SELF-FUNDED
PLAN DOCUMENT
FOR

Tidelands Health

GROUP MEDICAL PLAN

Restated
Effective Date: October 1, 2023

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Capitalized terms are defined in the Definitions section of this Plan Document.

ABOUT YOUR PLAN

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

Please review this booklet, which describes your health Plan. Be a selective medical consumer and assume the key role in keeping the cost of medical services at a minimum.

Your Plan Sponsor has established a comprehensive Group Health Plan (Plan) for its Employees. In connection with the Plan, your Plan Sponsor has retained the services of *Planned Administrators, Inc.* (PAI) (a third-party administrator) to process and pay health claims and to provide administrative services in connection with the operation of this Plan of Benefits. In addition to your plan providing services through the **Tidelands Health network**, PAI has contracted with **BlueCross BlueShield of South Carolina Preferred Blue and Private Healthcare Systems (PHCS) and PHCS Travel** as the Preferred Provider Organizations (PPOs). This program also includes a staff of Care Coordinators who are the single point patient contact for all health plan related questions. The Care Coordinators assist by coordinating information flow between the patient, health Plan and Providers.

You will receive maximum Benefits that can be paid when you use Providers who participate in the PPO Program (the term "PPO Providers" is explained further below) and when you obtain preauthorization (when required) for services. The Plan will pay more when you use Providers who participate in the Tidelands Health network. You will pay more if you do not use PPO Providers or if you do not obtain preauthorization (unless it is an emergency) before you receive medical care or services. This information explains how to obtain authorization for services or supplies covered under this 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 PPO Provider, you may:

- Ask the Provider if they participate in the PPO program referenced above.
- See the appropriate website for Provider information. Link available on www.TidelandsHealth.org or www.paisc.com.
- Call Quantum Health Care Coordinators.*

* The methods of verifying PPO participation 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.

The PPOs for this Group Health Plan are:

Within South Carolina	**Tidelands Health Providers** and the BlueCross BlueShield Preferred Blue Network
All other states	Private Healthcare Systems (PHCS)
For travel outside of South Carolina	Private Healthcare Systems (PHCS) Travel

PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies (as listed in the Definitions section) that have a written agreement with the PPO. Under their agreement with the PPO, PPO Providers will:

- File all claims for Benefits or supplies with PAI;
- Ask you to pay only the Deductible, per occurrence Copays and Coinsurance amounts, if any, for Benefits;
- Accept the preferred allowance as payment in full for Covered Expenses;
- Make sure that all necessary approvals are acquired from the Medical Services Department.

Non-PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies that 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, or 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 are responsible for the difference between the Non-PPO Provider's charge and the Allowed Amount for Covered Expenses.

Although Benefits typically are reduced when you use a Non-PPO Provider, Benefits provided by a Non-PPO Provider will be covered at the Preferred Blue PPO Provider level under these 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;
- For Dependents living out of state;
- For treatment by a Specialist when a PPO Provider Specialist is not available;
- For Non-PPO Provider ancillary services rendered in a PPO Provider Hospital;

Out of area Emergency Provision—If a Covered Member receives care for an Emergency Medical Condition from a NonParticipating Provider, the Plan will pay for Benefits at a PPO Provider level of Benefits if these conditions are met:

- 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 Copays, Coinsurance and all Plan of Benefits maximums, limits and exclusions.

If you have claims that meet all of these conditions, write or call PAI. PAI will review your claims to determine if additional Benefits can be provided.

Customer Service – Quantum Health Care Coordinators

Coordinated Health/Care (CHC) is committed to helping you understand your coverage and get maximum Benefits on your claims. If you have any questions about your coverage, you may call, email or write CHC at:

Coordinated Health/Care
Attn: Care Coordinators
1215 Polaris Parkway, Suite 229
Columbus, OH 43240-2037
877-498-6693
www.tidelandshealthplan.com

Once a claim has been processed, you will have access to an Explanation of Benefits (EOB) at www.paisc.com or by contacting your Quantum Health Care Coordinator. An EOB also will be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowed Amount, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

Time Limits to File a Claim

Claims must be filed no later than 18 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Unless expressly permitted by law, you, and your Dependent's Personal Health Information (PHI) generally cannot be released to any other person without your or your Dependent's consent. Nevertheless, there are instances when you may want someone to discuss your PHI with PAI or receive an Explanation of Benefits, etc. to manage your care. To comply with applicable laws and to comply with your request, you must sign a written authorization form. To obtain a copy of the form, please log in to your Member page at www.paisc.com, click on the Forms tab where you will find the PAI HIPAA Forms option. You can print this form and mail it to the PAI address, or you can call 800-768-4375 for a copy of the form.

A Provider may be considered a Covered Member's authorized representative without a specific designation by the Covered Member when the claim request is for an Urgent Care Claim. A Provider may be a Covered Member's authorized representative with regard to non-Urgent Care Claims for Benefits or an appeal of an Adverse Benefit Determination only when the Covered Member gives the Plan supervisor a specific written designation in a format that is reasonably acceptable to PAI to act as an authorized representative. All information and notifications will continue to be directed to the Covered Member unless the Covered Member gives contrary directions.

CARE COORDINATION PROCESS

I. Introduction

The Plan incorporates a "Care Coordination" process by Quantum Health. This process includes a staff of Care Coordinators who receive a notification regarding most healthcare services sought by Covered Members, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Members obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and for early identification of complex medical conditions. The Care Coordinators are available to Covered Members and their providers for information, assistance, and guidance, and can be reached toll-free by calling:

Quantum Health Care Coordinators: 877-498-6693

II. Process of Care Requirements

To receive the highest Benefits available in the Plan, Covered Members must follow the "Care Coordination Process" outlined in this section. In some cases, failure to follow this process of care can result in significant Benefit reductions, penalties, or even loss of Benefits for specific services. The process of care generally includes:

- Designating a coordinating Physician (Primary Care Physician, referred to as the PCP)
- Review and coordination process, including:
  - Referrals from a PCP for all visits to specialist Physicians
  - Pre-notification of certain procedures
  - Utilization Review
  - Concurrent Review of hospitalization and courses of care
  - Case Management

As described below, pre-notification authorizations are generally requested by the providers on behalf of their Covered Members.

III. Overview

A. Designated Coordinating Physician

All Covered Members are asked to designate a coordinating Primary Care Physician (PCP) for each member of their family. While such a designation is not mandatory, it is strongly recommended. **To ensure the highest level of Benefits and the best coordination of your care, all Covered Members are encouraged to designate an in-network primary care physician to be their coordinating Physician.**

The care coordination process generally begins with the "coordinating Physician," who is a Primary Care Physician who maintains a relationship with the Covered Member and provides general healthcare guidance, evaluation, and management. The following types of Physicians can be selected by Covered Members as their coordinating PCP:

- Family Medicine
- General Practice
- Internal Medicine
- Pediatrician (for children)
- An OB/GYN*

*OB/Gyn's are considered to be specialists and not PCPs, as they typically do not provide general care regarding all body systems and family conditions, comprehensive preventive screening and care of non-OB/Gyn-related symptoms and conditions. Most OB/Gyn's state that they are a specialist and NOT a PCP, and do not wish to be considered a PCP. For instance, you may ask your OB/Gyn if they want to treat sore

ankles, chest pain, or chronic joint pain; generally, the OB/Gyn will say no, and they are therefore not a PCP. However, if a patient's OB/Gyn wishes to serve as their PCP and agrees to provide comprehensive care for all body systems and preventive screening, the Care Coordinator will list this Physician as the patient's PCP and accept referral notifications from the OB/Gyn to other specialists.

Covered Members are encouraged to begin all healthcare events or inquiries with a call or visit to a PCP, who will guide patients as appropriate. In addition to providing care coordination and submitting pre-notification requests, the PCP will also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators may be able to assist you by providing a list of available PCPs and even contacting PCP offices on your behalf. Please contact the Care Coordinators at **877-498-6693**.

B. Use of In-Network Providers

The Plan offers a broad network of providers and provides the highest level of Benefits when Covered Members utilize "in-network" providers. These networks will be indicated on your Plan identification card. Services provided by out-of-network providers will not be eligible for the highest Benefits. Specific Benefit levels are shown in the Schedule of Benefits.

C. Review and Coordination Process

The Care Coordination process includes the following components:

1. Referrals for Specialty Care

It is recommended that the Covered Member begin every healthcare event with a call or visit to a PCP. If a PCP refers the patient to a Specialty Physician, it is recommended that the Covered Member contact Care Coordinators at **877-498-6693** to confirm if the specialist being referred to is in the Tidelands Health network or the BCBS Preferred Blue Network, and to confirm covered benefits.

OB/Gyn Office Visits: As noted above, OB/Gyn specialists are generally not considered to be PCPs. However, to ensure open and unhindered access to OB/Gyn care, all office visits to OB/Gyn specialists receive the same Benefit level as a PCP office visit. Covered Members do not have to obtain a referral from a PCP to see their OB/Gyn specialist or receive the highest level of Benefits for an office visit to an OB/Gyn.

2. Pre-notification of Certain Procedures

To be covered at the highest level of Benefit and to ensure complete care coordination, the Plan requires that certain care, services, and procedures be pre-certified **before** they are provided. Pre-notification requests are submitted to the Care Coordinators by a specialty Physician, designated PCP, other PCP, or other healthcare provider. Your Plan identification card includes instructions. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the pre-notification request and to ensure that the care, service and/or procedure meet Plan criteria. If a pre-notification request does not meet Plan criteria, the Care Coordinators will contact the Covered Member and healthcare provider and assist in redirecting care if appropriate.

Services that **require** pre-notification:

- Inpatient, Physical Rehabilitation and Skilled Nursing Facility Admissions
- Gastrointestinal endoscopies, sigmoidoscopies, esophagoscopies, proctoscopies, gastroscopies, lithotripsy and surgeries not performed in the Physician's office (colonoscopies do not require pre-notification)
- MRI
- Home Health Care
- Hospice Care
- DME – all rentals and any purchase $1500 or more
- Organ, Tissue and Bone Marrow Transplants
- Outpatient surgeries

- Diagnostic Genetic Testing (Preventative Genetic Testing (BRCA) does not require pre-notification)

Pre-notification is recommended for the following procedures:
- MRA and PET Scans
- Oncology Care and Services (chemotherapy and radiation therapy)
- Dialysis

PENALTIES FOR NOT OBTAINING PRE-NOTIFICATION:

A non-notification penalty is the amount you must pay if notification of the service is not provided prior to receiving a service. Covered expenses will be reduced by 50% if a Covered Member receives services but does not obtain the required notification for:
- Gastrointestinal endoscopies, sigmoidoscopies, esophagoscopies, proctoscopies, gastroscopies, lithotripsy, and surgeries not performed in the physician's office
- MRI
- Outpatient surgeries

If pre-notification is not obtained, Benefits for the following services **will not be covered**:
- Inpatient, Physical Rehabilitation and Skilled Nursing Facility admissions
- Home Health Care
- Hospice Care
- Admissions for physical rehabilitation
- Organ, Tissue, and Bone Marrow Transplants
- DME – all rentals and any purchase $1500 or more
- Diagnostic Genetic Testing

Please note that if your claim for services or Benefits is denied, you may request further review under the guidelines set out in the Appeal Procedures section of this booklet. Remember that a denial of a Pre-notification is a denied claim for purposes of an appeal.

3. Utilization Review

The Care Coordinators will review each pre-notification request to evaluate whether the care, requested procedures, and requested care setting all meet utilization criteria established by the Plan. The Plan has adopted the utilization criteria in use by the Care Coordinators. If a pre-notification request does not meet these criteria, the request will be reviewed by one of the medical directors for Quantum Health, who will review all available information and if needed consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field. He or she will then provide, through the Care Coordinators, a recommendation to the Plan Administrator whether the request should be approved, denied, or allowed as an exception. In this manner, the Plan ensures that pre-notification requests are reviewed according to nationally accepted standards of medical care, based on community healthcare resources and practices. Please note that if your claim for services or Benefits is denied, you may request further review under the guidelines set out in the Appeal Procedures section of this booklet.

4. Concurrent Review

The Care Coordinators will regularly monitor a hospital stay, other institutional admission, or ongoing course of care for any Covered Member, and examine the possible use of alternate facilities or forms of care. The Care Coordinators will communicate regularly with attending Physicians, the Utilization Management staff of such facilities, and the Covered Member and/or family, to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review, and authorization for Plan coverage of hospital days, is conducted in accordance with the utilization criteria adopted by the Plan and Quantum Health. Please note that if your claim for services or Benefits is denied, you may request further review under the guidelines set out in the Appeal Procedures section of this booklet.

5. Case Management

Case Management is ongoing, proactive coordination of a Covered Member's care in cases where the medical condition is, or is expected to become catastrophic, chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt case management intervention include but are not limited to, cancer, chronic obstructive pulmonary disease (COPD), multiple traumas, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high risk pregnancy, and premature birth.

Case Management is a collaborative process designed to meet a Covered Member's health care needs, maximize their health potential, while effectively managing the costs of care needed to achieve this objective. The case manager will consult with the Covered Member, the attending physician, and other members of the Covered Member's treatment team to assist in facilitating/implementing proactive plans of care which provides the most appropriate health care and services in a timely, efficient, and cost-effective manner.

If the case manager, Covered Member, and the Plan Administrator all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, the Plan Administrator may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined by the Plan Administrator.

In developing an alternative plan of treatment, the case manager will consider:

- The Covered Member's current medical status
- The current treatment plan
- The potential impact of the alternative plan of treatment
- The effectiveness of such care and
- The short-term and long-term implications this treatment plan could have

If an alternative plan of treatment is warranted, the Care Coordinators will submit this plan to the claims administrator and/or Stop-Loss Carrier for prior review and approval.

The Plan Administrator retains the right to review the Covered Member's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies which are not covered charges under the Plan if:

- The attending physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment
- The goal of the alternative care of treatment has been met
- The alternative plan of care is not achieving the desired results or is no longer beneficial to the Covered Member

6. Chronic Condition Management

Chronic Condition Management (also referred to as Disease Management) is a specialized support and coordination for Members with lifelong, chronic conditions such as diabetes, coronary artery disease, congestive heart failure, COPD, asthma, and hypertension. Chronic Condition Management is a collaborative process that is designed to help Members with better self-management of such conditions based on disease specific care pathways, including but not limited to: assisting Members in understanding chronic illness and care pathways, assisting Members in goal setting, facilitating dialog with physicians if there are complications or conflicts with the Member's care, evaluating ways to eliminate barriers to successful self-management, and to generally assist in maximizing their health through disease specific diet education and physical activity goals. Members who are identified from either claims data or biometrics are then flagged for Personal Health Navigation – the internal and organizational supported in-person disease management program. Additionally, identified members will be assessed for level of risk for each disease state and may be contacted proactively and telephonically by a member of the clinical support team through Quantum Health. Based on determined chronic condition level of risk and acuity, Members will receive varying levels of intervention and support to assist in their disease state specific care pathway progress. Participation in both the Personal Health Navigation and Quantum Health sponsored disease management program is voluntary for all Members, but participants may receive

various prescription medications and/or supplies at a reduced cost or may be entitled to benefits those non-participants do not receive.

