SELF-FUNDED PLAN DOCUMENT FOR

GROUP MEDICAL

Effective: July 1, 2010

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Please visit the website www.tccofsc.com and select StatusLink 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 summary plan description**
- **Leave customer service messages that will be responded to within 24 hours**

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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 Cooper & Co., Inc.* ("TCC of SC") to process and pay health claims and to provide services in connection with the operation of this Plan of Benefits. TCC of SC (also referred to as the "Claims Administrator") is located in Charleston, South Carolina.

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

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 Cooper & Company, Inc. (TCC of SC) (*)

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 Co-payments 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 Allowed Amount 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 of SC 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 of SC at the following:

TCC of SC
Attn: Claims
P.O. Box 22557
Charleston, SC 29413
(843) 722-2115/(800) 815-3314

How To File Claims For Services You Have Already Received

If you receive healthcare services or supplies from a PPO Provider, the PPO Provider should file your claims for you.

If you receive healthcare services or supplies from a Non-PPO Provider or non-participating Pharmacy, you will have to file your own claims. When filing your own claims, here are some things you will need:

1. **Claim Form for each patient.** You can get these forms from the customer service or you may print a copy off your TPA website at www.tccofsc.com.

2. **Itemized Bills from the Providers.** These bills should include:

- Provider's name and address
- Patient's name and date of birth
- Employee's ID number
- Description and cost of each service
- Date that each service took place
- Description of the Illness or Injury (diagnosis)

To file a claim you must complete the front of each claim form and attach the itemized bills to it. If you (or your Dependent for claims filed for your Dependent's care) have other insurance that has already paid some or all of the claims, be sure to attach a copy of the other insurance plan's Explanation of Benefits (EOB) notice. This will help prevent a delay of your claims processing.

Before you submit your claims, TCC of SC suggests you make copies of all claim forms and itemized bills for your records since TCC of SC cannot return them to you. Send your claims to TCC of SC at the address found in the *Customer Service* section above.

Time Limits to File a Claim

Claims must be filed no later than 12 months from the incurred dates of service in which you or your Dependents receive the medical services or supplies. Exceptions may be made where you show that you were not legally competent to file the claim.

Authorized Representatives and Representatives designated under HIPAA

Unless expressly permitted by law, you and your dependent's Protected Health Information generally cannot be released to any other person without your or your dependent's (where they are over the age of 18) consent. However, there are instances when you may want someone to discuss your Protected Health Information with TCC of SC, or receive an explanation of benefits, etc. to manage your care. In order to comply with applicable laws and also to comply with your request, your must sign a written authorization form. To obtain a copy of the form, please visit the TCC of SC website at www.tccofsc.com , go to member services and then select "forms". You can print this form and mail to the TCC of SC address or you can call 1-800-815-3314 for a copy of the form.

A Provider may be considered a Participant's authorized representative without a specific designation by the Participant when the claim request is for an Urgent Care Claim. A Provider may be a Participant's authorized representative with regard to non-Urgent Care claims only when the Participant gives TCC of SC or the Provider a specific designation, in writing in a format that is reasonably acceptable to the Plan to act as an authorized representative. If the Participant has designated an authorized representative, all information and notifications will be directed to that representative unless the Participant gives contrary directions. Providers may have certain independent rights to appeal a claim decision; however, such appeals shall not count against the Participant unless the Provider is specifically appealing on the Participant's behalf.

PRIOR APPROVAL OF TREATMENT

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

Items requiring approval are listed on the Schedule of Benefits Page 65.

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. Please do not call the TCC of SC customer service department. A customer service representative cannot give prior approval.

These numbers are also on the front 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 Participant's condition. A**pproval is not a guarantee that Benefits are payable or verification that Benefits are available. Payment is subject to participant eligibility, all Pre-existing Condition Limitations and all other Plan limitations and exclusions. The final determination will be made when we process your claim(s).**

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

If you or a Dependent is 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 you plan. **If the 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 five different types of approval:

1. Preadmission
2. Emergency Admission
3. Concurrent Care
4. Preauthorization Review

Here are more details about each one:

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.

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 of SC 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.)

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 a Non-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.

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.

- **Preauthorization Review** — A number of services and medical procedures require Preauthorization Review:
    - Inpatient Hospitalizations
    - MRI/CT Scans
    - Organ Transplants
- For more information about services and supplies that require Preauthorization Review, please see the *Covered Medical Expenses* section. If you have specific questions, please call or write TCC of SC.

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 of SC customer service department. TCC of SC will review your claims to determine if TCC of SC can provide additional Benefits.

CLAIM DETERMINATIONS AND APPEALS

CLAIM DETERMINATION

There are generally two types of claims. These are: (1) Pre-service Claims, which includes Urgent Care Claims and Concurrent Care Claims and (2) Post-service Claims. The time frames allowed for the Group Health Plan to provide a determination for each of these types of claims are listed below:

1. **Pre-service Claim** – A determination for most Pre-service Claims (other than Urgent Care Claims and Concurrent Care Claims as set forth below) will be provided to you (in writing or in electronic form) within 15 calendar days of our receipt of the claim.

   An extension of 15 calendar days may be required if TCC of SC determines that, for reasons beyond TCC of SC's control, an extension is necessary. If TCC of SC determines that an extension is required, TCC of SC will notify you within the initial 15 day time period that an extension is necessary.

   When TCC of SC requires an extension due to incomplete information, you will have 45 calendar days to provide the required information. If TCC of SC does not receive the required information within the 45 day time period, the claim may be denied. Additionally, TCC of SC will be entitled to an additional 15 days to reach a determination after the additional information is received from you or a Provider. If TCC of SC receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), TCC of SC will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

   A. **Urgent Care Claim** – A determination for Urgent Care Claims will be provided to you (in writing or in electronic form) within 72 hours of TCC of SC's receipt of the claim.

      An extension of 48 hours may be required if TCC of SC determines that you have failed to provide enough information for TCC of SC to make a determination. If TCC of SC determines that an extension is required, TCC of SC will notify you within 24 hours of the receipt of the Urgent Care Claim. If TCC of SC does not receive the required information from you or your Provider within 48 hours after notifying you, the claim may be denied. If TCC of SC receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), TCC of SC will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

      TCC of SC will consider a Provider to be your authorized representative without a specific designation by you when the Provider has submitted an Urgent Care Claim on your behalf.

   B. **Concurrent Care Decision** – If TCC of SC makes a decision to stop or reduce Benefits for Concurrent Care that had previously been approved, you will be notified sufficiently in advance of the reduction or termination of Benefits to allow you time to appeal the decision before the Benefits are reduced or terminated.

If you request Concurrent Care Benefits to be extended and the request involves Urgent Care, the request to extend a course of treatment or number of treatments must be made at least 24 hours prior to the expiration of the initially approved period. TCC of SC will make a decision within 24 hours.

2. **Post-service Claim** – A determination for Pre-service Claims will be provided to you (in writing or in electronic form) within 30 calendar days of our receipt of the claim if the decision is adverse to you.

   An extension of 15 calendar days may be required if TCC of SC determines that, for reasons beyond TCC of SC's control, an extension is necessary. If TCC of SC determines that an extension is required, TCC of SC will notify you within the initial 15 day time period that an extension is necessary.

   When an extension is required due to incomplete information, you will have 45 calendar days to provide the required information. If TCC of SC does not receive the required information within the 45 day time period, the claim will be denied. Additionally, TCC of SC will be entitled to an additional 15 days to reach a determination after the additional information is received from you or a Provider. If TCC of SC receives information after the timeframe for providing the information has passed (but within the timeframe for submitting an appeal), TCC of SC will treat the submission of the information as a request for an appeal and will process the claim in accordance with the appeal procedures.

Denial of Claims

If TCC of SC denies any part or all of a claim, you will receive an Explanation of Benefits ("EOB") or determination letter explaining the reason(s). A denial will include any Adverse Benefit Determination.

Your notice that you receive will contain:

i. The specific reason(s) for the Adverse Benefit Determination;
ii. A reference the specific Plan provisions on which the determination is based;
iii. A description of any additional material or information, if any, needed to complete the claim and the reasons such material or information are necessary;
iv. A description of the claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
v. The disclosure of any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or a statement that such information is available free of charge upon request); and,
vi. If the reason for the decision is based on an exclusion such as lack of Medical Necessity or Investigational or Experimental Services, an explanation of the scientific or clinical judgment for the determination (or a statement that such information will be provided to your free of charge upon request).

If after reviewing the notice that is provided, you do not understand why TCC of SC denied your claim, you can:

- Read the information in this booklet. It outlines the terms and conditions of your health coverage; or,
- Contact TCC of SC at (800) 815-3314.

If you have failed to follow the Plan requirements in submitting a claim, you will be notified within 5 calendar days.

APPEAL PROCEDURES

If you wish to file a formal appeal, you must write to:

Thomas Cooper & Company, Inc. (TCC of SC)
Attention: Appeals
P.O. Box 22557
Charleston, SC 29413

Your letter must state that a formal appeal is being requested and you must include all pertinent information regarding the claim that you want to have considered in the letter. The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision):

1. Pre-service Claim – You have 180 days to appeal the decision on a Pre-service Claim (including a Concurrent Care decision). TCC of SC will complete the appeal process within 15 calendar days after receiving the appeal. If you still do not agree with the decision, you can submit a second appeal within 90 days after receiving the decision

of the first appeal. TCC of SC will complete the second appeal process within 15 calendar days after receiving the second appeal.

2. Urgent Care Claim – You have 180 days to appeal the decision on an Urgent Care Claim. TCC of SC must complete the appeal process within 72 hours after receiving the appeal.
3. Post-service Claim – You have 180 days to appeal the decision on a Post-service Claim. TCC of SC will complete the appeal process within 30 calendar days after receiving the appeal. If you still do not agree with the decision, you can submit a second appeal within 90 days after receiving the decision of the first appeal. TCC of SC must complete the second appeal process within 30 calendar days after receiving the second appeal.

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;

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 Participant or any other Participant. Nothing contained in this Plan of Benefits shall obligate the Plan Administrator to approve an alternative treatment plan.

COVERED MEDICAL EXPENSES

This Plan of Benefits provides coverage for a wide range of services and supplies. The charges for these services and supplies are considered covered expenses to the extent that they are: Medically Necessary; prescribed; rendered by a Physician within the scope of his or her license; and provided for care and treatment of a covered Illness or Injury.

Applicable Deductible and/or co-pay amounts and Benefit Percentages payable are listed in the **Schedule of Benefits**. Covered medical expenses are subject to any limitations specified in the Schedule of Benefits. Covered medical expenses are subject to all exclusions. Covered medical expenses are only payable based on the Allowed Amount.

Covered medical expenses include, but are not limited to, charges for the following:

1. Charges made by an Ambulatory Surgical Center, Emergency Room on an outpatient basis or Alternate Facility clinic.

2. Eligible health services received at an **urgent care center** to treat urgent health care needs are covered as outlined in the **Schedule of Benefits.**

3. Charges for an **accident** will be treated as any other condition unless special provisions (e.g. deductible is waived) are outlined in the Schedule of Benefits. If these special provisions apply, the treatment must be rendered by a doctor **within 72 hours** of the accident and must not be otherwise covered under this Plan. This section does not allow payments for prosthetic devises of the fitting of these devises. This benefit is payable for **90 days** from the date of the accident.

   Coverage for treatment for an **inpatient accident** will be payable as outline in the Schedule of Benefits.

4. Charges for the cost and administration of an **anesthetic** to include spinal or general anesthesia or other anesthetic agents by injection or inhalation. When rendered by a physician or certified registered nurse or anesthetist.

5. Medical services for the diagnosis and treatment of **Attention Deficit Disorder (ADD)** are considered eligible for benefits under the Plan. Eligible services include diagnosis and pharmacologic management of ADD when provided by a physician and/or physical and occupational therapy ordered by duly-qualified physician.

6. 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 Allowed Amount of the surgical procedure.

7. Charges for **chiropractic treatment/manipulative treatment**, subject to the limitations, if any, stated in the Schedule of Benefits.

8. Charges for **cosmetic surgery**, only for the following situations:

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

   B. When due solely to surgical removal of all or part of the breast tissue because of an Injury or Illness to the breast; or

   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.

9. Charge for **dental services** rendered by a Physician for treatment of an Accidental Injury to natural teeth if all treatment is rendered within twelve (12) months of the Accidental Injury.

10. Charges for **Prescription Drugs** will be covered through the Plan's prescription drug card. There are separate copayments for generic, formulary name brand and non-preferred name brand drugs, as outlined in the SCHEDULE OF BENEFITS. Charges for covered prescription drugs prescribed by a physician for services rendered in the hospital will be covered as other expenses. Covered injectable prescription drugs that are not covered under the prescription drug card benefits will be covered under the medical expense benefits of the Plan with a letter of medical necessity.

11. Charges for oral **contraceptive** management for employees and dependent spouses (all contraceptives are not covered for dependent children under the age of 17).

    NOTE: Oral Contraceptives are covered separately by the Prescription Drug Card.

12. Charges for **Durable Medical Equipment** (such as renal dialysis machines, resuscitators or Hospital-type beds), required for temporary therapeutic use in the Participant's home by an individual patient for a specific condition when such equipment is not ordinarily used without the direction of a Physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by TCC of SC. Benefits will be reduced to standard equipment allowances when deluxe equipment is used. The rental or purchase benefits cannot exceed the purchase price of the equipment. Replacement Durable Medical Equipment is not covered unless such replacements are medically necessary due to pathological changes or normal growth.

13. Charges for professional **ambulance service** to the Hospital where treatment is given or between medical facilities when Medically Necessary; charges for air ambulance when Medically Necessary.

14. **Home Health Care**, subject to the limitations, if any, stated in the Schedule of Benefits, when rendered to a homebound Participant in the Participant's place of residence. Home Health Care must be rendered by or through a community Home Health agency, must be provided on a part-time visiting basis and must be provided according

to a Physician-prescribed course of treatment. 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.

15. Charges relating to **Hospice Care**, provided that the participant has a life expectancy of six (6) months or less and subject to the maximums, if any, stated in the Schedule of Benefits. This coverage includes bereavement counseling, a supportive service provided by the Hospice team to participants in the deceased's immediate family. The team helps the family adjust to the death of such terminally ill person cope with physical, psychological, spiritual, social, and economical stress and are covered as follows: the Participant was in the hospice care program on the date immediately before his/her death, and a Participant under the Plan of Benefits; the charges for such services are incurred by the immediate family within twelve (12) months of the terminally ill person's death.

16. **Hospital Charges** for:

    A. Daily room and board charges in a Hospital, not to exceed the daily semi-private room rate (charges when a Hospital private room has been used will be reimbursed at the average semi-private room rate in the facility). Hospitals with all private rooms will be allowed at the prevailing private room rate;

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

    C. Confinement in an intensive care unit, cardiac care unit or burn unit;

    D. Miscellaneous hospital services and supplies during Hospital confinement, if such charges should not have been included in the underlying hospital charge (as determined by the Plan);

    E. Inpatient charges for a well Newborn care for nursery room and board and for professional service. Eligible expenses will be subject to the allowed amounts for pediatric services and circumcision;

    NOTE: The deductible requirement is waived on charges for a covered newborn during the hospital stay of the mother.

    F. Outpatient Hospital services and supplies and emergency room treatment; and

17. M**edical supplies**, when ordered in writing by a physician and determined by the Plan to be appropriate for treatment of an Illness or Injury to include but not limited to the following;

    A. Charges for **artificial limbs** and their replacement, if deemed medically necessary**.**

    B. **Initial supply** of external breast prosthetic device, prescribed in connection with a mastectomy performed due to malignancy or other medically necessary condition and their replacement, if deemed medically necessary;

    C. **Blood transfusions**, including cost of blood, blood plasma, blood plasma expanders, and other blood products and other fluids to be injected into the circulatory system;

    D. Initial **contact lenses** or one pair of **eye glasses** if required immediately following and because of cataract surgery, and their replacement, if deemed medically necessary.

