PLAN OF BENEFITS

FOR

HOPEHEALTH
WITH HOPE, ALL THINGS ARE POSSIBLE

GROUP MEDICAL

Effective: September 1, 2020

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- Please visit the website **www.tccba.com** and select QicLink Benefits Exchange (QBE) to:
  - **View the status of your claim(s)**
  - **View the status of your deductible and Out-of-Pocket maximums**
  - **Order I.D. cards**
  - **View an electronic version of your Plan of Benefits**
  - **Leave customer service messages that will be responded to within 24 hours**

NON-GRANDFATHERED HEALTH PLAN

HopeHealth, Inc.'s health plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

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

ABOUT YOUR PLAN

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

Your Employer expects and encourages you to review this booklet which describes your health plan. Be a selective medical consumer and assume the major role in keeping the cost of medical services at a minimum.

Your Employer has established a comprehensive Group Health Plan ("Plan") for its employees. Your Employer has retained the services of *Thomas H. Cooper & Co., Inc.* ("TCC Benefits Administrator") to process and pay health claims and to provide services in connection with the operation of this Plan of Benefits. TCC Benefits Administrator (also referred to as the "Claims Administrator") is located in Charleston, South Carolina.

TCC Benefits Administrator has contracted with the **BlueCross and BlueShield of South Carolina Preferred Blue** network as the Preferred Provider Organization ("PPO") for your group. Providers who participate in the PPO are called "PPO Providers".

Employees residing in South Carolina should use the BlueCross and BlueShield Preferred Blue network as the Preferred Provider Organization (PPO) for this Plan, go to www.southcarolinablues.com.

Employees residing in North Carolina should use the MedCost network as the Preferred Provider Organization (PPO) for this Plan, go to www.medcost.com or call (800) 824-7406.

Employees residing in any other state or for employees and covered dependents traveling outside their respective home state, First Health network should be used as the Preferred Provider Organization (PPO), go to *www.firsthealth.com* ***or call (****800)-226-5116.*

You will receive maximum benefits when you use PPO Providers and when you obtain authorization (when required) for services. You will pay more if you do not use PPO Providers or if you do not obtain prior authorization (unless an emergency). The following information explains what a PPO Provider is and how you obtain authorization from the Medical Services Department for services or supplies covered by your health plan.

It is your responsibility to ensure that your Provider is a PPO Provider. You should verify your Provider's status before services are rendered. To verify whether your Provider is a network Provider you may:

- Ask the Provider if they participate in the PPO.
- Review your Provider directory (*)
- If available, review the appropriate website for Provider information (*)
- Call Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator) (*)

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

For South Carolina Employees, the Blue Cross and Blue Shield Preferred Blue Network is the PPO for this Group Health Plan.

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

- File all claims for Benefits or supplies with your Claims Administrator;
- Ask you to pay only the Deductible, per occurrence Copayments and Coinsurance amounts, if any, for Benefits;

- Accept the preferred allowance as payment in full for Covered Expenses; and
- Make sure that all necessary approvals are obtained from the Medical Services Department.

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

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

- In the event treatment is for an Emergency Medical Condition as defined in this Plan of Benefits and PPO Provider care is not available;
- Dependents who are living out-of-state;
- For treatment by a specialist when a PPO Provider specialist is not available; or
- For Non-PPO Provider Ancillary Services rendered in a PPO Provider Hospital.

CUSTOMER SERVICE

TCC Benefits Administrator is committed to helping you understand your coverage and obtain maximum benefits on your claims. If you have questions about your coverage, you may call or write TCC Benefits Administrator at the following:

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

PRE-AUTHORIZATION / PRIOR APPROVAL OF TREATMENT

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

Under this Plan of Benefits, the Benefits you receive will depend on whether the Provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum Benefits that can be paid if you use Participating Providers and you get Preauthorization, when required, before getting medical care. The amount you have to pay will increase when you do not use Participating Providers and if you do not get Preauthorization.

Members of TCC attempts to contract with Providers that practice at participating Hospitals. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider, you have no protection from balance billing from the Provider.

Where to Call for Approval

For prior approval for medical or surgical treatment or an Admission, call the Medical Review Department at (888) 275-7146. These numbers are also on the back of your ID card. Be sure to keep your card with you at all times. Please do not call the TCC Benefits Administrator customer service department. A customer service representative cannot give prior approval.

All admissions require Preadmission Review or Emergency Admission Review, and Continued Stay Review. If Preadmission Review is not obtained for all Facility Admissions, room and board will be denied. If approval is not obtained for Emergency Admissions within 24 hours or by 5 p.m. of the next working day following the Admission, room and board will be denied.

Some outpatient services require Pre-Authorization Review. If Pre-Authorization is not obtained, appropriate Benefits will be paid after 50% reduction in the Allowable Charge.

- **Pre-Authorization Review** — A number of services and medical procedures require Pre-Authorization Review:
    - Inpatient Hospitalizations
    - MRI/CT Scans/PET Scans
    - Durable Medical Equipment (over $500)
    - Organ Transplants
- For more information about services and supplies that require Pre-Authorization Review, please see the *Covered Medical Expenses* section. If you have specific questions, please call or write TCC Benefits Administrator.

These numbers are also on the back of your ID card. Be sure to keep your card with you at all times.

When you or your Provider call for review and approval, you will talk with a medical professional. He or she will ask you for the following information:

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

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

Approval means only that a service may be Medically Necessary for treatment of the Member's condition. **However, approval is not a guarantee that Benefits are payable or verification that Benefits are available. Benefits are subject to eligibility and all other Plan limitations and exclusions. The final determination will be made when TCC Benefits Administrator processes your claim(s).**

If you have any questions about whether a certain service will be covered, please contact TCC Benefits Administrator.

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

If your Physician recommends services and supplies for you or your Dependent for any reason, make sure you tell your Physician that your health insurance plan requires advance approval. Preferred Providers will be familiar with this requirement and will get the necessary approvals.

If you or your Dependent does not use a Preferred Provider, it is your responsibility to obtain approval before receiving the service, supply or being admitted. If you do not get prior approval, then you will pay more of your own money for these services and supplies.

Please note that if your request for prior approval is denied, you may request further review under the guidelines set out in the *Appeal Procedures* section of this booklet.

Types of Approval

There are four different types of approval:

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

Preadmission Review — Before you or a dependent are admitted to a Hospital or Skilled Nursing Facility, preadmission approval must be obtained. If you've just had a baby, approval must be obtained within 24 hours of your discharge if your Newborn is sick and must stay in the Hospital.

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

Emergency Admission — If you or a Dependent experiences an emergency Illness or Injury, go to the nearest emergency room right away or call 911 for help. TCC Benefits Administrator does not expect you to wait for approval before you go to the Hospital.

However, you must seek approval within 24 hours of the emergency Admission, or by 5 p.m. of the next working day following the Admission. (Exceptions may be made for reasons beyond your control.)

> **Penalty for not receiving appropriate approvals:** If emergency admission approval is not obtained, or if the emergency Admission is not approved, the Plan may not pay Benefits for any part of the room and board charges for a Preferred Hospital or Preferred Skilled Nursing Facility. While Preferred Providers are responsible for obtaining approval (and you may not be responsible for costs that result from a failure to obtain pre-approval at a Preferred Provider), approval for emergency Admission to a non-Preferred Provider facility is your responsibility and you will be responsible for 50% of the total allowable charge, in addition to other increased charges as a result of using anon-Preferred Provider facility.

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

> **Penalty for not receiving appropriate approvals:** If concurrent care approval is not obtained, or if the concurrent care is not approved, the Plan may not pay Benefits for any part of the room and board charges for a Preferred Hospital or Preferred Skilled Nursing Facility. While Preferred Providers are responsible for obtaining approval (and you may not be responsible for costs that result from a failure to obtain pre-approval at a Preferred Provider), approval for, approval for concurrent care to a Non-Preferred Provider facility is your responsibility and you will be responsible for 50% of the total allowable charge.

Out-of-area Emergency Provision

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

- You were traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- You were treated for an Accidental Injury or new Emergency Medical Condition.

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

If you have claims that meet all of these conditions, write or call the TCC Benefits Administrator customer service department. TCC Benefits Administrator will review your claims to determine if TCC Benefits Administrator can provide additional Benefits.

MEDICAL SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits.

GENERAL PROVISIONS

When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of the Plan of Benefits. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.

PLAN YEAR:

The P/Y for the Deductible and Out-of-Pocket accumulations is **September 1st through August 31st** of each year.

Unlimited Plan Year Maximum per Member

	HOPEHEALTH FACILITIES	PREFERRED PROVIDER (PPO):	NON-PREFERRED PROVIDER (Non-PPO):
Plan Year (P/Y) Deductible:			
Per Member:	$1,000	$1,000	$2,000
Per Family:	$3,000	$3,000	$6,000

Note: The amount applied toward the Non-PPO Deductible will not be used in the accumulation towards the satisfaction of the PPO Deductible.

	HOPEHEALTH FACILITIES	PREFERRED PROVIDER (PPO):	NON-PREFERRED PROVIDER (Non-PPO):
Plan Year (P/Y) Coinsurance Max:			
Per Member:	$1,500	$1,500	$2,000
Per Family:	$3,000	$3,000	$6,000

	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
Out-of-Pocket Amount			
Per Member:	$7,150	$7,150	$14,300
Per Family:	$14,300	$14,300	$28,600

The "**Out-of-Pocket"** Limit is the maximum dollar amount a Member will pay for Benefits in any one Benefit Year. Upon satisfaction of the Out-of-Pocket Limit, benefits for such Member will be payable at 100% of the Allowable Charge.

All Participating Provider cost sharing includes Copayments, Deductible and Coinsurance combine to meet this Out of Pocket Maximum.