IV. General Provisions for Care Coordination

A. Authorized Representative

The Covered Member is responsible for ensuring that all referrals and pre-notifications are approved and in place prior to the time of service to receive the highest level of Benefits. However, in most cases, the actual referral and pre-notification process will be executed by the Covered Member's Physician(s) or other providers. By subscribing to this Plan, the Covered Member authorizes the Plan and its designated service providers (including Quantum Health, the third-party administrator, and others) to accept healthcare providers making pre-notification submissions, or who otherwise have knowledge of the Covered Member's medical condition, as their authorized representative in matters of Care Coordination. Communications with and notifications to such healthcare providers shall be considered notification to the Covered Member.

B. Time of Notice

The referral and pre-notifications must be made to Care Coordinators within the following timeframe:

- At least **three business days,** before a scheduled (elective) Inpatient Hospital admission
- By the next business day after an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least **three business days** before receiving any other services requiring preauthorization

C. "Emergency" admissions and procedures

Any Hospital admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency for purposes of the utilization review notification.

D. Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery in an effort to best monitor the patient's care. The Plan and the Care Coordination process comply with all state and federal regulations regarding utilization review for maternity admissions. The Plan will not restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require prior notification or authorization for prescribing a length of stay not more than these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider Benefits for the actual length of the stay. The Plan will not set Benefit levels or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

E. Care Coordination is not a guarantee of payment of benefits

The Care Coordination process does not provide a guarantee of payment of Benefits. Approvals of referral and pre-notification notices for specialty visits, procedures, hospitalizations and other services indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a covered Benefit, that the Covered Member is eligible for such Benefits, or that other Benefit conditions such as co-pay, deductible, co-insurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

F. Result of not following the coordinated process of care

Failure to comply with the Care Coordination "process of care" may result in reduction or loss in Benefits. The Schedule of Benefits included in this Plan Document specifies such reduction in Benefits. The Penalties for not obtaining pre-notification section specifies applicable penalties. Charges you must pay due to any penalty for failure to follow the care coordination process do not count toward satisfying any deductible, co-insurance or out-of-pocket limits of the Plan.

G. Appeal of Care Coordination determinations

Covered Members have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of Benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. Where a Participating Provider renders medical services or supplies, generally the Participating Provider should either file the claim on a Covered Member's behalf or provide an electronic means for the Covered Member to file a claim while the Covered Member is in the Participating Provider's office. Nevertheless, the Covered Member is responsible for ensuring that the claim is filed.
2. Written notice of receipt of services on which a claim is based must be furnished to PAI, at its address listed in this booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Covered Member can show that it was not reasonably possible to give the notice within the required period and if notice were given as soon as reasonably possible. Upon receipt of the notice, PAI will furnish or cause a claim form to be furnished to the Covered Member. If the claim form is not furnished within fifteen (15) days after PAI receives the notice, the Covered Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Covered Member must submit written proof covering the character and extent of the services within this Plan of Benefits' fixed time for filing proof of loss.
3. For Benefits not provided by a Participating Provider, the Covered Member is responsible for filing claims with PAI. When filing the claims, the Covered Member will need:

    a. A claim form for each Covered Member. Covered Members can obtain claim forms from PAI at the telephone number indicated on the Identification Card or via the website, www.paisc.com.

    b. Itemized bills from the Provider(s). These bills should contain the:

        i. Provider's name and address;

        ii. Covered Member's name and date of birth;

        iii. Covered Member's Identification Card number;

        iv. Description and cost of each service;

        v. Date that each service took place;

        vi. Description of the illness or injury and diagnosis.

    c. Covered Members must complete each claim form and attach the itemized bill(s) to it. If a Covered Member has other insurance that already paid on the claim(s), the Covered Member also should attach a copy of the other Plan's Explanation of Benefits notice.

    d. Covered Members should make copies of all claim forms and itemized bills for the Covered Member's records, since they will not be returned. Claims should be mailed to PAI's address listed on the claim form.

4. PAI must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Covered Member shows it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than eighteen (18) months following the date services were received.
5. Receipt of a claim by PAI will be deemed written proof of loss and will serve as written authorization from the Covered Member to PAI to obtain any medical or financial records and documents useful to the Plan of Benefits. The Plan of Benefits, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible for paying claims only based on the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to PAI in support of a Covered Member's claim will be deemed to be acting as the agent of the Covered Member. If the Covered Member desires to appoint an Authorized Representative in connection with such Covered Member's claims, the Covered Member should contact PAI for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Group Health Plan will make a determination for each type of claim within these time periods:
   a. Pre-Service Claim
      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
      ii. If a Pre-Service Claim is improperly filed, or otherwise does not follow applicable procedures, the Covered Member will be sent notification within five (5) days of receipt of the claim.
      iii. An extension of fifteen (15) days is permitted if PAI (on behalf of the Group Health Plan) determines, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Covered Member within the initial fifteen (15) day period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Covered Member will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.
      PAI will coordinate Pre-Service Claim determinations with the *Coordinated Health/Care program.*

      To verify the status of your claims, you can contact your Care Coordinators at 877-698-6693.

   b. Urgent Care Claim
      i. A determination will be sent to the Covered Member in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.
      ii. If the Covered Member's Urgent Care Claim is determined to be incomplete, the Covered Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Covered Member then will have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.
      iii. If the Covered Member requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Covered Member will be notified within twenty-four (24) hours of receipt of the request for an extension.
   c. Post-Service Claim
      i. A determination will be sent within a reasonable period, but no later than thirty (30) days from receipt of the claim.
      ii. An extension of fifteen (15) days may be necessary if PAI (on behalf of the Group Health Plan) determines, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Covered Member within the initial thirty (30) day period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Covered Member will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal

Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.

d. Concurrent Care Claim

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

7. Notice of Determination

a. If the Covered Member's claim is filed properly, and the claim is in part or wholly denied, the Covered Member will receive notice of an Adverse Benefit Determination. This notice will:
   i. State the specific reason(s) for the Adverse Benefit Determination;
   ii. Reference the specific Plan of Benefits provisions on which the determination is based;
   iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
   iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Covered Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
   v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
   vi. Explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request) if the reason for denial is based on a lack of Medical Necessity, or Experimental or Investigational services exclusion or similar limitation.

b. The Covered Member will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

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

a. An appeal must be in writing;

b. An appeal must be sent (via U.S. mail or FAX) at the address or FAX number below:

Planned Administrators, Inc.
Attention: Appeals
P.O. Box 6927
Columbia, SC 29260
FAX 803-870-8012

c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question;

d. An appeal must include the Covered Member's name, address, identification number and any other information, documentation or materials that support the Covered Member's appeal.

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

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

4. The final decision on the appeal will be made within the time periods specified below:

a. Pre-Service Claim

PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal. PAI will coordinate Pre-Service Claim appeals with the *Coordinated Health/Care* program.

b. Urgent Care Claim

The Covered Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Plan Sponsor will communicate with the Covered Member by telephone or facsimile. The Plan Sponsor will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

c. Post-Service Claim

PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.

d. Concurrent Care Claim

The Plan Sponsor will decide the appeal of Concurrent Care Claims within the time frames set forth in the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, item 4 a.-c., depending on whether such claim also is a Pre-Service Claim, an Urgent Care Claim, or a Post-Service Claim.

To verify the status of your claims, you can contact your Care Coordinators at 877-498-6693.

5. Notice of Final Internal Appeals Determination

   a. If a Covered Member's appeal is denied in whole or in part, the Covered Member will receive notice of an Adverse Benefit Determination. This notice will:

      i. State specific reason(s) for the Adverse Benefit Determination;

      ii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;

      iii. State that the Covered Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

      iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination

      v. Explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request if the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, or Experimental or Investigational services or other limitation or exclusion;

      vi. Include a statement regarding the Covered Member's right to request an external review;

      vii. Include a statement regarding the Covered Member's right to bring an action under section 502(a) of ERISA.

   b. The Covered Member will also receive a notice if the claim on appeal is approved.

6. The Plan Sponsor may retain PAI and *Coordinated Health/Care* to assist the Plan Sponsor in making the determination on appeal. Regardless of its assistance, PAI is acting only in an advisory capacity and is not acting in a fiduciary capacity. The Plan Sponsor always retains the right to make the final determination.

C. EXTERNAL REVIEW PROCEDURES

1. After a Covered Member has completed the appeal process, a Covered Member may be entitled to an additional, external review of the Covered Member's claim at no cost to the Covered Member. An external review may be used to reconsider the Covered Member's claim if PAI has denied, either in whole or in part, the Covered Member's claim. To qualify for external review, the claim must have been denied, reduced, or terminated.

2. After a Covered Member has completed the appeal process (and an Adverse Benefit Determination has been made), such Covered Member will be notified in writing of such Covered Member's right to request an external review. The Covered Member should file a request for external review within four (4) months of receiving the notice of PAI's decision on the Covered Member's appeal. To receive an external review, the Covered Member will be required to authorize the release of such Covered Member's medical records (if needed in the review for the purpose of reaching a decision on Covered Member's claim).
3. Within six (6) business days of the date of receipt of a Covered Member's request for an external review, PAI will respond by either:
    a. Assigning the Covered Member's request for an external review to an Independent Review Organization and forwarding the Covered Member's records to such organization;
    b. Notifying the Covered Member in writing that the Covered Member's request does not meet the requirements for an external review and the reasons for PAI's decision.
4. The external review organization will take action on the Covered Member's request for an external review within forty-five (45) days after it receives the request for external review from PAI.
5. Expedited external reviews are available if the Covered Member's Physician certifies that the Covered Member has a serious medical condition. A serious medical condition, as used in the Claims Filing and Appeal Procedures section, C. External Review Procedures, item 5, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or would place the Covered Member's health in serious jeopardy. If the Covered Member may be held financially responsible for the treatment, a Covered Member may request an expedited review of PAI's decision if PAI's denial of Benefits involves Emergency Medical Care and the Covered Member has not been discharged from the treating Hospital.

TIDELANDS HEALTH WELLNESS ACTIVITIES AND INCENTIVES

A comprehensive menu of incentivized wellness activities is available at Tidelands Health to help you be healthy! Tidelands Health is excited to provide you with tools and resources to help you get and stay healthy with a variety of activities throughout the year. The wellness activities you complete during the year translate into a valuable incentives, including Tidelands Health funded Health Reimbursement Account (HRA) contributions to be used towards first dollar coverage for deductible and Copays in the following year.

Your Privacy
Your privacy is assured when you participate in any incentivized wellness activities. Your information is stored on the secure servers and only annual aggregate data is given to Tidelands Health to identify trends and accurately target wellness activities for the population as a whole, and no one at Tidelands Health has access to your Protected Health Information without your consent.

Please note: Your health plan is committed to helping you achieve your best health. Incentives for participating in the wellness based activities are available to all Employees. If you think you might be unable to meet a standard for a wellness activity incentive, you may qualify for an opportunity to earn the same incentive by different means. Contact the Wellness Department at 843-652-1363 or 843-652-1602 and we will work with you, and if you wish, with your doctor, to find a wellness program with the same incentive that is right for your health status.

MEDICAL SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits. Percentages stated are those paid by the Group Health Plan. Covered Expenses will be paid only for Benefits that are Medically Necessary.

Preauthorization Requirements:

- **All Admissions require Preauthorization—**If Preauthorization is not obtained, room and board charges will be denied. Other services may also require Preauthorization. Please see the Schedule of Benefits and Plan of Benefits for more information.
- **These services require Preauthorization.** If Preauthorization is not acquired, Benefits may be denied.
  - Ambulance (non-emergency)
  - Home Health Care
  - Hospice Care
  - Admissions for physical rehabilitation
  - Human organ and/or tissue Transplants
  - Durable Medical Equipment when the purchase price or rental cost of the equipment is $1500 or more
  - Diagnostic Genetic Testing (Preventative Genetic Testing (BRCA) does not require Preauthorization)

50% of the Allowed Amounts will be denied if Preauthorization is not acquired for these procedures:

- Magnetic Resonance Imaging (MRI)
- Lithotripsy
- Gastrointestinal Endoscopies
  - Sigmoidoscopies
  - Esophagoscopies
  - Proctoscopies
  - Gastroscopies
- Surgery not performed in a Physician's office

Benefit Year is from October 1st through September 30th.

Deductibles:	
Benefit Year Deductible: Benefits with an "*" indicate that the Benefit Year Deductible is waived.	**Domestic (Tidelands Health)** • $1,500 per Covered Member per Benefit Year at a Tidelands Health Provider, limited to $3,000 per family. **In-Network** • $3,000 per Covered Member per Benefit Year at a Preferred Provider (PPO), limited to $6,000 per family (includes Non-Participating Providers of ambulance services, Emergency Services, and Non-Emergency Services furnished at certain Participating Provider facilities). **Out-of-Network** • $4,500 per Covered Member per Benefit Year at a Non-Preferred Provider, limited to $9,000 per family.
No single Covered Member will be required to exceed the per-Covered Member Deductible. The family Deductible would be an accumulation of per Covered Member Deductible and could be from 3 family members meeting per Covered Member Deductible or 4 or more meeting a portion of per Covered Member Deductible.	
Covered Expenses that are applied to the Benefit Year Deductible shall contribute to Tidelands Health, Participating and Non-Participating Provider Benefit Year Deductibles.	

Maximums:	
Annual Out-of-Pocket Maximum: Includes Benefit Year Deductible, Coinsurance, Medical Copays and Prescription Drug Copays.	**Domestic (Tidelands Health)** • $3,000 per Covered Member and $6,000 per family at a Tidelands Health Provider. **In-Network** • $6,000 per Covered Member and $12,000 per family at a Participating Provider (includes Non-Participating Providers of ambulance services, Emergency Services, and Non-Emergency Services furnished at certain Participating Provider facilities). **Out-of-Network** • $9,000 per Covered Member and $18,000 per family at a Non-Participating Provider. Allowed Amounts are paid at 100% after the Out-of-Pocket Maximum is met. Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to Tidelands Health, Participating and Non-Participating Provider Out-of-Pocket Maximums. Penalties do not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits.