    E. Prescription drugs and medicines, including generic equivalents (reimbursable through the Prescription Drug Card, if applicable);

    F. Casts, splints, braces, crutches, surgical dressings, surgical trays, traction equipment;

    G. Syringes and other necessary diabetic supplies, insulin pumps and related supplies;

    H. Colostomy bags and related supplies;

    I. Necessary supplies for renal dialysis equipment or machines;

    J. Initial supply of artificial eyes, and their replacement, if deemed medically necessary.

18. Charges for **Mental Health, Alcohol and Substance Abuse Services** if rendered by a licensed medical Physician (M.D.), licensed psychologist (PH.D); clinical psychologist, licensed social worker, or licensed counselor.

Expenses for Psychological Testing are also covered. City of Seneca also has an outside vendor Employee Assistance Program (EAP) as stated in the Schedule of Benefits.

19. Charges for **Maternity and Newborn Care** (including circumcision)**.** The Plan of Benefits will comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan of Benefits will not restrict benefits 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 normal vaginal delivery, or to less than ninety-six (96) hours following a cesarean section. However, the mother's or Newborn's attending Provider, after counseling with the mother, may discharge the mother or her Newborn earlier than the forty-eight (48) hours (or ninety-six (96) hours if applicable).

    The maternity provision applies only to the employee or covered spouse of an employee.

20. 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, cerebral vascular accident (stroke) or congenital birth defect.
21. Charges by a licensed physiotherapist for **physical therapy** when prescribed by a physician. Physical or occupational therapy means treatment of a covered person by means of constructive activities. These activities should be designed to promote the restoration of the person's ability to function as they did prior to the injury or illness. Charges which involve preparing the patient for an occupation or securing a job are not covered. These benefits also do not apply to manipulative treatment. The Plan may require written treatment plans approved by a physician before determining benefits.
22. Charges for the following **oral surgical procedures**:
    A. Excision of wholly or partly un-erupted impacted teeth;
    B. Open or closed reduction of a fracture or dislocation of the jaw; and
    C. 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.
    D. Hospital charges for medically necessary care
23. Charges for temporamandibular joint dysfunction **(TMJ)** payable at the Plan percentage up to a **lifetime maximum of $3,000.**
24. Charges for **oxygen** and other gases and their administration.
25. Charges incurred for Admission in a **physical rehabilitation facility**, subject to the limitations, if any, stated in the Schedule of Benefits for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment. The Participant 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.
26. Charges for the services of a **Physician** for medical care and/ or surgical treatments including office, home visits, Hospital inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations, subject to the following:

    Physician office visit service includes charges for the office visit, medicines dispensed in the physician's office, diagnostic lab and x-ray procedures performed in and billed by the physician's office, diagnostic lab and x-ray procedures performed in and billed by the physician's office. These services are subject to the co-pay, regardless of whether or not an office visit charge is billed. Treatment rendered by a non-network provider will be subject to the deductible and the applicable co-insurance amounts outlined in the SCHEDULE OF BENEFITS.

    Services of a physician for manipulative treatment, maternity care and allergy treatments are not payable under this benefit.

In-Hospital medical service consists of a Physician's visit or visits to a Participant who is a registered bed-patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or Obstetrical service is required, as follows:

A. In-Hospital medical benefits will be provided limited to one visit per specialty per day;

B. In-Hospital medical benefits in a Skilled Nursing Facility;

C. When two or more Physicians, within the same study, render in-Hospital medical services at the same time, payment for such service will be made only to one Physician; and

D. Concurrent medical/surgical care benefits for in-Hospital medical service in addition to benefits for surgical service will be provided only:

1) When the condition for which in-Hospital medical service requires medical care not related to Surgical or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative and post-operative care but requires supplemental skills not possessed by the attending surgeon or his assistant; or

2) When a Physician, other than a surgeon admits a Participant to the Hospital for medical treatment and it later develops that surgery becomes necessary, such benefits cease on the date of surgery for the admitting Physician and become payable under the surgeon only; or

3) When the surgical procedure performed is designated by TCC of SC as a "warranted diagnostic procedure" or as a "minor surgical procedure".

27. **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 thirty (30)** 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 Participant is subsequently admitted to the Hospital.

28. Charges for **radiation therapy services (by x-ray, radium or other radioactive isotopes ordered by a physician. Chemotherapy treatment including intravenous chemotherapy services ordered by a physician. (to include a wig up to $500)**.

29. **Second Surgical Opinion** – The Plan does not require but will pay for a second surgeon's opinion as described in the Schedule of Benefits.

"Second Surgical Opinion" is a surgeon's opinion evaluation the need for surgery previously recommended by another surgeon. The following conditions must be met:

A. The surgery must require confinement in a hospital or treatment in an ambulatory surgical center;

B. The charge for the surgery, if performed, must qualify as an eligible charge;

C. The surgeon giving the second opinion must not be associated with the surgeon who gave the first opinion and must be board certified in the appropriate medical specialty, except: A board certified specialist is not required if the surgeon has been referred to the patient by a local medical society or if the recommended surgery does not require the use of general or spinal anesthesia;

D. The second opinion must be set forth in writing by the second surgeon after examination of the patient.

30. Charges for an Extended Care Facility or a **Skilled Nursing Facility** will be payable as follows:

A. Room and board charges will be payable for each day of confinement in an Extended Care Facility for 60 days of confinement per benefit period as outlined in the SCHEDULE OF BENEFITS. The term "room and board chares" as used here means charges made by an intermediate or Extended Care Facility for the cost of room, meals and services (such as general nursing services) provided to all inpatients on a routine basis; **and**

B. the Extended Care Facility confinement must be in lieu of a hospital confinement; **and**

C. the patient must be under the continuous care of a physician (physician's fees are payable as outline on the Schedule of Benefits).

31. Fees of a licensed **speech therapist.** Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an injury; or (iii) a sickness that is other than a learning or Mental Disorder. All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

32. Charges for **surgical procedures,** subject to the following:

    A. If two or more operations or procedures are performed at the same surgical approach, the total amount covered for the operations or procedures will be payable for the major procedure only, or benefits will be payable according to the recommendations of the Medical Services Department;

    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 according to the Allowed Amount for the operation or procedure bearing the highest allowance, plus one half of the Allowed Amount 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 paid according to the Allowed Amount for the procedure bearing the highest allowance, 50 percent (50%) for procedures bearing the second and third highest allowance, 25 percent (25%) for procedures bearing the fourth through the eighth highest allowance, and 10 percent (10%) for all other procedures;

    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 allowance for such operation or procedure;

    E. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the allowance, subject to the above paragraphs, will be pro-rated between them by TCC of SC when so required by the Physician in charge of the case; and

    F. Certain surgical procedures, which are normally exploratory in nature, are designated as "independent procedures: by TCC of SC, and the Allowed Amount is covered when such a procedure is performed as a separate and single entity. However, when an independent procedure is performed as an integral part of another surgical service, the total amount covered will be paid according to the Allowed Amounts for the major procedure only.

33. Charges for services for **voluntary sterilization** for Participants.

34. Charges incurred in connection with an out-patient surgical procedure, including charges for surgery, surgical facility, anesthesia, diagnostic x-rays and laboratory work performed on the day of the surgery.

35. Charges for routine **wellness services** as outlined in the Schedule of Benefits. This benefit includes well-child exams, routine immunizations, routine adult physical exams, routine lab work, routine gynecological exams and pap smears, routine mammograms, PSA testing and routine colonoscopies (age 50 and over).

36. Charges for **x-rays**, microscopic tests, and laboratory tests.

37. Charges for **self-injectable medications** are covered under the prescription drug card as outlined in the Schedule of Benefits.

38. Charges for **private duty nursing** services when provided by a registered nurse (RN) or licensed practical nurse (LPN), when such services are medically necessary for the care or cure of a specific disease or injury and **are rendered in the home.**

    Private duty nursing services are not a covered expense when such services are rendered primarily to assist in daily living (e.g., services which constitute personal care, such as getting in or out of bed, walking, assistance in dressing and feeding), preparation of special diets, supervision of medication which can usually be self-administered or administered by someone with lesser training, and which does not entail or require the continuous attention of and RN or LPN.

    Also, private duty nursing services are not a covered expense provider:

    A. Usually resides in the same household with the covered person; or

    B. Is related by blood, marriage, or legal adoption to the covered person or the spouse of the covered person; or

    C. Is on duty for more than one (1) eight (8) hour shift/person/day.

NOTE: The 100% payment after the maximum out of pocket limit has been reached does not apply to private duty nursing charges.

39. **Routine foot care** up to $300 per benefit period will be covered by the Plan

    NOTE: Notwithstanding the above, charges made for an **open cutting operation** which involves the exposure of (or cutting into) bones, tendons or ligaments or for partial or complete **removal of** the nail matrix or roots **are not subject** to the $300 limitation.

40. Charges for **dietary counseling** for treatment of diabetes or heart related conditions which are not solely related to weight control. The services must be rendered by a licensed dietitian or nutritionist under the supervision of physician. The Plan may review the requested treatment in order to determine if benefits are payable.

41. Charges for or in connection with **renal dialysis**.

42. Charges for **sleep apnea** when deemed medically necessary. A sleep study required to determine medical necessity for further treatment of sleep apnea will be covered by the Plan at the rate outlined in the Schedule of Benefits.

43. Treatment for impotence and prescriptions with the exceptions of prescriptions noted in Prescription Schedule of Benefits.

44. Charges in connection with human to human organ or tissue **transplants** to the extent they are **not experimental** and are not covered expenses under the Human Organ or Tissue Transplant Procedures or services that were received before and after the "benefit period" as defined in the Human Organ or Tissue Transplant Procedures will be covered.

    SPECIAL NOTE: All organ or tissue transplants must be pre-authorized by the Medical Review Department. Please refer to the Human Organ or Tissue Transplant Procedures for additional information.

45. Charges incurred as a result of **self-inflicted bodily injury** or self-induced illness will be covered when:

    A. A covered individual so injured does not know or understand the nature of quality of his actions.

    B. Is so impaired that the covered individual is not able to understand the moral character, general nature, consequences and effect of the act he/she is about to commit.

    C. The covered individual is impelled to do so by an irresistible impulse that essentially forced the covered individual to attempt suicide.

    D. The covered individual so injured has lost his/her reasoning faculties.

46. Charges for the **non-surgical treatment of morbid obesity** will be considered based on medical necessity and pre-approval **ONLY** when:

    A. The cause for the obesity is an organic illness **AND**

    B. The degree of obesity is considered a serious disease associated with a high incidence of medical complications and a significantly shortened life span, with a related co-morbid condition in addition to morbid obesity. **AND**

    C. There is documented compliance in a weight reduction program that is physician managed showing at least 6 months of diet/lifestyle weight reduction techniques to include records of weight, details of plan and compliance with the treatment plan.

    D. Drug therapy has been FDA approved, prescribed and managed by a medical physician, documentation of at least 6 months of diet/lifestyle weight reduction techniques to include records of weight, details of plan and compliance with the treatment plan.

    NOTE: This provision shall **exclude** charges for any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications, surgery of any kind, equipment or educational program **whether for obesity or any other diagnosis.**

HUMAN ORGAN OR TISSUE TRANSPLANT PROCEDURES

When pre-approved and performed by a Provider designated by your Plan, Benefits are payable for covered expenses for medical and surgical services and supplies incurred while the Participant 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, Coinsurance percentage and/or money maximum specified in the 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 Participant, 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 Participant, 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 Participant under this Plan of Benefits. The recipient will not be eligible for benefits when only the donor is a Participant.
5. When the recipient and the donor are both Participants, 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). All Benefits provided during a Transplant Benefit Period will apply toward the Transplant Lifetime Maximums listed below. For transplants not listed below, TCC of SC will determine the Transplant Lifetime Maximum on an individual basis.

• Liver	$225,000
• Lung (Single)	$130,000
• Lung (Double)	$250,000
• Heart	$120,000
• Heart & Lung (Single)	$130,000
• Heart & Lung (Double)	$250,000
• Pancreas and Kidney	$80,000
• Kidney (Single)	$60,000
• Kidney (Double)	$120,000
• Bone Marrow	$250,000
• Cornea	$25,000

Note: Amounts paid for Prescription Drugs will not apply to the transplant maximum.

MEDICAL EXCLUSIONS AND LIMITATIONS

The exclusions and limitations in this section apply to all expenses incurred by all Participants: The following are **excluded from coverage** under this Plan of Benefits:

1. Any service or supply that is not **Medically Necessary**.
2. Charges for or in connection with, the care or treatment of any injury or sickness due to war or any act of war; "war" includes armed aggression or hostilities resisted by armed forces of any country, combination of countries, civil or international organization, whether or not war is declared.
3. **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.
4. **Travel expense**, whether or not recommended by a Physician.
5. Any medical **social services, recreational or milieu therapy, education testing or training**, except as part of pre-Authorized Home Health Care or Hospice Care Program.
6. **Nutritional counseling, food supplements and other dietary supplies** even if the supplements are ordered or prescribed by a Physician. Exceptions to this exclusion are noted under the Schedule of Benefits and the Prescription Drug Benefits section.
7. Services, supplies or charges for **pre-marital and pre-employment physical examinations**.
8. Any service or supply for which a Participant is entitled to receive payment or Benefits (whether such payment or Benefits have been applied for or paid) under any law (now existing or that may be amended) of the United States or any state or political subdivision thereof, except for Medicaid. These include, but may not be limited to, Benefits provided by or payable under **worker's compensation laws**, the Veteran's Administration for care rendered for service-related disability, or any state or federal Hospital services for which the Participant is not legally obligated to pay whether or not such policy is actually in force. This exclusion applies if the Participant receives such Benefits or payments in whole or in part, and is applied to any settlement or other agreement regardless of how it is characterized and even if payment for medical expenses is specifically excluded.
9. Services to the extent that the Participant is entitled to payment or Benefits under any **State or Federal** program that provides health care benefits, including Medicare, but only to the extent that Benefits are paid or are payable under such programs.
10. Charges resulting from or occurring (1) during the **commission of a crime** by the Participant; (2) while engaged in an illegal act, illegal occupation, felonious act or aggravated assault or (3) intoxication (determined by a blood alcohol content in excess of the legal limit for intoxication in the occasion where the Injury or Illness occurred).
11. Charges incurred as a result of participating in a riot or **civil disturbance**, or while committing or attempting to commit an assault or any other unlawful act.
12. **Charges** incurred as a direct result of:

    A. The voluntary taking of drugs except as prescribed by a physician;

    B. A covered person's operation of a motor vehicle, watercraft or aircraft while under the influence of alcohol. The following shall apply to any charges incurred by a covered person as a direct result of such operation:

    - **No benefits shall be payable for the first $5,000** of such charges arising out of such incident. This excluded amount is in addition to and shall no be limited by or applied against any Plan deductible or co insurance. Any benefits in excess of the first $5,000 excluded in this paragraph of exclusions are covered expenses.
    - **No more than two (2) such occurrences per covered family unit** will be covered under this provision; charges related to any **additional occurrences will not be covered.**

The determination of whether the operator was under the influence of alcohol may be based on any available test results showing alcohol concentration in excess of applicable legal limits or other reliable evidence.

13. Charges incurred for services or supplies which constitute **personal comfort or beautification items**, such as television or telephone use.