The Out-of-Pocket Limit does not include Pre-Authorization Penalties, Premiums, Balance Billing Charges, Health Care this plan doesn't cover and expenses incurred due to reduction of the Allowable Charge payment level

MEDICAL SCHEDULE OF BENEFITS - Continued

INPATIENT HOSPITAL EXPENSES: Pre-Authorization required	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
Ancillary Charges:	N/A	80% after Deductible	60% after Deductible
Anesthesia:	N/A	80% after Deductible	60% after Deductible
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	N/A	80% after Deductible	$250 Copayment then 60% after Deductible
Newborn Nursery:	N/A	80% after Deductible	$250 Copayment then 60% after Deductible
Per-Admission Copayment (In addition to Plan Year Deductible)	N/A	N/A	$250 Copayment
Physical Rehabilitation Facility:	N/A	80% after Deductible	$250 Copayment then 60% after Deductible
Physician Expenses:	N/A	80% after Deductible	60% after Deductible
Room and Board:	N/A	80% after Deductible	$250 Copayment then 60% after Deductible
Skilled Nursing Facility:	N/A	80% after Deductible	$250 Copayment then 60% after Deductible

OUTPATIENT EXPENSES:	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
Anesthesia:	N/A	80% after Deductible	60% after Deductible
Cardiac Rehabilitation:	N/A	$150 Copayment then 80% after Deductible	$250 Copayment then 60% after Deductible
Diagnostic X-ray, Laboratory, Pathology, and Radiology: Note: MRI/CT Scans and PET Scans require Pre-Authorization	80% after Deductible	$150 Copayment then 80% after Deductible	$250 Copayment then 60% after Deductible
Emergency Room Charges: Copayment waived if admitted	N/A	80% after Deductible and $250 Copayment	60% after Deductible and $250 Copayment
Hospital and Physician Charges:	N/A	80% after Deductible	60% after Deductible
Hospital Surgical Services:	N/A	$150 Copayment then 80% after Deductible	$250 Copayment then 60% after Deductible
Pre-Admission Testing:	N/A	$150 Copayment then 80% after Deductible	$250 Copayment then 60% after Deductible

PHYSICIAN OFFICE EXPENSES:	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
Physician Office Visit: Including Surgery, Lab, X-ray, Pathology, Radiology, supplies, and injections	100%	$20 Copayment then 100%	60% after Deductible

SPECIALIST PHYSICIAN OFFICE EXPENSES:	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
Physician Office Visit: Including Surgery, Lab, X-ray, Pathology, Radiology, supplies, and injections	100%	$40 Copayment then 100%	60% after Deductible

URGENT CARE EXPENSES:	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
Urgent Care:	100%	$20 Copayment then 100%	60% after Deductible

MEDICAL SCHEDULE OF BENEFITS - Continued

WELLNESS SERVICES / PREVENTIVE SCREENINGS:	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
Gynecological Exam: Limited to two (2) per Plan Year	100%	100%	No Benefits
Physical Exam/Immunizations: Limited to once per Plan Year	100%	100%	No Benefits
Breast Feeding Pump, Support, Supplies and Counseling: Maximum Combined Benefit of $150 per pregnancy	100%	100%	No Benefits
Routine Colonoscopy:	100%	100%	No Benefits
Pap smear screenings: The report and interpretation only, limited to one (1) per Plan Year	100%	100%	No Benefits
Preventive Benefits under PPACA (Refer to https://www.healthcare.gov/preventive-care-benefits/ for guidelines)	100%	100%	No Benefits
Prostate Exam: Limited to once per Plan Year	100%	100%	No Benefits
***Routine Mammogram:** Covered for persons age 40 and older, once per Plan Year	100%	100%	No Benefits
Well Child Care/Immunizations:	100%	100%	No Benefits

*If Members are outside of South Carolina and the Mammography Network is not available, benefits will be paid at 100% at the Preferred Provider level.

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

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

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

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

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

MEDICAL SCHEDULE OF BENEFITS - Continued

TELEHEALTH EXPENSES:	PPO:	Non-PPO:
Primary Care Telehealth Provider Expense:	$20 Copayment then 100%	Not Covered
Specialist Care Telehealth Provider Expense:	$40 Copayment then 100%	Not Covered

OTHER SERVICES:	HOPEHEALTH FACILITIES	PPO:	Non-PPO:
All Other Benefits:	N/A	80% after Deductible	60% after Deductible
Ambulance:	N/A	80% after Deductible	80% after Deductible
Chiropractic Care: Limited to: $1,000 per member per Plan Year or 20 visits per member per Plan Year	N/A	$40 Copayment then 100%	60% after Deductible
Diabetic Education: Requires letter of Medical Necessity	$20 Copayment then 100%	80% after Deductible	No Benefits
Durable Medical Equipment: Pre-Authorization is required if over $500	N/A	80% after Deductible	60% after Deductible
Home Health Care:	N/A	80% after Deductible	60% after Deductible
Hospice Care:	N/A	80% after Deductible	60% after Deductible
Human Organ/Tissue Transplants:	N/A	80% after Deductible	60% after Deductible
***Occupational Therapy:**	N/A	80% after Deductible	60% after Deductible
Medical Massage Therapy Requires letter of Medical Necessity	$20 Copayment then 100%	80% after Deductible	No Benefits
***Physical Therapy:**	N/A	80% after Deductible	60% after Deductible
Radiation Therapy and Chemotherapy:	N/A	80% after Deductible	60% after Deductible
Second Surgical Opinion (not mandatory)**:**	N/A	80% after Deductible	60% after Deductible
***Speech Therapy:**	N/A	80% after Deductible	60% after Deductible
Treatment of Temporomandibular Joint Dysfunction (TMJ):	N/A	80% after deductible	60% after deductible

***Physical, Occupational & Speech/Hearing Therapy: Limited to a combined maximum of 30 visits per Plan Year.**

COVERED MEDICAL EXPENSES/BENEFITS

1. Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. The Group Health Plan pays the percentage of Billed Charges for Covered Expenses as indicated on the Schedule of Benefits. Covered Expenses will only be paid for Benefits:

a. Performed or provided on or after the Member Effective Date; and
b. Performed or provided prior to termination of coverage; and
c. Provided by a Provider, within the scope of his or her license; and
d. For which the required Pre-Admission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from the Claims Administrator; and
e. That are Medically Necessary; and
f. That are not subject to an exclusion under Medical Exclusions and Limitations of this Plan of Benefits; and
g. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.
h. That comply with the Claims Administrator's corporate medical policy.

The amount payable for Benefits is determined as set forth in this Plan of Benefits and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowable Charge.

2. Pre-Authorization

All Admissions and some Benefits require Pre- Authorization to determine the Medical Necessity. The Group Health Plan reserves the right to add or remove Benefits that are subject to Preauthorization. If Preauthorization is not obtained, Benefits may be reduced. Specific penalties are listed in the Preauthorization Section and/or Schedule of Benefits. PreAuthorization is obtained through the following procedures:

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

Preauthorization means only that the Claims Administrator has determined that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed.

3. Specific Covered Benefits

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

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

The Group Health Plan will provide the following Benefits:

1. **Allergy Injections -** Benefits will be paid for allergy injections as set forth below:

   a. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,
   b. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) weeks at either once per week or twice per week dosing; and,
   c. When any of the following conditions are met:
      i. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen;
      ii. The patient has a life threatening allergy to insect stings or food;
      iii. The patient has skin test and/or serologic evidence of a potent extract of the antigen; or
      iv. Avoidance or pharmacological (drug) therapy cannot control allergic symptoms.

2. **Ambulance Services** – Benefits will be paid for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:

   a. The transport is Medically Necessary and reasonable under the circumstances;
   b. A Member is transported;
   c. The destination is local within the United States; and,
   d. The facility is medically appropriate to treat the Member's condition.

   Benefits will be paid for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and the Claims Administrator confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. Transport from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility must be Pre-authorized. Repatriation for Member convenience is excluded and is not a Benefit for which Covered Expenses are payable.

   Preauthorization is required for transportation as an inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

   a. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);
   b. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;
   c. A ground ambulance transport would endanger the Member's medical condition; and,
   d. The transport is not related to a hospitalization outside the United States.

3. **Ambulatory/Hospital Surgical Center (Outpatient)** - Benefits will be paid for Surgical Services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

4. **Anesthesia** - Charges for the cost and administration of an anesthetic by Physician or professional anesthetist, however, anesthesia rendered by the attending surgeon or their assistant is excluded.

5. **Assistant Surgeon** - When an assistant surgeon is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the Allowable Charge of the surgical procedure.

6. **Blood Transfusions** – Blood transfusions including cost of blood, blood plasma, blood plasma expanders, and other blood products not donated or replaced by a blood bank.

7. **Breastfeeding pump, support, supplies, and counseling**: Charges for Breastfeeding pump, support, supplies and counseling for Pregnant and postpartum women are covered. This includes access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment. Purchase of manual or standard electric breast pump will be before or after the birth of the child. Breastfeeding supplies can be purchased during the first year after delivery as long as the maximum benefit of $150 per pregnancy has not been exhausted.

   Rental of heavy-duty, hospital grade electric breast pump and supplies are covered during the time a mother and infant are separated because the infant remains hospitalized upon the mother's discharge. Continued rental of a hospital grade electric pump is not covered once the baby has been discharged.

8. **Cardiac Rehabilitation** – Cardiac rehabilitation (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.

9. **Chiropractic Treatment** - Benefits will be paid for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

10. **Cleft Lip or Palate**- Benefits will be paid for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

    Benefits shall include, but not be limited to:

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

    Benefits for a cleft lip or palate must be Pre-Authorized. If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Group Health Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Group Health Plan.

11. **Clinical Trials** – Benefits will be paid for routine Member costs for routine Member costs for items and services related to clinical trials when:

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

12. **Contact Lenses/Eye Glasses** - Initial contact lenses or one pair of eye glasses required following cataract surgery.

13. **Contraceptives** – Prescription Drug Benefits, Medical Supplies, services or devices for the purpose of contraception as required under Preventive Services under PPACA..

14. **Cosmetic Surgery** - Charges for cosmetic surgery, only for the following situations:

    a. When the mal-appearance or deformity is due to a congenital anomaly;

b. When due solely to surgical removal of all or part of the breast tissue because of an Injury or Illness to the breast;
c. When required for the medical care and treatment of a cleft lip and palate.

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

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

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

17. **Durable Medical Equipment** - Benefits will be paid for Durable Medical Equipment. The Group Health Plan will decide whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Group Health Plan will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Group Health Plan determines is included in any Hospital room charge. Replacement Durable Medical Equipment is not covered unless such replacements are medically necessary due to pathological changes or normal growth. Replacement parts do not cover batteries, sales tax, or shipping and handling charges. **Pre-Authorization required for expenses over $500**.