Percentage of covered Benefits after deduction is met: **INPATIENT HOSPITAL SERVICES:** Preauthorization required except emergency room admissions	**In-Network** **Tidelands Health:**	**In-Network** **PPO:**	**Out-of-Network** **Non-PPO:**
Room and Board:	85%	75%	50%
All other (non-emergency) Benefits in a Hospital during an Admission (including, for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and X-ray services)	85%	75%	50%[1] [2]
Hospital Admission resulting from an emergency room visit:	85%	85%	85%[1]
Skilled Nursing Facility:	85%	75%	50%
Residential Treatment Center:	85%	75%	50%
Physical Rehabilitation Facility:	85%	75%	50%
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	85%	75%	50%
Newborn Nursery:	85%	75%	50%
Physician Expenses:	85%	75%	50%
Radiology/Pathology Charges:	100%	100%	50%
Surgery:	85%	75%	50%
Mental Health or Substance Use Facility (Non-Emergency Services):	85%	75%	50%[1] [2]
Mental Health or Substance Use, Physician Charges (Non-Emergency Services):	85%	75%	50%[1] [2]
Mental Health or Substance Use Facility (Emergency Room Admissions):	85%	85%	85%[1] [2]

MEDICAL SCHEDULE OF BENEFITS CONTINUED

Percentage of covered Benefits after deduction is met: **INPATIENT HOSPITAL SERVICES:** Preauthorization required except emergency room admissions	**In-Network** **Tidelands Health:**	**PPO:**	**Out-of-Network** **Non-PPO:**
Mental Health or Substance Use, Physician Charges (Emergency Room Admissions):	85%	85%	85%[1] [2]
Cardiac Rehabilitation:	85%	75%	50%
Anesthesia:	85%	75%	50%[1] [2]

[1]When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

[2]Non-PPO provider **at a PPO Provider Facility**: When services are received **from a Non-PPO provider in a PPO Provider Facility**, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

OUTPATIENT SERVICES:	**Tidelands Health:**	**PPO:**	**Non-PPO:**
Hospital and Ambulatory Surgical Center Charges:	85%	75%	50%[1] [2]
Hospital and Physician Charges (Non-Emergency Services):	85%	75%	50%[1] [2]
Emergency Room Charges:	85%	85%	85%
Emergency Room Physician Charges:	85%	85%	85%
Preadmission Testing:	85%	75%	50%[1] [2]
Anesthesia:	85%	75%	50%[1] [2]
Cardiac Rehabilitation:	85%	75%	50%[1] [2]
Mental Health or Substance Use (Non-Emergency Services): Preauthorization required	85%	75%	50%[1] [2]
Mental Health or Substance Use (Emergency Room) charges:	85%	85%	85%[1] [2]
Diagnostic Laboratory:	*100%	75%	50%
Diagnostic X-ray and Imaging (including MRI, CAT Scan):	85%	75%	50%
Diagnostic Pathology and Radiology Physician:	*100%	*100%	50%[1] [2]

[1]When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

[2]Non-PPO provider **at a PPO Provider Facility**: When services are received **from a Non-PPO provider in a PPO Provider Facility**, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

MEDICAL SCHEDULE OF BENEFITS CONTINUED

Remote Workers:

- **Employees who work remotely and are classified as telework positions, and who live 50 miles or more from a Tidelands Health hospital, will receive benefits at the Tidelands Health network level of benefits when they receive services from PPO providers within the Preferred Blue network, in South Carolina.**
- **Beginning January 1, 2024, remote workers in North Carolina will receive benefits at the Tidelands Health network level of benefits when they receive services from PPO providers within the MedCost Network.**
- **Remote workers in all other states outside of South Carolina or North Carolina will receive benefits at the Tidelands Health network level of benefits when they receive services from PPO providers within the PHCS network.**

PHYSICIAN OFFICE SERVICES:	Tidelands Health:	PPO:	Non-PPO:
Physician Office Visit: Including Labs, X-ray, Pathology, Radiology, Mental Health Care (including, but not limited to, Marriage/Family Counseling and Psychological Testing), Substance Use, Surgery, Supplies, and Injections provided in the Physician's office—Note: If sent to outside lab, etc., deductible and coinsurance apply			
Primary Care Physician: General Practitioners, Obstetricians, Gynecologists, Internists, Pediatricians and Mixed Specialty—Mental Health Care and Substance Use covered as Primary Care Physician—Nurse Practitioners and Physician's Assistant are covered	$25 Copay, then *100%	$50 Copay, then *100%	50%
Specialty Physician:	$50 Copay, then *100%	$100 Copay, then *100%	50%
Telehealth/Telemedicine:			
Primary Care Physician:	$25 Copay, then *100%	$50 Copay, then *100%	Not Covered
Specialty Physician:	$50 Copay, then *100%	$100 Copay, then *100%	
Allergy Services: Copay waived if visit is for Allergy Injections only	$50 Copay, then *100%	$100 Copay, then *100%	50%
Covid-19 Test:	*100%	*100%	50%
Pathology, Radiology, Labs, Supplies, Injections, or X-rays associated with Office Visit but billed separately:	85%	75%	50%
MRI or CAT Scan:	85%	75%	50%
Birth Control Device Surgery: Includes IUD, Implanon and Norplant	*100%	*100%	50%

Note: Obstetric services, dialysis and second surgical opinion performed in physician's office are subject to the deductible and coinsurance.

MEDICAL SCHEDULE OF BENEFITS CONTINUED

OTHER SERVICES:	Tidelands Health:	PPO:	Non-PPO:
Hospice Care: Preauthorization required	85%	75%	50%
Home Health Care: Preauthorization required	85%	75%	50%
Durable Medical Equipment: **Preauthorization is required if $1500 or more—Includes Insulin Pump Supplies**	85%	$1500 deductible then 85%	50%
Urgent Care: • ***Doctors Care (Tidelands Health affiliation*** for offices in Conway, Georgetown, Little River, Murrells Inlet, Myrtle Beach, North Myrtle Beach and Surfside Beach (SC))	85%	75% 100%, after copay	50%
Second Surgical Opinion (not mandatory)**:**	85%	75%	50%
Organ/Tissue Transplants: Preauthorization required—Please see page 32 for further details	85%	75%	50%
Air Ambulance Service:	85%	85%	85%[1] [2]
Ground Ambulance Service:	85%	85%	85%[1] [2]
Psychological Testing other than at Physician's Office:	85%	75%	50%
Physical/Occupational/Speech Therapy:	85%	75%	50%
Radiation Therapy and Chemotherapy:	85%	75%	50%
Temporomandibular Joint Disorder (TMJ):	85%	75%	50%
Morbid Obesity Surgery: Subject to the limits and conditions shown in the Benefits section	85%	75%	Not Covered
Diagnostic Colonoscopy:	*100%	*100%	Not Covered
Bone Density Scan:	*100%	Not Covered	Not Covered
Diabetic Self-Management Education: Includes Supplies and Training	85%	85%	85%
Impacted Wisdom Teeth: Payable only if Participant does not have dental coverage	Not Covered	75%	50%
Accidental Injury to Natural Teeth:	Not Covered	75%	50%
Oral Surgery:	Not Covered	75%	50%
Cataract Surgery:	85%	75%	50%
Minimally Invasive Lumbar Discectomy (MILD):	85%	75%	50%
Private Duty Nursing:	85%	75%	50%
Covid Related Medical Treatment:	85%	75%	50%
All Other Covered Expenses:	85%	75%	50%

[1]When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

[2]Non-PPO provider **at a PPO Provider Facility**: When services are received **from a Non-PPO provider in a PPO Provider Facility**, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

MEDICAL SCHEDULE OF BENEFITS CONTINUED

WELLNESS SERVICES	Tidelands Health:	PPO:	Non-PPO:
Annual Physical Exam:	*100%	*100%	Not Covered
Annual Prostate Exam:	*100%	*100%	Not Covered
Annual Gynecological Exam:	*100%	*100%	Not Covered
Well-Child Care: Services performed in the physician office, including Immunizations	*100%	*100%	Not Covered
Flu Shots:	*100%	*100%	*50%
Covid-19 Vaccines:	*100%	*100%	*50%
Routine Colonoscopy:	*100%	*100%	Not Covered
Cologuard: Per ACA guidelines	NA	*100%	Not Covered
****Women's Evidence-Informed Preventive Care and Screenings (visit the website noted below for covered services and any limitations)**	*100%	*100%	50%
Routine Mammograms: One mammogram is covered between ages 35 and 39 and then one each year for women 40 and over.	*100%	*100%	50%
Nutritional Counseling Visit: Limited to one (1) visit per Benefit Year	*100%	Not Covered	Not Covered
Blue Cross and Blue Shield of S.C. Mammography Network Provider:			
Routine Mammogram: Blue Cross Blue Shield of S.C. Mammography Benefit—One mammogram is covered between ages 35 and 39 and then one each year thereafter for women 40 and over.		*100%	

For information on Women's preventive care go to the following website: www.healthcare.gov/preventive-care-women or http://www.hrsa.gov/womens-guidelines

**A list of the preventive services required by ACA can be found on the HHS website at: www.healthcare.gov/preventive-care-benefits

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are subject to all of the Prescription Drug Exclusions listed in this document.

Prescription Drugs are provided through the ProAct Prescription Drug Program. ProAct uses the Medi-Span defined drug/therapeutic classification for product coverage and exclusion. Outpatient Prescription Drugs will be covered in this manner:

Note: Prescription Drug Out-of-Pocket maximum will be the Tidelands Health level.

Family Pharmacy (Tidelands Health):

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

Generic Drug	$5 Copay, then 100%
Brand Name Drug	$35 Copay, then 100%
Non-Preferred Drug	$60 Copay, then 100%

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

Generic Drug	$12.50 Copay, then 100%
Brand Name Drug	$50 Copay, then 100%
Non-Preferred Drug	$80 Copay, then 100%

Participating Pharmacies:

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

Generic Drug	$25 Copay, then 100%
Brand Name Drug	$55 Copay, then 100%
Non-Preferred Drug	$80 Copay, then 100%

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

Generic Drug	$25 Copay, then 100%
Brand Name Drug	$75 Copay, then 100%
Non-Preferred Drug	$110 copay, then 100%

Specialty Drugs (31-day supply):

Family Pharmacy	30% up to $150 maximum
All Other Retail Pharmacies	30% up to $200 maximum
Walgreens and CVS	30% up to $300 maximum

Participant is charged the difference between Brand Name and Generic cost, only if the Participant requests the Brand. (Participant will not be charged the difference if the Physician requests the Brand.)

Copay tier to be charged for Brand: Tier 2

Prescription drugs for Smoking Cessation will be covered at $0 Copay at Family Pharmacy.

Diabetic supplies: $5 Copay for 31-day supply, $15 for 90-day supply at Family Pharmacy.

Coverage for Covid-19 OTC (over-the-counter) test kits and antivirals used to treat Covid-19 (eg. Paxlovid, Lagevrio) will be determined by plan design relating to formulary placement.

Note: For information regarding generic and brand/formulary drugs, contact ProAct 877-635-9545 or online at Proactrx.com or by email at Support@ProActRx.com.

All Prescription Drugs are covered unless an exclusion applies except for the Prescription Drugs listed on the Schedule of Benefits.

Prescription Drugs that are not covered under the Plan of Benefits

Anorexiants (Diet Aids)
Cosmetic Drugs – including hair loss drugs, anti-wrinkle creams, hair removal creams and others
Acne products like tretinoin when used for cosmetic purposes only
Blood Glucose Monitoring Units
Blood Glucose Monitoring Watch
Fertility Agents – Oral
Fertility Agents – Injectable

Prescription Drugs that require Prior Authorization under the Plan of Benefits

Chantix
Growth Hormones
Multiple Ingredient Compounds that are $150 or more

CanaRx International Pharmacy

Employees could receive a 90-day supply of their Brand name prescription medications through Tidelands Health CanaRx international pharmacy. Tidelands Health CanaRx is a voluntary program and does not replace your current prescription Benefit Plan.

CanaRx includes hundreds of brand name drugs and provides these Benefits:
- $0 Copay for all prescriptions offered through the program
- Prescriptions shipped directly to your home with no shipping and handling costs
- No out-of-pocket expenses

To learn more about the drugs available through CanaRx and how to take advantage of this program:
- Phone 866-893-(MEDS) 6337
- Website www.TidelandsHealthCanaRx.com
- WebID: **TIDELANDS**

Noble Health Services- Specialty Pharmacy

Specialty medications often require a little extra attention to treat complex and chronic conditions. Specialty medications cost substantially more than traditional medications. Fill specialty medications at Noble Specialty Pharmacy, and Noble applies for any co-pay assistance on your behalf. Connect with Noble Specialty Pharmacy by contacting Noble Health Services at 888-843-2040 or email at ContactUs@NobleHealthServices.com

MEDICAL BENEFITS

A. Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will be paid only for Benefits:

1. Performed or provided on or after the Covered Member Effective Date;
2. Performed or provided prior to termination of coverage;
3. Provided by a Provider, within the scope of his or her license;
4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from PAI (the Covered Member should refer to the Schedule of Benefits for services that require Preauthorization);
5. That are Medically Necessary;
6. That are not subject to an exclusion of this Plan of Benefits;
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copays.

B. Specific Covered Benefits

If all of these requirements are met, the Group Health Plan will provide the Benefits described in this section:

1. All of the requirements of this Benefits Section must be met;
2. The Benefit must be listed in this section;
3. The Benefit (separately or collectively) must not exceed the dollar amount or other limitations contained on the Schedule of Benefits;
4. The Benefit must not be subject to one or more of the exclusions set forth in the Exclusions and Limitations Section.

The Group Health Plan will provide:

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

   a. The transport is Medically Necessary and reasonable under the circumstances;

   b. A Participant is transported;

   c. The destination is local within the United States; and,

   d. The facility is medically appropriate to treat the Participant’s condition.

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

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

a. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Participant's illness or injury (such as burn care, cardiac care, trauma care, and critical care);

b. The second Hospital is the nearest medically appropriate facility to treat the Participant's illness or injury;

c. A ground ambulance transport would endanger the Participant's medical condition; and,

d. The transport is not related to a hospitalization outside the United States.

