MEDICAL AND PRESCRIPTION DRUG 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.

"Accidental Injury": accidental bodily Injury caused by unexpected external means, resulting, directly and independently of all other causes, in necessary care rendered by a Physician.

"Actively at Work": a permanent, full-time Employee of the Employer who works at least the minimum number of hours per week 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 Participant's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Participant leaves or is discharged from the Hospital or Skilled Nursing Facility.

"Adverse Benefit Determination": any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, a denial reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which benefits are otherwise provide because it is determine to be Experimental or Investigational or not Medically Necessary or appropriate.

"Alcohol Abuse": the continued use, abuse and/or dependence of alcohol(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 ("DSM") of Mental Disorders* published by the American Psychiatric Association) or a comparable manual if the American Psychiatric Association stops publishing DSM.

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

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

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

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

a. has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis;

b. has continuous Physician services and registered professional nursing service whenever a patient is in the facility;

c. does not provide accommodations for patients to stay overnight;

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician; and

e. Ambulatory Surgical Center includes an endoscopy center.

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

"Annual Maximum": the total Benefits (under this Group Health Plan) to which a Participant is entitled to each Benefit Year for essential health benefits as defined under the (PPACA). The restricted annual dollar limit is for Benefit Years beginning on or after September 23, 2010, but prior to January 1, 2014. Refer to the Schedule of Benefits for the restricted annual dollar limit.

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

"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 Therapy": any behavioral modification using Applied Behavioral Analysis (ABA) techniques to target cognition, language, and social skills.

Behavioral Therapy does not include educational or alternative programs such as, but not limited to:

a. TEACCH;
b. Auditory Integration Therapy;
c. Higashi Schools/Daily Life;
d. Facilitated Communication;
e. Floor Time (DIR, Developmental Individual-difference Relationship-based model);
f. Relationship Development Intervention (RDI), Holding Therapy;
g. Movement Therapies;
h. Music Therapy; and
i. Pet Therapy.

"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 Percentage": the portion of eligible expenses payable this Plan of Benefits in accordance with the coverage provisions as stated in the Schedule 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 Participant each Benefit Year before the Plan Administrator will pay Covered Expenses. The Benefit Year Deductible is subtracted

from the Allowed Amount before Coinsurance is calculated. Participants 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.

"Certificate of Creditable Coverage": a document from a Group Health Plan or insurer that states that a Participant had prior Creditable Coverage with that Group Health Plan or insurer.

"**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, a Child who is on a Medically Necessary Leave of Absence, 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.

Under the Patient Protection and Affordable Care Act and the Health Coverage and the Education Reconciliation Act, a child does not include an individual who is eligible for other employer sponsored coverage if the Group Health Plan is a "grandfathered plan" beginning for plan years before January 1, 2014.

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

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

"COBRA": the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto.

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

For Prescription Drug Benefits, Coinsurance is the amount payable by the Participant 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.

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

"Continued Stay Review": the review that must be obtained by a Participant (or the Participant'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 Participant must pay directly to the Provider each time the Participant receives Benefits.

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

"Covered 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 Allowed Amount.

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

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

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

"Credit(s)": financial credits (including rebates and/or other amounts) to the Claims Administrator directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager. Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Employer or 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 or Specialty Drugs is based upon the Allowable Amount 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": care provided primarily for maintenance of the patient or care designed essentially to assist the patient in meeting his or her activities of daily living. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Custodial Care is not primarily provided for therapeutic value in the treatment of an Illness, Injury, disease, or condition.

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

"Dependent": the following individuals:

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

    i. incapable of financially supporting himself by reason of mental or physical disability,
    ii. dependent upon the Employee for at least 50 percent of his or her support and maintenance, and
    iii. is living in the Employee's household. Written proof that a Dependent is incapacitated and is a Dependent shall be furnished as required by the Plan Administrator.

The term "Dependent" does not include:

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

e. any person who is covered as a Dependent by another Participant of the same Employer.

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

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

"Durable Medical Equipment": equipment that:

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

"Effective Date": the date on which an employee or dependent is covered under this Plan of Benefits.

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

"Emergency Admission Review": the review that must be obtained by a Participant (or the Participant'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 Care": Benefits that are provided in a Hospital emergency facility to evaluate and treat an Emergency Medical Condition.

"Emergency Medical Condition": a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, or by acute symptoms developing from a chronic medical condition that would lead 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 Participant, or with respect to a pregnant Participant, the health of the Participant or her unborn child, in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

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

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

"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 Waiting Period for enrollment, whichever is earlier.