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

19. **Emergency Services –** Benefits will be paid for the treatment of Emergency Medical Conditions. Benefits are only available to treat an Emergency Medical Condition 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.

20. **Gynecological Examination -** Benefits will be paid for routine gynecological examinations each Benefit Year for female Members

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

22. **Home Health Care** - Home Health Care, subject to the limitations, if any, stated in the Medical Schedule of Benefits, when rendered to a homebound Member in the Member'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. Benefits for Home Health Care include 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.

23. **Hospice Care** - Benefits will be paid for Hospice Care.

24. **Hospital Services** - Benefits will be paid for Admissions as follows:

    a. Semiprivate room, board, and general nursing care;
    b. Private room, at semi-private rate;
    c. Services performed in a Special Care Unit when it is Medically Necessary that such services is performed in such unit rather than in another portion of the Hospital;
    d. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

e. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,
f. In a Long-Term Acute Care Hospital.

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

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

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

26. **In-Hospital Medical Service** - Benefits will be paid for licensed medical doctor or Behavioral Health Provider's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

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

iii. When the same Provider renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

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

28. **Mammogram Testing** - Benefits will be paid for mammography testing regardless of Medical Necessity for Members that are within the appropriate age guidelines. Benefits will be paid for additional mammograms during a Benefit Year based on Medical Necessity.

29. **Medical Supplies** - Benefits will be paid for Medical Supplies; provided that the Group Health Plan will not pay Covered Expenses separately for Medical Supplies that are (or in the Claims Administrator on behalf of the Group Health Plan determination, should be) provided as part of another Benefit.

30. **Mental Health Services** - Benefits will be paid for the inpatient and outpatient treatment for Mental Health Service.

31. **Obstetrical Services** - Benefits will be paid for obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Member who is a Child except for life-threatening pregnancy complications to either the mother or fetus. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

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

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

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

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

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

34. **Orthognathic Surgery** - The Benefits will be paid for any service related to the treatment of malposition's or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities.

35. **Orthopedic Devices** –Benefits will be paid for Pre-Authorized Orthopedic Devices.

36. **Outpatient Hospital and Ambulatory Surgical Center Services** - Benefits will be paid for Surgical Services and diagnostic services including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center

37. **Outpatient Rehabilitation Services** - Benefits will be paid, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

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

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

38. **Oxygen** –Benefits will be paid for Pre-Authorized oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

39. **Pap Smear –**Benefits will be paid for a pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. Benefits will be paid for additional pap smears during a Benefit Year based on Medical Necessity.

40. **Physical Examination** - Benefits will be paid for physical examinations for Members that are within the appropriate age guidelines regardless of Medical Necessity.

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

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

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

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

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

    a. The tests must be made within seven (7) days prior to Admission; and
    b. The tests must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the Illness or Injury for which the Member is subsequently admitted to the Hospital.

45. **Prescription Drugs** –

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

       For more information about Prescription Drugs, please refer to the PDL which can be found on the Claims Administrator's website. A list of drugs that are not covered by the Claims Administrator is also on the PDL.

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

b. The Group Health Plan may, in its discretion, use Utilization Management programs for Prescription Drugs..

46. **Preventive Services** – Benefits will be paid for preventive health services required under PPACA as follows:

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

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

47. **Prostate Examination** –Benefits will be paid for one (1) prostate examination per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Members that are within the appropriate age guidelines. The Employers Group Health Plan will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

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

Prosthetic Devices do not include bioelectric, microprocessor or computer programmed prosthetic components.

49. **Provider Services** - Benefits will be paid for Provider Services, provided that when different levels of Provider Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level of Provider Services

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

51. **Reconstructive Surgery Following Mastectomy** - In the a case of a Member who is receiving Covered Expenses in connection with a mastectomy the Benefits will be paid for each of the following (if requested by such Member):

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

52. **Rehabilitation**- Benefits will be paid, as specified in the Schedule of Benefits, for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment if the following criteria are met:

a. All such treatment must be ordered by a licensed medical doctor;
b. All such treatment may require Preauthorization and must be performed by a Provider and at a location designated by the Group Health Plan;
c. The documentation that accompanies a request for rehabilitation meets the criteria outlined in the Claims Administrator's medical policy; and,
d. All such rehabilitation Benefits are subject to periodic review by the Group Health Plan.

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

53. **Residential Treatment Center**: Benefits will be paid for a Preauthorized Residential Treatment Center as set forth on the Schedule of Benefits.

54. **Second Opinion** - Expenses for a Second Opinion (Not Mandatory). The Second Opinion must be rendered by a board certified surgeon who is not professionally or financially associated with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the Second Opinion is different from the first, a third opinion will also be payable provided the opinion is obtained before the procedure is performed. The conditions that apply to a Second Opinion also apply to any third surgical opinion.

55. **Skilled Nursing Facility** - Benefits will be paid for Admissions in a Skilled Nursing Facility as follows:

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

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

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

56. **Sleep Apnea** - Care and treatment for sleep apnea.

57. **Smoking Cessation Treatment** – Prescription drugs used for or related to smoking cessation.

58. **Specialty Drugs -** Benefits will be paid for Specialty Drugs as set forth in the Prescription Drug Section. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Claims Administrator. Certain Specialty Drugs may be considered medical Benefits and may;

    a. Require Preauthorization; and/or,

    b. Be subject to certain place of service requirements.

    For any Specialty Drugs paid as medical Benefits, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply as set forth on the Schedule of Benefits. A list of Specialty Drugs, as well as information about any related requirements and/or restrictions, may be obtained by contacting the Claims Administrator at the number listed on the Identification Card or at www.tccba.com.

59. Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy and does not change due to receipt of any Credits by the Group Health Plan.

60. **Speech Therapy** - Fees of a licensed speech therapist. Covered Expenses for speech therapy services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

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

61. **Substance Use Disorder Services** - Benefits will be paid for Substance Use Disorder Services or as set forth on the Schedule of Benefits.

62. **Surgical Procedures** – Benefits will be paid for Surgical Services performed by a licensed medical doctor or oral surgeon, as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

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

        a. If two or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only;
        b. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be paid be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one half of the Allowable Charge for all other operations or procedures performed;
        c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, 50 percent (50%) for the procedure bearing the second and third highest Allowable Charge, 25 percent (25%) for the procedures bearing the fourth through the eighth highest Allowable Charge, and 10 percent (10%) for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and 50 percent (50%) of the charge for each subsequent procedure;
        d. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure;
        e. If two or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Group Health Plan when so requested by the medical doctor or oral surgeon in charge of the case; and
        f. Certain surgical procedures are designated as separate procedures by the Group Health Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

    2. Assistant Surgeon services, that consists of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, Physician's assistant or in-house Physician. The Group Health Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

    3. Anesthesia services, that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

63. **Telehealth –** Benefits will be paid for TeleHealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

64. **Temporomandibular Joint (TMJ) Disorder** –Benefits will be paid for any service for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

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

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

MEDICAL EXCLUSIONS AND LIMITATIONS

THE GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS SECTION EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

1. **Abortions** - Any charges for elective abortions.
2. **Acupuncture** - Acupuncture treatment or services.
3. **Acts of War** - Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.
4. **Admissions that are not Pre-Authorized** - If Pre-Authorization is not received for an otherwise Covered Expense related to an Admission. Benefits may be reduced as set forth in the Pre-Authorization Section.
5. **Allowable Charges** - Charges which are not necessary for treatment of an active Illness or Injury or are in excess of the Allowable Charge or are not recommended and approved by a Physician.
6. **Ambulance** - Ambulance services:

    1. That do not meet coverage guidelines outlined in the Ambulance Services description in the Benefits Section;
    2. That are not Medically Necessary and reasonable;
    3. For transport to a more distant Hospital solely for the Member's convenience, regardless of the reason, or to allow the Member to use the services of a specific Provider or Specialist. The Group Health Plan will pay the base rate and mileage for a Medically Necessary ambulance transport to the nearest medically appropriate facility. If the transport is to a facility that is not the nearest medically appropriate facility, the Member is responsible for additional cost incurred to go to the Member's preferred facility;
    4. If the Member is medically stable and the situation does not involve an emergency, except as specified in the Benefits Section; or,
    5. For transport from a Hospital in connection with a hospitalization outside the United States.

    Any and all travel expenses including, but not limited to, transportation, lodging and repatriation are excluded.
7. **Auto Accidents** - This Plan of Benefits does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.
8. **Batteries/Tax/Shipping** - Charges for batteries, sales tax or shipping and handling charges.
9. **Behavioral, Educational or Alternate Therapy Programs** - Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:

    1. ABA therapy;
    2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
    3. Higashi schools/daily life;
    4. Facilitated communication;
    5. Floor time;
    6. Developmental Individual-Difference Relationship-based model (DIR);
    7. Relationship Development Intervention (RDI);
    8. Holding therapy;
    9. Movement therapies;
    10. Music therapy; and,
    11. Animal assisted therapy.
10. **Benefit Limitations** - Charges which exceed any benefit limitations stated in the Medical Schedule of Benefits of this Plan of Benefits.

11. **Benefits Provided by State or Federal Programs -** Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including, but not limited to, Medicare, TRICARE and Medicaid, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability or any state or federal Hospital services for which the Member is not legally obligated to pay.

12. **Biofeedback Charges** – Any Biofeedback charges.

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

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

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

16. **Complications from Non-Covered Services** - Complications arising from a Member's receipt or use of either services or Medical Supplies or other treatment that are not Benefits.

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

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

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

    A cosmetic or reconstructive service may, under certain circumstances, be considered restorative in nature for which Benefits are available, but only if the following requirements are met:

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

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

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

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

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

21. **Cranial Orthotics** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

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

23. **Dental Services** - Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be Pre-Authorized if the need for dental services results from an accidental injury within one (1) year prior to the date of such services and the Member is not covered by other health or dental insurance.

24. **Discount Services** – Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Member's use of Discount Services. Discount Services are not covered under this Plan of Benefits and Members must pay for Discounted Services.

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

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

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

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

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

30. **Growth Hormone Therapy** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, growth hormone therapy for patients over 18 years of age. Growth hormone therapy for patients 18 years of age or younger is excluded unless for documented growth hormone deficiency.

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

32. **Hearing Aids** - Charges for services or supplies in connection with hearing aids or exams for their fitting.