2. Covered Expenses made by an **Ambulatory Surgical Center** or minor emergency medical clinic.
3. Covered Expenses for the cost and administration of an **anesthetic**; however, anesthesia rendered by the attending surgeon or his/her assistant is excluded.
4. Covered Expenses for **artificial limbs or breast prosthesis**, to replace body parts when the replacement is necessary because of physiological changes.
5. 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.
6. Covered Expenses for the treatment of **autism.**
7. **Blood transfusions**, including cost of blood, blood plasma, blood plasma expanders and other blood products not donated or replaced by a blood bank.
8. Charges for **Bone Density Scan.**
9. Phase II **cardiac rehabilitation** (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.
10. Charges incurred for Routine Participant Costs for items and services related to **clinical trials** are covered when:

    A. The Participant has cancer or other life-threatening disease or condition;

    B. The referring Provider is a Participating Provider that has concluded that the Participant's involvement in such a trial would be appropriate;

    C. The Participant provides medical and scientific information establishing that the Participant's involvement in such a trial would be appropriate;

    D. The services are furnished in connection with an Approved Clinical Trial.

    Group Health Plans may not:

    A. Deny a Qualified Individual participation in an Approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or condition;

    B. Deny (or limit or impose additional conditions on) a Qualified Individual the coverage of Routine Participant Costs for items and services furnished in connection with participation in the trial;

    C. Discriminate against an individual on the basis of the individual's participation in the trial.

    USE OF IN-NETWORK PROVIDERS: If one or more Participating Providers participate in an Approved Clinical Trial, then the Plan requires that the Qualified Individual participate in the trial through a Participating Provider accepting patients for the trial.

    USE OF OUT-OF-NETWORK PROVIDERS: Qualified Individuals participating in Approved Clinical Trials conducted outside the State in which the Qualified Individual resides will receive out-of- network Benefits for Routine Participant Costs.

11. Charges for **Colonoscopies.**
12. Initial **contact lenses or** one pair of **eyeglasses** required following cataract surgery;
13. Covered Expenses for **cosmetic surgery**, only for these situations:

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

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

C. When required for the medical care and treatment of a cleft lip and palate.

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

14. 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.

15. **Diabetic Self-Management Education**—Coverage will be provided for equipment, supplies and outpatient self-management training and education for the treatment of covered persons with diabetes mellitus. Diabetes outpatient self-management training shall be provided by a registered or licensed health care professional with certification in diabetes by either the National Certification Board of Diabetes Educators, State of South Carolina (certified through the Department of Health and Human Services), or approved by the Diabetes Initiative of South Carolina and the South Carolina Department of Health and Environmental Control. These services must be medically necessary and preapproved by Tidelands Health. Benefit year deductible, any applicable per-occurrence deductibles and Copays will apply to this benefit.

16. Covered Expenses for Prescription **Drugs** requiring a written prescription of a licensed Physician; such drugs must be necessary for the treatment of an illness or injury.

17. Covered Expenses for **Durable Medical Equipment** (such as renal dialysis machines, resuscitators, or Hospital-type beds), required for temporary therapeutic use in the Covered Member's home by an individual patient for a specific condition when such equipment ordinarily is not 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 the Plan supervisor. 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. **Preauthorization required for expenses of $1500 or more**.

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

19. Covered Expenses for **Emergency Services** will be paid for the treatment of Emergency Medical Conditions. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital emergency room or department and only for as long as the condition continues to be considered an Emergency Medical Condition, unless otherwise required by applicable law.

20. Covered Expenses for Preauthorized **Home Health Care** when rendered to a homebound Covered Member in the Covered Member's current place of residence.

21. Covered Expenses for Preauthorized **Hospice Care** provided in an inpatient or outpatient setting.

22. **Hospital Covered Expenses** for:

A. Daily room and board charges in a Hospital, not to exceed the daily semiprivate room rate (charges when a Hospital private room has been used will be reimbursed at the average semiprivate 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 Covered Member 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 Covered Member 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 Covered Member 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 well newborn care for nursery room and board and for professional service. Eligible expenses will be subject to the fee schedule rates for pediatric services and circumcision;

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

23. **Mammograms**.

24. Covered Expenses for **maternity care**.

25. Any expenses incurred in obtaining **medical records** in order to substantiate Medical Necessity.

26. Covered Expenses for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces (not dental braces) or other **Medical Supplies** determined by the Plan to be appropriate for treatment of an illness or injury.

27. Covered Expenses for **Mental Health Services** if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker or licensed professional counselor. Nurse Practitioners are covered. Expenses for Psychological Testing are also covered.

28. Charges for **Minimally Invasive Lumbar Discectomy (MILD)**.

29. Charges for surgical treatment of **Morbid Obesity** are covered as shown in the Medical Schedule of Benefits provided:
    A. the Covered Member is morbidly obese as described below and meets all of the following criteria:
        a. have a Body Mass Index (BMI) of 40 or greater, or
        b. have a Body Mass Index (BMI) of 35 associated with at least <u>one</u> of the following problems:
            (1). there is significant respiratory insufficiency or sleep apnea documented by respiratory function studies, blood gases, sleep studies, etc.;
            (2). there is significant circulatory insufficiency documented by objective measurements;
            (3). there is documentation that management of primary diseases such as arteriosclerosis, diabetes, heart disease, hypertension, etc., is significantly (e.g., requiring prescription drug treatment) complicated by morbid obesity;
    B. Morbid obesity has been present for four of the previous five years;
    C. The Covered Member has no specifically correctable cause for the obesity, e.g., an endocrine disorder;
    D. The Covered Member has achieved full growth (for adolescents-bone age shows closure or epiphyseal plates);
    E. A thorough evaluation has been documented to assess the patient's suitability for surgery and their ability to comply with lifelong follow up, must include <u>all</u> of the following:
        a. Evaluation of the patient's understanding of the procedure to be performed, including the procedure's risks and benefits, behavioral changes prior to and after the surgical procedure (including dietary and exercise requirements), follow up requirements with the performing surgeon, and anticipated psychological changes.
        b. Evaluation of the Covered Member's family/caregivers support and understanding of the information listed above.
        c. Nutritional/dietary assessment by a nutritionist/dietician, as well as follow up plans.
        d. Psychological assessment of the Covered Member's ability to understand and adhere to the program by a mental health professional to include assessment of any diagnosable mental health conditions that may affect treatment, readiness, and ability to adhere to required lifestyle modifications and follow up/social support. Medical clearance for surgery;
        e. Surgery for morbid obesity is eligible for coverage when it is part of a comprehensive pre-surgical, surgical, and post-surgical program.

30. Covered Expenses for **newborn care**. 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 length of Hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section

(not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, PAI may not require that a Provider obtain authorization from PAI for prescribing a length of stay not more than forty-eight (48) or ninety-six (96) hours as applicable. Nevertheless, Preauthorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

31. Covered Expenses for the treatment and services rendered by an **occupational therapist** in a home setting, at a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing outpatient facility.

32. Covered Expenses for these **oral surgical procedures**:

    A. Excision of any impacted teeth if Covered Member does not have Dental coverage;

    B. Open or closed reduction of a fracture or dislocation of the jaw;

    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.

33. Charges for **Organ/Tissue Transplant** procedures subject to the limitations shown in the Human Organ and Tissue Transplant Procedures section of this Plan.

34. Medically necessary **orthotics and treatment for flat feet** will be covered, subject to prior preauthorization.

35. Covered Expenses for **oxygen** and other gases and their administration.

36. Covered Expenses incurred for Admission in a **physical rehabilitation facility or Skilled Nursing Facility**, for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment. The Covered Member must be under the continuous care of a Physician, and the attending Physician must certify that the individual requires nursing care 24 hours a day. Nursing care must be rendered by a registered nurse or a licensed vocational or practical nurse. The confinement cannot be primarily for domiciliary, custodial, personal-type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis, or mental disorders.

37. Covered Expenses for the treatment or services rendered by a **physical therapist** in a home setting, a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing duly licensed outpatient therapy facility.

38. Covered Expenses 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:

    In-Hospital medical service consists of a Physician's visit or visits to a Covered Member 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:

    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;

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

        i. 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 postoperative care but requires supplemental skills not possessed by the attending surgeon or his assistant;

        ii. When a Physician other than a surgeon admits a Covered Member 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;

iii. When the surgical procedure performed is designated by the Plan supervisor as a "warranted diagnostic procedure" or as a "minor surgical procedure."

39. **Preadmission 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:

    A. Must be made within seven (7) days prior to Admission;

    B. Must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the illness or injury for which the Covered Member is subsequently admitted to the Hospital.

40. **Preventive services** are covered according to:

    A. United States Preventive Services Task Force (USPSTF recommendations Grade A or B);

    B. Centers for Disease Control and Prevention (CDC) recommendations for immunizations;

    C. Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screening.

    D. Women's preventive services as provided under the Affordable Care Act (ACA). For additional information on Women's preventive services go to: www.healthcare.gov/preventive-care-benefits

    These Benefits are provided without any cost-sharing by the Covered Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as shown in the Schedule of Benefits. Note: Bone density is performed only at the Tidelands Health network level. The full list of covered women's preventive services can be found on the HHS website at: http://www.hrsa.gov/womens-guidelines

41. Covered Expenses for **Private Duty Nursing**.

42. Covered Expenses for **radiation therapy** or treatment, and **chemotherapy**.

43. Covered Expenses at a **Residential Treatment Center.**

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

45. Fees of a licensed **speech therapist** for restorative speech therapy for speech loss or impairment due to:

    A. Surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy).

    B. An injury or illness.

46. Covered Expenses for **Substance Use** treatment will be payable if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker or licensed professional counselor. Nurse practitioners are covered. Services or charges for Detoxification are also covered.

47. Covered Expenses for **surgical procedures**, subject to:

    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 Review 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 prorated between them by the Plan supervisor when so required by the Physician in charge of the case;

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

48. Treatment of dysfunctional conditions related to the muscles or mastication, malposition, or deformities of the jaw bones(s), orthognathic deformities, or **Temporomandibular Joint (TMJ) disorders.**

49. Covered Expenses for services for **voluntary sterilization** for Covered Members.

50. Covered Expenses for **x-rays**, microscopic tests, and **laboratory tests**.

HUMAN ORGAN OR TISSUE TRANSPLANT BENEFITS

When Preauthorized by *Coordinated Health/Care* (and performed by a Provider *Coordinated Health/Care* designates), Benefits are payable for all expenses for medical and surgical services and supplies incurred while covered under this Plan of Benefits for human organ/tissue Transplants as indicated in these paragraphs. The Benefits are subject to the Benefit Year Deductible amount, Coinsurance percentage and/or money maximum specified in the Medical Schedule of Benefits.

1. Benefits are available for human organ, tissue, and bone marrow transplantation, subject to determination made on an individual, case-by-case basis in order to establish Medical Necessity. Preauthorization must be obtained in writing from the Medical Review 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 Covered Member, the Benefits of the Plan 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 Covered Member, the donor will receive Benefits for care and services necessary to the extent that such Benefits are not provided under any recipient who is not a Covered Member under this Plan of Benefits. The recipient will not be eligible for Benefits when only the donor is a Covered Member.
5. When both the recipient and the donor are Covered Members, Benefits will be provided for both in accordance with the respective Group Health Plan Covered Expenses.

Health care Benefits for Transplants include Covered Expenses such as patient workup, travel (as specified below), pre-Transplant care, the Transplant, post-Transplant care, and immunosuppressive drugs (while inpatient).

***Transplant Travel Expense Services**

Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a Preauthorized organ/tissue Transplant from a Preauthorized, in-network Transplant facility.

Health care Benefits for Transplant travel services are subject to the Transplant travel Benefit maximum of $5,000 and include coverage for travel expenses incurred by you or your covered Dependent as well as for charges resulting from transportation, lodging (up to $150 a day) and food (up to $75 a day) associated with a Preauthorized organ/tissue Transplant.

These Benefits are not subject to any individual or family deductible shown in the Medical Schedule of Benefits referenced within this document. These Benefits are only available if you or your Dependent is the recipient of an organ/tissue Transplant. No Benefits are available if you or your Dependent is a donor.

The term "recipient" is defined to include you or your covered Dependent regarding Preauthorized Transplant-related services during any:

a) Evaluation;

b) Candidacy;

c) Transplant event;

d) Post-Transplant care.

Travel expenses for the person receiving the Transplant will include charges for:

a) Transportation to and from the Transplant site (including charges for a rental car used during a period of care at the Transplant facility);

b) Lodging while at or traveling to and from the Transplant site;

c) Food while at or traveling to and from the Transplant site.

The charges associated with the items a), b) and c) above also will be considered covered travel expenses for one companion to accompany you. The term companion includes a spouse, family member, legal guardian of you or your Dependent, or any person not related to you but actively involved as your caregiver.

By way of example, but not of limitation, travel expenses will not include any charges for:

a) Transplant travel Benefit costs incurred due to travel within 60 miles of your home;

b) Laundry bills;

c) Telephone bills;

d) Alcohol or tobacco products;

e) Transportation charges that exceed coach class rates.

MEDICAL EXCLUSIONS AND LIMITATIONS

Notwithstanding any provision of the Plan to the contrary, if the Plan generally provides Benefits for a type of injury, then in no event shall a limitation or exclusion of Benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions), even if the medical condition is not diagnosed before the injury.

1. Any service or supply that is not **Medically Necessary**.
2. Charges incurred as a **result of declared or undeclared war or any act of war** or caused during service in the armed forces of any country.
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 expenses**, whether or not recommended by a Physician.
5. Any medical **social services, recreational or Milieu Therapy, education testing or training**, except as part of Preauthorized Home Health Care or Hospice Care program.
6. **Vitamins, 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 Medical 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 Covered Member 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 **workers' compensation laws**, the Veteran's Administration for care rendered for service-related disability, or any state or federal Hospital services for which the Covered Member is not legally obligated to pay. This exclusion applies if the Covered Member 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 the Covered Member is entitled to payment or Benefits under any **state or federal** program that provides health care benefits, including Medicare, but only to the extent Benefits are paid or are payable under such programs.
10. Charges incurred for which the Covered Member is not in the absence of this coverage **legally obligated** to pay or for which a charge would not ordinarily be made in the absence of this coverage.
11. Any illness or injury received, directly or indirectly, related to and/or contributed to, in whole or in part, while committing or attempting to commit a felony or while engaging or attempting to engage in an **illegal act or occupation**.
12. Charges incurred for services or supplies that constitute **personal comfort or beautification items**, such as television or telephone use.
13. All **cosmetic procedures** and any related **medical supplies,** in which the purpose is improvement of appearance or correction of deformity without restoration of bodily function. Examples of services that are cosmetic and are not covered are: rhinoplasty (nose); mentoplasty (chin), rhytidoplasty (face lift); surgical planing (dermabrasion); and blepharoplasty (eyelid).
14. Charges for **custodial care,** including sitters and companions**.**
15. Charges which are not necessary for treatment of an active illness or injury or are more than 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 Covered Member's diagnosis and/or treatment of the Covered Member's 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. Any Medical Supplies or services rendered by a Covered Member to himself or herself or by a Covered Member's **immediate family** (parent, Child, spouse, brother, sister, grandparent, or in-law).
18. 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.
19. Charges incurred in connection with **routine vision care, eye refractions, the purchase or fitting of eyeglasses, contact lenses, non-prescription lenses or hardware, hearing aids, 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.
20. Charges incurred for treatment on or to the **teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes**.
21. **Infertility—**Services, supplies or drugs related to any treatment for infertility, including, but not limited to, fertility drugs, gynecological or urological procedures; the purpose of which is primarily to treat infertility, artificial insemination, in-vitro fertilization, reversal of sterilization procedures, any charges related to surrogacy and surrogate parenting.
22. **Experimental or Investigational** services, including surgery, medical procedures, devices, or drugs. The Group Health Plan reserves the right to approve, upon medical review, non-labeled use of chemotherapy agents that have been approved by the Food and Drug Administration (FDA) for cancer.
23. Charges incurred for treatment or supplies of weak, strained, or **flat*,** unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses, or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease and except surgery for ingrown toenails).

