Terms To Know

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This section explains some of the terms used throughout this *MPTN Advantage* Plan Document and SPD. Please refer to it as you encounter terms that require clarification or explanation.

For More Information …

If you need more information about participating in health care coverage, including eligibility, contact Human Resources at 1-888-287-4369.

Affordable Care Act (applicable to the medical plan)

The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Allowable Expense(s) (applicable to the medical plan)

The Maximum Allowable Amount for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this plan's allowable expenses shall in no event exceed the other plan's allowable expenses.

When some "other plan" provides benefits in the form of services (rather than cash payments), the plan administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Ambulatory Surgical Facility (applicable to the medical plan)

A health care facility that provides surgical services, but usually does not have overnight accommodations. Such a facility must be licensed as an ambulatory surgical facility, by the state in which it is located, or must be owned or operated by a hospital licensed by the state in which it is located.

Approved Clinical (applicable to the medical plan)

A phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "approved clinical trial," the plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate, or the participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted

and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan's network area unless out-of-network benefits are otherwise provided under the plan.

Beneficiary

Your beneficiary is the person or entity you designate (or who is designated by the terms of the benefit plan), who is or may become entitled to a benefit from the plan.

Benefit Period

A plan year — January 1 – December 31.

Cause

"Cause" is defined by the Plan as a continuous treatment prescribed within a clinical treatment plan for a specific diagnosis.

Child

In addition to the employee's own blood descendant of the first degree or lawfully adopted child, a child placed with a covered employee in anticipation of adoption, a covered employee's child who is an alternate recipient under a Qualified Medical Child Support Order as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other child for whom the employee has obtained legal guardianship.

Claim (applicable to the medical plan)

A request for a plan benefit or benefits, made by a plan beneficiary in accordance with the plan's reasonable procedure for filing such requests for benefits. Claims include requests for:

- the approval of benefits for urgent care (urgent care claims),
- the approval of care before the care has been provided (pre-service claims, such as pre-certification),
- the approval of care after the care has been provided, and
- the approval of a course of care previously approved by the plan but for which benefits are now being denied or reduced (concurrent care claims).

Clean Claim (applicable to the medical plan)

A "clean claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A clean claim does not include claims under investigation for fraud and abuse or claims under review for medical necessity and reasonableness, or fees under review for usual and customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim (applicable to the medical plan)

A provider submits a clean claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The plan administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a clean claim if the plan participant has failed to submit required forms or additional information to the plan as well.

Coinsurance (applicable to the medical and dental plans)

The percentage stated in the Benefit Summary that the insured will pay for a covered service after a person receiving the service has satisfied any applicable deductible.

Copay (applicable to the medical and dental plans)

A flat amount you pay directly to the provider.

Covered Compensation (applicable to the 401(k) plan)

For 401(k) Plan purposes, covered compensation includes the following:

- Salary and wages,
- Overtime pay,
- Reported tips,
- Tokes,
- Your annual bonus, commissions, shift differential, and gratuities,
- Before-tax contributions you make to your 401(k) account, health care coverage, flexible spending accounts (health care and/or dependent care), and
- Any other applicable compensation reportable on your W-2.

Covered compensation does not include the following:

- Moving reimbursements,
- Severance pay,
- Certain taxable income not directly related to service performed (such as cash and non-cash gifts and awards under team member achievement programs and Human Resources campaigns),
- Any imputed income derived from MPTN-paid group term life insurance, and any other amounts contributed to team member benefit plans for which a deduction is permitted under the Internal Revenue Code, and
- Compensation in excess of IRS limits, which relates to the limit on compensation that can be recognized in a tax-qualified retirement plan.

Custodial Care (applicable to the dependent care flexible spending account)

Services for personal care such as help in walking and getting out of bed, assistance in bathing, dressing, feeding, and using the toilet, supervision or medication which can usually be self-administered and services which do not entail or require the continuing attention of trained medical or paramedical personnel.

Deductible (applicable to the medical and dental plans)

The specific dollar amount stated in the Benefit Summary that each participant must pay for covered services in a benefit period before the plan pays benefits.

Dependent Children

Eligible dependent children include children:

- **By birth**
- **By adoption**
- **By marriage (that is, stepchildren), and for whom you are legally responsible.**

Disabled (applicable to the short-term disability plan)

The defined term “disabled” is used by the STD Plan. For the LTD Plan, see the defined term “totally disabled.”

You are considered disabled if, due to your illness or injury:

- You are unable to perform the material and substantial duties of your regular occupation, and
- You are not working in any occupation.