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

    a. Services and supplies not included in the Medical Schedule of Benefits, but not limited to, general housekeeping services, Custodial Care, domiciliary care and rest cures; and

    b. Services of a person who ordinarily resides in the home of the Member, or is a close relative of the Member; and transportation services.

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

    a. Pre-Authorized;
    b. Performed by a Provider as designated by the Claims Administrator; or
    c. Listed as a covered transplant on the Schedule of Benefits.

35. **Hypnotism** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, hypnotism treatment or services.

36. **Illegal Acts** - Any illness or injury received while committing or attempting to commit a felony or while engaging or attempting to engage in an illegal act or occupation.

37. **Incapacitated Dependents** – Any Service, Supply or Charge for and Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits.

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

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

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

41. **Investigational or Experimental Services** - Services or supplies or drugs that are Investigational or Experimental.

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

43. **Long-Term Care or Custodial Services** - Charges for long term care services:

    a. Rest care;
    b. Long-term acute or chronic psychiatric care;
    c. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication);
    d. Care in a sanitarium;
    e. Custodial or long-term care; or,
    f. Psychiatric or Substance Use Disorder treatment, including: Therapeutic Schools; Wilderness/Boot Camps; Therapeutic Boarding Homes; Half-way Houses; and Therapeutic Group Homes.

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

45. **Medical Equipment/Supplies** - Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, non-Prescription Drugs, and medicines, first aid supplies and non-Hospital adjustable beds.

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

47. **Missed Provider Appointments** – Charges for a Member's appointment with a Provider that the Member didn't attend.

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

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

50. **Not Medically Necessary Services or Supplies** - Any service or supply that is *not Medically Necessary*. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

51. **Obesity Related Procedures** –

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

52. **Orthotics** - charges in connection with orthotics, except for diabetic shoes**.**

53. **Over-The-Counter Drugs** – Drugs that are available on an over-the-counter basis or otherwise available without a prescription, except for insulin.

54. **Pain Management Programs** – Services, supplies or charges for any kind of pain management, including but not limited to, wellness or alternative treatment programs, acupuncture, massage therapy, Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy and hypnotism. The Claims Administrator may, in its discretion under certain limited circumstances, approve services for a multi-disciplinary pain management program, as defined herein. A multi-disciplinary pain management program is a program that includes physicians of different specialties and non-physician Providers who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, the purpose of which is intended to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for a multi-disciplinary pain management program must be Preauthorized in advance. Preauthorization approval shall be on a case by case basis, in the discretion of the Claims Administrator, and contingent upon such program, and the Providers offering such program, complying with the Claims Administrator's Provider credentialing and medical policy requirements, which may change from time to time based on new evidence-based medical information available to the Claims Administrator. The Member is solely responsible for seeking Preauthorization in advance, regardless of the state of location of the Provider offering the multi-disciplinary pain management program.

55. **Participating Provider Charges not Pre-authorized -** For any service that requires Preauthorization, the penalty for not obtaining Preauthorization will vary from state to state, depending on the contractual agreements the Claims Administrator has with its local Providers in that state. Generally, this is a penalty to the Provider, but in some cases, the Member may be held liable.

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

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

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

    The provision of coverage is subject to reasonable medical management techniques and include coverage for preconception care and various services necessary for prenatal care recommended for age – and developmentally-appropriate adult women. For a list of preventive services that are covered is:

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

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

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

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

62. **Private Duty Nursing** – Charges for Private duty nursing services.

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

64. **Prosthetic Devices** - replacement prosthetics or braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

65. **Pulmonary Rehabilitation** – Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, pulmonary rehabilitation, except in conjunction with a covered lung transplant.

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

67. **Relationship Counseling** - Relationship counseling, including marriage counseling, for the treatment of premarital, marital or relationship dysfunction.

68. **Repatriation** - Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country to the Member's residence in the United States.

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

    a. Prescription Drugs that are specifically listed on the website as excluded;
    b. Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;
    c. Prescription Drugs for non-covered therapies, services, devices or conditions;
    d. Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
    e. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs;
    f. Dosages that exceed the recommended daily dosage of any Prescription Drug based on the following guidelines as described in the current:
        ii. United States Pharmacopeia (USP);
        iii. Facts and Comparisons; and/or
        iv. Physicians' Desk Reference;
    j. Prescription Drugs used for or related to (including hair growth and skin wrinkles), obesity or weight control, sexual dysfunction, infertility or impotence (except when prescribed for benign prostatic hypertrophy), including but not limited to fertility drugs, except as specified on the Schedule of Benefits;
    k. Over-the-Counter Drugs and over-the-counter supplies or supplements, except for Over-the-Counter Drugs that are designated by the Claims Administrator as Prescription Drugs and are listed as covered on the PDL and are prescribed by a Provider;
    l. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition except for:
        i. Prescription Drugs for a specific medical condition that has at least two (2) formal clinical studies; or,
        ii. Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one (1) standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals;
    m. Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care or are not provided in compliance with any applicable place of service requirements;

n. Prescription Drugs or services that require Preauthorization by the Claims Administrator and Preauthorization is not obtained;
o. Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);
p. Prescription Drugs which are part of a Utilization Management program and do not meet the requirements of such program;
q. Prescription Drugs which are new to the market and which are under clinical review by the Claims Administrator shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;
r. Prescription Drugs, regardless of therapeutic class, that are determined to offer no clinical or cost effective advantage over other comparable Prescription Drugs already covered under the PDL; and,
s. Non-prescription mineral supplements, non-prescription vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency

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

71. **Services for Certain Diagnoses or Disorders** - Medical Supplies or services or charges for the diagnosis or treatment of learning disabilities, developmental speech delay, perceptual disorders, intellectual disabilities, vocational rehabilitation, animal assisted therapy, eye movement desensitization and reprocessing (EMDR), behavioral therapy for solitary maladaptive habits, or rapid opiate detoxification, except as specified on the Schedule of Benefits.

72. **Services for Counseling or Psychotherapy** - Counseling and psychotherapy services for the following conditions are not covered:

a. Feeding and eating disorders in early childhood and infancy;
b. Tic disorders, except when related to Tourette's disorder;
c. Mental disorders due to a general medical condition;
d. Sexual function disorders;
e. Medication induced movement disorders; or,
f. Nicotine dependence unless specifically listed as a Covered Benefit of this Plan of Benefits or on the Schedule of Benefits.

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

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

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

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

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

78. **Sitters/Companions** – Charges for Sitters or companions.

79. **Travel Expenses** - Travel expense, whether or not recommended by a Physician.

80. **Tubal Ligation/Vasectomy** - Charges incurred for the *Reversal of sterilization*.

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

82. **Wheelchairs or Power Operated Vehicles –** Manual or motorized wheelchairs or power operated vehicles such as scooters for mobility outside of the home setting, except as specified on the Schedule of Benefits. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity by the Group Health Plan.

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

    If the Group Health Plan pays Benefits for an injury or illness and the Group Health Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Group Health Plan shall have the right of recovery as outlined in Workers' Compensation Section of this Plan of Benefits.

PRESCRIPTION DRUG BENEFITS

Prescription Drug benefits are subject to all of the exclusions contained in the Exclusions section of this Plan of Benefits.

Outpatient Prescription Drugs will be covered in the following manner:

Participating Pharmacies:

Copay per Prescription (31-day supply maximum per prescription):

Generic	$15 copay, then 100%
Preferred Brand Name	$50 copay, then 100%
Non Preferred Brand Name	$70 copay, then 100%
Specialty	$300 copay, then 100%

Mail Order Division:

Copay per Prescription (90-day supply maximum per prescription):

Generic	$37.50 copay, then 100%
Preferred Brand Name	$125 copay, then 100%
Non Preferred Brand Name	$175 copay, then 100%

Note: To manage prescriptions, check order status, check costs, prescription coverage, and savings opportunities**, please reference www.tccba.com and utilize the TCC Pharmacy link by going to "Members", click "Self-Funded", then click "Visit TCC Pharmacy", then click "register or sign in"**

All prescription drugs are covered unless an exclusion applies or as required under the Prior Authorization, Quantity Limits and Step Therapy Programs.

For clarification, the following ARE COVERED unless specified otherwise:

- All prescription drugs are covered unless specified otherwise in this Drug Coverage Options section.
- DESI drugs --These drugs are determined by the FDA (Food and Drug Administration) as lacking substantial evidence of effectiveness. The DESI drugs do not have studies to back up the medications' uses, but since they have been used and accepted for many years without any safety problems, they continue to be used in today's market place.
  - Controlled substance 5 (CV) OTC's are covered. (Examples: Robitussin AC syrup and Naldecon-CX) Federal law designates these medications as OTC. However, depending on certain state Pharmacy laws, the medications may be considered Prescription Medications and are, therefore, all covered.
  - Single entity vitamins - These vitamins have indications in addition to their use as nutritional supplements. For this reason, we recommend covering these medications. Single entity vitamins are used for the treatment of specific vitamin deficiency diseases. Some examples include: vitamin B12 (cyanocobalamin) for the treatment of pernicious anemia and degeneration of the nervous system, vitamin K (phytonadione) for the treatment of hypoprothrombinemia or hemorrhage, and folic acid for the treatment of megaloblastic and macrocytic anemias.

For clarification, the following are NOT COVERED:

- Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, ostomy supplies, Durable Medical Equipment, and non-medical substances regardless of intended use.
- Any over-the-counter medication, unless specified otherwise.
- Blood products, blood serum
- Experimental medications do not have NDC numbers and therefore, are not covered.

CLAIMS FILING PROCEDURES

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

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

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

4. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

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

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Group Health Plan will make a determination for each type of claim within the following time periods:

   a. **Pre-Service Claim**

      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
      ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.

iii. An extension of fifteen (15) days is permitted if the Claims Administrator (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary the Claims Administrator will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Claims Administrator does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Claims Administrator will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Claims Administrator receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal.

b. **Urgent Care Claim**

i. A determination will be sent to the Member in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Member requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. **Post-Service Claim**

i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Claims Administrator (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary, the Claims Administrator will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Claims Administrator does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Claims Administrator will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Claims Administrator receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal.

d. **Concurrent Care Claim**

The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination

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

i. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;
iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's claim;
iv. Reference the specific Plan of Benefits provisions on which the determination is based;
v. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
vi. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
vii. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
viii. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
ix. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);
x. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals; and,
xi. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes
xii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
c. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.
d. The Member will also receive a notice if the claim is approved.

APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

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

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

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

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

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

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

5. The final decision on the appeal will be made within the time periods specified below:
   a. Pre-Service Claim

      The Claims Administrator (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.
   b. Urgent Care Claim
      The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Claims Administrator (on behalf of the Group Health Plan) will communicate with the Member by telephone or facsimile. The Claims Administrator (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
   c. Post-Service Claim
      The Claims Administrator (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.
   d. Concurrent Care Claim
      The Claims Administrator (on behalf of the Group Health Plan will decide the appeal of Concurrent Care claims within the time frames set forth in paragraphs above (5) (a-c),depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Final Internal Appeals Determination
   a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an

Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

i. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;
iii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
iv. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
v. Describe any voluntary appeal procedures offered by the Claims Administrator (on behalf of the Group Health Plan) and the Member's right to obtain such information;
vi. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
viii. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;
ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes
x. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received, to give the Member a reasonable opportunity to respond prior to that date.
c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date.
d. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
e. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.
f. A Member's claim and appeals will be decided pursuant to a good faith interpretation of the Plan of Benefits, in the best interest of the Member, without taking into account either the amount of the Benefits that will be paid to the Member or the financial impact on the Plan.
g. The Member will also receive a notice if the claim on appeal is approved.

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

EXTERNAL REVIEW PROCEDURES

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at no cost to the Member. An external review may be used to reconsider the Member's claim if the Claims Administrator has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:
   a. It does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; or,

b. It is an Investigational or Experimental Service and it involves a life-threatening or seriously disabling condition.

2. After a Member has completed the appeal process, (and an Adverse Benefit Determination has been made) such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within four (4) months of receiving the notice of the Claims Administrator's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim).

3. Within five (5) business days of the date of receipt of a Member's request for an external review, the Claims Administrator will respond by either:
   i. Assigning the Member's request for an external review to an independent review organization and forwarding the Members records to such organization; or,
   ii. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Claims Administrator's decision.

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

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

CASE MANAGEMENT

COMPREHENSIVE CASE MANAGEMENT

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

A. Evaluation and assistance for the Employee, their Physician, and family to help develop a plan of services to meet specific needs;

B. Assistance with obtaining unusual equipment or supply needs;

C. Assistance in home care planning and implementation;

D. Arrangements for needed nursing/caregiver services;

E. Providing help with assessment of rehabilitation needs and Provider arrangements;

F. Offering appropriate and effective alternative care/therapy suggestions for Mental Health Services and/or treatment for Substance Use Disorder as determined by medical care review;

G. Monitoring and assuring treatment programs and interventions for Mental Health Services and/or treatment for Substance Use Disorder; and

H. Functioning as an effective resource for information on treatment facilities and available care for Mental Health Services and/or treatment for Substance Use Disorder.

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

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

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

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

HUMAN ORGAN OR TISSUE TRANSPLANT PROCEDURES

When pre-approved and performed by a Provider designated by the Claims Administrator, Benefits are payable for covered expenses for medical and Surgical Services and supplies incurred while the Member is covered under this Plan of Benefits for Human Organ/Tissue transplants as indicated in the following paragraphs. The Benefits related to Human Organ or Tissue Transplants are subject to the Deductible amount and Coinsurance percentage specified in the Medical Schedule of Benefits.

1. Benefits are available for human organ, tissue and bone marrow transplantation, subject to determination made on an individual, case by case, basis in order to establish medical necessity. Pre-Authorization must be obtained in writing from the Medical Services Department.

2. Benefits will be provided only when the Hospital and Physician customarily charge a transplant recipient for such care and services.

3. When only the transplant recipient is a Member, the Benefits of the Plan of Benefits will be provided for the recipient. Benefits will also be provided for the donor under this Plan of Benefits to the extent that such Benefits are not provided under any other form of coverage. In no such case under the Plan of Benefits will any payment of a "personal service" fee be made to any donor. Only the necessary Hospital and Physicians' medical care and services expenses with respect to the donation will be considered for Benefits.

4. When only the donor is a Member, the donor will receive benefits for care and services necessary to the extent that such benefits are not provided under any recipient who is not a Member under this Plan of Benefits. The recipient will not be eligible for benefits when only the donor is a Member.

5. When the recipient and the donor are both Members, benefits will be provided for both in accordance with the respective Group Health Plan covered expenses.

Health care benefits for transplants include covered expenses such as patient work-up, pre-transplant care, the transplant, post-transplant care, and immunosuppressive drugs (while inpatient).

ELIGIBILITY/ELECTION FOR COVERAGE

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

ELIGIBILITY

To be eligible for coverage under the Plan of Benefits an employee must:

A. Every Employee who is Actively at Work on a regular, full time basis for at least thirty (30) hours per week, and has completed Probationary Period on or after the Employer Effective Date is eligible to enroll (and to enroll his or her Dependents) for coverage under this Plan of Benefits.

B. If an Employee is not Actively at work on a regular, full time basis for at least thirty (30) hours per week, forty-eight weeks per year or has not completed the Probationary Period such Employee is eligible to enroll (and to enroll his or her Dependents) beginning on the next day that the Employee is:

   1. Actively at Work on a regular, full time basis for at least thirty (30) hours per week; and;
   2. Has Completed the Probationary Period.

C. Dependent Child under the age of 26.

D. The Employee must furnish written proof of the requirements for an Incapacitated Dependent, as outlined in the Definitions Section, to the Employer no later than thirty-one (31) days after the Child's attainment of the maximum age as listed in the Eligibility Section. The Employee will provide proof upon request.

E. Spouse.

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

G. Probationary Periods and/or contribution levels will not be based on any factor which discriminates in favor of higher wage employees as required under PPACA.

ELECTION OF COVERAGE

Any Employee may enroll for coverage under the Group Health Plan for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Employer. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents may also enroll if eligible under the terms of any Special Enrollment procedure.

The Employee is required to submit a marriage license and file it with the Employer. The Claims Administrator reserves the right to request documentation of such marriage.

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

ANNUAL ENROLLMENT PERIOD

Employees who do not enroll within thirty-one (31) days from date of hire must wait until the Annual Enrollment Period **(month of August)** to enroll for coverage unless eligible for Special Enrollment. Coverage for employees enrolling during the Annual Enrollment Period or during a Special Enrollment period will become effective on the **first day of the month following enrollment.**

EFFECTIVE DATE OF COVERAGE

MEMBER EFFECTIVE DATE

Employee coverage under this Plan of Benefits is effective with respect to an eligible employee on the date this Plan of Benefit's enrollment requirements have been met, provided the Employee is Actively at Work on that date and the Employee has applied for coverage on or before such date. If the Employee applies for coverage within thirty-one **(31)** days of becoming eligible, the Employee's coverage shall become effective the first day of the month following enrollment. If an Employee is not in active service on the date coverage would otherwise become effective, coverage shall become effective on the date he or she returns to active service.

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

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

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

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

2. Employees and Dependents Eligible After the Plan of Benefits Effective Date

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

3. Dependents Resulting from Marriage

   Dependent(s) resulting from the marriage of an Employee will have coverage upon enrollment provided they have been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within thirty-one (31) days after marriage. If a Dependent resulting from a marriage is not enrolled within thirty-one (31) days after the marriage, coverage will begin on the date chosen by the Employer and after the payment of the applicable Premium.

4. Newborn Children

   A newborn Child will have coverage upon the date of the Child's birth provided he or she has been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within thirty-one (31) days after the Child's birth for the Child to have coverage from the date of birth. If a newborn Child is not enrolled within the time frame set forth in the prior sentence, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium and Administrative Charge.

5. Adopted Children

   For an adopted Child of an Employee, coverage shall commence as follows:
   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth.
   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth and if the Employee has obtained temporary custody of the Child.

c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.

If an adopted Child is not enrolled within the time frame set forth in (a)-(c) above, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium and Administrative Charge.

6. Special Enrollment

In addition to enrollment under the effective date section 2-5, the Claims Administrator shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

a. The Employee or Dependent was covered under a Group Health Plan at the time coverage was previously offered to the Employee or Dependent;
b. The Employee stated in writing at the time of enrollment that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and,
c. The Employee or Dependent's coverage described above:
    i. Was under a COBRA continuation provision and the coverage under the provision was exhausted;
    ii. Was not under a COBRA continuation provision described Effective Date Section (6)(c)(i) and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment), or reduction in the number of hours of employment, or if the Employer's contributions toward the coverage were terminated;
    iii. Was one of multiple Plans offered by an Employer and the Employee elected a different plan during an open enrollment period or when an Employer terminates all similarly situated individuals;
    iv. Was under a Health Maintenance Organization (HMO) that no longer serves the area in which the Employee lives, works or resides; or,
    v. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion or termination of coverage or Employer contribution described.
d. Medicaid or State Children's Health Insurance Program (SCHIP) Coverage
    i. The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or,
    ii. The Employee or Dependent becomes eligible for Premium assistance under a Medicaid or SCHIP plan; and,
    iii. The Employee or Dependent requests such enrollment not more than sixty (60) days after either:
        aa. date of termination of Medicaid or SCHIP coverage; or,
        bb. determination that the Employee or Dependent is eligible for such assistance.
        cc. A Member whose Child becomes eligible to enroll in and receive child health assistance under a SCHIP plan also may disenroll the Child from the Plan of Benefits, pursuant to applicable procedures and deadlines established by the state.

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

DEPENDENT CHILD'S ENROLLMENT

1. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits.
2. Absent the sponsorship of an Employee, Dependents are not eligible to enroll for coverage under this Plan of Benefits.

MEMBERSHIP APPLICATION

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

MEMBER CONTRIBUTIONS

The Member is solely responsible for making all payments for any Premium.

DISCLOSURE OF MEDICAL INFORMATION

The Member agrees that the Claims Administrator may obtain claims information, medical records and other information necessary for the Claims Administrator to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits under this Plan of Benefits.

COMMON "LIFE-QUALIFYING EVENTS" AND REQUIREMENTS

Employees and Dependents are generally eligible to enroll in the Employers Group Health Plan within thirty-one (31) days of being hired, during Open Enrollment or when certain events occur during the plan year. This enrollment grid outlines the events that give rise to a right to enroll in coverage as well as the documentation required. The effective date outlined below will apply provided that the Employee has enrolled (or enrolled Dependent) within thirty-one (31) days of the event. If an Employee does not enroll (or enroll the Dependent) within thirty-one (31) days of the event, the Employee (or the Dependent) will not be eligible to enroll until the next Open Enrollment Period.

