)	N/A (0%)
Specialty EHB Drug	70%	N/A 0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

**Individual maximum of $9,200 is embedded for covered individuals with Dependent coverage.*

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

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

[19] "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[20]	$4,000/single	$8,000/family
Out-of-Network Aggregate Deductible	$7,500/single	$20,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[21]	$7,250/single	$14,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network[22]**	**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)	80%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	80%	50%
All Other Covered Expenses (including Urgent Care)	80%	50%
Physician Office Visits	80%	50%
Emergency Room Visits & Emergency Ambulance Transport	80%	80%
Prescription Drug	**In-Network**	**Out-of-Network**
Generic, Preferred, Non-Preferred	80% (30 day) 60% (90 day mail) 60% (90 day retail)	N/A (0%)
Specialty EHB Drug	80%	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

**Individual maximum of $9,200 is embedded for covered individuals with Dependent coverage.*

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

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

[22] "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[23]	$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[24]	$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[25]**	**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)	N/A (0%)
Prescription Drug	**In-Network**	**Out-of-Network**
Generic, Preferred, Non-Preferred	90% (30 day) 75% (90 day mail) 75% (90 day retail)	N/A (0%)
Specialty EHB Drug	90%	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

**Individual maximum of $9,200 is embedded for covered individuals with Dependent coverage.*
*** Excludes any other procedures performed during the visit*

[23] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[24] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[25] "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[26]	$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[27]	$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[28]**	**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	**In-Network**	**Out-of-Network**
Generic Preferred Non-Preferred	$12/$80/$200 (30 day) $30/$200/$500 (90 day mail) $36/$240/$600 (90 day retail)	N/A (0%)
Specialty EHB Drug	$250	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please see your SPD and contact SaveOnSP at 1-800-683-1074 for more information.	

** Individual maximum of $9,200 is embedded for covered individuals with Dependent coverage.*
*** Excludes any other procedures performed during the visit.*

[26] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[27] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[28] "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[29]	$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[30]	$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[31]**	**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	**In-Network**	**Out-of-Network**
Generic Preferred Non-Preferred	$12/$80/$200 (30 day) $30/$200/$500 (90 day mail) $36/$240/$600 (90 day retail)	N/A (0%)
Specialty EHB Drug	$250	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

**Individual maximum of $9,200 is embedded for covered individuals with Dependent coverage.*
*** Excludes any other procedures performed during the visit.*

[29] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[30] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.
[31] "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[32]	$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[33]	$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[34]**	**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	**In-Network**	**Out-of-Network**
Generic Preferred Non-Preferred	$12/$80/$200 (30 day) $30/$200/$500 (90 day mail) $36/$240/$600 (90 day retail)	N/A (0%)
Specialty EHB Drug	$250	N/A (0%)
Specialty Non-EHB Drug	100% coverage is available at no cost to you through SaveOnSP Program Participation. Please contact SaveOnSP at 1-800-683-1074 for more information.	

**Individual maximum of $9,200 is embedded for covered individuals with Dependent coverage.*

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

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

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

[34] "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).