Emancipation

A person under 18 years of age, who is totally self-supporting and according to applicable law, has become emancipated.

Emergency (applicable to the medical plan)

The sudden onset of a medical condition of sufficient severity that, in the absence of immediate medical attention, could result in:

- permanently placing a beneficiary's health in jeopardy,
- causing other serious medical consequences,
- causing serious impairments to body functions, or
- causing serious or permanent dysfunction of any body organ or part.

Emergency Medical Condition (applicable to the medical plan)

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services (applicable to the medical plan)

With respect to an Emergency Medical Condition:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient; and
- Additional services, as medically required under ERISA section 716 and underlying regulations.

Employer

The employer is the Mashantucket Pequot Tribal Nation (MPTN), which shall include the following divisions:

- The Mashantucket Pequot Tribal Government, and all governmental entities, including:
    - The Mashantucket Pequot Museum and Research Center,
    - PRxN/Pequot Plus Health Benefit Services, and
    - The Mashantucket Pequot Gaming Enterprise (doing business as Foxwoods Resort Casino).

Essential Health Benefits (applicable to the medical plan)

"Essential health benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are essential health benefits shall be made in accordance with the benchmark plan of the State of Connecticut as permitted by the Departments of Labor, Treasury, and Health and Human Services.

Experimental/Investigative (applicable to the medical plan)

Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an approved clinical trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
- Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    - maximum tolerated dose;
    - toxicity;
    - safety;
    - efficacy; and
    - efficacy as compared with the standard means of treatment or diagnosis;
- If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    - maximum tolerated dose;
    - toxicity;
    - safety;
    - efficacy; and
    - efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

- Only published reports and articles in the authoritative medical and scientific literature;
- The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The plan administrator retains maximum legal authority and discretion to determine what is experimental.

Family Deductible (applicable to the medical plan)

A family deductible is met when the accumulation of all individual family member's deductibles combined, not exceeding each member's individual deductible, meet the total family deductible amount. A new deductible applies each year.

Family Out-of-Pocket Maximum (applicable to the medical plan)

The family out-of-pocket maximum is met when the accumulation of all individual family member's out-of-pocket expenses combined, not exceeding each member's individual out-of-pocket maximum, meet the total family out-of-pocket maximum. A new out-of-pocket maximum applies each year.

FML

Means the MPTN Family and Medical Leave Policy.

FML Leave

Means a leave of absence, which the Company extends to an Employee under the provisions of the FML.

GINA (applicable to the medical plan)

Means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

Home Health Care Agency (applicable to the medical plan)

A public agency or private organization that provides services in a beneficiary's home. All providers must be certified as such by the state in which they operate or deliver services.

Hospice Home Care (applicable to the medical plan)

An alternative to lengthy treatment for a terminally ill patient. The patient's physician must establish a plan of treatment and the services must be provided by an approved provider of hospice care. A wide range of in-home services are available, including prescription drugs, medical supplies, durable medical equipment, and other essential medical services.

Hospital (applicable to the medical plan, the short-term disability plan, and the long-term disability plan)

A legally constituted institution having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by a registered nurse on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or a facility operated exclusively for the treatment of the aged, drug addicted, or alcoholic, whether or not such facilities are operated as a separate institution by a hospital.

A hospital must be licensed and accredited by the Joint Commission on Accreditation of Hospitals.

Incurred (applicable to the medical and dental plans)

Means that a covered expense is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Inpatient (applicable to the medical plan)

An individual who is treated as a registered bed patient in a hospital or skilled nursing facility and for whom a room and board charge is made.

Intensive Care or Coronary Care Units (applicable to the medical plan)

Those areas of a hospital where necessary supplies, medications, equipment and a skilled staff are available to provide care to critically or seriously ill patients who require constant observation.

Kidney Dialysis Clinic (applicable to the medical plan)

A facility that provides kidney dialysis services. For its services to be considered covered, the facility must be approved by Medicare.

Licenses and Certifications (applicable to the short-term disability and the long-term disability plans)

Please note that the loss of a professional or occupational license or certification does not, by itself, amount to a disability or total disability.