EVENT	EFFECTIVE DATE	DOCUMENTATION REQUIRED
MARRIAGE	Date of marriage	Marriage Certificate, application along with a copy of social security card
DIVORCE	Date of divorce	A copy of the first and last pages of the divorce decree is required. The date the ex-spouse is terminated will coincide with the date the divorce decree is signed by the Judge and stamped by the Clerk of Court.
BIRTH	Date of Birth	Birth Certificate (Long Form)
DEATH	Date of Death	Proof of Death
ADOPTION (placement or final)	Date of legal adoption or placement for adoption	The court documents are required
SPOUSE GAIN OR LOSS OF COVERAGE	Date the coverage is lost or gained	The spouse must obtain a letter from his or her employer or prior carrier stating: a. The termination date; b. The type of coverage; and c. Reason for termination of coverage.

TERMINATION OF COVERAGE

A. GENERALLY

Termination of an Employee's coverage and all of such Employee's Dependents coverage will occur on the earliest of the following conditions:

1. The last day of the month in which employment is terminated;
2. The date the Group Health Plan is terminated;
3. The date an Employee retires unless the Group Health Plan covers such individual as a retiree;
4. The date an Employee ceases to be eligible for coverage as set forth in the Eligibility Section;
5. The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed ninety (90) days from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993;
6. In addition to terminating when an Employee's coverage terminates, a Dependent spouse's coverage terminates on the date of entry of a court order ending the marriage between the Dependent spouse and the Employee regardless of whether such order is subject to appeal.
7. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under the Group Health Plan;
8. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent; or,
9. Death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

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

C. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium. If Premiums are not paid by the Employee coverage ends as of the due date of that Premium contribution.

D. NOTICE OF TERMINATION TO MEMBERS

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

E. REINSTATEMENT

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

F. EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of any notice under Group Health Plan. The Member further agrees that notifications received from, or given to, the Employer by the Claims Administrator are notification to the Employees except for any notice required by law to be given to the Members by the Claims Administrator.

G. QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Group Health Plan shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements
   a. Timely Notifications and Determinations
      In the case of any Medical Child Support Order received by the Group Health Plan:
      i. The Employer as the Plan Administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Claims Administrator's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,
      ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.
   b. Establishment of Procedures for Determining Qualified Status of Orders
      The Employer as the Plan Administrator shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:
      i. Shall be in writing;
      ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under the Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,
      iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.
   c. Actions Taken by Fiduciaries
      If a Plan fiduciary for the Group Health Plan acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Group Health Plan obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients
   a. Under ERISA
      A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under the Group Health Plan for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

   b. Direct Provision of Benefits Provided to Alternate Recipients
      Any payment for Covered Expenses made by the Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.
   c. Plan Enrollment and Payroll Deductions
      If an Employee remains covered under the Group Health Plan but fails to enroll an Alternate Recipient under the Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional Premium from the Employee's paycheck.

d. Termination of Coverage

Except for any coverage continuation rights otherwise available under the Group Health Plan, the coverage for the Alternate Recipient shall end on the earliest of:

i. The date the Employee's coverage ends;
ii. The date the Qualified Medical Child Support Order is no longer in effect;
iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,
iv. The date the Employer eliminates family health coverage for all of its Employees.

CONTINUATION OF COVERAGE
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan of Benefits or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Name of Entity/Sender:	HopeHealth, Inc.
Contact--Position/Office:	Celeste Johnson, HR Manager
Address:	360 N Irby Street, Florence, SC, 29501
Phone Number:	(843) 656-0349

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Name of Entity/Sender:	HopeHealth, Inc.
Contact--Position/Office:	Celeste Johnson, HR Manager
Address:	360 N Irby Street, Florence, SC, 29501
Phone Number:	(843) 656-0349

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a

maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity/Sender:	HopeHealth, Inc.
Contact--Position/Office:	Celeste Johnson, HR Manager
Address:	360 N Irby Street, Florence, SC, 29501
Phone Number:	(843) 656-0349

COORDINATION OF BENEFITS

A. APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Benefits. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the Coordination of Benefits with Medicare may also apply. The Group Health Plan does not coordinate with individual health plans.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

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

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

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

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

As a condition of receiving Benefits, the Member must:

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

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

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE AS MEMBERS

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

1. The other Plan has rules coordinating its benefits with those of the Group Health Plan; and,

2. There is a statutory requirement establishing that the Group Health Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA; or,
3. Both the other Plan's rules and the Group Health Plan's rules require that benefits be determined under this Plan of Benefits be determined those of the other Plan

D. ADDITIONAL ORDER OF DETERMINATION RULES

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

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

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

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

   The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents
   If two (2) or more Plans cover a person as a Dependent Child of divorced, separated, or unmarried parents, benefits for the Child are determined in the following order:

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

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

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined in (D)(3). Once the Dependent Child reaches the age of eighteen (18) and/or the terms of the court decree are no longer applicable, the Plan which has covered the Dependent for a longer period of time will be primary

4. Active and Inactive Employees
   The Plan that covers a person as an Employee who is neither laid off nor retired, or as that Employee's dependent, is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

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

Coordination of benefits for retirees over age sixty-five (65) who have Medicare Part A and B benefits are determined by calculating the liability of the Group Health Plan in the absence of Medicare and "carving-out" or subtracting Medicare's payment.

MEDICARE FOR DISABLED BENEFICIARIES UNDER AGE 65*

The Group Health Plan is primary and Medicare will be secondary for the Covered Employee and their Covered Dependent spouse or child who is under age 65 and eligible for Medicare by reason of disability.

*For Plans with 100 or more Members. (If under 100 Members, Medicare is primary for disabled individuals).

MEDICARE FOR PERSON WITH END STAGE RENAL DISEASE (ESRD)

For Employees or Dependents under age 65, or 65 and over and still Actively at Work, if Medicare eligibility is due solely to End-Stage Renal Disease (ESRD), this Plan of Benefits will be primary during the first thirty (30) months of Medicare coverage. Thereafter, this Plan of Benefits will be secondary with respect to Medicare coverage. If an Employee or Dependent is age 65 or over, working and develops or is undergoing treatment for ESRD, Medicare will become primary as of the month they become entitled to ESRD benefits.

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

7. COBRA
   COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. The Group Health Plan as Primary Plan
   When the Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

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

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

When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the benefits payable under the, Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Group Health Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Group Health Plan. The benefits payable by the Primary Plan and the Benefits payable by the Group Health Plan will not total more than the Allowable Charge.

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

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

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

G. PAYMENT

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

H. RIGHT OF RECOVERY

If the amount of the payments made by the Group Health Plan is more than the Group Health Plan should have paid, the Group Health Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

SUBROGATION / RIGHT OF REIMBURSEMENT

A. BENEFITS SUBJECT TO THIS PROVISION

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

B. STATEMENT OF PURPOSE

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

1. Another Party

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

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

2. Member

   As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, Dependent or representatives, other than the Group Health Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, Dependent, spouse or person who has or will receive Benefits under the Group Health Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

3. Recovery

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

4. Reimbursement

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

5. Subrogation

   Subrogation shall mean the Group Health Plan's right to pursue the Member's claims for medical or other charges paid by the Group Health Plan against Another Party.

C. WHEN THIS PROVISION APPLIES

This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally

responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Group Health Plan, to transfer to the Group Health Plan all rights to recover damages in full for such Benefits.

D. DUTIES OF THE MEMBER

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

As a condition of receiving Benefits, the Member must:

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

E. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT

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

F. WHEN A MEMBER RETAINS AN ATTORNEY

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

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

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

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

H. WHEN A MEMBER DOES NOT COMPLY

When a Member does not comply with the provisions of this section, the Group Health Plan or Claims Administrator shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Group Health Plan by the amount due as satisfaction for the Reimbursement to the Group Health Plan. The Group Health Plan or Claims Administrator may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances

shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Group Health Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Group Health Plan's attorneys' fees and costs, regardless of the action's outcome.

I. PRIOR RECOVERIES

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Coverage for Re-constructive Surgery Following Mastectomies

This Plan of Benefits provides medical and surgical benefits with respect to a mastectomy. In a case of a beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C. Prosthesis and physical complications at all stages of mastectomy, including lymphedemas.

The Plan of Benefit's Benefit Year Deductible and Copayment will apply to these benefits.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Group Health Plan shall at all times comply with FMLA as outlined in the regulations issued by the Department of Labor. During any leave taken under the FMLA, the Employer will maintain coverage under this Plan of Benefits on the same basis as coverage would have been provided if the Employee had been continuously employed during the entire leave period.

WORKERS' COMPENSATION PROVISION

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

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Group Health Plan or Claims Administrator may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Group Health Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Employer's Group Health Plan or Claims Administrator, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's right of recovery, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Claims Administrator may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Claims Administrator of an injury or illness for which his/her Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
2. Execute and deliver to the Claims Administrator an accident questionnaire

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

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

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

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

In accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), this Plan will provide continuation of coverage to covered Staff Members (and/or dependents) if the Staff Member is absent from employment by reason of service in the uniformed services.

1. In any case in which an Employee or any of such Employee's Dependents has coverage under the Plan of Benefits, and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits. The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:

    a. The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or,
    b. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

2. An Employee who elects to continue coverage under this section of the Group Health Plan must pay one hundred and two percent (102%) such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.

3. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Group Health Plan upon re-employment. Except as otherwise provided in this section upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This section applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under the Group Health Plan by reason of the reinstatement of the coverage of such Employee.

4. Item (3 above) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

ERISA RIGHTS

If the Plan of Benefits is covered by ERISA, each Member in the Plan of Benefits is entitled to certain rights and protections under ERISA. ERISA provides that all Members shall be entitled to:

A. RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Group Health Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Group Health Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Group Health Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Plan Administrator may assess a reasonable charge for the copies.

3. Receive, upon request, a summary of the Group Health Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. CONTINUATION COVERAGE

1. Members are entitled to continue health care coverage for themselves and their Dependents if there is a loss of coverage under the Group Health Plan as a result of a Qualifying Event. The Member or Dependents may have to pay for such continuation coverage. Employee Members should review the documents governing COBRA continuation coverage rights.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan and control its assets are called "fiduciaries," and have a duty to do so prudently and in the interest of the Members. The Employer is the fiduciary of the Group Health Plan.