14. All **Cosmetic Procedures** in which the purpose is improvement of appearance or correction of deformity without restoration of bodily function. Some procedures may, under certain circumstances, be considered to be restorative in nature, when they are performed to correct a loss of function, pain, a mal-appearance or deformity that was caused by physical trauma, surgery or congenital anomaly. Coverage of cosmetic procedures that are deemed medically necessary including but not limited to the following:

    A. Adipectomy – excision of fat

    B. Blepharaplasty – eyelid

    C. Jaw surgery – upper and/or lower

    D. Lipectomy – excision of fatty tissues

    E. Mammoplasty – suspension, augmentation, or reduction

    F. Mentoplasty – chin

    G. Rhinoplasty – nose

    H. Rhytidectomy – abdomen, legs, hips or buttocks

    I. Rhytidoplasty – face lift

    J. Sclerotherapy – varicose veins

    K. Superficial chemosurgery – acid peel of face

    L. Surgical planning - dermabrasion

In order for benefits to be available for such restorative surgery, coverage for the proposed surgery or treatment must have Pre-Authorization by the Medical Review Department prior to the date of that surgery or treatment. Coverage for cosmetic surgery is available as outlined in the Covered Expenses section of this Plan of Benefits.

15. Charges which are not necessary for treatment of an active Illness or Injury or are in excess of the **Allowed Amount** or are not recommended and approved by a Physician.

16. 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.

17. Charges for services rendered by a Physician, nurse or licensed therapist who is a **Close Relative** of the Participant, or resides in the same household as the Participant.

18. Charges **incurred outside the United States** if the Participant traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

19. Charges for inpatient confinement, primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent, custodial or rest care, or any medical examination or test **not connected with an active Illness or Injury**, unless otherwise provided under any preventable care covered under this Plan of Benefits.

20. Charges incurred in connection with **routine vision care, eye refractions, the purchase or fitting of eyeglasses, contact lenses, or such similar aid devices**. 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 for correcting nearsightedness, farsightedness and/or astigmatism unless deemed medically necessary.

21. Charges incurred for treatment on or to **the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes**. Benefits will be payable for charges incurred for treatment required because of Accidental Injury to natural teeth, tumor related, or for any oral surgical procedure listed under this Plan of Benefit's Covered Medical Expenses.

22. Charges related to **fertility**, or **infertility,** including assistance in correcting and testing for such conditions. Testing will include (but not be limited to) preconception testing or genetic testing for purposes of determining fertility or infertility or the prospect or outcome of pregnancy whether in its application to the offspring(s) or parent.

    NOTE: This exclusion will not apply when a pregnancy is covered under this Plan, and testing, such as the initial ultrasound and amniocentesis, ordered by the physician to detect any defect in the child to be born.

23. Charges for or in connection with the **reversal of male or female** sterilizations.

24. **Experimental and/or Investigational** services, supplies, care and treatment. The Group Health Plan reserves the right to approve, upon medical review, chemotherapy agents that have been approved by the Federal Drug Administration (FDA) for cancer.

25. 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.

26. Any service or supply rendered to a Participant for the treatment of **obesity** or for the purpose of weight reduction. This includes all procedures designed to restrict the Participant's ability to assimilate food. For example, gastric by-pass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the purpose of which is to restrict the ability of the Participant to take in food, digest food or assimilate nutrients. Also excluded from coverage are those procedures concerning the correction of complications that arise from such excluded diversionary or restrictive procedures; procedures whose purpose is the reversal of these restrictive or diversionary procedures and such reconstructive procedures as may be necessitated by the weight loss produced by these non-covered restrictive or diversionary procedures. This provision shall also exclude charges for any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications, surgery of any kind, equipment or educational program whether for obesity or any other diagnosis. This exclusion will not apply to charges for dietary counseling for diabetes or heart related conditions.

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

28. Any service or treatment for complications resulting from any **non-covered procedures**.

29. Any service or supply rendered to a Participant for the diagnosis or treatment of **sexual dysfunction** (with the exclusion of impotence see prescription Schedule of Benefits) except when Medically Necessary due to an organic disease. This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition.

30. Charges for **abortion**, whether voluntary or otherwise, except for charges incurred when:

    A. The life of the mother would be endangered if the fetus were carried to term; or

    B. Where medical complications have arisen; or

    C. As a result of rape or incest.

31. Charges for a **Dependent children's pregnancy**, childbirth, including abortions or related medical conditions **except for pregnancy as the result of a Criminal Act or Complication of Pregnancy**. "Complications of Pregnancy" are the following;

    A. Conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from but are adversely affected by or caused by pregnancy, such as:

       Acute nephritis, nephrosis, cardiac decomposition, missed abortion and similar conditions of comparable severity, including hypermesis gravidarum and pre-eclampsia.

    but does not include:

       False labor, occasional spotting, physician prescribed bed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

    B. Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

32. 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.
33. Charges incurred for **take home drugs** upon discharge from the Hospital.
34. Charges for **custodial or domiciliary care** (sitters or companions). This is defined as care designed essentially to assist an individual to meet his activities of daily living, such as (but not limited to), services for personal care, feeding, and help in walking, and getting in and out of bed.
35. **Charges in connection with orthotics, except for diabetic shoes, or 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.
36. Charges for **hearing exams** and hearing aids unless otherwise covered under the Plan for such conditions as Acoustic Neuromas or accidental injuries.
37. Care and treatment of **hair loss**.
38. **Exercise programs** for treatment of any condition.
39. Charges for purchase or rental of medial equipment such as the following (but not limited to): Air conditioners, air-purification units, humidifiers, allergy-free pillows, vacuum cleaners, blanket or mattress covers, electric heating units, swimming pools, mattresses, waterbeds, exercising equipment, vibratory equipment, elevators or stair lifts, saunas, steam baths, special vehicles, adaptive equipment to assist in driving or transportation, 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 or equipment that cannot be used solely by the covered patient.
40. **Acupuncture or hypnosis**
41. **Contraceptive management service and supplies** (oral contraceptives are covered through the prescription drug card). **All forms of contraceptives are specifically excluded for dependent children under th e age of 17.**
42. **Any charges related to smoking cessation** unless authorized by the Plan's Tobacco Cessation Program.
43. Charges which exceed any **benefit limitations** stated in the Schedule of Benefits of this Plan Document.
44. Benefits will **not** be payable for charges incurred due to self-inflicted bodily injury or self-induced illness when:
    A. The injuries have been "intentionally" self-inflicted".
    B. The covered individual so injured has the mental capacity to form the requisite degree of intent to commit self-harm.
    C. Injuries sustained in connection with recreational activities provided the injury does not result from any medical condition (physical or mental) or from domestic violence.
    D. The injury is a result of an "accidental" activity that the covered individual did not expect death or bodily harm to result from the activity, his expectation of survival.
45. Biofeedback charges.
46. Any expenses incurred in obtaining **Medical Records** in order to substantiate Medical Necessity.
47. Charges for batteries, sales tax or shipping and handling charges.
48. Charges for altering the size or shape of the breast, male or female, unless this type of surgery is reconstructive surgery due to a mastectomy caused by a malignancy or unless it is a result of a medically necessary condition.
49. Charges for the care, services or treatment required as a result of **complication or consequences** from a treatment or surgical procedure not covered under this plan.
50. Charges primarily for the **convenience** of the patient or the patient's family.
51. Charges for services or treatment of learning disabilities, dyslexia, **developmental delays**, behavioral problems, behavioral disorders, or conduct disorders.
52. Charges for **educational testing, training, or counseling.**

53. Charges for **failure** to keep a scheduled visit or completion of forms.
54. Charges for **medical social services**, unless otherwise covered under the Plan.
55. Expenses for which **no amount** was invoiced to the patient.
56. Charges that would not have been made to the individual had the patient **not been covered by this Plan;** the fact that an individual is covered under this plan will not create an obligation to pay where such obligation would not otherwise have existed.
57. Charges incurred while the patient is not under the **direct care** of a physician, unless otherwise specified in the plan.
58. Charges for **personal items** (i.e., toothbrushes, combs, etc.) included in any fee for medical treatment.
59. Charges for **pre-existing conditions** except as set forth under the "Pre-existing Conditions" section of this document.
60. Charges for **sex change** surgery or charges for any treatment gender identity disorders.
61. Charges **submitted** more than twelve (12) months after the date of service.
62. Charges for **telephone consultation** between the patient and provider.
63. Any **transplant related** expenses for which benefits are payable under the Human Organ or Tissue Transplant Program are excluded from coverage under this Plan.
64. Prescription Drug Exclusions. The following are not covered under the this Plan of Benefits:
    - 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.
    - Investigational or Experimental medications. Prescription Drugs that have not been prescribed by a Physician;
    - Any vitamins (unless prescribed by a Physician) except for prenatal vitamins;
    - Prescription Drugs not approved by the Food and Drug Administration;
    - Prescription Drugs for non-covered therapies, services, or conditions;
    - Prescription Drug refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
    - Unless different time frames are specifically listed on the Schedule of Benefits, more than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy) or unless the quantity is limited by a QVT program;
    - 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, including fees for the administration or injection of a Prescription Drug;
    - Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
    - Prescription Drugs used for or related to cosmetic purposes, including hair growth, unless otherwise specified on the Schedule of Benefits;
    - Prescription Drugs related to any treatment for infertility, including but not limited to, fertility drugs;

- Prescription Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;

- Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements;

- Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for 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 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);

- Prescription Drugs that are not consistent with the diagnosis and treatment of a Participant'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;

- Prescription Drugs or services that require Pre-Authorization by the Corporation and Pre-Authorization is not obtained;

- 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);

- Prescription Drugs that are not Medically Necessary;

- Prescription Drugs for obesity, weight control or smoking cessation;

- Prescription Drugs that are not authorized when a part of a Step Therapy program; and

- Prescription Drugs used for cosmetic purposes.

65. Home Health Care Exclusions. The following are excluded from coverage under the Home Health Care benefit:

- Services and supplies not included in the Schedule of Benefits, but not limited to, general housekeeping services and services for Custodial Care; and
- Services of a person who ordinarily resides in the home of the participant, or is a Close Relative of the participant; and Transportation services.

The Plan is not in lieu of, and does not affect, any requirement for coverage by any Workers' Compensation Law.

Only charges for treatment, services or supplies specified under **"COVERED EXPENSES"** will be payable under the Plan.

ELIGIBILITY FOR COVERAGE

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

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

A. Be employed and compensated by the Employer on a regular, full time basis for at least thirty (30) hours per week; and

An eligible employee may initially enroll in the Plan of Benefits on the first day of the month following ninety (90) days of Full-time Employment.

RETIRED EMPLOYEES ELIGIBILITY
Retired employees are eligible for coverage under the Plan subject to the following definitions:

1. An eligible employee must be retired from the City of Seneca which has elected coverage for retirees;

   AND;

2. Eligible retired employees must meet the following requirements;

   a. The individual must meet the requirements for retirees as defined under the "South Carolina Retirement System" or other qualified retirement program through which the City of Seneca member may be covered;

   AND;

   b. At least 10 of the service years must have been continuous with the City of Seneca immediately preceding retirement.

3. The effective date of coverage as a retired employee must be **the date the employee would have lost coverage as an active employee.** Therefore, if an employee is not eligible or declines retiree coverage for himself or any eligible dependent, even if the employee and/or dependent continued coverage via COBRA, the employee and/or dependent will not be allowed to elect retiree coverage at a later date.

4. An eligible employee who is eligible for coverage as a retiree under the Plan will continue to be considered a retiree under the Plan if he/she returns to full-time active employment with the City of Seneca from which he/she retired.

TEACHERS AND EMPLOYEES RETENTION INCENTIVE (TERI) RETIREES:

An employee who retires under the TERI program will continue to be covered as an active employee provided there is not a break in full-time employment status.

SPECIAL NOTE: Once a TERI employee begins to receive a retirement check (rather than money being escrowed), this individual will be considered a Retiree as outlined in the provisions for **RETIREES.**

LAW ENFORCEMENT RETENTION INCENTIVE (LERI) RETIREES:

An employee who retires under the LERI program will be considered a Retiree as outline in the provisions for **RETIREES.**

CONTINUATION PROVISIONS FOR DEPENDENTS OF ELIGIBLE RETIREES:

Coverage for eligible dependents of deceased Retiree may be continued provided the Retiree and dependent(s) were covered under the Retiree Provisions of this Plan. An eligible dependent may continue coverage as a surviving beneficiary on this Plan subject to the following guidelines:

1. A spouse can continue coverage until he/she remarries or obtains other medical coverage;

2. Children can continue coverage under the same terms and conditions as dependents of an active employee;

3. Eligible spouses or dependent children may be responsible for the full cost of coverage.

ELECTED (or APPOINTED) OFFICIALS ELIGIBILITY

ELIGIBILITY

Active Elected (or Appointed) Officials may be considered for coverage under the Plan and may be able to continue coverage under the Plan as long as the Elected (or Appointed) Official performs the normal duties on a regular weekly schedule for that position he/she has been Elected (or Appointed) to perform.

EFFECTIVE DATE OF COVERAGE

An Elected (or Appointed) Official may enroll in the Plan within 30 days of the date of the election (or appointment). If coverage is requested within 30 days of the election (or appointment) date, coverage will become effective on the **first of the month following the employer's required waiting period.**

If coverage is requested **more than 30 days after the date of eligibility** (original effective date of coverage), then enrollment may occur during **City of Seneca's Annual Open Enrollment Period**, the **Open Enrollment Period** provided by a **Cafeteria/Section 125 Plan (if applicable)**, or due to a **Special Enrollment event** subject to the requirements set forth by the **Health Insurance Portability and Accountability Act (HIPAA).**

CONTINUATION PROVISIONS

An Elected (or Appointed) Official will be eligible for the Continuation Provisions under this Plan when the individual is no longer eligible as an active Elected (or Appointed) Official. Refer to the **"CONTINUATION PROVISIONS"** section of this document.

RETIREMENT

An Elected (or Appointed) Official may be eligible for Retirement coverage under the Plan if the individual meets the requirements for retirees as defined under the "South Carolina Retirement System" (or other qualified retirement program through which the City of Seneca member may be covered) **and** meets the length of service requirements set forth by the City of Seneca.

ORDER OF PAYMENT

If an Elected (or Appointed) Official has other group coverage available under a Group Medical or Dental Plan with and **employer** (**current or former to include coverage as a retired employee**), or as a **dependent** under his or her spouse's Group Medical or Dental Plan (as an active or retired employee), this Plan will pay on a **secondary** basis in accordance with the **Coordination or Non-Duplication of Benefits** wording under the Coordination of Benefits section. Refer to the **"COORDINATION OR NON-DUPLICATION OF BENEFITS SECTION"**

DEPENDENT ELIGIBILITY

A Dependent will be eligible for coverage in accordance with the following:

(1) A covered Employee's Spouse and children from birth to the limiting age of 26 years. When the child reaches either limiting age, coverage will end on the child's birthday. Notwithstanding the preceding, a dependent child under the age of 26 who is eligible to enroll in an employer sponsored health plan other than a group health plan of a parent.

Plan may request verification of a dependent child's eligibility on an annual basis between the ages of 23 and 26. Such verification shall only relate to the dependent child's eligibility to enroll in an employer sponsored health plan other than a group health plan of a parent are not eligible.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term “children” shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children.

Step-children who reside in the Employee’s household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee’s household.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase “child placed with a covered Employee in anticipation of adoption” refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term “placed” means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(2) *A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent’s reaching the limiting age, subsequent proof of the child’s Total Disability and dependency.*

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator’s choice, at the Plan’s expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee’s home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any Spouse who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

EFFECTIVE DATE OF COVERAGE

EMPLOYEES EFFECTIVE DATE

The effective date of coverage will be as follows, provided the employee has not signed a Refusal of Coverage form (see "Special Enrollment Periods")

1. If the employee makes written request for coverage (via the Plan's application) on or before the date he/she becomes eligible (the effective date of coverage), then coverage will be effective on the first of the month following the employers' required waiting period.

2 If the employee makes this written request after the date he/she becomes eligible (the effective date of coverage), but within 30 days after this date, then coverage will be effective on one of the following dates:

a) The first of the month following the date of the application; or
b) The date the employee became eligible if the required contributions are made.