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

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

a. Coverage only for accident, or disability income insurance, or any combination thereof;
b. Coverage issued as a supplement to liability insurance;
c. Liability insurance, including general liability insurance and automobile liability insurance;
d. Worker's compensation or similar insurance;
e. Automobile medical payment insurance;
f. Credit-only insurance;
g. Coverage for on-site medical clinics;
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": a treatment, procedure, service, device, or drug (treatment) which will considered to be experimental or investigational if:

a. The treatment has not been approved by the United States Food and Drug Administration (FDA) at the time the treatment is provided; or
b. The treatment is identified as a Phase I, II, III, or IV clinical trial or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis; or
c. The treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution; or
d. The treatment is being provided subject to the covered member's execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternatives; or
e. The predominant opinion of medical experts as expressed in published peer-reviewed literature is that further research is necessary in order to determine safety, toxicity, or efficacy in comparison to conventional alternatives.

Experimental or Investigational Treatment will be considered an eligible claim expense under this plan of benefits when the following criteria are met:

1. Treatment protocol identified as a Phase II, III, or IV clinical trial, or the equivalent, will be considered an eligible claim expense when all of the following criteria are met:

    a. There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative; and

    b. The clinical trial is subject to review by an IRB and has been approved by the governing local IRB; and

c. The covered member has executed an informed consent, which has been approved by the IRB; and

d. The treatment protocol has been approved by one or more of the following organizations, the treatment is being provided within one of the centers designated by the clinical trial sponsor as a participating center and is being provided under the direction of the principal investigator at that center:

i. National Institutes of Health (NIH).

ii. NIH cooperative group or center.

iii. United States Department of Health and Human Services (HHS), which includes the Center of Medicare and Medicaid Services (CMS).

iv. FDA.

v. United States Department of Defense.

vi. United States Department of Veterans Affairs; or

2. Treatment utilizing drugs previously approved by the FDA or non-approved indications when all of the following criteria are met:

a. There is not clearly superior non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative.

b. The provider has complied with all of the IRB's requirements for providing the treatment; or

3. Treatment utilizing Investigator sponsored trials which are done in accordance with IRB approved protocols in and academic medical center that is a recipient of NIH grants and which meets all of the criteria in 1.(a) through 1.(d) above. Investigator sponsored trials will be considered on a case-by-case basis. Investigator or drug company sponsored trials in which there is no academic medical center involvement and where the principal investigator is not affiliated with an academic medical center will not be considered for coverage except by recommendation of an independent third party reviewer.

To determine if any treatment meets the standards of coverage the Plan Administrator reserves the right to obtain an independent third party review.

"FMLA" the Family and Medical Leave Act of 1993, as amended.

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

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

"Genetic Information": information about genes, gene products, and inherited characteristics that may derive from the Participant or family member of the Participant. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

"Grace Period": a period of time as determined by the Employer that allows for the Participant 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 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": any of the following factors: health status, medical conditions, (including both physical and mental Illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, (including conditions arising out of acts of domestic violence), or disability.

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

"Home Health Care": part-time or intermittent care to a home-bound Participant in such Participant's private residence and:

a. Is licensed and primarily engaged in providing skilled nursing care and other therapeutic services;
b. Has policies established by a professional group associated with the agency or organization that includes at least one Physician and one registered nurse (R.N.) who provide full-time supervision of such services; and
c. Maintains complete medical records on each individual and has a full-time administrator.

"Home Health Care Plan": must meet these tests: it must be a formal written plan made by the Participant's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the Participant.

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

"Hospital": a short-term, acute care 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 Participants.

"ID Card": the card issued by the Claims Administrator to a Participant that contains the Participant's identification number.

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

"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 update items (1) and (2) 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.

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

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

"Late Enrollee": an Employee (Participant or Dependent 19 or over) who enrolls under this Plan of Benefits other than during:

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

"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 Participants (typically over an extended period of time) although such Participants 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 Participants 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 Participants.

"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 charges made for similar services, supplies or equipment by Providers and filed with the Claims Administrator during the preceding calendar year;
b. The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices; or
c. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of the Claims Administrator, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Participants upon written request; or
d. An amount that has been agreed upon by a Provider and the Claims Administrator; or
e. An amount established by the Claims Administrator in its sole discretion. In determining the Maximum Payment under this paragraph e, the Claims Administrator may, through its medical staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

"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.

3. A Medical Child Support Order must clearly specify:
   a. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order; and,
   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; and,
   c. The period to which such order applies; and,
   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; and
   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:

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

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

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

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

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

"Mental Disorder": Mental Illness includes, but is not limited to, bipolar affective disorder, schizophrenia, psychotic Illness, manic depressive Illness, depression and depressive disorders, anxiety and anxiety disorders and any other mental and nervous condition classified in *Diagnostic and Statistical Manual ("DSM") of Mental Disorders* published by the American Psychiatric Association.