    *Medically necessary orthotics and treatment for flat feet will be covered, subject to preauthorization.
24. 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.
25. Any service or treatment for complications resulting from any **non-covered procedures**.
26. Any service or supply rendered to a Covered Member for the diagnosis or treatment of **sexual dysfunction** (including impotence) except when Medically Necessary due to an organic disease.
27. Any charges for **elective abortions,** except for abortion performed in accordance with federal Medicaid guidelines.
28. Charges for a **Dependent Child's pregnancy**, including abortions, except for pregnancy as the result of a criminal act. Limited prenatal coverage will be provided in accordance with ACA's Women's Evidence-Informed Preventive Care and Screenings guidelines.
29. Charges not included as part of a Hospital bill for autologous **blood donation** that involves collection and storage of a patient's own blood prior to elective surgery.
30. Charges incurred for **take-home drugs** upon discharge from the Hospital.
31. **Sitters** or **companions.**
32. **Spare items** of the nature of braces of the leg, arm, back and neck, artificial arms, legs or eyes, lenses for the eye, or hearing aids, unless needed due to physiological changes.
33. Care and treatment of **hair loss**.
34. **Exercise programs** for treatment of any condition.
35. Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket, or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or

stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, non-Prescription Drugs, and medicines, first aid supplies and non-Hospital adjustable beds.

36. **Acupuncture or hypnosis**, except when performed by a Physician in lieu of anesthesia.
37. Care and treatment for **sleep apnea**, unless Medically Necessary.
38. **Prescription drugs used for or related to cosmetic purposes, hair growth or fertility** unless noted as covered under the Medical Schedule of Benefits or the Prescription Drug Benefits.
39. Charges that exceed any **Benefit limitations** stated in the Medical Schedule of Benefits of this Plan document.
40. Charges for **Chiropractic Care.**
41. Admissions or portions thereof for **custodial care or long-term care** including:
    A. Rest cares;
    B. Long-term acute or chronic psychiatric care;
    C. Care to assist a Covered Member in the performance of activities of daily living (including, but not limited to walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
    D. Care in a sanitarium;
    E. Custodial or long-term care;
    F. Psychiatric or Substance Use residential treatment when provided at therapeutic schools; wilderness/boot camps; therapeutic boarding homes; halfway houses; and therapeutic group homes.
42. **Counseling and psychotherapy services** for these conditions are not covered:
    A. Feeding and eating disorders in early childhood and infancy;
    B. Tic disorders, except when related to Tourette's disorder;
    C. Elimination disorders;
    D. Mental disorders due to a general medical condition;
    E. Sexual function disorders;
    F. Sleep disorders;
    G. Medication-induced movement disorders;
    H. Nicotine dependence, unless specifically listed as a covered Benefit in the Plan of Benefits or on the Medical Schedule of Benefits.
43. Medical supplies, services or charges for the diagnosis or treatment of sexual and gender identity disorders, personality disorders, learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, mental retardation, or vocational rehabilitation.
44. Expenses for any **treatment administered outside of the United States** if the Participant traveled to the location where the treatment was received for the purpose of obtaining the treatment.
45. **Prescription Drug Exclusions** under this Plan of Benefits:
    A. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, ostomy supplies and non-medical substances regardless of intended use;
    B. Any over-the-counter medication, unless specified otherwise;
    C. Blood products, blood serum;
    D. Prescription Drugs that have not been prescribed by a Physician;
    E. Prescription Drugs not approved by the Food and Drug Administration;
    F. Prescription Drugs for non-covered therapies, services, or conditions;

G. 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 or ninety (90) day supply for Prescription Drugs obtained through the Tidelands Health Family Pharmacy or Retail Pharmacy or unless the quantity is limited by a Quantity Management Program;

H. Any type of service or handling fee (except for 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;

I. 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;

J. 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;

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

L. 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);

M. Prescription Drugs that are not consistent with the diagnosis and treatment of a Covered Member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;

N. Prescription Drugs or services that require Preauthorization by PAI and Preauthorization is not obtained;

O. Prescription Drugs for injury or disease that are paid by workers' compensation benefits (if a workers' compensation claim is settled, it will be considered paid by workers' compensation benefits);

P. Prescription Drugs that are not Medically Necessary;

Q. Prescription Drugs that are not authorized when a part of a Step Therapy program.

46. **Behavioral, Educational, or Alternate Therapy Programs:**

Any behavioral, educational, or alternative therapy techniques to target cognition, behavior language and social skills modification, including:

A. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;

B. Higashi schools/daily life;

C. Facilitated communication;

D. Floor time;

E. Developmental Individual—Difference Relationship-based model (DIR);

F. Relationship Development Intervention (RDI);

G. Holding therapy;

H. Movement therapies;

I. Music therapy;

J. Animal assisted therapy.

47. **Home Health Care Exclusions**:

A. Services and supplies not included in the Medical Schedule of Benefits, but not limited to, general housekeeping services and services for custodial care;

B. Services of a person who ordinarily resides in the home of the Covered Member, or is a Covered Member's immediate family member (parent, Child, spouse, brother, sister, grandparent, or in-law);

C. Transportation services.

Notwithstanding the above exclusions, in the event that, after review of the medical records, other documentation, and case notes, the health care management medical director (or similarly titled position) of Coordinated Health/Care (CHC), deems a plan of treatment and procedures are appropriate care for a Covered Member, the Plan shall deem the cost of the plan of treatment and procedures a Covered Expense.

ELIGIBILITY FOR COVERAGE

Eligibility:	
Waiting Period:	For Employees whose date of hire (or date of movement into a Benefit eligible status) falls on the first day of the month, the Eligibility date is the first day of the following month. For Employees, whose date of hire (or date of movement into a Benefit eligible status) falls on any day other than the first day of the month, the Eligibility date is the first day of the month following the completion of thirty (30) days of full-time employment. Employees moving from full-time to part-time status and part-time to full-time do not have to satisfy the new Waiting Period requirement. Individuals who exit Tidelands Health employment and return to Tidelands Health employment within 45 calendar days from the most recent exit date will not serve a new Waiting Period for all Benefits in which they were enrolled at the time employment terminated. Residents are eligible for Benefits as of their date of hire.
Actively at Work: Full-time Employees: Part-time Employees:	 At least 64-80 hours per biweekly pay period At least 40-63 hours per biweekly pay period
Dependent Child, in addition to meeting the requirements contained in the Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	An Employee may cover a Dependent Child up to the end of the calendar month during which the Dependent Child reaches age 26 for medical Benefits.
Coverage for Covered Members will terminate on the last day of the month in which employment is terminated.	

A. ELIGIBILITY

1. Every Employee who is Actively at Work and who has completed the Waiting Period on or after the Employer Effective Date is eligible to enroll (and to enroll his or her Dependents) for coverage under this Plan of Benefits.
2. If an Employee is not Actively at Work or has not completed the Waiting Period, such Employee is eligible to enroll (and to enroll his or her Dependents) beginning on the next day that the Employee is:
   a. Actively at Work;
   b. Has completed the Waiting Period.
3. Dependents are not eligible to enroll for coverage under Plan of Benefits without the sponsorship of an Employee who is enrolled under this Plan of Benefits.

B. ELECTION OF COVERAGE

Any Employee may enroll for coverage under the Group Health Plan for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Plan Sponsor. Every eligible Employee may enroll eligible Dependents. However, if both the husband and wife are Employees, they may choose to have one covered as the Employee, and the spouse covered as a Dependent of the Employee, or they may choose to have both covered as Employees. Eligible children may be enrolled as Dependents of one spouse, but not both. Dependents must be enrolled within thirty (30) days of the date on which they first become Dependents. Employees and Dependents also may enroll if eligible under the terms of any late enrollment or Special Enrollment procedure.

Employees who do not enroll within thirty (30) days from date of hire must wait until the Annual Enrollment Period (**month of August)** to enroll for coverage unless eligible for Special Enrollment. Coverage for employees enrolling during the Annual Enrollment Period will become effective on the first day of **October.**

C. COMMENCEMENT OF COVERAGE

Coverage under the Group Health Plan will commence as follows:

1. Employees and Dependents eligible on the Plan Sponsor Effective Date

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

   If PAI receives an Employee's Membership Application dated after the Plan Sponsor's Effective Date, coverage will commence as determined by the appropriate waiting period.

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

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

3. Dependents Resulting from Marriage

   Dependent(s) resulting from the marriage of an Employee will have coverage effective the date of marriage provided they have enrolled for coverage within thirty (30) days after marriage and the coverage has been paid for under this Plan of Benefits.

4. Newborn Children

   A newborn Child will have coverage from the date of birth provided he or she has been enrolled for coverage within thirty (30) days after the Child's birth and the coverage has been paid for under this Plan of Benefits.

5. Adopted Children

   For an adopted Child of an Employee, coverage shall commence as follows:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty (30) days after the date of the Child's birth.

   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty (30) days after the date of the Child's birth, and if the Employee has been awarded temporary custody of the Child.

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

6. Special Enrollment

   In addition to enrollment under Eligibility for Coverage Section (C)(2-5) above, the Group Health Plan shall permit an Employee or Dependent who is not enrolled to enroll if:

   a. The Employee or Dependent was covered under a group health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent;

   b. The Employee stated in writing at the time of enrollment that the reason for declining enrollment was because the Employee or Dependent was covered under a group health Plan or had Creditable Coverage at that time. This requirement shall apply only if the Plan Sponsor required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time;

c. The Employee or Dependent's coverage described above:

i. Was under a COBRA continuation provision and the coverage under the provision was exhausted;

ii. Was not under a COBRA continuation provision described in section 6(c)(i), above, and either the coverage was terminated because of loss of eligibility for the coverage (including because of legal separation, divorce, death, termination of employment) or reduction in the number of hours of employment), or if the Plan Sponsor's contributions toward the coverage were terminated;

iii. Was one of multiple Plans offered by a Plan Sponsor and the Employee elected a different Plan during an open enrollment period or when a Plan Sponsor terminates all similarly situated individuals;

iv. Was under a HMO that no longer serves the area in which the Employee lives, works, or resides;

v. Under the terms of the Plan, the Employee requests the enrollment not later than thirty (30) days after date of exhaustion described in 6(c)(i) above, or termination of coverage or Plan Sponsor contribution described in 6(c)(ii) above.

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

D. CHANGES AFTER A LIFE EVENT

You may also make a change in your Benefit elections if you experience a Life Event during the year. New elections must be made within 30 days after the Life Event and must be consistent with your change in status. If you do not make a new election within this 30-day period, you must wait until the next annual enrollment. Documentation of the Life Event may be required. Notice and documentation of the Life Event should be submitted to the Human Resources Department. Life Events are:

- Change in your legal marital status—examples are marriage, divorce, annulment, or death of your spouse;
- Change in the number of your Dependents—such as the birth or adoption of a Child, legal guardianship, or the death of a Dependent;
- Change in a Dependent's eligibility—such as a Child exceeding the dependent-Child age limit;
- Termination or commencement of employment—for you, your spouse, or your Dependent child;
- Change in your residence—if you move outside your current medical coverage area and your current Medical plan option is not available;
- A loss of Other Coverage – due to lifetime maximum limit on all Benefits is realized;
- A gain or loss of eligibility for coverage—under Medicare or Medicaid;
- Loss of Other Coverage—such as a loss of coverage under your spouse's Employer's plan. If the other coverage was COBRA coverage, the loss must occur because you exhausted COBRA coverage;
- Difference in the open enrollment period—between the Plan and the plan of your spouse or Dependent;
- A court order that legally requires you to provide coverage—for example, you receive a Qualified Medical Child Support Order (QMCSO).

When you marry, you may add your spouse, enroll yourself if you are not already enrolled, and add any eligible Children. If you have a new Child (by birth, adoption, or placement for adoption), you may add the new Child, and your spouse and enroll yourself if you are not already enrolled.

If you drop coverage for a Child in accordance with a QMSCO (court order), you must provide a copy of the court order and proof that the Child has coverage through your spouse (ex-spouse).

To be consistent with a change in election, your Life Event must affect your eligibility for coverage. For example, divorce is a Life Event enabling you to make a change in your coverage. Dropping coverage for your spouse and/or joining the plans if you were covered under your spouse's plan would be consistent. Dropping coverage for a Dependent Child at the same time would not be consistent since the Child's eligibility does not change because of the divorce (except stepchildren).

If you experience a Life Event, you must notify Human Resources within 30 days and indicate what new election you want to make. Documentation of the Life Event—such as a copy of a birth certificate for a new child—may be required. Human Resources will advise you if your new election does not satisfy the consistency rule.

Election changes you make because of a Life Event will be effective on the date of the life event. Coverage for a new Child (by birth or adoption) will begin on the date of birth or adoption (or placement).

Medicaid or State Children's Health Insurance Program Coverage

A. The Employee or Dependent was covered under a Medicaid or State Children's Health Insurance Program Plan and coverage was terminated due to loss of eligibility;

B. The Employee or Dependent becomes eligible for assistance under a Medicaid or State Children's Health Insurance Program Plan;

C. The Employee or Dependent requests such enrollment not more than sixty (60) days after either:

   i. the date of termination of Medicaid or State Children's Health Insurance Program coverage;

   ii. determination that the Employee or Dependent is eligible for such assistance.

You must request enrollment within 60 days of the documented date of notification from the agency.

E. DEPENDENT CHILD'S ENROLLMENT

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

F. COVERED MEMBER CONTRIBUTIONS

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

G. DISCLOSURE OF MEDICAL INFORMATION

By accepting Benefits or payment of Covered Expenses, the Covered Member agrees that the Group Health Plan (and including BlueCross on behalf of the Group Health Plan) may obtain claims information, medical records, and other information necessary for the Group Health Plan to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits.