3. If the employee makes this written request more than 30 days after the date he/she becomes eligible (the effective date of coverage), the employee will then be considered a "Late Enrollee" and coverage will be effective according to the "Annual Open Enrollment", "Open Enrollment" provisions or as specified in the "Special Enrollment Periods" provision.

DEPENDENT EFFECTIVE DATE

If both the husband and wife are employed by the Employer, and both are eligible for Dependent coverage, either the husband or wife, but not both, may elect Dependent coverage for their eligible Dependents. No one can be covered under this Plan of Benefits as both an Employee and a Dependent. A person's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that person for coverage or in making benefit payments.

Coverage for Dependents will commence as follows:

A. If (during the Employee's initial eligibility period) the Employee submits an enrollment form requesting Dependent coverage, the Dependent(s) will be covered on the same date that Employee coverage becomes effective.

B. If a Covered Employee requests coverage for his Dependent(s) within thirty-one **(31)** days from the date the Employee acquires the Dependent(s), but after the date on which Employee Coverage became effective, coverage for the Dependent will become effective on the first day of the month following enrollment.

C. If a Covered Employee requests coverage for his Dependent(s) more than thirty-one **(31)** days from his Effective Date of coverage, such Dependent will be a Late Enrollee and subject to all Late Enrollee provisions.

D. If a Dependent child is properly enrolled as a Dependent within thirty-one **(31)** days of the child's date of birth, the Child will be covered from the moment of birth, subject to the covered medical expenses and exclusions of this Plan of Benefits. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.

E. For adopted and foster children of the Employee, coverage shall commence as follows:

1. If the Employee provides the Plan Administrator with a decree of adoption thirty-one (31) days after the date of the child's birth, coverage will be retroactive to the moment of the Child's birth.

2. If the Employee institutes adoption proceedings within thirty-one (31) days after the child's birth and the Employee has obtained temporary custody of this child, coverage shall be retroactive to the moment of the Child's birth.

3. For adopted children other than Newborns, coverage shall begin upon Employee's obtaining temporary custody. Such coverage may continue for up to a year; provided that if an order of adoption is entered, the coverage shall continue so long as the child meets the definition of a Dependent. Coverage may be extended upon order of a court.

F. For any Employee or Dependent enrolling during the annual enrollment period, coverage will become effective **July 1st** of the following year.

In all cases, any required premium must be paid before coverage will become effective.

For a spouse taking Dependent coverage based on the birth, placement or adoption of a child, coverage shall commence on the same date for the spouse as would apply to the child.

Each Employee who wants coverage for his Dependent(s) hereunder must submit a request for coverage (on a form approved by the Plan Administrator).

ANNUAL ENROLLMENT PERIOD
Eligible employees who do not initially enroll in the Plan of Benefits on the first day of the month following ninety (90) days of Full-time Employment. Must wait until the Annual Enrollment Period (**month of June)** to enroll for coverage for themselves or eligible dependents 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.**

LATE ENROLLMENT PERIOD
An Employee who enrolls for coverage under this Plan of Benefits other than during the first period in which the Employee is eligible to enroll (if such initial enrollment period lasts at least thirty (30) days) or during a Special Enrollment period, is a Late Enrollee and is subject to the requirements of this provision.. Late Enrollees are subject to an eighteen **(18)** month Pre-existing Condition Exclusion Period.

SPECIAL ENROLLMENT PERIOD
A Special Enrollment Period is a period during which an Employee or Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage under certain permitted circumstances. A Special enrollment Period applies (and the Employee or Dependent may enroll in this Plan of Benefits) if:

A. The Employee or Dependent was covered under another Group Health Plan or had Health Insurance coverage at the time coverage was previously offered to the Employee or Dependent; and
B. The Employee provided a written statement at the time of eligibility that other Health Insurance Coverage was the reason for declining enrollment, provided the Employer required such a statement and notified the Employee of this requirement and the consequences for non-compliance; and
C. The Employee's or Dependent's coverage described above:
   (1) was under a COBRA continuation provision and the coverage was exhausted, or
   (2) was not under a COBRA continuation provision and the coverage was terminated as a result of loss of eligibility or reduction in the number of hours of employment, or
   (3) was either 1) one of multiple plans offered by an employer and the Employee elected a different plan during an open enrollment period or 2) when an employer terminates all similarly situated individuals; or
   (4) was under an HMO that no longer serves the area in which the Employee lives, works or resides; or
   (5) was under a Plan where the member incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to operation of the lifetime limit on all benefits; and
   (6) The Dependent was not a member of the plan prior to revision of the Dependent eligibility section to include Dependent to age 26 and the Dependent elects to participate within 30 days of receipt of notice by the Dependent or the Employee associated with such Dependent) of the opportunity to enroll.

D. The Employee or Dependent requests such enrollment not more than thirty-one (31) days after date of exhaustion of coverage or termination of coverage or Employer contribution.

Under the Special Enrollment provisions of this Plan of Benefits, if an Employee is enrolled in or is eligible under a Plan of Benefits and he/she marries, has a child or adopts a child (or child placed for adoption), the new Dependent(s) may obtain coverage under this Plan of Benefits. The Employee and Employee's spouse may also enroll at this time as long as they meet this Plan of Benefit's eligibility requirements. Coverage must be added or terminated within thirty-one (31) days of such event. Coverage will be effective on the date of the event. If coverage is added more than

thirty-one (31) days from the life event/family status change or special enrollment event, such enrollee will be considered a Late Enrollee and subject to all Late Enrollee provisions.

A twelve (12) month Pre-existing Condition Exclusion Period will apply to Special Enrollees; however, the Pre-existing Condition Exclusion Period can be reduced by the Special Enrollee's Creditable Coverage (as submitted by the Employee or Dependent).

You may request a Certificate of Creditable Coverage at any time by contacting the TCC of SC Customer Service Department at 1 (800) 815-3314.

SPECIAL ENROLLMENT GRID

Members and Dependents may initially enroll in the Plan of Benefits on the first day of the month following ninety (90) days of Full-time Employment**.**, 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 Member has enrolled (or enrolled their Dependent) within 31 days of the event. If a Member does not enroll (or enroll the Member's Dependent) within 31 days of the event, the Member (or the Member's Dependent) will not be eligible to enroll until the next open enrollment period.

EVENT	**EFFECTIVE DATE**	**DOCUMENTATION REQUIRED**
MARRIAGE	date of marriage	Verification of the date of marriage and the application to add a new spouse.
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.
BIRTH	date of birth	The application to add the newborn child.
DEATH	date of death	An application to notify City of Seneca, of the death and company policy on continued coverage for covered survivors.
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 c. reason for termination
SPOUSE HAS SIGNIFICANT DOLLAR INCREASE IN COVERAGE	date the coverage increased more than 20%	The spouse must obtain a letter from his/her employer prior carrier stating: a. the termination date b. the type of coverage c. reason for termination d. amount of old and new premiums

TERMINATION OF COVERAGE

A. EMPLOYEES COVERAGE TERMINATION

Except as provided in the Group Health Plan's COBRA continuation provision, coverage will terminate on the earliest of the following occurrences:

1. The end of the month in which employment is terminated;
2. If the covered Employee fails to remit required contributions for his coverage when due, his coverage will terminate at the end of the period for which contribution was made;
3. The date that the covered Employee ceases to be in a class eligible for coverage;
4. The date the Employee transfers to coverage under a Health Maintenance Organization (HMO);
5. The termination date of the Group Health Plan;
6. The date the Employee dies;
7. The date the Employee or Employer, if applicable, fails to pay any required contributions; in this event, coverage terminates on the last day of the period for which contributions have been paid.
8. In the event the Employer ceases to offer coverage for a particular type of group health insurance, they must provide notice to each Participant receiving this type of coverage at least ninety (90) days prior to said date; the Employer must offer to each Participant receiving this type of coverage the option to purchase any other Health Insurance Coverage currently being offered by the Employer, and the Employer must act uniformly without regard to the claims experience of those sponsors or any health status related factor relating to any Participants or new participants who may become eligible for such coverage.

B. DEPENDENT'S COVERAGE TERMINATION

Except as provided in the Plan of Benefit's COBRA continuation provision, coverage will terminate on the earliest of the following occurrences:

1. The day on which the covered Employee's coverage is terminated;
2. At the end of the period for which contributions were made by the covered Employee for the covered Dependent;
3. The date the covered Employee ceases to be in a class eligible for Dependent coverage;
4. The date he or she reaches the maximum age stated in the **"Eligibility"** section of this Plan of Benefits;
5. The date the covered Dependent becomes eligible as a covered Employee;
6. The date Dependent coverage is discontinued under the Plan of Benefits;
7. The termination date of the Plan of Benefits.
8. The date the Employee or Employer, if applicable, fails to pay any required contributions; in this event, coverage terminates on the last day of the period for which contributions have been paid.

NOTE: An employee may cancel coverage for a dependent during the Plan Year, but coverage cannot be reinstated for a previously terminated dependent except during an authorized enrollment period.

C. LEAVE OF ABSENCE

For an **approved** leave of absence, benefits may be continued **for no more than 12 weeks** beyond the date the employee ceases to be at active full-time work, after exhausting all accumulated leave or all employer **approved leave of absence**. An Employee who returns to work within 12 weeks of an approved leave of absence will retain the same insurance status as prior to the said date, provided **all** required contributions have been paid in full. No new Pre-existing Condition Exclusion Waiting Period or eligibility Waiting Period will apply unless these conditions were still to be met at the time of leave of absence.

In the event the Plan does not approve to cover an employees leave of absence longer than 12 weeks benefits will need to be elected for continuation through COBRA.

An employee who returns to work **after 12 weeks** of an approved leave of absence will be considered a new Employee and will be subject to all eligibility requirements, including all requirements relating to the Effective Date of coverage and Pre-Existing Condition provisions (except as provided under the provision entitled "status change").

NOTE: Leave of absence shall mean all approved leave without pay, including absences due to Workers' Compensation.

D. STATUS CHANGE

If an Employee or Dependent has a status change while covered under this Plan of Benefits (i.e. Employee to Dependent, COBRA to active) and no interruption in coverage has occurred, the Plan of Benefits will allow continuity of coverage with respect to any Pre-Existing Condition provisions and Waiting Period.

PRE-EXISTING CONDITION PROVISIONS

A pre-existing condition is a condition regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within a six (6) month period ending on the date of hire for a newly hired employee and dependents, if any or the date of the written request to add coverage under Annual Enrollment or Special Enrollment.

PRE-EXISTING CONDITION EXCLUSION PERIOD

Treatment for a Pre-existing Condition(s) will not be covered for twelve (12) months (eighteen months (18) for Late Enrollees) following a Participant's Enrollment Date. Once this exclusion period has been satisfied, normal benefits will be payable.

The Pre-existing Condition Exclusion Period **does not apply** to pregnancy (regardless of whether the woman had previous coverage) or to coverage for a newborn Dependent child provided that the **requirements related to enrollment** for a newborn Dependent child or adopted child **are met**.

The Plan's Pre-existing Condition Exclusion Period may be reduced by the amount of any immediately preceding continuous Creditable Coverage as long as there is no break in coverage of sixty-three (63) consecutive days or more. Individuals have a right to demonstrate prior health coverage to reduce the Plan's Pre-Existing Condition Exclusion Period by providing a Certificate of Creditable Coverage or other proof of coverage.

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;

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

The Plan of Benefit's Benefit Year Deductible and Co-payment 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.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that Employers allow the following categories of eligible people continue coverage under the Group Health Plan after such individuals would ordinarily not be eligible. This coverage is available for a period of up to 18, 29 or 36 months, depending on the circumstances.

A. 18 months for Employees whose working hours are reduced – (during a non-FMLA leave of absence or when an Employee changes from full-time to part time)-and any family members who also lose coverage for this reason;

B. 18 months for Employees who voluntarily quit work and any family members who also lose coverage for this reason;

C. 18 months for Employees who are part of a layoff, and any family members who also lose coverage for this reason;

D. 18 months for Employees who are fired, unless the firing is due to gross misconduct of the Employee, and any family members who also lose coverage for this reason;

E. 29 months for Employees and all covered family members who are determined to be disabled under the Social Security Act before or during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the Employer within 60 days of the determination of disability and before the end of the first 18 months of continuation of coverage. However, if the determination was prior to termination, the Notice can be provided with COBRA election form in order to secure the extension;

F. 36 months for Employees' widows or widowers and their Dependent children who were covered by the Plan of Benefits on the day before the qualifying event;

G. 36 months for separated (in states where legal separation is recognized) or divorced husbands or wives of the Employee and their Dependent children who were covered by the Plan of Benefits on the day before the qualifying event;

H. 36 months for Dependent children who lose coverage under the Plan of Benefits because they no longer meet the Plan's definition of a Dependent child;

I. 36 months for covered family members when the Employee and covered family members lose coverage due to Medicare entitlement;

J. For plans providing coverage for retired employees and their Dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan of Benefits until the date of death of the retiree. If a retiree dies while on this special continued coverage, a surviving spouse and other eligible Dependents may elect to continue coverage for up to 36 additional months.

Except for items E, G, and H, above, the Plan Administrator is responsible for getting the proper form(s) to the Participant unless a contract is in effect with an outside vendor so continuation of coverage can be applied for.

For items E, G, and H, the Participant is responsible for notifying the Plan Administrator within sixty (60) days that the qualifying event has occurred. The notice must be given in writing to the Plan Administrator at the address shown on

page i of this document and should contain the following information: (1) name of benefit plan, (2) Covered Employee's name, (3) your name and address, and (4) the type of qualifying event and the date it occurred. Upon receipt of notice the Employer will then forward the COBRA application form to the Participant or the appropriate Dependent.

The Participant or the appropriate Dependent must complete a COBRA application form and return it to the Plan Administrator no later than 60 days (called the election period) from the later of; (1) the date the Participant's coverage ends, or (2) the date the Participant receives notice of the right to apply for continuation coverage.

An application by the Participant or their spouse for continuation of coverage also applies to any other family members who also lose coverage for the same reason. However, each family member losing coverage for the same reason is entitled to make a separate application for continuation of coverage. If there is a choice among types of coverage under the Plan of Benefits, each family member can make a separate selection from the available types of coverage.

During an 18-month continuation of coverage period, some persons may have another situation occur to them from among items B, C, D, and F through I. They will be entitled to continuation of coverage for an overall total of up to **36** months. For items G and H, the Participant must notify the Plan Administrator within **60** days that the situation has occurred.

Premiums for continuation of coverage should be paid to the Plan Administrator or their designated party. The Plan Administrator has the right to require you to pay the entire premium, even if active employees only pay part of the premium. The Plan Administrator also has the right to charge and keep an extra two percent administration fee each month. For disabled employees who have applied for the 29 month COBRA continuation period, the Plan Administrator has the right to charge 150% of the applicable premium each month for the 19th month through the 29th month of coverage.

For those Participants electing COBRA continuation of coverage, the first premium payment must be postmarked and mailed to the Plan Administrator by the 45th day after the Participant elects continuation coverage. Thereafter, premium payments are due on the first of each month. There is a 31-day grace period for payment of the monthly premiums.

Trade Adjustment Assistance

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center at (866) 628-4282. TTD/ITY callers may call (866) 626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact/2002act_index.cfm.

COBRA Continuation of Coverage ends earlier than the maximum continuation period under the following circumstances:

A. When premiums are not paid on time.

B. When the Participant who has continuation of coverage becomes covered under another group health plan or Medicare, after the date of the COBRA election, through employment or otherwise, which does not contain any exclusion or limitation (other than such an exclusion or limitation which is not applicable under the law) with respect to any pre-existing limitation of you or any Dependent.