Maximum Allowable Amount (applicable to the Pequot Open Plan)

For physicians and ancillary services: The maximum benefit payable for a specific coverage item or benefit under the plan. The **Maximum Allowable Amount** will be a negotiated rate, if one exists. If and only if there is no negotiated rate for a given claim, the plan administrator will exercise its discretion to determine the **Maximum Allowable Amount** based on any of the following:

Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

For hospitals/facilities: The **Maximum Allowable Amount** shall mean the benefit payable for a specific coverage item or benefit under the plan. The **Maximum Allowable Amount** will be a negotiated rate, if one exists; if no negotiated rate exists, the **Maximum Allowable Amount** will be determined by the plan to be the Medicare reimbursement rates utilized by the Centers for Medicare and Medicaid Services ("CMS"), based on current-year CMS data for the year in which the date of service occurs, multiplied by 140%.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

1. Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS;
2. Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care; or
3. Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings.

No participant shall be entitled to and in no event will the Plan's maximum liability for any claim exceed the **Maximum Allowable Amount**.

The **Maximum Allowable Amount** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary (applicable to the medical plan)

Medical Care Necessity, Medically Necessary, Medical Necessity and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a plan participant for the purposes of evaluation, diagnosis or treatment of that plan participant's sickness or injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the plan participant's sickness or injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the plan participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the plan participant's sickness or injury without adversely affecting the plan participant's medical condition.

- It must not be maintenance therapy or maintenance treatment. Its purpose must be to restore health.
- It must not be primarily custodial in nature.
- It must not be a listed item or treatment not allowed for reimbursement by the Centers for Medicare and Medicaid Services (CMS) .
- The plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an allowable expense.

For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the participant is receiving or the severity of the participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the plan administrator's own medical advisors. The plan administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review (applicable to the medical plan)

Medical Record Review is the process by which the plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the plan administrator may determine the Maximum Allowable Amount according to the medical record review and audit results.

Medical Utilization Company (applicable to the medical plan)

A third party contracted by the plan to provide pre-certification, concurrent care review, retrospective review of claims to ensure the care was medically necessary, and review of care for appropriate treatment setting and level of care.

Mental or Nervous Disorder (applicable to the medical plan)

Means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

Monthly Earnings (applicable to the long-term disability plan)

Your usual monthly rate of pay from the Employers as of your last day worked plus the tips and tokes, as determined by Employer, as of the date of disability It includes income actually received from commissions, but does not include:

- bonuses,
- overtime pay, shift differential or
- any other fringe benefit or extra compensation.

Commissions will be average for the lesser of:

- The 12 full calendar month period of your employment with your Employer just prior to the date of loss; or
- The period of actual employment with your Employer.

Other Plan (applicable to the medical plan)

“Other plan” shall include, but is not limited to:

1. Any primary payer besides the plan.
2. Any other group health plan.
3. Any other coverage or policy covering the participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers’ compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Outpatient (applicable to the medical plan)

An individual who receives services or supplies while not an inpatient.

Out-of-Pocket Maximum (applicable to the medical plan)

The limit on covered expenses you pay each plan year. When you reach this maximum, the plan pays 100% of covered benefits.

Outpatient Surgery (applicable to the medical plan)

Surgical services performed in an outpatient department of a hospital, in a doctor’s office or in a surgical center.

Participant

Any employee or dependent who is eligible for benefits (and enrolled) under the plan.

Patient Protection and Affordable Care Act (PPACA) (applicable to the medical plan)

The “Patient Protection and Affordable Care Act (PPACA)” means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See “Affordable Care Act”).

Physician

A legally licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), performing covered services that are within the scope of his or her license. Doctors of Dental Surgery (D.D.S.), Doctors of Dental Medicine (D.M.D.), Doctors of Optometry (O.D.), Doctors of Podiatric Medicine (D.P.M.) and Doctors of Chiropractic (D.C.) will be considered physicians when performing covered services that are within the scope of their licenses.

Plan Year

January 1 – December 31.

Pre-Admission Testing (applicable to the medical plan)

X-rays, electrocardiogram and laboratory tests made on an outpatient basis within seven (7) days before admission to the hospital.

Pre-Certification (applicable to the medical and dental plans)

Obtaining a third-party approval to ensure a requested procedure is medically necessary and delivered in the clinically appropriate setting. Pre-certification approval does not always mean the procedure is covered by the plan.

Pre-Existing Conditions (applicable to the short-term disability and long-term disability plans)

A pre-existing condition is any condition for which:

- You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines during the three months just prior to your effective date of coverage or any increase in coverage, and
- The disability begins in the first 12 months after your effective date of coverage.

Prior to Effective Date or After Termination Date

Prior to Effective Date or After Termination Date are dates occurring before a participant gains eligibility from the plan, or dates occurring after a participant loses eligibility from the plan, as well as charges incurred prior to the effective date of coverage under the plan or after coverage is terminated, unless Extension of Benefits applies.