TERMINATION OF THIS PLAN OF BENEFITS

A. TERMINATION OF THIS PLAN OF BENEFITS

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

1. The date the Plan Sponsor terminates the Plan and offers no other group health plan.
2. The date an Employee retires.
3. The date an Employee ceases to be eligible for coverage as set forth in the Eligibility Section.
4. The last day of the month in which employment is terminated. Note: An Employee may be considered Actively at Work during any leave taken pursuant to the Family and Medical Leave Act of 1993.
5. In addition to terminating when an Employee's coverage terminates, a Dependent spouse's coverage terminates on the date of entry of a court order ending the marriage between the Dependent spouse and the Employee regardless of whether such order is subject to appeal.
6. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Dependent under the Group Health Plan.
7. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent.
8. The date the Plan discontinues dependent coverage for any and all Dependents.
9. The date the Dependent becomes eligible for coverage as an Employee.
10. Death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

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

C. TERMINATION DUE TO A RESCISSION OF COVERAGE

If a Covered Member:

1. Performs an act, practice, or omission that constitutes fraud;
2. Makes an intentional misrepresentation of material fact.

The Covered Member's coverage under this Plan of Benefits will terminate retroactively at one of these times:

1. If event occurs upon application for participation in the Plan, the Covered Member's coverage will be void from the time of his/her effective date;
2. If event occurs at any other time, the Covered Member's coverage will terminate retroactively to the date of the event occurrence, as outlined above.

In the event your coverage is rescinded, you will be given 30 days' advance written notice of the Rescission as well as the retroactive effective date. Any Premiums paid will be returned once the Plan Administrator deducts the amount for any claims paid. A Covered Member has an internal appeal right following written notice of a Rescission of coverage as outlined within the Claims Filing and Appeal Procedures section of this document.

D. EXCEPTIONS TO TERMINATION PROVISIONS (DURING ABSENCE FROM EMPLOYMENT)

1. FMLA Qualified Leave of Absence

If the Covered Employee takes a qualified leave of absence as recognized by the Family and Medical Leave Act of 1993 (FMLA) or similar state law, coverage for the Employee and any covered Eligible Dependents may be continued for the duration of the qualified leave in accordance with the applicable FMLA provision. The Employee will be responsible for making any required contributions to the Plan.

2. Other Approved Leave of Absence

If a Covered Employee takes an approved leave of absence, coverage for the Employee and any covered Eligible Dependents may be continued as defined in Tidelands Health HR policies and procedures for FMLA and Non-FMLA Leaves of Absence. The Employee will be responsible for making any required contributions to this Plan.

E. REINSTATEMENT

If a Covered Member's coverage (and including coverage for the Covered Member's Dependents) for Covered Expenses under the Group Health Plan terminates while the Covered Member is on leave pursuant to the Family and Medical Leave Act because the Covered Member fails to pay such Covered Member's Premium, the Covered Member's coverage will be reinstated without new probationary periods if the Covered Member returns to work immediately after the leave period, re-enrolls and, within thirty (30) days following such return, pays all such Employee's portion of the past due amount and then current Premium.

F. PLAN SPONSOR IS AGENT OF COVERED MEMBERS

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

G. PERSONNEL POLICIES

Except as required under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Plan Sponsor's current personnel policies regarding Waiting Periods, continuation of coverage, or reinstatement of coverage shall apply during these situations: Plan Sponsor-certified disability, leave of absence, layoff, reinstatement, hire or rehire.

H. REHIRED EMPLOYEES

Individuals who exit Tidelands Health employment and return to Tidelands Health employment within 45 calendar days from the most recent exit date will not serve a new Waiting Period for all benefits in which they were enrolled at the time employment terminated.

I. 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 Waiting Period.

Notices:

As an Employee, Tidelands Health requires the Member to have a Primary Care Physician and it is highly recommended that all Dependents have a Primary Care Physician. A Member has the right to designate any Primary Care Physician who participates in the network and is available to accept the member or any of the member's family. If an out-of-network Primary Care Physician is selected, higher out-of-pocket expenses will apply.

You do not need prior authorization from Tidelands Health or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain

procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact PAI at 800-768-4375.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In the case of a Covered Member who is receiving Covered Expenses in connection with a mastectomy, the Group Health Plan will pay Covered Expenses for (if requested by such Covered Member):

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

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

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

The Plan of Benefits' Benefit Year Deductible and Copay will apply to these Benefits.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Group Health Plan must comply with FMLA as outlined in the regulations issued by the U.S. Department of Labor. During any leave taken under the FMLA, the Plan Sponsor 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.

In general, eligible Employees may be entitled to:

Twelve workweeks of leave in a 12-month period for:

- the birth of a Child and to care for the newborn Child within one year of birth;
- the placement with the Employee of a Child for adoption or foster care and to care for the newly placed Child within one year of placement;
- to care for the Employee's spouse, Child, or parent who has a serious health condition;
- a serious health condition that makes the Employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter, or parent is a covered military member on "covered active duty."

Twenty-six workweeks of leave in a single 12-month period to care for a covered service member with a serious injury or illness of a service member spouse, son, daughter, parent, or next of kin to the Employee (military caregiver leave).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

You, your spouse, and your Dependent children may be able to continue your health care coverage under certain circumstances when it would normally end. When continuation rights (also called COBRA rights) begin, what coverage you can continue, how long you can continue coverage and your cost for coverage are described in more detail below.

COBRA Qualifying Events

You, your spouse, and Dependent children will be able to continue health coverage when a Qualifying Event occurs. The events described below are Qualifying Events only if the event results in a loss of coverage.

COBRA Qualifying Events which affect the Employee, Spouse, and dependent Children are:

- Termination of Employee's employment except for gross misconduct;
- Layoff;
- Employee's retirement;
- A reduction in your work hours which makes the Employee ineligible for health care coverage;
- Employee does not return from a Family Medical Leave or other leave.

COBRA Qualifying Events which affect Employee's spouse are:

- Divorce;
- Employee's death;
- Employee's entitlement to Medicare.

The Employee or spouse must notify Tidelands Health if divorce occurs. Notification must be provided in writing within 60 days after the date of the event. If neither the Employee, nor the spouse notifies Tidelands Health Human Resources of the divorce within 60 days, coverage for the spouse will end, and he or she will lose the right to COBRA continuation coverage. Tidelands Health will notify the spouse of his or her COBRA rights in the event of an Employee's death.

COBRA Qualifying Events which affect dependent children are:

- Marriage of a child;
- Child reaching the maximum age for coverage under the Plan;
- Child is no longer dependent on Employee for support – e.g., enlists in the military, works full time, or moves outside the US;
- Divorce (if child loses eligibility for coverage)
- Employee's death;
- Employee's entitlement to Medicare.

Employee or spouse (or child over age 17) must notify Tidelands Health Human Resources when any of these events occurs. Written notification must be provided within 60 days after any of these events occurs. If Human Resources does not receive written notification within 60 days, coverage for the child will end, and he/she will lose his/her COBRA continuation. Tidelands Health will notify your spouse, child over 17 or your child's guardian of his/her COBRA rights in the event of your death.

COBRA continuation is not available under all circumstances that cause a loss of coverage.

Qualified Beneficiaries

Qualified beneficiaries are individuals who can continue health care coverage when a Qualifying Event occurs. Qualified beneficiaries include you, your spouse, and your Dependent children. To be a qualified beneficiary, the individual must be covered under the Plan when the Qualifying Event occurs. Any child born to you or whom you

adopt while you are covered under COBRA will also be a qualified beneficiary if you or your spouse enrolls the new child within 30 days of the birth or adoption.

COBRA Coverage
When a COBRA Qualifying Event occurs, a qualified beneficiary will have the right to continue the coverage he or she had on the date of the Qualifying Event. When a COBRA Qualifying Event occurs, you will be able to elect continuation coverage for yourself, your spouse, and your Dependent children. Your spouse can also make his/her own COBRA election and may make an election for your children. If your child is over age 17 when the Qualifying Event occurs, he/she may make his/her own COBRA election.

Electing COBRA Coverage
If the Qualifying Event is your termination of employment, retirement, layoff, failure to return from FMLA or leave, or is a reduction in your work hours, Tidelands Health will send a notice explaining your COBRA rights. The letter will be sent soon after the Qualifying Event occurs. The letter will be sent to you, or to you and your spouse if you are married. For other Qualifying Events, Tidelands Health will send the letter soon after you or your Dependent notifies us of the Qualifying Event.

You and other qualified beneficiaries will have 60 days from the date of the COBRA letter or loss of coverage whichever is later to elect to continue coverage. If you do not elect COBRA continuation, your coverage under the Plan will stop at the end of the month following the date of the Qualifying Event. If you, or another qualified beneficiary, elect coverage within 60 days, COBRA continuation coverage will start on the date after coverage stops because of the Qualifying Event.

If you decline COBRA coverage when first offered, but your circumstances change, you can still elect continuation coverage if you make the election within the 60-day period starting with the date of the COBRA notice. The same rules apply to your spouse and Dependent child. If this happens, you will receive COBRA continuation coverage, but it will not start until the date you made the election. As an example, assume the following:

Termination of Employment	March 15, 2023
COBRA Notice Sent	March 20, 2023
COBRA Coverage Declined	March 25, 2023
COBRA Coverage Elected	April 20, 2023

Since the COBRA election was made within the 60-day period beginning on March 20, you will have COBRA coverage starting on April 20, 2023.

Changing COBRA Coverage
COBRA coverage is a continuation of the coverage in effect when the Qualifying Event occurs. Changes in coverage can only be made when you (or another Qualified Beneficiary) experience a Life Event, or at annual enrollment.

If you elected COBRA and the health plan is later changed for active Employees, your coverage will also change.

PAYING FOR COBRA COVERAGE
You must pay the total cost of COBRA coverage plus a 2% administrative fee. Total cost means the amount that you and Tidelands Health pay for the coverage, not just your monthly contribution as an active Employee. Your first premium payment is due 45 days after the date you elect COBRA coverage. The first payment will include premiums from the date COBRA coverage begins to the end of the month in which you make the election. If payment is not received within 45 days, coverage will end at the end of the month following the date of the Qualifying Event.

After the first payment, premiums are due monthly. Monthly premiums are due on the first day of the month and must be received within 31 days. If your premium is not received by the end of the 31-day grace period, COBRA coverage will end on the premium due date.

If COBRA coverage is being continued beyond 18 months because of disability, the cost of COBRA coverage for the 19th through the 29th month of coverage may be up to 150% of the total cost of coverage if the disabled individual

elects coverage. If the disabled individual does not elect coverage, but his family does elect the extended coverage, the cost may be up to 102% of the total cost of coverage.

The cost for COBRA coverage may change each year if the cost for the coverage changes for Tidelands Health. Cost changes normally occur in October. You will be notified of any change in cost before the change begins.

DURATION OF COBRA COVERAGE

Maximum Duration for COBRA Coverage

Up to 18 Months—the maximum amount of time that you (or your Dependent) can continue COBRA coverage under the medical plan is 18 months if the Qualifying Event is: termination of employment, layoff, reduction in your hours of employment, or non-return from FMLA, medical leave or other leave of absence.

Up to 29 Months—if you, your spouse or one of your Dependent children is disabled either when the Qualifying Event occurs or within 60 days after the Qualifying Event occurs, you may be able to continue COBRA coverage during disability for an additional 11 months up to a total of 29 months. To be eligible for the additional 11 months of coverage you, your spouse or your Dependent child must:

- Be determined to be disabled by Social Security;
- Notify Tidelands Health in writing within 60 days of the date of the Social Security determination with a copy of the Social Security letter. A copy of the Social Security determination letter must also be provided to Tidelands Health before the end of the first 18 months of COBRA continuation coverage.

If you, your spouse, or your Dependent child is later determined to be not disabled by Social Security, you must provide a copy of the Social Security letter within 30 days after receipt.

Up to 36 Months—for all other Qualifying Events, your Spouse or Dependent child who is losing coverage may be able to continue COBRA coverage for up to 36 months. If there are multiple Qualifying Events, COBRA continuation is available for up to 36 months from the date of the first Qualifying Event. For example, you take COBRA coverage when your employment terminates. While you and your family are on COBRA continuation, your child reaches age 26 and would lose coverage. That child has a second qualifying event and is eligible for COBRA continuation for up to 36 months from the date you lost coverage because of termination of employment. Notification must be provided to Tidelands Health Human Resources.

Termination of COBRA Coverage (Other than Maximum Duration)

COBRA coverage will end before the 18-, 29- and 36-month time frames described above when any of the following happens:

- The qualified beneficiary stops paying the required COBRA premium;
- The qualified beneficiary becomes enrolled in Medicare Part A, Medicare Part B or Medicare + Choice (after the date COBRA was elected);
- The qualified beneficiary is being continued on COBRA beyond 18 months and is notified that he is no longer determined to be disabled by Social Security;
- Tidelands Health no longer provides a health care plan to any Employee.

Uniformed Services Employment and Re-employment Rights Act (**USERRA)**

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

   i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins;

   ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

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

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

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

D. This Section shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

REIMBURSEMENT OF PAYMENTS MADE BY PLAN

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. To help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. Assignment of Rights (Subrogation). The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) because of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the plan administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

   This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision, Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in Plan's Reimbursement Activities. The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s) that may be obligated to provide payments or benefits to or for the benefit of the covered person). The covered person is required to (a) cooperate fully in Plan's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a Copayee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the plan administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the plan administrator to enforce the Plan's rights.

Failure by a covered person to follow the above terms and conditions may result, at the discretion of the plan administrator, in a reduction from future benefit payments available to the covered person under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

WORKERS' COMPENSATION PROVISION

This policy does not provide Benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Covered Member that arises out of, in connection with, or as the result of any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Covered Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Covered Member but the Covered Member elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation Benefits for which he/she is eligible; fails to timely file a claim for Workers' Compensation Benefits; or seeks treatment for the injury or illness from a provider that is not authorized by the Covered Member's Plan Sponsor.

If the Group Health Plan, or its designee, including PAI (hereinafter referred to as "the Plan") pays Benefits for an injury or illness and the Plan determines the Covered Member also received Workers' Compensation Benefits by means of a settlement, judgment, or other payment for the same injury or illness, Covered Member shall reimburse the Plan in full all Benefits paid by the Plan relating to the injury or illness.

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

As a condition of receiving Benefits under this Plan of Benefits, the Covered Member agrees to notify the Plan of any Workers' Compensation claim he/she may make and agrees to reimburse the Plan as described herein. The Covered Member shall not do anything to hinder the Plan's right of recovery. The Covered Member shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the Workers' Compensation carrier or any other insurance coverage to which the Covered Member may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold Benefits due the Covered Member under this Plan of Benefits. Failure to reimburse the Plan as required under this Section will entitle the Plan to invoke the Workers' Compensation Exclusion and deny payment for all claims relating to the injury or illness and/or deny future Benefit payments for any such Covered Member until the reimbursement amount has been paid in full.