C. When a disabled person covered under the extended 29 months COBRA continuation period has been determined by the Social Security Administration to be no longer disabled, coverage ends for the disabled person and any covered family members on the later of 30 days after the determination or 18 months. (Notification must be given to the Company within 30 days of final determination.)

D. When the Group Health Plan no longer has health coverage for its employees

Special Enrollment Period
A Special Enrollment period is a period during which an Employee or Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage under certain permitted circumstances. A Special Enrollment Period applies (and the Employee or Dependent may enroll in this Plan of Benefits) in either of the following circumstances:

I. General

A. The Employee or Dependent was covered under another Group Health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent; and
B. The Employee provided a written statement at the time of eligibility that other Health Insurance Coverage was the reason for declining enrollment, provided the Employer required such a statement and notified the Employee of this requirement and the consequences for non-compliance; and
C. The Employee's or Dependent's coverage described above:

1) was under a COBRA continuation provision and the coverage was exhausted, or
2) was not under a COBRA continuation provision and the coverage was terminated as a result of loss of eligibility, or reduction in the number of hours of employment, or the employer's contributions to such coverage were terminated; or
3) was either:
   i) one of multiple plans offered by an employer and the Employee elected a different plan during an open enrollment period; or,
   ii) when an employer terminates all similarly situated individuals; or

4) was under an HMO that no longer serves the area in which the Employee lives, works or resides; or
5) was under a Plan where the member incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits, and

D. The Employee or Dependent requests such enrollment not more than thirty-one (31) days after date of exhaustion of coverage or termination of coverage or Employer contribution.

II. Medicaid or SCHIP Coverage

A. The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or
B. The Employee or Dependent becomes eligible for assistance under a Medicaid or SCHIP plan; and
B. The Employee or Dependent requests such enrollment not more than sixty (60) days after either (i) date of termination of Medicaid or SCHIP coverage or (ii) determination that the Employee or Dependent is eligible for such assistance.

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. Staff Members performing military duty of more than 30 days may elect to continue coverage; however, the Staff Member may be required to contribute up to 102% of the full cost of coverage.

Health Insurance Protection:
If a Staff Member leaves employment to perform military service, the Staff Member has the right to elect to continue their existing coverage for the Staff Member and his eligible dependents for the maximum periods of coverage as follows:

A. The 24 month period beginning on the date on which the Staff Member's absence begins; or
B. The day after the date on which the Staff Member fails to apply for or return to a position of employment if deployment is less than 24 months.

If the Staff Member does not elect to continue coverage during his military service, the Staff Member has the right to be reinstated under this coverage when he is reemployed, without any waiting periods or exclusions (e.g., pre-existing condition exclusions) expect for service-connected illnesses or injuries

Termination of USERRA Coverage:
Coverage continuation will terminate on the earliest of the following:
A. The date the employer ceases to provide any group health plan to any Staff Member and/or covered dependent;
B. The date the required contribution is not made;
C. The date the Staff Member is no longer considered an employee;
D. The date the Staff Member or covered dependent reaches the end of the 24 month continuation.

NOTE: At the end of the 24 month USERRA period if the Staff Member is still deployed, the Staff Member (and/or eligible dependents) will be entitled to continuation coverage under the provisions of COBRA, whether or not the coverage was continued under USERRA coverage provisions.

SUBROGATION / RIGHT OF REIMBURSEMENT

In the event benefits provided to or on behalf of a Participant under the terms of this Plan of Benefits, the Participant agrees, as a condition of receiving benefits under the Plan of Benefits, to transfer to the Group Health Plan all rights to recover damages in full for such benefits when the Injury or Illness occurs through the act or omission of another person, firm, corporation, or organization. The Group Health Plan shall be subrogated, at its expense, to the rights of recovery of such Participant against any such liable third party.

If, however, the Participant receives a settlement, judgment, or other payment relating to an Injury or Illness from another person, firm, corporation, organization or business entity for the Injury or Illness, the Participant agrees to reimburse the Group Health Plan in full, and in first priority, for benefits paid by the Group Health Plan relating to the Injury or Illness. The Group Health Plan's right of recovery applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical benefits, pain and suffering, lost wages, other specified damages, or whether the Participant has been made whole or fully compensated for his/her injuries.

The Group Health Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal Injury protection (PIP), malpractice, or any other insurance coverage's which are paid or payable.

The Group Health Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization of the Group Health Plan.

The Participant shall not do anything to hinder the Group Health Plan's right of subrogation and/or reimbursement. The Participant shall cooperate with the Group Health Plan and execute all instruments and do all things necessary to protect and secure the Group Health Plan's right of subrogation and/or reimbursement, including assert a claim or lawsuit against the third party or any insurance coverage's to which the Participant may be entitled. Failure to cooperate with the Group Health Plan will entitle the Group Health Plan to withhold benefits due the Participant under the Plan of Benefits Document. Failure to reimburse the Group Health Plan as required will entitle the Group Health Plan to deny future benefit payments for all Participants under this policy until the subrogation/reimbursement amount has been paid in full.

It is further agreed that the Participant will sign a written agreement to repay the Group Health Plan in full out of any money that the Participant receives from a negligent person or organization. If the Participant fails to sign such an

agreement, the Group Health Plan reserves the right to withhold payment of the Participant's claims, which relate to the negligence of another person or organization, until such time as the Participant signs the agreement to repay.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Covered Person is covered by this Plan and another plan or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered by two or more plans, the plans will coordinate benefits when a claim is received. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan – 50% or 80% or 100% -- whatever it may be. If there is a balance due it will be the responsibility of the Covered Person.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover over-payments. All benefits contained in the plan document are subject to this provision.

ORDER OF DETERMINATION

If a Participant covered hereunder is also covered for comparable benefits or services under another Plan which is the Primary Plan, benefits applicable under these plans will be reduced so that, for Benefits incurred, benefits available under all Plans shall not exceed the Allowable Expenses of such Benefits.

This Plan of Benefits determines its order of benefits using the first of the following, which applies:

A. **General** - A Plan that does not coordinate with other Plans is always the Primary Plan;

B. **Non-Dependent/Dependent** - The benefits of the Plan which covers the person as an Employee (other than a Dependent) is the Primary Plan; the Plan which covers the person as a Dependent is the Secondary Plan;

C. **Dependent Child/Parents Not Separated or Divorced** - Except as stated in (D) below, when this Plan of Benefits and another Plan cover the same child as a Dependent of different parents:

   1. The Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but

   2. If both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the Primary Plan; the Plan which covered the parent the shorter time is the Secondary Plan;

   3. If the other Plan does not have the birthday rule, but has the gender rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

D. **Dependent Child/Separated or Divorced Parents** - If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   1. First, the Plan of the parent with custody of the child;

   2. Then, the Plan of the spouse of the parent with custody;

   3. Finally, the Plan of the parent without custody of the child.

   However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, then that parent's Plan is the Primary Plan. If a court decree exists stating that the parents shall share joint custody, without stating that one of the parents is financially responsible for the health care of the child, the order of liability will be determined according to the rules for Dependent children whose parents are not separated or divorced. Anyone who legally adopts the child will assume natural parent status.

E. **Active/Inactive Employee** - The Primary Plan is the Plan which covers the person as an Employee who is neither laid off nor retired (or as that Employee's Dependents). The Secondary Plan is the Plan which covers that person

as a laid off or retired employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as result the Plans do not agree on the order of benefits, this rule does not apply.

F. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the Primary Plan is the Plan which covered an Employee or Participant longer. The Secondary Plan is the Plan which covered that person the shorter time.

G. In the case of a Plan that contains order of benefit determination rules that declare that Plan to be excess to or **always secondary to all other Plans**, this Plan of Benefits will coordinate benefits as follows:

1. If this Plan of Benefits is Primary, it will pay or provide benefits on a Primary basis;
2. If this Plan of Benefits is secondary, it will pay or provide benefits first, but the amount of benefits payable will be determined as if this Plan of Benefits were the Secondary Plan. The liability of this Plan of Benefits will be limited to such payment;
3. If the Plan does not furnish the information needed by this Plan of Benefits to determine benefits within a reasonable time after such information is requested, this Plan of Benefits shall assume that the benefits of the other plan are the same as those provided under this Plan of Benefits, and shall pay benefits accordingly. When information becomes available as to the actual benefits of the other plan, any benefit payment made under this Plan of Benefits will be adjusted accordingly.

H. **Right To Coordination of Benefits Information**

The Plan Administrator and its Claims Administrator have the right:

1. To obtain or share information with any insurance company or other organization regarding coordination of benefits without the claimant's consent; and
2. To require that the claimant provide the Plan Administrator with information on such other Plans so that this provision may be implemented;
3. To pay over the amount due under this Plan of Benefits to an insurer or other organization if this is necessary, in the Plan Administrator's or its Claims Administrator's opinion, to satisfy the terms of this provision.

I. **Facility of Payment**

Whenever payments which should have been made under this Plan of Benefits in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organizations or person making such other payments any amount it will determine in order to satisfy the intent of this provision, and amount so paid will be deemed to be benefits paid under this Plan of Benefits and to the extent of such payment, the Plan Administrator will be fully discharged from liability under this Plan of Benefits. The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan of Benefits rather than the amount payable in the absence of this provision.

J. **Medicare**

If the Participant is an active Employee age 65 and over, the Participant must elect either:

1. The Plan of Benefits as the participant's primary medical coverage and Medicare as the Participant's secondary medical coverage; or
2. Medicare, for the Participant's medical coverage.

The covered Dependent spouse, age 65 and over, of any active employee, must also make an election.

If the Employee elects Medicare as their medical coverage, their covered Dependent spouse will also have Medicare as his or her medical coverage. If the Participant elects the Group Health Plan as their primary medical coverage, their covered Dependent spouse may elect Medicare as his or her medical coverage or he or she may continue coverage under the Group Health Plan. Unless an election is made to choose Medicare as Primary, coverage will automatically continue under the Group Health Plan, and this Plan of Benefit's benefits will be primary. If Medicare is elected, coverage under the Group Health Plan will be secondary.

This Group Health Plan coordinates benefits with Medicare by applying the "Carve-Out" rule. The concept of this rule is to "carve-out" or subtract Medicare's payment from what this Plan of Benefits would have paid in the absence of the Medicare payment. The Group Health Plan will then pay the remaining amount as secondary benefits. The benefits payable by Medicare and benefits payable by this Plan of Benefits will not total more than the Allowed Amount.

When Medicare is primary and the Group Health Plan is secondary, Medicare (Parts A and B) will be considered a plan for the purposes of coordination of benefits. The Group Health Plan will coordinate benefits with Medicare whether or not the Participant or their covered Dependent spouse is/are actually receiving Medicare benefits.

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 participants. (If under 100 participants, 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.

ERISA RIGHTS

As a Participant in this Group Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employer Benefits Security Administration.

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 make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Group Health Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Group Health Plan on the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your Group Health Plan could apply if you have Creditable Coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases. Without evidence of Creditable Coverage, you may be subject to a Pre-Existing Condition Exclusion Period for twelve (12) months (eighteen (18) months for Late Enrollees) after your Enrollment Date.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Group Health Plan. The people who operate your Group Health Plan, called "fiduciaries" of the Group Health Plan, have a duty to do so prudently and in the interest of you and your Dependents and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Group Health Plan and do not receive them within thirty (30) days, you may file suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in State or Federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of domestic relations order or a medical child support order, you may file suit in Federal court. If plan fiduciaries misuse the Group Health Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S Department of Labor, or you may file suit in a Federal court. The court will decide who will pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

MEDICARE CREDITABLE COVERAGE LETTER

Important Notice from CITY OF SENECA 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 **CITY OF SENECA** 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:

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.

CITY OF SENECA has determined that the prescription drug coverage offered by the **CITY OF SENECA** is, on average for all plan participants, 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 November 15th through December 31st.

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

Current Drug Benefits:

Participating Pharmacies:

Generic	$10 co-payment
Formulary Name Brand	20% co-insurance with a minimum of $25 and a maximum of $45
Non-Preferred Name Brand	30% co-insurance with a minimum of $55 and a maximum of $75
Specialty Drugs	$75 co-payment

Mail Order Division:

Generic	$25 co-payment
Formulary Name Brand	20% co-insurance with a minimum of $60 and a maximum of $110
Non-Preferred Name Brand	30% co-insurance with a minimum of $135 and a maximum of $185
Specialty Drugs	$185 co-payment

Group Number: **730**
Group Name: **CITY OF SENECA**
Effective Date of Coverage: **JULY 1, 2010**

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 **CITY OF SENECA** 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

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 **CITY OF SENECA** 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 at www.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:	**JULY 1, 2010**
Name of Entity/Sender:	**CITY OF SENECA**
Contact—Position/Office:	**BELINDA HARPER**
Address:	**221 EAST NORTH 1ST STREET, SENECA, SC 29678**
Phone Number:	**(864) 885-2722**

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

Neither the Group Health Plan nor any health insurance issuer or business associate servicing this Plan of Benefits will disclose Protected Health Information to the Employer except as set forth below or as otherwise allowed by law.

1. Disclosure of Protected Health Information to Employer.
    a. The Group Health Plan and any health insurance issuer or business associate servicing the Group Health Plan will disclose Protected Health Information to the Employer only to permit the Employer to carry out plan administration functions for the Group Health Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 CFR-Parts 160-64). Any disclosure to and use by the Employer of Protected Health Information will be subject to and consistent with the provisions of paragraphs 2 and 3 of this section.
    b. Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Protected Health Information to the Employer unless the disclosures are explained in the Notice of Privacy Practices distributed to the Participants.
    c. Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.
2. Restrictions on Employer's Use and Disclosure of Protected Health Information.
    a. The Employer will neither use nor further disclose Protected Health Information, except as permitted or required by the Plan of Benefits, as amended, or required by law.

b. The Employer will ensure that any agent, including any subcontractor, to whom it provides Protected Health Information, agrees to the restrictions and conditions of the Plan of Benefits, including this section, with respect to Protected Health Information.

c. The Employer will not use or disclose Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

d. The Employer will report to the Group Health Plan any use or disclosure of Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

e. The Employer will make Protected Health Information available to the Participant who is the subject of the information in accordance with 45 CFR §164.524.

f. The Employer will make Protected Health Information available for amendment, and will on notice amend Protected Health Information, in accordance with 45 CFR § 164.526.

g. The Employer will track disclosures it may make of Protected Health Information so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

h. The Employer will make available its internal practices, books, and records, relating to its use and disclosure of Participants' Protected Health Information, to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

i. The Employer will, if feasible, return or destroy all Protected Health Information, in whatever form or medium (including in any electronic medium under the Employer'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 Participant who is the subject of the Protected Health Information, when the Participants' Protected Health Information 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 Protected Health Information, the Employer will limit the use or disclosure of any Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

3. Adequate Separation Between the Employer and the Group Health Plan.

a. The following employees or classes of employees or other workforce members under the control of the Employer may be given access to Protected Health Information received from the Group Health Plan or a health insurance issuer or business associate servicing the Group Health Plan:

Benefits Coordinator

Chief Financial Officer

Privacy Officer

Human Resources Department

This list includes every employee or class of employees or other workforce members under the control of the Employer who may receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Group Health Plan in the ordinary course of business.

b. The employees, classes of employees or other workforce members identified in paragraph 4(a) of this section will have access to Protected Health Information only to perform the plan administration functions that the Employer provides for the Group Health Plan.

c. The employees, classes of employees or other workforce members identified in paragraph 4(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this section of the Plan of Benefits. The Employer will promptly report such breach, violation or noncompliance to the Group Health Plan, as required by paragraph 3(d) of this section, 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 on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

4. Employer Obligations to the security of Electronic Protected Health Information ("ePHI"):

   a. Where ePHI will be created, received, maintained or transmitted to or by the Plan Administrator on behalf of the Group Health Plan, the Plan Administrator shall reasonably safeguard the ePHI as follows:

      1) Employer shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan Administrator creates, receives, maintains or transmits on behalf of the Group Health Plan;

      2) Employer shall ensure that they, and any agent, including subcontractor, to whom it provides ePHI agrees to, implement reasonable and appropriate security measures of ePHI;

      3) Plan Administrator shall ensure that they apply the same requirements and restrictions for Protected Health Information (PHI) referenced within this section, PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION Numbers 1-3, to ePHI.