Reasonable (applicable to the medical plan)

Reasonable and/or reasonableness shall mean in the administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the plan administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) the national medical associations, societies, and organizations; (b) the Centers for Medicare and Medicaid Services (CMS); and (c) the Food and Drug Administration (FDA). To be reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The plan administrator

retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the plan administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable.

Charge(s) and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Amount), when they result from provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the plan, to identify charge(s) and/or service(s) that are not reasonable and therefore not eligible for payment by the plan.

Restorative Therapy (applicable to the medical plan)

Services that are provided to restore function when there is an expectation that a condition will improve significantly in a reasonable period of time.

Residential Treatment Facility (applicable to the medical plan)

A facility which is primarily engaged in providing detoxification and rehabilitation treatment for alcoholism and substance abuse. A residential treatment facility must be licensed and accredited by the Joint Commission on Accreditation of Hospitals.

Serious and Sudden Illness (applicable to the medical plan)

An ailment which, if not immediately diagnosed and treated, would lead to death. Please see the following list as examples of sudden and severe illnesses:

- Convulsions
- Drowning
- Edema, pulmonary
- Embolism, cerebral, pulmonary
- Epitasis (nosebleed), severe, uncontrolled
- Heat exhaustion and prostration
- Hemophilia, acute bleeding
- Hemorrhage, severe uncontrolled
- Hypertension, acute crisis
- Ketoacidosis
- Kidney stones, acute attack
- Larynx, foreign body removal
- Menorrhagia, profuse
- Myocardial Infraction
- Paralysis
- Poisoning due to drugs (by injection or overdose), carbon monoxide, plants, insecticide, heavy metals, venom, chemicals
- Seizures, acute
- Venomous animal bites

Skilled Nursing Facility (applicable to the medical plan)

An institution or distinct part of an institution that provides skilled nursing services to its patients. It must provide more than custodial care and be licensed by the state. A skilled nursing facility must be licensed and accredited by the Joint Commission on Accreditation of Hospitals.

Substance Abuse and/or Substance Use Disorder (applicable to the medical plan)

Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially

alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of “Substance Use Disorder” is applied as outlined below.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12 month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household).
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
- Craving or a strong desire or urge to use a substance.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Substance Abuse Treatment Facility (applicable to the medical plan)

A provider of continuous structured 24 hours per day programs of inpatient treatment and rehabilitation for drug dependency or alcoholism. A substance abuse treatment facility must be licensed to provide this type of care by the state in which it operates and be accredited by the Joint Commission on Accreditation of Hospitals.

Totally Disabled (applicable to the short-term disability and long-term disability plans)

The defined term “totally disabled” is used by the LTD Plan. For the STD Plan, see the defined term “disabled.”

For the first 24 months that you are disabled, you are considered totally disabled and eligible for LTD benefits if:

- You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and You have a 20% or more loss in monthly earnings due to the same illness or injury.

After the first 24 months that you are disabled, you are considered totally disabled and eligible for LTD benefits if:

- You are working in any occupation and continue to have a 20% or more loss in monthly earnings due to your illness or injury, or
- You are not working and, due to the same illness or injury, are unable to erform the duties of any gainful occupation for which you are reasonably suited by education, training, or experience.

Total and Permanent Disability (applicable to the 401(k) plan)

For purposes of the 401(k) Plan, a total and permanent disability is a physical or mental impairment, permanent in nature, that:

- results in a team member being unable to continue in his or her normal employment duties for the employer, and
- can be expected to result in death or to be of long, continued and indefinite duration.

A 401(k) Plan participant who qualifies for federal Social Security disability benefits will be considered to have suffered a total and permanent disability.

Usual and Customary (applicable to the medical plan)

Covered expenses which are identified by the plan administrator, taking into consideration any or all of the following: the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply; the cost to the provider for providing the services; the prevailing range of fees charged in the same “area” by providers of similar training and experience for the service or supply; and/or the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health

care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term “customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term “usual and customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The plan administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and customary charges may, at the plan administrator’s discretion, alternatively be determined and established by the plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Weekly Earnings (applicable to the short-term disability plan)

Your usual weekly rate of pay from the Employers as of your last day worked plus the tips and tokes, as determined by Employer, as of the date of disability. It includes income actually received from commissions, but does not include:

- bonuses,
- overtime pay, shift differential or
- any other fringe benefit or extra compensation

Commissions will be average for the lesser of:

- the 52 full calendar week period of your employment with your Employer just prior to the date of disability begins; or
- the period of actual employment with your Employer.