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

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

"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;
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.

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

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

"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.

"Occupational Therapy": is a program of care which focuses on the physical cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment.

"Open Enrollment Period": is the month of December each year. During this month, Employees previously not enrolled under this Plan may apply for coverage. Coverage shall become effective the first of the following month.

"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 Participant's body.

"Outpatient Care and/or Services": is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

"Out-of-Pocket Maximum": the maximum amount (if listed on the Schedule of Benefits) or otherwise Covered Expenses incurred during a Benefit Year that a Participant will be required to pay. The Out-of-Pocket Maximum is Coinsurance payable by the Participant. Copayments and Benefit Year Deductibles may not apply toward the Out-of-Pocket Maximum (as set forth on the Schedule of Benefits).

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

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

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

"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 Participants.

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

"Participating Provider Agreement": an agreement between the Claims Administrator (or another partner of TCC Benefits 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.

"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.

"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.

"Physician": a person who is:

1. Not an:
    a. Intern;
    b. Resident;
    c. In-house physician; and

2. Duly licensed by the appropriate state regulatory agency as a:
    a. Medical doctor;
    b. Oral surgeon;
    c. Osteopath;
    d. Podiatrist;
    e. Chiropractor;
    f. Optometrist;
    g. Psychologist with a doctoral degree in psychology;

3. Legally entitled to practice within the scope of his or her license; and

4. Customarily bills for his or her services.

"Physician Services": the following 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 the Claims Administrator:

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 includes the following 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 Participant in a Hospital or Skilled Nursing Facility;
b. Benefits rendered in a Participant's home;
c. Surgical Services;
d. Anesthesia services, including the administration of general or spinal block anesthesia;
e. Radiological examinations;
f. Laboratory tests; or
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:

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": this Preferred Provider 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.

"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.

"Pre-Authorized/Pre-Authorization": the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Participant. 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 Participant. Notwithstanding Pre-Authorization, payment for Benefits is subject to a Participant's eligibility, and all other limitations and exclusions contained in this Plan of Benefits. A Participant's entitlement to Benefits is not determined until the Participant'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 Participants. 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.

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

"Premium": the monthly amount paid to the Employer by the Participant for coverage under this Plan of Benefits. Payment of Premiums by the Participant constitutes acceptance by the Participant 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 ordered by a medical doctor or oral surgeon as a prescription;
b. Not be entirely consumed at the time and place where the prescription is dispensed; and

c. Be purchased for use outside a Hospital.

"Prescription Drug Copayment": the amount payable, if any, set forth on the Schedule of Benefits, by the Participant for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible or the Out-of-Pocket Maximum.

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

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

"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 engaged within the scope of such person or entity's license in the practice of any of the following:

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

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

"QMCSO": a 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;
A proceeding under Title II of COBRA with respect to the 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 Participant's benefit within a certain time frame. The limits established for these drugs are based on FDA approved indications.

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

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

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

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

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

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

"Speech Therapy": is a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but do have deficits in higher level language functioning as a result of trauma or identifiable organic disease process.

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

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

"Substance Abuse Services": services or treatment relating to Substance Abuse.

"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": means that the Participant is able to 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 Physician's statement of disability upon periodic request by the Employer's Group Health Plan.

"Transplant": The transplant of organs from human to human, including bone marrow, stem cell and cord blood transplants. Transplants include only those transplants that: (a) are approved for Medicare coverage on the date the Transplant is performed; and (b) are not otherwise excluded by this Plan of Benefits.

A Transplant must be performed at a Transplant Facility in order to be considered for reimbursement under this Plan of Benefits. Skin and Cornea transplants are not considered a Transplant for the purpose of determining eligible expenses under this Plan of Benefits.

"Transplant Facility": A hospital which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a Transplant and:

- For organ transplants: is an approved member of the United Network for Organ Sharing for such Transplant or is approved by Medicare as a transplant facility for such Transplant;
- For unrelated allogeneic bone marrow or stem cell transplants: is a participant in the National Marrow Donor Program;
- For autologous stem cell transplants: is approved to perform such Transplant by:
    a. the state where the Transplant is to be performed;
    b. Medicare;
    c. the Foundation for the Accreditation of Hemopoietic Cell Therapy

Outpatient transplant facilities must be similarly approved.

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

The Claims Administrator will determine whether a claim is an urgent care claim based on the information provided at the time that the claim is submitted.

"Urgent Care Claims": any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function; or, in the opinion of a medical doctor or oral surgeon with knowledge of the Participant's medical condition, would subject the Participant 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.

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