COORDINATION OF BENEFITS

Coordination of benefits rules apply when a Covered Member is covered by this Plan of Benefits and covered by any other Plan or Plans. When more than one coverage exists, one Plan normally pays its Benefits in full, and the other Plan pays a reduced Benefit. This Plan of Benefits will always pay either its Benefits in full or a reduced amount that, when added to the Benefits payable by the other Plan or Plans, will not exceed 100% of Allowed Amounts. Only the amount paid by the Plan of Benefits will be included for purposes of determining the maximums in the Schedule of Benefits. Through the coordination of Benefits, a Covered Member or Dependent will not receive more than the Allowed Amounts for a loss.

The coordination of Benefits provision applies whether or not a claim is filed under the other Plan or Plans. The Covered Member agrees to provide authorization to this Plan of Benefits to obtain information as to Benefits or services available from any other Plan or Plans, or to recover overpayments. All Benefits contained in the Plan of Benefits are subject to this provision.

When this Plan of Benefits is primary, Benefits are determined before those of the other Plan. The Benefits of the other Plan are not considered. When this Plan of Benefits is secondary, Benefits are determined after those of the other Plan. Benefits may be reduced because of the other Plan's benefits. When there are more than two Plans, this Plan of Benefits may be primary as to one and may be secondary as to another.

ORDER OF DETERMINATION

If a Covered Member covered hereunder is also covered for comparable benefits or services under another Plan that is the Primary Plan, Benefits applicable under this Plan of Benefits will be reduced so that, for Benefits incurred, Benefits available under all Plans shall not exceed the Allowed Amounts of such benefits.

This Plan of Benefits determines its order of Benefits using the first of these that 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 that covers the person as an Employee (other than a Dependent) is the Primary Plan; the Plan that 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 that covered the parent the longer time is the Primary Plan; the Plan that 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.

   Nevertheless, 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 that covers the person as an Employee who is neither laid off nor retired (or as that Employee's Dependent). The Secondary Plan is the Plan that 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 that covered an Employee longer. The Secondary Plan is the Plan that 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 PAI have the right:

1. To get or share information with any insurance company or other organization regarding coordination of Benefits without the claimant's consent;
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 more than the amount due under this Plan of Benefits to an insurer or other organization if this is necessary, in the Plan Administrator or PAI's opinion, to satisfy the terms of this provision.

I. **Facility of Payment**

Whenever payments that 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**

Individuals Age 65 or Older

If you are a Covered Member and are age 65 or older, this Plan is the primary payer. Medicare will be the secondary payer.

If you are a retiree and are age 65 or older and are eligible to participate in this Plan, Medicare will be the primary payer and this Plan will pay secondary.

If you are not a Covered Member and are age 65 or older, Medicare will be your only medical coverage.

Disabled Covered Members*

If you are a Covered Member who is disabled, this Plan is the primary payer and Medicare is the secondary payer.

*This applies for Plans with 100 or more Employees. (If the Plan has less than 100 Employees, Medicare is primary for disabled individuals).

End-Stage Renal Disease

If you have End-Stage Renal Disease and are a Covered Member, this Plan is the primary payer and Medicare is the secondary payer for the first 30 months of eligibility or entitlement to Medicare. After 30 months, Medicare will be the primary payer, and this Plan will be the secondary payer.

COBRA - Age 65 or Older or Disabled

If you are age 65 or older or disabled, and covered by Medicare and COBRA, Medicare will be the primary payer and the COBRA coverage will pay secondary.

Coordination:

When Medicare is primary and the Plan is secondary, Medicare (Parts A and B) will be considered a Plan for the purposes of coordination of Benefits. The Plan will coordinate Benefits with Medicare whether or not the Covered Member or their Dependents is/are receiving Medicare Benefits.

ERISA RIGHTS

As a Covered Member 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 Covered Members 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 Employee Benefits Security Administration ("EBSA").

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself and your Dependents if there is a loss of coverage under the Group Health Plan because of a Qualifying Event. You or your Dependents may have to pay for such continuation coverage. You should review the documents governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Members, ERISA imposes duties upon the people who are responsible for the operation of an Employee welfare Benefit Plan. The people who administer an Employee welfare Benefit Plan are called "fiduciaries" and have a duty to do so prudently and in the interest of the Covered Members. The Plan Sponsor is the fiduciary of the Group Health Plan.

Enforce Your Rights

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

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 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 that 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 a domestic relations order or a Medical Child Support Order, you may file suit in federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

No one, including your Plan Sponsor, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Benefit or exercising your rights under ERISA.

Assistance with Your Questions

If you have any questions about the 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Group Health Plan will disclose (or require PAI to disclose) Covered Member's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Group Health Plan consistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of the sections below.

1. Disclosure of Protected Health Information to Plan Sponsor.

    a. The Group Health Plan and any health insurance issuer or business associate servicing the Group Health Plan will disclose PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Group Health Plan consistent with the requirements of the HIPAA and its implementing regulations, as amended. Any disclosure to and use by the Plan Sponsor of PHI 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 Covered Member's PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Covered Members.

    c. Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Covered Member's PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor.

2. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.

    a. The Plan Sponsor will neither use nor further disclose Covered Member's PHI, except as permitted or required by the Plan documents, as amended, or required by law.

    b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Covered Member's PHI, agrees to the restrictions and conditions of the Plan of Benefits, with respect to PHI.

    c. The Plan Sponsor will not use or disclose Covered Member PHI for employment-related actions or decisions or in connection with any other Benefit or Employee benefit plan of the Plan Sponsor.

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

    e. The Plan Sponsor will make PHI available to the Covered Member who is the subject of the information in accordance with HIPAA.

    f. The Plan Sponsor will make PHI available for amendment, and will on notice amend Covered Member PHI, in accordance with HIPAA.

    g. The Plan Sponsor will track disclosures it may make of Covered Member PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

    h. The Plan Sponsor will make available its internal practices, books, and records, relating to its use and disclosure of Covered Members' PHI, to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

    i. The Plan Sponsor will, if feasible, return or destroy all Covered Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Covered Member who is the subject of the PHI, when the Covered Members' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Covered Member PHI, the Plan Sponsor will limit the use or disclosure of any Covered Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

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

   a. Certain classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to Covered Member PHI received from the Group Health Plan or business associate servicing the Group Health Plan:

   b. These Employees will have access to PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Group Health Plan.

   c. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Covered Member PHI in breach or violation of or noncompliance with the provisions of this section of the Plan of Benefits. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Group Health Plan, and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Covered Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

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

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

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

   a. Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Group Health Plan. Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect this information;

   b. The Plan Sponsor shall report any security incident of which it becomes aware to the Group Health Plan as provided below.

      i. In determining how and how often Plan Sponsor shall report security incidents to Group Health Plan, both Plan Sponsor and Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential Benefit gained from reporting them. Consequently, both Plan Sponsor and Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C, and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:

         - Pings on a Party's security system,
         - Port scans,
         - Attempts to log on to a system or enter a database with an invalid password or username,
         - Denial-of-service attacks that do not result in a server being taken off-line, and
         - Malware (e.g., worms, viruses)

ii. Plan Sponsor shall, however, separately report to Group Health Plan (i) any successful unauthorized access, use, disclosure, modification, or destruction of the Group Health Plan's ePHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; or (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's ePHI.

GENERAL INFORMATION

Whereas Plan Sponsor establishes this Group Health Plan and the applicable Benefits, rights and privileges that shall pertain to participating Employees, hereinafter referred to as "Employees" and the eligible Dependents of such Employees, as herein defined, for which Benefits are provided through a fund established by the Plan Sponsor and hereinafter referred to as the "Plan of Benefits":

ADMINISTRATIVE SERVICES ONLY
PAI provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self-funded health Plan, and the Plan Sponsor assumes all financial risk and obligation with respect to claims.

CLERICAL ERRORS
Clerical errors by *Coordinated Health/Care*, the Plan Sponsor or PAI will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

CONTINUATION OF CARE
If a Participating Provider's contract ends or is not renewed for any reason other than fraud or a failure to meet applicable quality standards and the Participant is a Continuing Care Patient, the Participant may be eligible to continue to receive in-network Benefits from that Provider with respect to the course of treatment relating to the Participant's status as a Continuing Care Patient.

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

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

IDENTIFICATION CARD
A Covered Member 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 Covered Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS
PAI and the Plan Sponsor are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment, and health-care operations for the administration of the Benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS
No action at law or in equity can be brought under the Group Health Plan until such Covered Member has exhausted the administrative process (including the exhaustion of all appeals) as described in this booklet. No such action may be brought after the expiration of any applicable period prescribed by law.

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.

NEGLIGENCE OR MALPRACTICE
PAI and the Plan Sponsor do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Covered Member by a Provider is rendered or supplied by such Provider and not by PAI or the Plan Sponsor. PAI and the Plan Sponsor are not liable for any improper or negligent act, inaction, or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supplies, or medication.

NOTICES
Except as otherwise provided in this Plan of Benefits, any notice under the Group Health Plan may be given by United States mail, postage paid and addressed:

1. To PAI:
   Planned Administrators, Inc.
   Post Office Box 6927
   Columbia, South Carolina 29260
2. To a Covered Member: To the last known name and address listed for the Employee on the membership file. Covered Members are responsible for notifying PAI and **Tidelands Health** of any name or address changes within thirty-one (31) days of the change.
3. To the Plan Sponsor: To the name and address last given to PAI. The Plan Sponsor is responsible for notifying PAI and Covered Members of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS
On occasion, PAI (on behalf of the Group Health Plan) or the Plan Sponsor 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 Group Health Plan or the Plan Sponsor waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE
Each Covered Member must provide the Group Health Plan (and its designee, including PAI) and the Plan Sponsor with information regarding all other Health Insurance Coverage to which such Covered Member is entitled.

PAYMENT OF CLAIMS
Except for the Covered Member's Provider, a Covered Member is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Group Health Plan may pay Covered Expenses directly to the Employee or to the Non-Participating Provider upon receipt of due proof of loss for services provided by a Non-Participating Provider. Where a Covered Member has received Benefits from a Participating Provider or Contracting Provider, the Group Health Plan will pay Covered Expenses directly to such Participating Provider or Contracting Provider.

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

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

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 Plan Sponsor the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge or otherwise terminate the employment of any employee.

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.

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

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.

ADMINISTRATIVE INFORMATION

Benefit Year/Plan Year:	**Begins October 1** of each year and continues for 12 consecutive months **through September 30.**
Plan Name:	Tidelands Health Medical Plan
Name and Address of the Employer establishing the Plan:	Georgetown Hospital System dba Tidelands Health 606 Black River Road Georgetown, South Carolina 29440
Employer's ID Number:	02-0598440
ERISA Number:	504
Plan Number:	6714
Type of Welfare Plan:	Medical
Plan Funding:	Paid by the Employer and/or the Employee determined by the level of coverage (Employee, Employee spouse, Employee + Child(ren), Family) selected.
Claim Administration:	Planned Administrators Incorporated (PAI) P.O. Box 6927 Columbia, South Carolina 29260 803-462-0151 or 800-768-4375
Member Services:	Coordinated Health/Care Attn: Care Coordinators 1215 Polaris Parkway, Suite 229 Columbus, OH 43240-2037 877-498-6693 www.tidelandshealthplan.com
Plan Sponsor/Plan Administrator/Corporation/ Company/Fiduciary/Agent for Service of Legal Process:	Georgetown Hospital System dba Tidelands Health 606 Black River Road Georgetown, South Carolina 29440 843-520-8275
Plan Termination:	The Plan Administrator reserves the right, through the 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.
Plan Document:	A full description of the medical benefits appears in this official Plan document which is the final authority. These papers may also be examined in the company office of the Employer within 30 days after your written request is received by the Plan Administrator.

DEFINITIONS

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

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

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

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 Covered Member'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 that results from the application of any utilization review as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. **A Rescission of coverage, whether or not the Rescission has an adverse effect on any particular Benefit, also is considered an Adverse Benefit Determination.**

Allowable Charge: the amount PAI agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment, unless otherwise required by applicable law;
2. The Allowable Charge for Emergency Services (including air ambulance services) provided by Non-Participating/Non-Contracting Providers, as well as non-Emergency Services provided by Non-Participating/Non-Contracting Providers at Participating/Contracting Hospitals, Hospital outpatient departments, Critical Access Hospitals, or Ambulatory Surgical Centers, will pay in accordance with applicable federal law; and,
3. In addition to the Participant's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Participant may be balance billed by the Non-Participating/Non-Contracting Provider for any difference between the Allowable Charge and the Billed Charge, except where prohibited by applicable law.

   For covered items and services described in item 2, above, the Allowable Charge will be the Recognized Amount (less any applicable Benefit Year Deductible, Copayment and/or Coinsurance), unless otherwise prescribed under applicable law. If the Provider disputes such Allowable Charge and initiates a 30-day open negotiation and/or independent dispute resolution process in accordance with applicable federal law, PAI will administer such processes.

   Notwithstanding anything herein to the contrary, the Participant's responsibility for Benefit Year Deductibles, Copayments and/or Coinsurance for covered items and services provided by Non-Participating/Non-Contracting Providers described in item 2, above, will be calculated as if the item or service was furnished by a Participating/Contracting Provider, and based on the Recognized Amount (which may differ from the Allowable Charge).

Ambulatory Surgical Center: a licensed facility that:

1. Has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis;
2. Provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the Participant is in the facility;
3. Does not provide inpatient accommodations; and,

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

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

Approved Clinical Trial: means* a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is:

1. A Federally Funded Trial—the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of these:
    a. The National Institutes of Health;
    b. The Centers for Disease Control and Prevention;
    c. The Agency for Health Care Research and Quality;
    d. The Centers for Medicare & Medicaid Services;
    e. Cooperative group or center of any of the entities described in clauses (i) through (iii) or the Department of Defense or the Department of Veterans Affairs;
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
    g. Any of these departments if the conditions described in paragraph, *Conditions for Departments are met:
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. A Food and Drug Administration Trial—the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. A Drug Trial for investigating new drug applications—the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

*Conditions for Departments. The conditions for a study or investigation conducted by a Department referenced above are that the study or investigation has been reviewed and approved through a system of peer review that the Health and Human Services determines:

1. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health;
2. Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

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

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

Benefits: medical services or Medical Supplies that are:

1. Medically Necessary;
2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);
3. Included in this Plan of Benefits;
4. Not limited or excluded under the terms of this Plan of Benefits.