      4) Employer shall report to the Group Health Plan any successful Security Incident involving the unauthorized access to or use or disclosure of ePHI.

      5) Employer shall ensure that the adequate separation required by Number 3 above is supported by reasonable and appropriate security measures.

GENERAL INFORMATION

Employer has established this Group Heath Plan and the applicable benefits, rights and privileges for participating employees, ("Employees") and such Employees eligible Dependents. Benefits are provided through a fund established by the Employer.

PURPOSE
The purpose of this Plan of Benefits is to set forth the provisions of the Group Health Plan, which provide for the payment or reimbursement of all or a portion of eligible medical expenses. It is intended that the terms of this Plan of Benefits are legally enforceable and that the Plan of Benefits be maintained for the exclusive benefit of eligible Employees and their covered Dependents.

PLAN INTERPRETATION
The Plan Administrator has full discretionary authority to interpret and apply all Plan of Benefits provisions, including, but not limited to, all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Group Health Plan data, and perform other Group Health Plan connected services; however, final authority to construe and apply the provisions of the Plan of Benefits rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, shall be final and binding.

CONTRIBUTIONS TO THE PLAN
The Employer shall from time to time evaluate the costs of the Group Health Plan and determine the amount to be contributed by the Employer (if any) and the amount to be contributed (if any) by each covered Employee. The Group Health Plan will notify employees in writing of any changes.

PROTECTION AGAINST CREDITORS
No benefit payment under this Plan of Benefits shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, exception or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Employer shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Employer, in its sole discretion, may terminate the interest of such Participant or former Participant, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Employer may determine, any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN AMENDMENTS
This document contains all the terms of the Plan of Benefits and may be amended from time to time by the Plan Administrator. Any changes so made shall be binding on each Participant and on any other participants referred to in this Plan of Benefits. When necessary, the **City of Seneca's** Plan Administrator will have the authority and right to amend the contents of this Plan Document.

TERMINATION OF PLAN
The Plan Administrator reserves the right at any time to terminate the Group Health Plan by a written instrument to that effect. All previous contributions by the Plan Administrator shall continue to be issued for the purpose of paying benefits under the provisions of this Plan of Benefits with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to covered Employees, until all contributions are exhausted.

PLAN IS NOT A CONTRACT
This Plan of Benefits constitutes the entire Group Health Plan. The Plan of Benefits will not be deemed to constitute a contract of employment or give any Employee of the Employer the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any employee.

MISSTATEMENT OF AGE
If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

ERISA
It is the intention of the Employer to establish hereby a program of benefits constituting an "Employee Welfare Benefit Plan" otherwise called a "Group Health Plan" under ERISA.

LEGAL ACTIONS
No action at law or in equity can be brought under the Group Health Plan until you have exhausted the administrative process (including the exhaustion of all appeals) as described in this booklet. No such action can be brought against the Group Health Plan more than six years after Claims Administrator receives a claim.

ADMINISTRATIVE SERVICES ONLY
TCC of SC provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Employer's Group Health Plan is a self-funded health plan and may have additional insurance to assume exposure to the financial risk and obligation with respect to claims.

AMENDMENT
Upon thirty (30) days prior written notice, the Employer may unilaterally amend this Plan of Benefits.

CLERICAL ERRORS
Clerical errors by TCC of SC 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.

GOVERNING LAW
The Employer's Group Health Plan is governed by and subject to ERISA and any other applicable federal law. If ERISA or another federal law does not apply, the Employer's Group Health Plan is 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 Employer's Group Health Plan conflicts with such law, the Employer's Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD
A Participant must present their Identification Card prior to receiving Benefits.

Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Participant 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
TCC of SC 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 healthcare operations for the administration of the Benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

NEGLIGENCE OR MALPRACTICE
TCC of SC and Employer do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Participant by a Provider is rendered or supplied by such Provider and not by TCC of SC the Employer. TCC of SC 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 the Employer's Group Health Plan may be given by United States mail, postage paid and addressed:

1. To TCC of SC:
   Thomas Cooper & Company, Inc. (TCC of SC)
   P.O. Box 22557
   Charleston, SC 29413

2. To a Participant: To the last known name and address listed for the Employee. Participants are responsible for notifying TCC of SC 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 TCC of SC. The Employer is responsible for notifying TCC of SC and Participants of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS
On occasion, TCC of SC (on behalf of the Employer's Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Employer's Group Health Plan or Employer waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE
Each Participant must provide the Employer's Group Health Plan (and its designee, including TCC of SC) and Employer with information regarding all other health insurance coverage to which such Participant is entitled.

PAYMENT OF CLAIMS
A Participant is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Employer's Group Health Plan may pay all Covered Expenses directly to the Employee upon receipt of due proof of loss. Where a Participant has received Benefits from a Participating Provider or contracting provider, the Employer's Group Health Plan may pay Covered Expenses directly to such Participating Provider or contracting provider.

PHYSICAL EXAMINATION
The Employer's Group Health Plan has the right to examine, at their own expense, a Participant 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 Employer's Group Health Plan (through its designee, including TCC of SC) may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

GRANDFATHERED HEALTH PLAN

This City of Seneca believes this Medical Plan of Benefits is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your (Health Plan) may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator; City of Seneca, 221 East North 1st Street Seneca, SC 29678, (864) 885-2722. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ADMINISTRATIVE INFORMATION

Benefit Year:		Begins July 1st of each year and continues for 12 consecutive months through June 30th.
1.	Plan Name:	**City of Seneca Health Plan**
2.	Name and Address of the Employer establishing the Plan:	**City of Seneca** 221 East North 1st Street Seneca, SC 29678
3.	Employer's ID Number:	57-6001105
4.	Plan Number:	730
5.	Type of Welfare Plan:	Medical
6.	Plan Funding:	Paid by the Employer and/or the Employee determined by the level of coverage (employee, employee spouse, family) selected.
7.	Claims Administrator:	**Thomas H. Cooper & Co., Inc. (TCC of SC)** PO Box 22557 Charleston, SC 29413
8.	Agent Service of Legal Process:	**City of Seneca**
9.	Plan Administrator Name :	**City of Seneca**
10.	Named Trustee:	**City of Seneca**
11.	Named Fiduciary:	**City of Seneca**
12.	Plan Termination:	The Plan Administrator reserves the right, through 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.
13.	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.

DEFINITIONS

NOTE: *The following definitions are for informational purposes only. Please refer to your Schedule of Benefits and Covered Medical Expenses sections for the Benefits that are available under your Plan.*

"Accidental Injury": accidental bodily injury caused by unexpected external, violent, unexpected and unintentional means resulting directly and independently of all other causes, in necessary care rendered by a Physician. This definition and all provisions in this Plan exclude accident benefits for charges incurred for treatment to teeth, gums or mouth due to eating, chewing, or biting.

"Actively at Work": a permanent, full-time Employee of the Employer working on a regular weekly basis of at least **30 hours** per week. The Employee must be Actively At Work on the Participant's Effective Date of coverage, performing his or her normal duties, unless the Employee's absence from work is due to a Health Status Related Factor other an absence related to Substance Abuse or chemical dependency.
An employee shall be deemed actively at work on each day of a regular paid vacation, or on a regular non-working day, on which he is not disabled, provided he was actively at work on the last preceding regular working day.

"Admission": the period of time between a Participant's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Participant 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 participant's or beneficiary'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 provide because it is determine to be Experimental or Investigational or not Medically Necessary or appropriate.

"Allowed Amount": the amount payable under this Plan of Benefits with respect to particular Benefits. The Allowed amount is based on:

a. The actual charges made for similar services, supplies or equipment by Providers and filed with TCC of SC during the preceding plan year;
b. The Allowed Amount for the preceding year adjusted by an index based on national or local economic factors or indices; or
c. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of TCC of SC, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Participants upon written request; or
d. An amount that has been agreed upon by a Provider and the network used by TCC of SC; or
e. An amount established by TCC of SC in its sole discretion.

In determining the Allowed Amount under this paragraph f, TCC of SC may, through its medical staff and/or consultants, determine the Allowed Amount based on a number of factors, including, for example, comparable or similar services or procedures.

"Alternate Facility" A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law: pre-scheduled surgical services, emergency health services, prescheduled rehabilitative, laboratory or diagnostic services. An Alternative Facility may also provide mental health services or substance abuse services on an outpatient basis.

"Alternative Medical Treatment": A medical treatment plan developed between the employee (covered dependent), the physician, and the case manager that is intended to provide the most appropriate care in a timely, efficient and cost effective manner.

"Ambulatory Surgical Center": any public or private specialized facility (state licensed and approved whenever required by law) with an organized medical staff of Physicians that:

a. has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis; and
b. has continuous Physician services and registered professional nursing service whenever a patient is in the facility; and
c. does not provide accommodations for patients to stay overnight; and
d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician. Ambulatory Surgical Center includes and endoscopy center.

"Ancillary Services": services rendered in connection with inpatient or outpatient care in a Hospital or in connection with medical emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical emergency.

"Benefits": a service or supply as specified in this Plan of Benefits or on the Schedule of Benefits for which benefits will be provided under the terms of the Plan of Benefits. To be covered under this Plan of Benefits, medical services or medical supplies must be:

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

"Benefit Percentage": the portion of eligible expenses payable this Plan of Benefits in accordance with the coverage provisions as stated in the Schedule of Benefits.

"Birthing Center" a free-standing facility that:

a. is licensed to provide a setting for parental care, delivery and immediate postpartum care; and
b. has an organized staff of Physicians; and
c. has permanent facilities that are equipped and operated primarily for childbirth; and
d. has a contract with at least on nearby Hospital for immediate acceptance of patients who require Hospital care; and
e. does not provide accommodations for patients to stay overnight; and
f. provides continuous services of Physicians, registered nurses or certified nurse Midwife practicioners when a patient is in the facility

"Brand Name Drug": a Prescription Drug manufactured by one company. A Preferred Brand Name Drug is one preferred for use by the Prescription Benefit Manager and is normally less expensive than an equivalent Non-Preferred Brand Name Drug.

"**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" includes a child of a divorced or divorcing Employee who has a right to enroll in the Plan of Benefits under a Qualified Medical Child Support Order. A Participant must provide TCC of SC with a copy of the medical child support order to review the terms of the order before coverage can begin for such a Child. Participants and beneficiaries may obtain, without charge, a copy of the QMCSO procedures from TCC of SC.

"Claims Administrator": Thomas Cooper & Company, Inc. (TCC of SC)

"Close Relative": includes the spouse, mother, father, grandparents, sister, brother, child, or in-laws of the Participant.

"Coinsurance": the portion of eligible expenses which is payable by the Participant.

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

"Co-payment": the amount payable by the Participant each time the Participant receives a Covered Service subject to a Co-payment as shown on the Schedule of Benefits.

"Cosmetic Procedure": a procedure performed solely for the improvement of a Participant's appearance rather than for the improvement or restoration of bodily function.

"Covered Person": A covered person is an employee, retired employee or elected official (or eligible dependents of the same) who has become covered under the Plan.

"Creditable Coverage": with respect to an individual, means coverage of the individual under any of the following:

a. a group health plan;
b. Health Insurance Coverage;
c. Medicare: Part A or Part B, Title XVIII of the Social Security Act;
d. Medicaid: Title XIX of the Social Security Act—Other than coverage consisting solely of benefits under Section 1928;
e. Title 10 United States Code Chapter 55 (i.e. medical and dental care for members and certain former members of the uniformed forces and their Dependents);
f. a medical care program of the Indian Health Service or of a tribal organization;
g. a state health benefits risk pool (including South Carolina Health Insurance Pool (SCHIP);
h. a health plan offered under chapter 89 of title 5. United States Code (the Federal Employee Health Benefits Program);
i. a public health plan (including that of the U.S. Federal Government as well as that of a foreign country or its political subdivision);
j. a health benefit plan under Section 5(e) of 22 United States Code 2504(e), the Peace Corps Act.
k. a state Children's Health Insurance Program (S-CHIP).

Creditable Coverage does not include coverage consisting solely of Excepted Benefits (as defined within the definition of Health Insurance coverage.

"Custodial Care": care provided primarily for maintenance of the patient or care designed essentially to assist the patient in meeting his or her activities of daily living. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Custodial Care is not primarily provided for therapeutic value in the treatment of an Illness, Injury, disease, or condition.

"Deductible": the amount of Benefits as indicated in the Schedule of Benefits that the Participant (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:

1. An Employee's spouse; or
2. an Employee's Child under the age of [26]; or
3. a Dependent who is
    a. incapable of financially supporting himself by reason of mental or physical disability, and
    b. dependent upon the Employee for at least 50 percent of his or her support and maintenance, and
    c. is living in the Employee's household. Written proof that a Dependent is incapacitated and is a Dependent shall be furnished as required by the Plan Administrator.

The term "Dependent" does not include:

a. an Employee;
b. a member of any armed forces (except if an active duty member for thirty (30) days or less per year);
c. any person who has permanent residence outside of the U.S.A.;
d. a spouse who is legally separated or divorced from the participant, unless coverage is required due to a court order or decree and provided that such spouse has met all requirements of a valid separation or divorce contract in the state granting such separation or divorce;
e.. any person who is covered as a Dependent by another Participant of the same Employer.

"Detoxification": a Hospital service providing treatment to diminish or remove from a Patient's body the toxic effects of chemical substances, such as alcohol or drugs, usually as an initial step in the treatment of a chemical-dependent person. The amount of days needed for treatment is determined through the pre-approval process.

"Durable Medical Equipment": equipment that:

a. Can stand repeated use; and,
b. Is Medically Necessary, and,
c. Is customarily used for the treatment of a Participant's illness, injury, disease or disorder; and,
d. Is appropriate for use in the home; and,
e. Is not useful to a Participant in the absence of illness or injury; and
f. Does not include appliances that are provided solely for the Participant's comfort or convenience; and,
g. Is a standard, non-luxury item (as determined by the Employer's Group Health Plan); 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. Items such as air conditioners, de-humidifiers, whirlpool baths, and other equipment which have non-therapeutic uses are not considered Durable Medical Equipment.

"Effective Date": The date that coverage is in force for this Plan of Benefits. It will be the first of the month following any required eligibility waiting period or the first of the month following approval of any required documentation for coverage. For a newborn or an adopted child, the effective date will be the date of the event (date of birth, adoption, etc.

"Eligible Expenses": are expenses in which;

a. Are incurred for services, treatments, or supplies
b. Are medically necessary;
c. Are incurred on the recommendation of a physician;
d. Are not in excess of the Allowed Amount;
e. Are not excluded from the terms of the Plan;
f. Are not exceed any amounts to be paid under the Plan
g. Are incurred while the Plan is in force for the covered person.

"Electronic Protected Health Information": protected health information (see also definition of Protected Health Information) that is transmitted or maintained in any electronic media.

"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:

1. Placing the health of the Participant, or with respect to a pregnant Participant, the health of the Participant or her unborn child, in serious jeopardy; or

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

"Employee": an individual who is eligible for coverage as provided in the eligibility section of this Plan of Benefits, and who is so designated to TCC of SC by the Employer.

"Employer": the entity which is sponsoring this Group Health Plan and its related subsidiaries. The Employer is identified on the cover of this Plan of Benefits.