D. ENFORCEMENT OF EMPLOYEE RIGHTS

1. If a Member's claim for a Benefit is denied or ignored, in whole or in part, such Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps a Member can take to enforce the rights described above. For instance, if a Member requests a copy of Group Health Plan documents or the latest annual report from the Group Health Plan and does not receive them within thirty (30) days, such Member may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay such Member up to $110 a day until such Member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Member has a claim for Benefits that is denied or ignored, in whole or in part, such Member may file suit in a state or federal court. In addition, if a Member disagrees with the Group Health Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, such Member may file suit in federal court. If it should happen that the Group Health Plan fiduciaries misuse the Group Health Plan's money, or if a Member is discriminated against for asserting such Member's rights, such Member may seek assistance from the U.S. Department of Labor, or such Member may file suit in a federal court. The court will decide who should pay court costs and legal fees. If a Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order such Member to pay these costs and fees, for example, if it finds such Member's claim is frivolous.

3. No one, including the Employer, the Members' union, or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

E. ASSISTANCE WITH QUESTIONS

If a Member has any questions about the Group Health Plan, the Member should contact the Plan Administrator. If a Member has any questions about this statement or about a Member's rights under ERISA, or if a Member needs assistance in obtaining documents from the Plan Administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Member may also obtain certain publications about the Member's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MEDICARE CREDITABLE COVERAGE LETTER

Important Notice from HopeHealth, Inc. About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will be affected. If you do decide to join a Medicare drug plan and drop your current HopeHealth,Inc.coverage, be aware that you and your dependents may not be able to get this coverage back.

Current Drug Benefits:

Participating Pharmacies:

Copay per Prescription (31-day supply maximum per prescription):

Generic	$15 copay, then 100%
Preferred Brand Name	$50 copay, then 100%
Non Preferred Brand Name	$70 copay, then 100%
Specialty	$300 copay, then 100%

Mail Order Division:

Copay per Prescription (90-day supply maximum per prescription):

Generic	$37.50 copay, then 100%
Preferred Brand Name	$125 copay, then 100%
Non Preferred Brand Name	$175 copay, then 100%

Group Number: 448
Group Name: HopeHealth, Inc.
Effective Date of Coverage: September 1, 2020

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

You should also know that if you drop or lose your current coverage with HopeHealth, Inc.and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through HopeHealth, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web atwww.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).
Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 1, 2020
Name of Entity/Sender: HopeHealth, Inc.
Contact--Position/Office: Celeste Johnson, HR Manager
Address: 360 N Irby Street, Florence, SC, 29501

DEFINITIONS

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

"ACA": the Affordable Care Act of 2010, as amended.

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

"Admission": the period of time between a Member's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged from the Hospital or Skilled Nursing Facility.

"Adverse Benefit Determination": any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit), except to the extent attributable to a failure to pay any required Premiums or Employee contributions.

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

a. The Allowable Charge shall not exceed the Maximum Payment;
b. The Allowable Charge for Emergency Services provided by Non-Participating Providers will pay in accordance with the definition of Maximum Payment; and,
c. In addition to the Member's liability for deductibles, co-payments and/or co-insurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the billed charges.

"Alternate Recipient": any Child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

"Ambulatory Surgical Center" a licensed facility that:

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

"Authorized Representative": an individual (including a Provider) whom the Member designates in writing to act on his or her behalf.

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

"Behavioral Health Services": all Mental Health Services and/or Substance Use Disorder Services performed by a licensed Behavioral Health Provider.

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

a. Medically Necessary;
b. Pre-Authorized (when required under Plan of Benefits or the Schedule of Benefits);
c. Included in this Plan of Benefits; and
d. Not limited or excluded under terms of this Plan of Benefits.

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

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

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

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

"**Child":** an Employee's Child, whether a natural Child, adopted Child, foster Child, stepchild, or Child for whom an Employee has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, and a Child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Group Health Plan. The term "Child" does not include the spouse of an eligible Child.

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

"Claims Amount": the amount paid (or payable) for Members' claims (including fees such as Access Fees, AEA Fees and amounts paid as part of a VBP or in settlement of claims or in satisfaction of a judgment).

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

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

"COBRA Administrator": the Group Health Plan or its designated subcontractor, the Claims Administrator or its designated subcontractor (who the Claims Administrator has contracted with to provide administrative services related to COBRA).

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

For Prescription Drug Benefits, Coinsurance is the amount payable by the Member calculated by multiplying the percentage listed on the Schedule of Benefits and the negotiated pharmacy price for that item at the time of the sale.

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

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

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

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

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

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

"Credit(s)": rebates and/or other amounts which may be received by the Claims Administrator from drug manufacturers a Pharmacy Benefit Manager and/or another third party. Credits are not payable to Members and will be retained by the Claims Administrator to help stabilize overall rates and to offset expenses.

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

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

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

"Dependent": the following individuals:

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

"Discount Services": from time to time Benefits in the form of discounts for certain Provider Services or products will be provided to Members by networks of complementary healthcare Providers with which the administrator has an agreement for various programs. This discount applies to services the Group Health Plan does not cover. The Claims Administrator will not be responsible for any costs associated with these programs. The services available may include, but are not limited to, chiropractors, massage therapists, acupuncturists, fitness clubs and hearing aids.

"Durable Medical Equipment": equipment that:

a. Can stand repeated use;
b. Is Medically Necessary;
c. Is customarily used for the treatment of a Member's Illness, injury, disease or disorder;
d. Is appropriate for use in the home;
e. Is not useful to a Member in the absence of Illness or injury;

f. Does not include appliances that are provided solely for the Member's comfort or convenience;
g. Is a standard, non-luxury item; and
h. Is ordered by a medical doctor, oral surgeon, podiatrist, or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment when the required Preauthorization is obtained.

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

"Emergency Medical Condition": a medical condition 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:

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

"Emergency Services": 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.

"Employee": any Employee of the Employer who is eligible for coverage, as provided in the Eligibility Section of this Plan of Benefits, and who is so designated to the Claims Administrator by the Employer.

"Employer": the entity providing this Plan of Benefits.

"Employers Effective Date": the date the Claims Administrator begins to provide services under this Agreement.

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

"ERISA": the Employee Retirement Income Security Act of 1974, and any amendments thereto.

"Excepted Benefits": for purposes of HIPAA**,** the following insurance coverage does not constitute Creditable Coverage including the following:

a. Coverage only for accident, or disability income insurance, or any combination thereof;
b. Coverage issued as a supplement to liability insurance;
c. Liability insurance, including general liability insurance and automobile liability insurance;
d. Worker's compensation or similar insurance;
e. Automobile medical payment insurance;
f. Credit-only insurance;
g. Coverage for on-site medical clinics; and
h. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

<u>If offered separately</u>:

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

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

a. Coverage only for a specified disease or Illness;

b. Hospital indemnity or other fixed indemnity insurance.

If offered as a separate insurance policy:

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

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

"Genetic Information": information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from an individual or family member of the individual. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted purposely to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

"Global Payment/Total Cost of Care": a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and Prescription Drugs.

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

"Group Health Plan": this Employee welfare Benefit Plan established and/or sponsored by the Employer to provide health Benefits to Employees and/or their Dependents, directly or through insurance, reimbursement or otherwise.

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

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

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

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

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

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

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

"Identification Card (ID Card)": the card issued by the Claims Administrator to a Member that contains the Member's identification number.

"Incapacitated Dependent": a Child who is:

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

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will provide updated information regarding items (a) and (b) each year or upon the Claims Administrator's request. A Child who is not incapacitated by the maximum Dependent Child age listed in the Eligibility Section will not be covered.

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

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

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

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

"Mail Service/Home Delivery Pharmacy": a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription by mail.

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

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

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

e. The lowest amount of reimbursement the Claims Administrator allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

"Medical Child Support Order": any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits;

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

a. The name and the last known mailing address (if any) of each Member Employee and the name and mailing address of each Alternate Recipient covered by the order;
b. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;
c. The period to which such order applies; and
d. Each Group Health Plan to which such order applies.

If the Medical Child Support Order is a national medical support notice, the order must also include:

a. The name of the issuing agency;
b. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and
c. The identification of the underlying Medical Child Support Order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

"Medically Necessary/Medical Necessity:"
using United States standards, health care services and/or Behavioral Health Services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical or behavioral health practice;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
c. Not primarily for the convenience of the patient's caregiver(s) or Provider; and
d. 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.

All requirements of the above-referenced definition must be met in order for a health care service or Behavioral Health Service to be deemed Medically Necessary. The failure of a health care service or Behavioral Health Service to meet any one of the above referenced requirements means, in the discretion of the Claims Administrator or CBA, the health care service or Behavioral Health Service does not meet the definition of Medically Necessary/Medical Necessity.

For the purposes of determining Medically Necessary/Medical Necessity:

a. The Claims Administrator and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which in their discretion are determined to be generally accepted standards by the medical and/or behavioral health community;
b. "Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Claims Administrator or CBA; and,
c. The Claims Administrator may, in their discretion use, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC its affiliated companies, or other entities general recognized as providing industry guidance and expertise, which reflect and are clinically appropriate health care services and Behavioral Health Service and generally accepted standards of medical and behavioral health practice. MCG Health, LLC and/or its affiliated companies and/or other entities are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies.

Medical Supplies: supplies that are:

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

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

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

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

"Mental Health Services": treatment (except treatment for Substance Use Disorder Services) for a condition that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

"Natural Teeth": teeth that:

a. Are free of active or chronic clinical decay;
b. Have at least 50% bony support;

c. Are functional in the arch;
d. Have not been excessively weakened by multiple dental procedures; or
e. Teeth that have been treated for one (1) or more of the conditions referenced in a-d above, and as a result of such treatment have been restored to normal function.

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

"Non-Preferred Drug": a Prescription Drug that does not appear on the list of Preferred Drugs.

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

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

"Out-of-Pocket Maximum": the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Member will be required to pay.

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

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

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

"Patient-Centered Medical Home (PCMH)": a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

"Pharmacy Benefit Manager(PBM)": the pharmacy benefit manager with whom the Claims Administrator contracts to perform PBM services.

