DEFINITIONS

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

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

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

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

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

a. the Allowable Charge shall not exceed the Maximum Payment and
b. In addition to the Member's liability for deductibles, co-payments and/or co-insurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the billed charges.

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

"Ambulatory Surgical Center" a licensed facility that:

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

"Autism Spectrum Disorder": the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

a. Autistic Disorder;
b. Asperger's Syndrome;
c. Pervasive Developmental Disorder--Not Otherwise Specified

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For Prescription Drug Benefits, Coinsurance is the amount payable by the Member calculated as follows:

a. The percentage listed on the Schedule of Benefits; multiplied by,
b. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale; and,

c. Without regard to any Credit or allowance that may be received by the Claims Administrator.

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

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

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

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

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

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

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

Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these Credits. Any Coinsurance that a Member must pay for Prescription Drugs or Specialty Drugs is based upon the Allowable Charge at the pharmacy, and does not change due to receipt of any Credit by the Claims Administrator. Copayments are not effected by any Credit.

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

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

"Dependent": the following individuals:

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

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

"Domestic Partner": a Dependent who:

1. Is unmarried, at least eighteen (18) years of age, mentally competent, resides with the other partner and intends to reside with the other partner for an indefinite amount of time;
2. Is not related to the other partner by adoption or blood;
3. Is the sole Domestic Partner of the other partner with whom he/she has a close committed and personal relationship, and has been a member of this domestic partnership for the last twelve (12) months;
4. Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and,
5. Is financially interdependent. Financial interdependence is demonstrated by submission of three (3) or more of the following documents:

a. a joint mortgage or lease;
b. a designation of one (1) of the partners as beneficiary in the other partner's Will or life insurance policy;
c. a durable property and health care powers of attorney;
d. a joint title to an automobile;
e. a joint bank account or credit account; or,
f. such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

The Employee and applicant for coverage as a Domestic Partner will be required to sign an Affidavit of Domestic Partnership. The Claims Administrator reserves the right to request documentation of any of the foregoing prior to commencing coverage of the Domestic Partner.

"Durable Medical Equipment": equipment that:

a. Can stand repeated use;
b. Is Medically Necessary;
c. Is customarily used for the treatment of a Member's Illness, injury, disease or disorder;
d. Is appropriate for use in the home;
e. Is not useful to a Member in the absence of Illness or injury;
f. Does not include appliances that are provided solely for the Member's comfort or convenience;
g. Is a standard, non-luxury item (as determined by the Employer's Group Health Plan); and
h. Is ordered by a medical doctor, oral surgeon, podiatrist, or osteopath.

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

"Emergency": an unexpected and usually dangerous situation that calls for immediate action.

"Emergency Admission Review": the review that must be obtained by a Member (or the 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 manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

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

"Emergency Services": services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital Emergency room or department.

"Employee": any Employee of the Employer who is eligible for coverage, as provided in the Eligibility Section of this Plan of Benefits, and who is so designated to the Claims Administrator by the Employer, even if such classification is determined to be erroneous or is retroactively revised.

"Employer": the entity providing this Plan of Benefits.
"Employers Effective Date": the date the Claims Administrator begins to provide services under the Administrative Services Agreement.

"Employer's Group Health Plan": the Group Health Plan adopted by the Employer as the Plan Sponsor. This Plan of Benefits outlines certain terms of the Employer's Group Health Plan.

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

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

"Excepted Benefits":

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

<u>If offered separately</u>:

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

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

a. Coverage only for a specified disease or Illness;
b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

"Generic Drug": a Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. 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 an individual or family member of the individual. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted purposely to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

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

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

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

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

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

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

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

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

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

"Hospital": a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed 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 Members.

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

"Incapacitated Dependent": a Child who is:

a. Incapable of financial self-sufficiency by reason of mental or physical disability; and

b. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

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

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

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

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

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

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

    i. Governmental reimbursement rates applicable to the service, procedure, supply or equipment, or
    ii. Reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or
e. The lowest amount of reimbursement the Claims Administrator allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

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

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

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

A Medical Child Support Order must clearly specify:

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

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

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

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of 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:

a. In accordance with generally accepted standards of medical practice;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
c. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,
d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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

For the purposes of determining Medically Necessary/Medical Necessity:

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

Medical Supplies: supplies that are:

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

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

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

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

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

"Natural Teeth": teeth that:

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

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

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

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

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

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

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

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

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

"Pharmacy Benefit Manager": an entity that has contracted with the Employer or with the Claims Administrator and is responsible for the administration of the Prescription Drug Benefit in accordance with the Employer's Group Health Plan.

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

a. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and

b. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

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

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

"Plan of Benefits": the Benefit booklet provided by the Claims Administrator to the Employer which, reflects the Claims Administrator's understanding of the Benefits offered under the Employer's Group Health Plan based on the Benefits Checklist completed by the Employer and submitted to the Claims Administrator. The Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.

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

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

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

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

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

"Pre-Authorized/Pre-Authorization": the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. Pre-Authorization means only that the Benefit is Medically Necessary. Pre-Authorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Pre-Authorization, payment for Benefits is subject to a Member's eligibility, and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed. The Pre-Authorization process is outlined in the Pre-Authorization / Prior Approval Section.

"Preferred Brand Drug": a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

"Preferred 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 Members. Preferred Drugs are subject to periodic review and modification by the Claims Administrator, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

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

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

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

a. Required to be labeled that it has been approved by the Food and Drug Administration;

b. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only" prior to being dispensed or delivered, or labeled in a similar manner; or
c. Insulin.

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

a. Be prescribed by a licensed Provider acting within the scope of his or her license;
b. Not be entirely consumed at the time and place where the prescription is dispensed; and
c. Be purchased for use outside a Hospital.

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

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

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

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

"Pre-Service Claim": any request for a Benefit where Preauthorization must be obtained 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

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

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

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

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

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

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

- Speech Therapy
- Occupational Therapy; or
- Osteopathy

The term Provider also includes a Hospital, a Rehabilitation Facility, a Skilled Nursing Facility, a physician assistant and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon. The term Provider does not include interns, residents, in-house physicians, physical trainers, lay midwives or masseuses.

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

"Provider Services": includes the following services:

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

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

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

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

C. Additionally, Provider Services shall include behavioral health services when performed by a Behavioral Health Provider, nurse practitioner, physician assistant, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Claims Administrator.

"QMCSO": a Medical Child Support Order that:

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

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

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

"Quantity versus Time (QVT) Limits": limits that restrict access by limiting the amount of Prescription Drugs that are covered under a Member's benefit within a certain time frame. The limits established for these drugs are based on Food and Drug Administration (FDA) approved indications.

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

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

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

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

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

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

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

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

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

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

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

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

"Step Therapy Program": programs that require a Member to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medications.

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

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

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

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

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

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