"Enrollment Date": the first day of coverage in the Employer's Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

"Experimental or Investigational": one or more of the following is true of a treatment, procedure, device, drug or medicine:

1. it cannot be lawfully marketed without U.S. Food and Drug Administration approval, and approval for marketing for the condition treated has not been given at the time the device, drug or medicine is furnished.
2. reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, and/or efficacy (or efficacy as compared with the standard means of treatment or diagnosis): (1) it is undergoing phase I, II, or III clinical trials or is under study; or (2) further clinical trials or studies are needed, according to the experts' consensus of opinion. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug or medicine).
3. which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

"Excepted Benefits": benefits or coverage that 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;
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.

"Extended Care Facility": an institution or a distinct part thereof which operates under law and which for compensation from its patients:

a. Is primarily engaged in providing skilled nursing care 24 hours a day for persons recovering from sickness or injury;
b. Is under the full-time supervision of a physician or a registered nurse;
c. Admits patients as recommended by a physician, maintains medical records for all patients, and has (under an agreement) the services of a physician always available.
d. Has written transfer agreement in effect with one or more hospitals; and
e. Is not, except incidentally, a place for custodial care, rest, the aged, drug addicts or alcoholics, or for rehabilitation, speech or occupational therapy.

The term "Extended Care Facility" does not include a rest home or a place for the care of the aged or care of alcohol or chemical dependency. The **criteria used by Medicare** to determine skilled nursing will be used by the Plan.

"Full-time Employment": a basis whereby an Employee is employed by the Employer for at least a set number of hours determined by the Employer and stated in the Eligibility section of this document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he receives regular earnings from the Employer.

"Generic Drug": a Prescription Drug approved by the FDA as a bio-equivalent substitute and manufactured by one or more companies as a result of the expiration of the original patent for the equivalent Brand Name Drug. Brand Name Drugs that are cross-licensed to other companies, who then market the Brand Name Drug under a generic name prior to the patent expiring may be considered and processed under the Brand name level of benefits.

"Genetic Information": information about genes, gene products, and inherited characteristics that may derive from the Participant or family member of the Participant. This 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.

"Group Health Plan": an employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement or otherwise. This Plan of Benefits established by the Employer is a Group Health Plan.

"Health Insurance Coverage": benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-tern, limited-duration insurance.

"Health Status-Related Factor": any of the following factors: health status, medical conditions, (including both physical and mental Illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, (including conditions arising out of acts of domestic violence), or disability.

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

"Home Health Care": an agency or organization that:

a. Is licensed and primarily engaged in providing skilled nursing care and other therapeutic services; and

b. Has policies established by a professional group associated with the agency or organization that includes at least one Physician and one registered nurse (R.N.) who provide full-time supervision of such services; and

c. Maintains complete medical records on each individual and has a full-time administrator.

"Hospice Care": a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. The plan provides care to meet the special needs of the family unit during the final stages of a terminal Illness. Care is provided by a team made up of trained medical personnel, homemakers, and counselors. The team acts under an independent hospice administration and it helps the family unit cope with physical, psychological, spiritual, social, and economical stress.

Hospice service and supplies can also be received;

a. When the patient is confined at home;
b. On an outpatient basis at a hospice facility while the patient is residing at home; or
   When confined as an inpatient in a hospice facility. However, the attending physician must certify in writing, that it is medically necessary that the hospice care be provided in an inpatient hospice setting rather than in a home setting or on an outpatient basis.

**Palliative care is a course of treatment directed toward lessening or controlling pain. It makes no attempt to cure a terminal illness or to prolong the life of a patient.

**Curative treatment which attempts to cure a sickness, injury or medical condition in order to preserve the life of a patient or to improve the patient's state of health.

"Hospice Facility": an establishment which:

a. Complies with all licensing, staffing, operating, and other legal requirements in the state where it is located and in a any other states where it provides services;
b. Is mainly engaged in providing palliative care for the terminally ill on a continuous 24 hour basis under the supervision of :
   i. A duly licensed physician; or
   ii. A registered nurse

If the care is not supervised by a physician, the hospice facility must have a duly licensed physician available on a prearranged basis;

c. Maintains clinical records on all terminally ill individuals; and
d. Is not mainly a place for the aged, a nursing or convalescent home, a custodial or rest home.

A hospice facility may operate by itself or as part of a hospital

"Hospice Care Program": a formal program directed by a Physician to provide Hospice Care. To qualify as a Hospice Care Program, the program must meet the standards set by the National Hospice Organization. If such program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a Hospice Care Program.

"Hospital": a short term, acute care

a. general hospital,
b children's hospital,
c. eye, ear, nose, and throat hospital,
d. maternity hospital, or
e. any other type of short-term acute care hospital licensed by the state in which it operates, which for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which provides continuous twenty-four (24) hour-a-day service by licensed, registered, graduate nurses physically present and on duty. Such institutions or facilities must be accredited as a hospital by the **Joint Commission on Accreditation of Healthcare Organization (JCAHO)** or have a transfer agreement with a fully equipped hospital.

The term hospital does not include long-term, chronic care institutions that are, other than incidentally, a nursing home or place for rest, the aged, drug addicts, alcoholics, the treatment of mental or nervous conditions, or rehabilitative care whether or not such institution or facility is affiliated with or part of a Hospital..

"Illness": a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy.

"Injury": a bodily injury caused by an accident, which results directly from the accident and independently of all other causes.

"Intensive Care Unit": an accommodation in a Hospital which is reserved for critically and seriously ill patients requiring constant audiovisual observation as prescribed by the attending Physician, and which provides room and board, nursing care by registered nurses whose duties are confined to care of patients in the Intensive Care Unit, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

"Late Enrollee/Entrant": a Participant under a Group Health Plan who enrolls under the Group Health Plan other than during:

a. The first period in which he or she is eligible to enroll under the Group Health Plan if the initial enrollment period is a period of at least thirty (30) days; or
b. Special Enrollment period

"Lifetime Maximum": the total Benefits (under this Group Health Plan) to which a Participant is entitled during such Participant's lifetime.

"Manipulative Treatment": treatment that includes the diagnosis, analysis, adjustment and therapy of subluxations of the musculoskeletal structure for other than fractures. It also includes the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body. Such services are for the purposes of removing nerve interference related to distortion, misalignment, or subluxation of or in the spine.

"Medically Necessary/Medical Necessity": health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. in accordance with generally accepted standards of medical practice;
b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
c. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

"Medicare": the program of medical care benefits provided under Title XVII of the Social Security Act of 1965 as amended.

"Mental Disorder": neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

"Mental Health Services": treatment (except treatment for Substance Abuse) 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.

"Midwife": a person who is certified or licensed to assist women in the act of childbirth.

"Morbid Obesity": A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent life insurance tables for a person of the same height, age, and mobility as the covered person.

"Newborn": an infant from the date of his birth until the initial Hospital discharge.

"Newborn Care": inpatient Physician Hospital services for a Newborn including initial work-up and pediatric exam, but excluding services for Illness or Injury.

"Out of Pocket Maximum": The out of pocket maximum is indicated in the Schedule of Benefits. Once this amount has been paid by an employee for a covered person, benefits will be paid at 100% for the balance of the year, **unless otherwise indicated in the Plan.**

"Palliative Treatment": Treatment which temporarily relieves pain or discomfort due to a dental emergency. Can also be a medical care that relieves the pain and discomfort of a hospice patient.

"Participant": an Employee or Dependent who has enrolled (and qualifies for coverage) under this Plan of Benefits.

"**Participant Effective Date**": the date on which a Participant is covered for Benefits under the terms of this Plan of Benefits.

"Pharmacy": a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

"Physician": a person licensed as a medical doctor, dentist, surgeon, chiropractor, osteopath, podiatrist, certified consulting psychologist or psychiatrist, certified licensed nurse-Midwife, clinical psychologist under the direction of a psychiatrist, licensed social worker or optometrist. Physician may include a person participating in a teaching program.

"Plan": Any of the following providing medical or dental benefits or services:

a. This Plan of Benefits;
b. Any group, blanket of franchise health insurance;
c. A group contractual prepayment or indemnity plan;
d. A Health Maintenance Organization (HMO), whether group practice or individual practice association;
e. A labor-management trustee plan or a union welfare plan;
f. An Employer or multi-Employer plan or employee benefit plan;
g. A government program;
h. Insurance required or provided by statute;
i. Any coverage for a student which is sponsored by, or provided through, a school or other educational institution;
j. Group automobile insurance;
k. Individual automobile insurance coverage on an automobile leased or owned by a participant; or
l. Individual automobile insurance coverage such as Med-Pay, Personal Injury Protection (PIP), etc., based upon the principles of no-fault auto insurance coverage.

"Plan Administrator": the entity charged with the administration of the Plan of Benefits. The Employer (City of Seneca) is the Plan Administrator of this Plan of Benefits.

"Plan of Benefits": this Plan of Benefits including the Schedule of Benefits, and all endorsements, amendments, riders or addendums.

"Plan Year": The Plan Year is the period of July 1 through June 30 of the following year.

"Post-service Claim": any claim that is not a Pre-service Claim.

"Pre-existing Condition(s)": a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was received or recommended during the six (6) month period preceding the Enrollment Date, if applicable. Genetic Information may not be treated as a Pre-Existing Condition in the absence of a diagnosis of a specific condition related to the Genetic Information.

"Pre-existing Condition Exclusion Period": the period during which this Plan of Benefits will not provide Benefits to a Participant for Pre-Existing Conditions, not to exceed twelve (12) months (eighteen (18) months for a Late Enrollee).

"Preferred Provider": a Physician, Hospital, or other Provider who has a signed contract with one of the networks used by this Plan of Benefits and who has agreed to provide Benefits to a Participant and submit claims to TCC of SC and to accept the Allowed Amount as payment in full for Benefits. The participating status of a Provider may change.

"Pregnancy": Includes prenatal care, postnatal care, childbirth and any complications associated with Pregnancy.

"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, Pre-existing Condition limitations 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; and,
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:

a. Be ordered by a medical doctor or oral surgeon as a prescription; and,
b. Not be entirely consumed at the time and place where the prescription is dispensed; and,
c. Be purchased for use outside a Hospital.

Prescription Drugs also include the following which may not otherwise meet the definition of Prescription Drugs:

- 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, Claims Administrator recommends 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.

"Primary Plan": the plan with primary responsibility for the Participants claims as determined by the coordination of benefit provisions of this Plan of Benefits**.**

"Protected Health Information (PHI)": individually identifiable health information collected electronically, orally, or via paper. PHI includes information such as the patient's name, social security number, telephone number, medical record number, address, including ZIP code as well as medical records.

"Provider": any person or entity licensed by the appropriate state regulatory agency and legally engaged 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

Provider includes a Long Term Care Hospital, a Hospital, a Rehabilitation Facility, Skilled Nursing Facility, and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives or masseuses.

"QMCSO": a Qualified Medical Child Support Order in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA), as amended.

"Rehabilitation Hospital": a licensed facility that is engaged primarily in providing rehabilitation care to patients on an inpatient basis. Rehabilitation care consists of the combined use of medical, educational, and vocational services to enable patients disabled by disease or Injury to achieve the highest possible level of function ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

"Schedule of Benefits": the pages so titled and made part of this handbook that specify the amount of coverage provided and the applicable Co-payments, Coinsurance, Deductibles, and limitations.

"Second Opinion": an opinion from a Physician regarding a service recommended by another Physician before the service is performed, to determine whether the proposed service is Medically Necessary and covered under the terms of this Plan of Benefits.

"Secondary Plan": the Plan that has secondary responsibility for paying a Participant's claim as determined through the coordination of benefits provisions of this Plan of Benefits.

"Security Incidents": the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system.

"Semi-Private Room and Board": the charges made by a hospital for the cost of room, meals and services (such as general nursing services) provided to all in-patients on a routine basis in a room designed to accommodate at least 2 or more bed patients.

"Significant Break in Coverage": an individual must not experience a break in coverage of 63 days or more from one health plan to the next. COBRA continuation coverage will be considered applicable benefits for crediting coverage towards a pre-existing condition. Waiting periods are not considered breaks in coverage. Likewise, days in waiting period are not included as creditable coverage.

"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 Enrollment": the period during which an Employee or eligible Dependent who is not enrolled for coverage under this Group Health Plan 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 Physician": A Physician who has majority of his/her practice in areas other than family practice, general medicine, internal medicine, obstetrics/gynecology and pediatrics.

"Substance Abuse": 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).

"Surgical Services": any procedure in the categories listed below;

a. the incision, excision or electrocauterization of any organ or part of the body
b. the manipulative reduction of a fracture or dislocation;
c. the suturing of a wound
d. endoscopic surgeries for diagnostic purposes or removal of foreign objects;
e. surgical injections

"Transplant Benefit Period": the period of time which for transplant of:

a. an organ, the period which begins on the Admission date and continues for 12 months; or
b. bone marrow, the period which begins on the first date of mobilization therapy, marrow/stem cell harvest date or inpatient Admission date for the transplant procedure, whichever comes first, and continues for 12 months.

"Transplant Lifetime Maximum": the maximum amount of Benefits provided in a Lifetime for each of the transplants listed in the Schedule of Benefits. Once the Transplant Lifetime Maximum has been met, no additional transplant benefits will be provided for that type of transplant.

"Transplant Lifetime Maximum": the maximum amount of Benefits provided in a Lifetime for each of the transplants listed in the Schedule of Benefits. Once the Transplant Lifetime Maximum has been met, no additional transplant benefits will be provided for that type of transplant.

"Totally Disabled": as applied to a Participant means the complete inability of the Participant to perform the important daily duties of the Participant's occupation, for which the Participant is reasonably suited by education, training or experience. As applied to a Participant who is a Dependent, the term means the Dependent is prevented solely because of a non-occupational Injury or non-occupational disease from engaging in all of the normal activities of a person in good health and of like age.

"TMJ Disorder/Dysfunction": a disorder of the temporomandibulaor join (the joint which connects the mandible or jawbone to the temporal bone) which is generally characterized by pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat, or shoulder, popping or clicking of the jaw, limited jaw movement or locking, malocclusion, overbite or under bite, or mastication (chewing) difficulties.

"Urgent Care": Covered Services required in order to treat an unexpected Illness or Injury that is life-threatening and required in order to prevent a significant deterioration of the Participant's health if treatment were delayed.

"Urgent Care Claims": any claim made by you or by a Provider or Physician (with knowledge of your current medical condition), where, if the normal Pre-service Claim review time frames of the Plan of Benefits were used:

a. Your life, health or ability to regain maximum function could be seriously jeopardized; or

b. You, in the opinion of the Physician, would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

TCC of SC will determine whether a claim is an urgent care claim based on the information provided at the time that the claim is submitted.

"Waiting Period": a period of continuous employment with the Employer that an Employee must complete before becoming eligible to enroll in the Plan of Benefits.

MEDICAL SCHEDULE OF BENEFITS

All benefits are subject to the Allowed Amount and Benefit Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. Percentages stated are those paid by the Group Health Plan.

Lifetime Maximum per Participant is $2,000,000.
The Transplant Lifetime Maximum is $250,000.

	PREFERRED PROVIDER (PPO):	NON-PREFERRED PROVIDER (Non-PPO):
Plan Year (P/Y) Deductible:		
Individual:	$1,000	$1,000
Family:	3 per family	3 per family

Note: The amount applied toward the PPO Deductible will also be used in the accumulation towards the satisfaction of the Non-PPO Deductible.

PLAN YEAR:
The P/Y for the Deductible and Out-of-Pocket accumulations is **July 1st through June 30th** of each year.

	PPO:	Non-PPO:
Out-of-Pocket Amount (excluding the Deductible)		
Individual:	$2,500	$3,500
Family:	$5,000	$7,000
NOTE: The Plan Year Out of Pocket Maximum does not include the following:		
Deductibles Co-payments Pre-certification Penalties		
Private Duty Nursing Prescription Drug Card Co-payments and Co-Insurance		

The "**Out-of-Pocket"** Limit is the maximum dollar amount a Participant will pay for covered expenses in any one Plan Year. Upon satisfaction of the Out-of-Pocket Limit, benefits for such Participant will be payable at 100% of the Allowed Amount.