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

Care Coordinator: A Care Coordinator provides customer service for the Tidelands Health plan, including benefits and eligibility verification, claims resolutions, and patient advocacy while working with an in-house team of nurses to provide health guidance, pre-notification, case management and chronic condition support.

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

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

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

Continuation of Care: the payment of Participating Provider level of Benefits for services rendered by certain Non-Participating Providers for a definite period of time in order to ensure continuity of care for covered Participants for a Serious Medical Condition.

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

Continuing Care Patient: a Participant who, with respect to a Provider or facility, is either:

1. Undergoing a course of treatment for a serious and complex condition from the Provider or facility;
2. Undergoing a course of institutional or inpatient care from the Provider or facility;
3. Scheduled to undergo non-elective surgery from the Provider or facility, including receipt of postoperative care;
4. Pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or,
5. Receiving treatment for a terminal illness from the Provider or facility.

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

Copay: the amount specified on the Schedule of Benefits that the Covered Member must pay directly to the Provider each time the Covered Member receives Benefits.

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

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

Covered Member Effective Date: the date on which a Covered Member is covered for Benefits under the terms of this Plan of Benefits.

Credit(s): financial credits (including rebates and/or other amounts) to Group Health Plan and/or PAI directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager (PBM). Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Participants.

Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these credits. Any Coinsurance that a Participant must pay for Prescription Drugs is based on the Allowed Amount at the Pharmacy and does not change due to receipt of any Credit received by Group Health Plan and/or PAI. Copays are not affected by any Credit.

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

Dependent: an individual who is:

1. An Employee's spouse including legally married same sex couples;
2. A Child under the age set forth in the Eligibility for Coverage section;
3. An Incapacitated Dependent.

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.

Discount Services: services (including discounts on services) that are not Benefits but may be offered to Covered Members from time to time as a result of being a Covered Member.

Durable Medical Equipment: equipment that:

1. Can stand repeated use;
2. Is Medically Necessary;
3. Is customarily used for the treatment of a Covered Member's illness, injury, disease, or disorder;
4. Is appropriate for use in the home;
5. Is not useful to a Covered Member in the absence of illness or injury;
6. Does not include appliances that are provided solely for the Covered Member's comfort or convenience;
7. Is a standard, nonluxury item (as determined by the Group Health Plan);
8. 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, dehumidifiers, whirlpool baths, and other equipment that have nontherapeutic uses are not considered Durable Medical Equipment.

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

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

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

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

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

Employee: any employee of the Employer (also known as Plan Sponsor) who is eligible for coverage as provided in the eligibility section of this Plan of Benefits, and who is so designated to PAI by the Employer (also known as Plan Sponsor).

Employer: Tidelands Health.

Employer Effective Date: the date PAI begins to provide services under this Plan of Benefits, also known as Plan Sponsor Effective Date.

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

Excepted Benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. 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>:

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

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

1. Coverage only for a specified disease or illness;
2. Hospital indemnity or other fixed indemnity insurance.

<u>If offered as a separate insurance policy</u>:

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

Experimental or Investigational: surgical procedures or medical procedures, supplies, devices, or drugs that, at the time provided, or sought to be provided, are in the judgment of PAI not recognized as conforming to generally accepted medical practice, or the procedure, drug, or device:

1. Has not received required final approval to market from appropriate government bodies;
2. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated to be as beneficial as established alternatives;
4. Has not been demonstrated to improve net health outcomes;
5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the experimental or investigational setting.

Generic Drug: a Prescription Drug that has a chemical structure that is identical to and has the same bioequivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

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

Grace Period: a period of time as determined by the Plan Sponsor that allows for the Covered Member to pay any Premium due.

Group Health Plan: an Employee welfare Benefit Plan adopted by the Plan Sponsor 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 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-term, limited-duration insurance.

Health Status Related Factor: information about a Covered Member's health, including 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 Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

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

Hospice Services – provided in the client's home or in the home of a family member; generally, hospice services are not available to Participants who are inpatients in hospital or nursing home facilities.

Hospice services include:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use;
9. Durable Medical Equipment (A separate Preauthorization is not needed when we approved the entire Hospice Service plan);
10. Family counseling concerning the patient's terminal condition.

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

Identification Card: the card issued by PAI to a Covered Member that contains the Covered Member's identification number.

Incapacitated Child: 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.

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**.**

Independent Review Organization: An external review organization approved by the South Carolina Department of Insurance and accredited by a nationally recognized private accrediting organization, and not affiliated with the health carrier.

Late Enrollee: an Employee who enrolls under this Group Health Plan other than during:

1. The first period in which the Employee or Dependent is eligible to enroll if such initial enrollment period is a period of at least thirty (30) days;
2. A Special Enrollment period (as set forth in the Eligibility for Coverage section).

Life-Threatening Condition: means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Mail Service Pharmacy: a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maternity Management Program: the voluntary program offered by the Group Health Plan to Covered Members who are pregnant.

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

1. The actual charge submitted to PAI for the service, procedure, supply or equipment by a Provider;

2. An amount based upon the reimbursement rates established by the Plan Sponsor in its Benefits Checklist;

3. An amount that has been agreed upon in writing by a Provider and PAI;

4. An amount established by PAI, based upon factors including, but not limited to:

    a. Governmental reimbursement rates applicable to the service, procedure, supply or equipment; or,

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

5. The lowest amount of reimbursement PAI allows for the same or similar service, procedure, supply or equipment when provided by a Participating/Contracting Provider.

In addition, the Maximum Payment for Emergency Services or Air Ambulance Services by a Non-Participating/Non-Contracting Provider, or Non-Emergency Services by a Non-Participating/Non-Contracting Provider at a Participating/Contracting Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, will be the Recognized Amount, unless a different Maximum Payment amount is permitted or required under applicable law.

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

1. Provides Child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits;
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health Plan.
3. A Medical Child Support Order must clearly specify:
    a. The name and the last known mailing address (if any) of each Covered Member Employee and the name and mailing address of each alternate recipient covered by the order;
    b. A reasonable description of the type of coverage to be provided by the group health Plan to each such alternate recipient or the manner in which such type of coverage is to be determined;
    c. The period to which such order applies;
    d. Each group health Plan to which such order applies.
4. If the Medical Child Support Order is a national medical support notice, the order must also include:
    a. The name of the issuing agency;
    b. The name and mailing address of an official or agency that has been substituted for the mailing address of any alternate recipient;
    c. The identification of the underlying Medical Child Support Order.

5. A Medical Child Support Order meets the requirement of this definition only if such order does not require a group health Plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

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

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

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

Medical Supplies: supplies that are:

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

Mental Health Services: treatment (except Substance Use Services) for a condition that is defined, described, or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and 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.

Milieu Therapy: type of treatment in which the patient's social environment is manipulated for his/her benefit.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay;
2. Have at least 50% bony support;
3. Are functional in the arch;
4. Have not been excessively weakened by multiple dental procedures;
5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above and, because of such treatment, have been restored to normal function.

Non-Participating Provider: any Provider who does not have a current, valid contract with one of the networks used by this Plan of Benefits.

Non-Preferred Brand Name Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Name Drugs and has not been chosen by PAI, Plan Sponsor or its designated Pharmacy Benefit Manager to be a Preferred Brand Name Drug, including any Brand Name Drug with an "A" rated Generic Drug available.

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

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

Out-of-Pocket Maximum: the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Covered Member will be required to pay. The Out-of-Pocket Maximum includes Copays, Coinsurance and Benefit Year Deductibles payable by the Covered Member as set forth on the Schedule of Benefits.

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

Participating 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 Covered Member and submit claims to PAI and to accept the Allowed Amount as payment in full for Benefits. The participating status of a Provider may change.

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 who is:

1. Not an:
    a. Intern;
    b. Resident;
2. Duly licensed by the appropriate state regulatory agency as a:
    a. Medical doctor;
    b. Oral surgeon;
    c. Osteopath;
    d. Podiatrist;
    e. Optometrist;
    f. Psychologist with a doctoral degree in psychology;
3. Legally entitled to practice within the scope of his or her license;
4. Customarily bills for his or her services.

Physician Services: these services performed by a Physician within the scope of his or her license, training, and specialty and within the scope of generally acceptable medical standards as determined by PAI:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury;
2. Basic diagnostic services and machine tests;

3. Physician Services include services when performed by a medical doctor, osteopath, podiatrist, or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:
    a. Benefits rendered to a Covered Member in a Hospital or Skilled Nursing Facility;
    b. Benefits rendered in a Covered Member's home;
    c. Surgical Services;
    d. Anesthesia services, including the administration of general or spinal block anesthesia;
    e. Radiological examinations;
    f. Laboratory tests;
    g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives.

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

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

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

Plan Administrator: the entity charged with the administration of the Plan of Benefits. The Plan Sponsor is the Plan Administrator of this Plan of Benefits.

Plan of Benefits: This Plan of Benefits including the membership application, the Schedule of Benefits, and all endorsements, amendments, riders, or addendums.

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

Plan Sponsor: also known as the Employer.

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

Preadmission Review: the review that must be obtained by a Covered Member (or the Covered Member's representative) prior to all Admissions that are not related to an Emergency Medical Condition.

Preauthorized/Preauthorization: the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Covered Member. Preauthorization means only that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Covered Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Covered Member's eligibility and all limitations and exclusions contained in this Plan of Benefits. A Covered Member's entitlement to Benefits is not determined until the Covered Member's claim is processed.

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

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

Prescription Drugs: a drug or medicine that is:

1. Required to be labeled that it has been approved by the Food and Drug Administration;
2. 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;
3. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

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

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

1. 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 marketplace.
2. Controlled substance 5 (CV) OTC's are covered. (Examples: Robitussin AC syrup and Naldecon-CX) Federal law designates these medications as OTC. Nevertheless, depending on certain state Pharmacy laws, the medications may be considered prescription medications and are, therefore, all covered.
3. Single entity vitamins – These vitamins have indications in addition to their use as nutritional supplements. For this reason, Plan 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.

Prescription Drug Copay: the amount payable, if any, set forth on the Schedule of Benefits, by the Covered Member for each Prescription Drug filled or refilled. This amount will be applied to the Benefit Year Deductible and the Out-of-Pocket Maximum.

Pre-Service Claim: any claim or request for a Benefit where prior authorization or approval must be obtained from BlueCross Medical Review Department before receiving the medical care, service, or supply.

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

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

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

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:

- 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.

Qualified Individual: means an individual who is a Participant in a health Plan who meets these conditions:

1. The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition;
2. Is either:
    a. Referred by a participating health care provider and has concluded that the individual's participation in such trial would be appropriate;
    b. The Participant provides medical and scientific information establishing that their participation in the trial would be appropriate.

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

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

The plan administrator shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the Plan pursuant to valid QMCSO. You may receive a copy of the Plan's QMCSO procedures without charge, by contacting the plan administrator.

Qualifying Event: for continuation of coverage purposes, a Qualifying Event includes:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work or no longer eligible and therefore ineligible for coverage under the Plan of Benefits;
2. Death of the Employee;
3. Divorce or legal separation of the Employee from his or her spouse;
4. A Child ceasing to qualify as a Dependent under this Plan of Benefits.
5. Entitlement to Medicare by an Employee, or by a parent of a Child;
6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Quantity Management Program: limits that restrict the quantity of Prescription Drugs that are covered under a Participant's Plan within a certain period. The limits established for these drugs are based on FDA and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. The limits, which are designed to promote the safe use of medications, affect only the amount of medication your Plan covers.

Recognized Amount: the lesser of the Non-Participating/Non-Contracting Provider's Billed Charges or PAI's median contracted rate for Participating/Contracting Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

Rescission: a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if the cancellation or discontinuance of coverage:

1. Has only a prospective effect;
2. Is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

A Rescission retroactively canceling coverage is permitted if an individual performs an act, practice or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan or coverage.

Residential Treatment Center: a licensed institution, other than a Hospital, which meets all six of these requirements:

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

Routine Participant Costs: include all items and services consistent with what is typically covered by the Plan for a Qualified Individual who is not enrolled in a clinical trial. This DOES NOT include services that are considered:

1. The investigational item, device, or service, itself;
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Participant;

A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Schedule of Benefits: the pages of this Plan of Benefits so titled that specify the coverage provided and the applicable Copays, Coinsurance, Benefit Year Deductibles, Out-of-Pocket Maximums and Benefit 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 Covered Member's claim as determined through the coordination of benefits provisions of this Plan of Benefits.

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

Skilled Nursing Facility: A licensed institution and accredited, other than a Hospital, which meets all six of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients; and
2. Has the services of a Physician available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and PRN as indicated; and
3. Has a physician or RN on full-time duty who is in charge of patient care, along with one (1) or more RNs or LPNs on duty at all times (twenty-four (24) hours a day; seven (7) days a week); and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and isn't, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. Is operating lawfully as a skilled nursing facility in the area where it is located.

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

Specialty Physician: a Physician who specializes in a particular branch of medicine.

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

Step Therapy: a program that requires a Participant to use lower-cost medications that are used to treat the same condition before getting higher-cost medications.

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

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

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

Transplant: The transfer of organs or tissues, including bone marrow, stem cells and cord blood, from human to human. Transplants are covered only at facilities approved by *Coordinated Health/Care* in writing and include only those procedures that otherwise are not excluded by this Plan of Benefits. Preauthorization is required. Transplant Physician Charges are subject to the Benefit Year Deductible.

Transplant Benefit Period: the period that for Transplant of:

1. an organ, the period that begins one day prior to the Admission date for Transplant and continues for a 12-month period. Anti-rejection drugs are not subject to the Transplant Benefit Period;
2. bone marrow, the period that begins one day prior to the date marrow ablative therapy begins, or one day prior to the day the preparative regimen for non-myeloablative Transplant begins and continues for a twelve (12) month period. Mobilization therapy and stem-cell harvest are also included. Anti-rejection drugs are not subject to the Transplant Benefit Period.

Urgent Care: treatment required to treat an unexpected illness or injury that is life-threatening and required to prevent a significant deterioration of the Covered Member's health if treatment were delayed.

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

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

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Tidelands Health
Employee Medical Plan
Effective Date: October 1, 2023

Plan Document Signature Page

Employer hereby amends and restates by this Plan Document an employee welfare benefit plan. It is intended that this Plan Document will serve to describe the nature, funding and benefits of the Plan. It is also intended that this Plan Document shall conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as the act applies to employee welfare benefit plans. If any portion of the Plan Document, now or in the future, conflicts with ERISA or Federal regulations, such regulations will govern.

Dianne M. Callihan

By

Director, Benefit Services

Title

Dianne M. Callihan

Typed/Printed Name

2/14/2024

Date

Witness
Amanda Icatar

Tidelands Health
Plan Sponsor
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