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

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

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules apply only to one (1) of the parts, each part is considered a separate Plan.

"Plan Administrator": the entity charged with the administration of the Group Health Plan. The Employer is the Plan Administrator of the Group Health Plan.

"Plan of Benefits": the document which reflects the Benefits offered under the Group Health Plan based on the Benefits Checklist. The Plan of Benefits includes the Schedule of Benefits. Employer agrees that the Plan of Benefits will, at a minimum, be incorporated as a part of the Group Health Plan.

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

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

"Post-service Claim": any claim that is not a Pre-service Claim or any claim that is submitted after the medical care, service or supply has been provided.

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

"Preadmission Review": the review that must be obtained by a Member (or the Member's representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Pre-admission Review process is outlined in the Pre-Authorization/Prior Approval of Treatment Section.

"Pre-Authorized/Pre-Authorization": the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. The Pre-Authorization process is outlined in the Pre-Authorization / Prior Approval Section.

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

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

"Pre-service Claim": any claim or request for a Benefit where prior authorization or approval must be obtained from Medical Services Department before receiving the medical care, service or supply. An approval means only that a service is Medically Necessary for treatment of your condition, but is not a guarantee or verification of Benefits. Payment is subject to your eligibility, and all other Plan of Benefit limitations and exclusions. A Final Benefit determination will be made when your claim is processed.

"Prescription Drugs": a drug or medicine that is:

a. Required to be labeled that it has been approved by the Food and Drug Administration;
b. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only" prior to being dispensed or delivered, or labeled in a similar manner; or
c. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must be prescribed by a licensed Provider acting within the scope of his or her license.

Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of the Claims Administrator. Such designated Over-the-Counter Drugs will be listed on the PDL.

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

"Prescription Drug List (PDL)Formulary": a listing of drugs approved for a specified level of Benefits by the Claims Administrator, under the Plan of Benefits. This list shall be developed and subject to periodic review and modification by the Corporation. The most up-to-date version of the PDL is available on the Claims Administrator's website.

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

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

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

"Probationary Period": the period of continuous employment (if included on the Schedule of Benefits) with the Employer that an Employee must complete before becoming eligible to enroll in the Plan of Benefits. The Employer may require an additional orientation period.

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

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

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

- Medicine
- Dentistry
- Optometry
- Podiatry
- Chiropractic Services
- Physical Therapy
- Behavioral Health
- Oral Surgery
- Speech Therapy
- Occupational Therapy
- Osteopathy

The term Provider also includes a Hospital, a Rehabilitation Facility, a Skilled Nursing Facility, a physician assistant and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon and Behavioral Health Services when performed by a Behavioral Health Provider, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Claims Administrator. The term Provider does not include interns, residents, physical trainers, lay midwives or masseuses.

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

"Provider Services": includes the following services:

A. When performed by a Provider or a Behavioral Health Provider within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards:

   1. Office visits, which are for the purpose of seeking or receiving care for a preventive service illness or injury; ,
   2. Basic diagnostic services and machine tests; or,
   3. Behavioral Health Services.

B. When performed by a licensed medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:

1. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;
2. Benefits rendered in a Member's home;
3. Surgical Services;
4. Anesthesia services, including the administration of general or spinal block anesthesia;
5. Radiological examinations;
6. Laboratory tests; and,
7. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.

"Qualified Medical Child Support Order (QMCSO)": a Medical Child Support Order that:

a. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or
b. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

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

a. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked;
b. Death of the Employee;
c. Divorce of the Employee from his or her spouse;
d. A Child ceasing to qualify as a Dependent under this Plan of Benefits;
e. Entitlement to Medicare by an Employee, or by a parent of a Child;
f. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

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

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

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

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

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

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

"Skilled Nursing Facility": an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

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

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

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

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

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

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

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

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

"TeleHealth": the exchange of Member information during which Members can have a telephone or web consultation with a licensed health care professional.

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

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

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

“Utilization Management”: the use of techniques, such as step therapy, that allow the Corporation to manage the cost of Benefits by assessing their appropriateness using evidence-based criteria or guidelines before they are provided.

ADMINISTRATIVE INFORMATION

1.	Plan Year:	Begins September 1st of each year and continues for 12 consecutive months through August 31st.
2.	Plan Name:	HopeHealth, Inc.
3.	Name and Address of the Employer establishing the Plan:	HopeHealth, Inc. 360 N Irby Street Florence, SC 29501
4.	Employer's ID Number:	57-0984427
5.	Plan Number:	448
6.	Type of Welfare Plan:	Medical
7.	Plan Funding:	Paid by the Employer and/or the Employee determined by the level of coverage (employee, employee spouse, family) selected.
8.	Claims Administration:	Thomas H. Cooper & Co., Inc. (TCC Benefits Administrator)
9.	Agent and Address for Service of Legal Process:	HopeHealth, Inc. 360 N Irby Street Florence, SC 29501
10.	Plan Administrator Name and Address:	HopeHealth, Inc. 360 N Irby Street Florence, SC 29501
11.	Named Trustee:	HopeHealth, Inc.
12.	Named Fiduciary:	HopeHealth, Inc.
13.	Plan Termination:	The right is reserved in the Plan for the Plan Administrator, by action of its Board of Directors, to terminate, suspend, withdraw, amend or modify the Plan in whole or in part, with respect to any class or classes of employees, at any time, with proper notification and subject to the terms of the Plan and any applicable laws.
14.	Plan Document	A full description of the medical benefits appears in the official Plan document which is the final authority. These papers may be examined in the company office of the Employer within 30 days after your written request is received by the Plan Administrator.

ADMINISTRATIVE SERVICES ONLY

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

AMENDMENT

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

AUTHORIZED REPRESENTATIVES

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

CLERICAL ERRORS

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

DISCLOSURE OF PHI TO PLAN SPONSOR

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

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

1. The Plan Sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Group Health Plan Documents, as amended, or required by law.
2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan of Benefits, with respect to Member's PHI.
3. The Plan Sponsor will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
5. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.
6. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.
8. The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of Member PHI, to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member

who is the subject of the PHI, when the Member's PHI is no longer needed for the Group Health Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Group Health Plan.
11. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides ePHI (that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Group Health Plan), agrees to implement reasonable and appropriate security measures to protect this information.
12. Plan Sponsor shall report any security incident of which it becomes aware to the Group Health Plan as provided below.
    i. In determining how and how often Plan Sponsor shall report security incidents to Group Health Plan, both Plan Sponsor and Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:
        i. Pings on a Party's firewall;
        ii. Port scans;
        iii. Attempts to log on to a system or enter a database with an invalid password or username;
        iv. Denial-of-service attacks that do not result in a server being taken off-line; and,
        v. Malware (e.g., worms, viruses).
    ii. Plan Sponsor shall, however, separately report to Group Health Plan (i) any successful unauthorized access, use, disclosure, modification, or destruction of the Group Health Plan's ePHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; or (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's ePHI.

B. Adequate Separation between the Plan Sponsor and the Group Health Plan.

1. Only Employees or other workforce members under the control of the Plan Sponsor ("Employees") who, in the normal course of their duties, assist in the administration of Employee Benefits or the Group Health Plan or the Group Health Plan finances, or other classes of Employees as designated in writing by the Plan Sponsor may be given access to Member PHI received from the Group Health Plan or business associate servicing the Group Health Plan.
2. These Employees will have access to Member PHI only to perform the Group Health Plan administration functions that the Plan Sponsor provides for the Group Health Plan.
3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section. Plan Sponsor will promptly report such breach, violation or noncompliance to the Group Health Plan, and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

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

Plan Sponsor certifies that the Group Health Plan contains and that the Plan Sponsor agrees to the provisions outlined above.

GOVERNING LAW

The Group Health Plan and Plan of Benefits (including the Schedule of Benefits) are governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Group Health Plan and Plan of Benefits are governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Group Health Plan or Plan of Benefits conflicts with such law, the Group Health Plan and Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Member must present their Identification Card prior to receiving Benefits.

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

INFORMATION AND RECORDS

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

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover on the Group Health Plan until such Member has exhausted the appeal process as set forth in Appeals Section. No such action may be brought after the expiration of any applicable period prescribed by law.

MEMBERSHIP APPLICATION

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

NEGLIGENCE OR MALPRACTICE

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

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under this Plan of Benefits may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

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

2. To a Member: To the last known name and address listed for the Employee related to such Member on the Membership Application. Members are responsible for notifying the Claims Administrator of any name or address changes within thirty-one (31) days of the change.

3. To the Employer: To the name and address last given to the Claims Administrator. The Employer is responsible for notifying the Claims Administrator and Members of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, the Claims Administrator (on behalf of the Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of the Group Health Plan or Plan of Benefits. Such a decision does not mean the Group Health Plan or Employer waives or gives up any rights under the Group Health Plan or Plan of Benefits in the future.

OTHER INSURANCE

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

PAYMENT OF CLAIMS

A Member is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Group Health Plan may pay all Covered Expenses directly to the Employee upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Employee, the Employee is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, Benefits will be paid directly to such Participating Provider.

PHYSICAL EXAMINATION

The Group Health Plan has the right to examine, at their own expense, a Member whose Injury or sickness is the basis of a claim (whether Pre-Service, Post-Service, Concurrent or Urgent Care. Such physical examination may be made as often as the Group Health Plan (through its designee, including TCC Benefits Administrator) may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

REPLACEMENT COVERAGE

If the Group Health Plan replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered of the Plan of Benefits Effective Date of the Group Health Plan, provided such persons are enrolled for coverage as stated in the Eligibility Section.

NOTICE OF PRIVACY PRACTICES

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

Our Privacy Promise

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

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

Uses and Disclosures of Medical Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Individual Rights

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

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

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

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

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

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

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

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

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

Questions and Complaints

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

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

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

Contact Information

Attn: Phil Ericksen, Sr. VP and CMO
4400 Leeds Ave, Suite 130
North Charleston, SC 29405

(843) 722-2115 (telephone)
(843) 722-2866 (fax)

Final Acceptance by the Group for the attached Plan of Benefits dated September 1, 2020

IN WITNESS WHEREOF, HopeHealth, Inc. has caused its name to be signed by its proper officer thereunto duly authorized to evidence the adoption of this Plan on the below date.

By _____

Title Chief Administrative Officer

Date 9/15/2020

Non-Discrimination Statement and Foreign Language Access

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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