Note: The amount applied toward the PPO Out-of-Pocket will also be used in the accumulation towards the satisfaction of the Non-PPO Out-of-Pocket Limit.

All benefits are subject to the Allowed Amount and Benefit Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. Percentages stated are those paid by the Group Health Plan.

INPATIENT HOSPITAL EXPENSES: Pre-Authorization required	**PPO:**	**Non-PPO:**
Per-Admission Co-payment	N/A	N/A
Room and Board:	70% after deductible	50% after deductible
Extended Care/Skilled Nursing Facility: Limited to 60 days per Plan Year	70% after deductible	50% after deductible
Physician Charges:	70% after deductible	50% after deductible
Hospital Surgical Services:	70% after deductible	50% after deductible
Physical Rehabilitation Facility:	70% after deductible	50% after deductible
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	70% after deductible	50% after deductible
Newborn Nursery: See Hospital and Physician Services for newborn expenses exceeding mother's length of stay.	70% after deductible	50% after deductible
Ancillary Charges:	70% after deductible	50% after deductible
Anesthesia:	70% after deductible	50% after deductible
INPATIENT PRECERTIFICATION REQUIREMENT		
Pre-Certification is required for all inpatient hospital admissions. In case of an emergency admission, please call the Medical Review Department number shown on your ID card within 48 hours or the next working day. If pre-certification is not obtained prior to an elective confinement, the covered person will be responsible for the total billed charges. NOTE: Certification does not guarantee coverage. Certain procedures may not be eligible covered health services. Please contact the Plan Third Party Administrator at the number shown on your ID card to inquire if the service is subject to any Plan limitations or exclusions.		

OUTPATIENT EXPENSES:	**PPO:**	**Non-PPO:**
Hospital and Physician Charges:	70% after deductible	50% after deductible
Emergency Room Charges: Co-Payment per Visit (Waived if Admitted)	70% after deductible and $100 co-payment	70% after deductible and $100 co-payment
Urgent Care Facility: Primary Care Physician Office Visit: *Co-Payment per Office Visit* Specialist Physician Office Visit: *Co-Payment per Office Visit* Includes lab and x-ray services performed and billed by the physician's office.	 100% after $35 co-payment 100% after $50 co-payment	 50% after deductible 50% after deductible
Pre-Admission Testing:	70% after deductible	50% after deductible
Anesthesia:	70% after deductible	50% after deductible
Cardiac Rehabilitation:	70% after deductible	50% after deductible
Diagnostic X-ray, Laboratory, Pathology, and Radiology: Inpatient, Outpatient and Independent Lab Facility	70% after deductible	50% after deductible

All benefits are subject to the Allowed Amount and Benefit Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. Percentages stated are those paid by the Group Health Plan.

PHYSICIAN OFFICE EXPENSES:	PPO:	Non-PPO:
Primary Care Physician Office Visit: Including Lab, X-ray, Pathology, Radiology, supplies, and injections performed and billed by the physicians office.	100% after $35 co-payment	50% after deductible
Primary Care Physician is defined as: Family Practice, General Practice, Internal Medicine, Pediatricians, and OB/GYN		
Specialty Care Physician Office Visit: Including Lab, X-ray, Pathology, Radiology, supplies, and injections performed and billed by the physicians office.	100% after $50 co-payment	50% after deductible
Surgery performed in Physicians Office:	70% after deductible	50% after deductible
All Other Covered Services:	70% after deductible	50% after deductible

NOTE: The Physician Office Co-payment applies to PPO Physicians services that are performed in the PPO Physicians office with the exception of the following:

Allergy Injections and Serum expenses
Manipulative Treatment & Chiropractic Care
Prenatal Office Visits (after the initial visit)
Chemotherapy/Radiation Therapy/ Infusion Services
Physical/Occupational/Speech Therapy
Surgery and related expenses

All of the charges are subject to the Plan Year deductible and will be payable at the applicable percentage outlined above.

HUMAN ORGAN AND TISSUE TRANSPLANT	APPROVED TRANSPLANT FACILITY	NON-APPROVED FACILITY
Human Organ/Tissue Transplants: TCC of SC must be notified **PRIOR** to a transplant evaluation. Precertification and Case Management is **required** for all transplant services. **Benefits will be reduced 50% for non-compliance.**	100% deductible waived	Not Covered
Travel and Lodging: For the patient and caregiver	100% up to $10,000 per Lifetime	Not Covered

OTHER SERVICES:	PPO:	Non-PPO:
Chiropractic Care: Limited to $50 per visit and 24 visits per Plan Year	70% after deductible	50% after deductible
Hospice Care:	70% after deductible	50% after deductible
Home Health Care: Limited to 100 visits per Plan Year for Non-PPO Providers	70% after deductible	50% after deductible
Durable Medical Equipment:	70% after deductible	50% after deductible
Second Surgical Opinion (not mandatory)**:**	100% after office visit Co-payment	50% deductible
Ambulance:	70% after deductible	70% after deductible
Physical Therapy: Limited to 40 visits per condition	70% after deductible	50% after deductible
Occupational Therapy: Limited to 40 visits per condition	70% after deductible	50% after deductible

MEDICAL SCHEDULE OF BENEFITS-continued

All benefits are subject to the Allowed Amount and Benefit Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. Percentages stated are those paid by the Group Health Plan.

OTHER SERVICES:	PPO:	Non-PPO:
Routine Foot Care: Limited to $300 per Plan Year	70% after deductible	50% after deductible
Private Duty Nursing:	50% after deductible	50% after deductible
Speech Therapy:	70% after deductible	50% after deductible
Radiation Therapy/Chemotherapy and Infusion:	70% after deductible	50% after deductible
Allergy Injections/Serum Services:	70% after deductible	50% after deductible
Surgical Sterilization:	70% after deductible	50% after deductible
TMJ Services: Limited to $3,000 Lifetime Maximum	70% after deductible	50% after deductible
Medical Supplies:	70% after deductible	50% after deductible
All Other Covered Services:	70% after deductible	50% after deductible

WELLNESS CARE SERVICES:	PPO:	Non-PPO:
Routine Adult Wellness Services: Coverage Includes; routine physical exam, routine lab & x-ray services, routine GYN exams, routine pap smears, routine prostate exam and related lab test (i.e., PSA) and immunizations.	100% deductible waived Limited to $300 Plan Year Maximum	100% deductible waived Limited to $300 Plan Year Maximum
Routine Mammograms: Age 40 and older Limited to one per Plan Year	100% deductible waived	100% deductible waived
Routine Colonoscopies- Age 50 and older Coverage includes related services performed on same day **(limited to one procedure every 10 years)**	100% deductible waived	100% deductible waived
Routine Well Child Services- to age 19 Coverage Includes; routine physical exam, routine lab & x-ray services, routine hearing and vision test and routine immunizations. Immunizations – Birth to 12 months *Charges billed with a non-routine diagnosis will not be payable under this benefit-See Hospital and Physician Services.	100% deductible waived Limited to $300 Plan Year Maximum 100% deductible waived	100% deductible waived Limited to $300 Plan Year Maximum 100% deductible waived

MENTAL HEALTH SERVICES, ALCOHOL & SUBSTANCE ABUSE TREATMENT

The City of Seneca covers Mental Health Services, Alcohol and Substance Abuse Treatment under this Plan of Benefits. However, also have a separate Employee Assistance Program (EAP) in which they have contracted with an independent provider. For questions regarding these services you may contact them directly:

Behavioral Health EAP

Anderson-Oconee Behavioral Health Services / www.aobhs.org

Anderson (864) 260-4168
Oconee (864) 882-7563

MEDICAL SCHEDULE OF BENEFITS-continued

All benefits are subject to the Allowed Amount and Benefit Year Deductible, unless otherwise indicated by an asterisk (*). Please refer to the Covered Expenses section for a complete listing of Benefits and any additional Conditions/Limitations that may apply. Percentages stated are those paid by the Group Health Plan.

ITEMS THAT REQUIRE PRECERTIFICATION		
The following items require precertification: • **Inpatient Hospital Admission** • **Human organ and/or tissue transplants** • **CT Scan** • **MRI**		

PRECERTIFICATION

Precertification concentrates on services that are costly or highly utilized. Precertification is required for the following diagnostic procedures:

- **CT Scan** performed as an Outpatient or in a Physician's office
- **MRI** performed as an Outpatient or in a Physician's office

Precertification for these services should be requested **at least 48** hours before the service is proved. You should call TCC of SC at **(888) 275-7146** with the following information:

- The name of the patient and relationship of the covered Employee
- The name, patient identification number and address of the covered Employee
- The name and group number of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility and proposed date of the procedure
- The diagnosis and/or type of services to be provided

Please remember that precertification does not guarantee coverage or payment. Contact TCC of SC at (800) 815-3314 to verify your eligibility and benefits.

PRESCRIPTION DRUG BENEFITS

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

Prescription Drugs are provided through the Caremark Prescription Drug Program. Caremark uses the Medispan defined drug/therapeutic classification for product coverage and exclusion. Outpatient Prescription Drugs will be covered in the following manner:

Participating Pharmacies:

Co-pay or Co-Insurance per Prescription (34-day supply maximum per prescription):

Generic	$10 co-payment
Formulary Name Brand	20% co-insurance with a minimum of $25 and a maximum of $45
Non-Preferred Name Brand	30% co-insurance with a minimum of $55 and a maximum of $75
Specialty Drugs	$75 co-payment

Mail Order Division:

Co-pay or Co-Insurance per Prescription (90-day supply maximum per prescription):

Generic	$25 co-payment
Formulary Name Brand	20% co-insurance with a minimum of $60 and a maximum of $110
Non-Preferred Name Brand	30% co-insurance with a minimum of $135 and a maximum of $185
Specialty Drugs	$185 co-payment

Note: For a list of Preferred/Non-Preferred drugs, please reference www.tccofsc.com and utilize the Caremark Rx link under "About TCC".

All prescription drugs are covered unless exclusion applies in the Prescription Drugs listed in the Schedule of Benefits.

** If Plan selects **Drug Limitations Option (QVT)**, the Drug Limitations form is separate and must be completed with Clinical direction**.**

DRUG COVERAGE OPTIONS

Caremark uses the Medispan defined drug/therapeutic classification for product coverage and exclusion.

- **YES = Drug Covered**
- **NO = Drug Not Covered**
- **PA = Prior Authorization -- Drug requires an Override to be covered ***

	YES	NO	PA*
ADD and Narcolepsy Drugs **Prior authorization may be required for Attention Deficit Disorder drugs for persons over the age of 18**	X		
Anabolic Steroids	X		
Anorexients (Diet Aids)		X	
Anti-rejection Drugs (Immunosuppressant)	X		
Anti-Smoking Aids (requiring a prescription)		X	
Acne Medicines -	**YES**	**NO**	**PA***
• Tretinoin (Retin-A, Micro, Avita, Ziana)		X	
• Differin		X	
• Tazorac		X	
Compounds if covered are covered at 150% of AWP or submitted whichever is less and second tier Brand co-pay applies. Compounds will pay according to all other plan edits unless otherwise stated.	X		
Contraceptives- All types **NO COVERAGE FOR DEPENDENT CHILDREN UNDER THE AGE OF 17**	**YES**	**NO**	**PA***
• Contraceptives Oral	X		
• Extended Cycle Contraceptives Oral (Seasonale, Seasonique) – The minimum number of days supply per fill will be 84 days will maximum of 91-days supply. Indicate the co-pay you wish to apply at retail. ☐ 1 co-pay ☐ 2 co-pays **X 3 co-pays** ☐ other	X		
• Contraceptive Emergency (i.e. Preven & Plan B)		X	
• Contraceptive Devices (i.e. IUD, Diaphragm)		X	
• Contraceptive Injectable - Depo-Provera – Note: 90 day supply per fill		X	
• Contraceptive Implants		X	
• Topical Contraceptives (i.e. Ortho-Evra)		X	
• Contraceptive vaginal ring (i.e. Nuvaring)		X	
Cosmetic Drugs - including hair loss drugs, anti-wrinkle creams, hair removal creams and others *(requiring a prescription)*		X	
Diabetic Medications and Supplies	**YES**	**NO**	**PA***
• Amylin Analogs (Symlin)	X		
• Incretin Mimetics (Byetta)	X		
• Insulin	X		
• Insulin – Needles and Syringes	X		
• Inhaled Insulin Supplies: (if available)	X		
• Lancets and Devices	X		
• Alcohol Swabs	X		
• Blood Testing Strips: Glucose	X		
• Urine Testing Strips: Glucose	X		
• Acetone Testing Strips	X		
• Ketone Testing Strips	X		

DRUG COVERAGE OPTIONS *(continued)*	YES ✔	NO ✔	PA ✔
• Glucagon Emergency Injection Kit	X		
• Glucose (oral)	X		
• Blood Glucose Monitoring Units	X		
• Blood Glucose Monitoring Units Disposable	X		
• Blood Glucose Monitoring Units Continuous	X		
• Blood Glucose Monitoring Watch		X	
Emergency Allergic Reaction Kits (Bee Sting Kits, Epi-pen, Ana-kit)	X		
Fertility	**YES**	**NO**	**PA***
• Fertility Agents - Oral		X	
• Fertility Agents - Injectable		X	
Fluoride (Topical Fluoride dental products – requiring a prescription)	X		
Growth Hormone		X	
Impotency Drugs (Injectable, Oral, Suppository, Kits) All dosages except Yohimbine for males age 18 and older limited to 30 days or 6 units, whichever is lesser per claim for Retail and limited to 90 days or 18 units whichever is lesser per claim for Mail Order	X		
Injectables (All injectables, unless otherwise noted on this form)		X	
IV Injectables (unless otherwise noted on this form)	X		
Migraine Medicines (kit, nasal spray, tablet, injectables)	X		
Multiple Sclerosis Meds (examples Betaseron, Avonex, Copaxone, Rebif)	X		
Multiple Vitamins			
➢ **Multiple Vitamins (that require a prescription)**	X		X
➢ **Prenatal Vitamins (that require a prescription)**	X		
➢ **Pediatric (that require a prescription)**	X		
Other – enter any additional options			
➢ **Not covered Yohimbine**		X	
➢ **Not covered Mifeprex**		X	
➢ **Not covered Allergy serums**		X	
➢ **Covered Synagis and Respigam**	X		
➢ **Covered Thalomid (limited to 28 day supply)**	X		
➢ **Not covered inhaler assisting devices**		X	
➢ **All legend vitamins are not covered**		X	
➢ **Hemophilia factors are covered**		X	
Quantity Limits – All quantity limits require the completion of additional forms completed by Clinical Manager. – **Quality Limits and Dose Management will apply**			
Age Limit is a "through" date. Example: Select coverage through age 25. Claim rejects at age 26 and above.			

***Prior Authorization** – Caremark will not enter Prior Authorization Overrides without authorization in writing from the Group. Members would need to make requests to their HR Departments and then the HR Department would send written authorization to the Caremark Account Services team to have a PA entered to allow the claim to pay.

** If Plan selects **Drug Limitations Option (QVT)**, the Drug Limitations form is separate and must be completed with Clinical direction.

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, 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.

Questions and Complaints

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

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your privacy rights, you may tell 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 can give you 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

Name of Entity/Sender:	**CITY OF SENECA**
Contact—Position/Office:	**Finance Officer/Clerk Treasurer**
Address:	**221 East North 1st Street, Seneca, SC 29678**
Phone Number:	**(864) 885-2722**

Final Acceptance by the Group for the attached Medial Summary Plan Description dated **JULY 1, 2010.**

IN WITNESS WHEREOF, CITY OF SENECA 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 Belinda S. Kaiser

Title Finance Officer / Clerk-Treasurer

Date 11-24-10