Local Education Plan Document

The legal publication that defines eligibility, enrollment, benefits and administrative rules of the state group insurance program

2016

TABLE OF CONTENTS

INTRODUCTION **1**
ASSIGNMENT. 1
CHOICE OF LAWS. 2
CONFLICT OF PROVISIONS. 2
EXECUTION OF THE PLAN. 2
FRAUD. 2
LIABILITY OF EMPLOYER. 2
PLAN IS NOT A CONTRACT OF EMPLOYMENT. 2
ARTICLE I DEFINITIONS **3**
1.01 "BENEFIT ANALYSIS" 3
1.02 "BENEFITS ADMINISTRATION" 3
1. 03 "CLAIMS ADMINISTRATOR" 3
1. 04 "COBRA" 3
1. 05 "COBRA PARTICIPANT" 3
1. 06 "COMMITTEE" 3
1. 07 "COVERAGE(S)" 4
1.08 "COVERED EXPENSES" 4
1.09 "COVERED PERSON" 4
1.10 "CUSTODIAL CARE" 4
1.11 "DEPENDENTS" 4
1.12 "DURABLE MEDICAL EQUIPMENT" 5
1.13 "ELIGIBILITY DATE" 5
1.14 "EMERGENCY" 5
1.15 "EMPLOYEE" 6
1.16 "EMPLOYEE ASSISTANCE PROGRAM (EAP) SERVICES ADMINISTRATOR" 6
1.17 "EMPLOYER" 6
1.18 "FAMILY AND MEDICAL LEAVE" 7
1.19 "FORMULARY" 7
1.20 "GRANDFATHERED" 7
1.21 "HIPAA" 8
1.22 "ILLNESS" 9
1.23 "INJURY" 9
1.24 "INPATIENT" 9
1.25 "IN-NETWORK" 9
1.26 "JOINT CUSTODY" 9
1.27 "LEAVE OF ABSENCE" 9
1.28 "LEGAL CUSTODY" 9
1.29 "LEGAL GUARDIAN" 9
1.30 "LOCAL EDUCATION AGENCY (LEA)" 9
1.31 "MAXIMUM ALLOWABLE CHARGE" 10
1.32 "MEDICALLY NECESSARY" OR "CLINICALLY NECESSARY" 10
1.33 "MEDICAL SUPPLIES" 10
1.34 "MEDICARE" 10
1.35 "MEMBER HANDBOOK" 11
1.36 "MEMORANDUM OF UNDERSTANDING (MOU)" 11
1.37 "OUT-OF-NETWORK" 11
1.38 "OUT-OF-POCKET EXPENSES" 11
1.39 "OUTPATIENT" 11
1.40 "OUTPATIENT SURGERY" 12
1.41 "PARTNERS FOR HEALTH WELLNESS PROGRAM" 12
1.42 "PARTNERSHIP PROMISE" 12
1.43 "PHARMACY BENEFITS MANAGER (PBM)" 12
1.44 "PLAN" 12
1.45 "PLAN YEAR" 12
1.46 "POSITIVE PAY STATUS" 12
1.47 "PREFERRED PROVIDER ORGANIZATION (PPO)" 12

1.48 "Pregnancy" 13
1.49 "PCP" or "Primary Care Physician" 13
1.50 "Prior Authorization" 13
1.51 "Provider" 14
1.52 "Qualified Beneficiary" 16
1.53 "Qualifying Event" 16
1.54 "Retiree" 16
1.55 "Shared Parenting" 17
1.56 "Specialist" 17
1.57 "State" 17
1.58 "Urgent Care" 17
1.59 "Utilization Review Organization" 17
ARTICLE II ELIGIBILITY AND ENROLLMENT 18
2.01 Employee Eligibility. 18
2.02 Eligibility of Re-hired Employees. 18
2.03 Employee Enrollment and Effective Date of Coverage. 18
2.04 Dependent Eligibility. 19
2.05 Dependent Enrollment and Effective Date of Coverage. 19
2.06 Substantiation of Dependent Eligibility. 20
2.07 Employee and Spouse Both Employed by the Employer. 21
2.08 Late Applicant Requirements. 21
2.09 Transferring Between Health Insurance Plans. 23
2.10 Election of a Plan Option. 23
ARTICLE III PARTICIPATION DURING APPROVED LEAVE AND REINSTATEMENTS 25
3.01 Continuation of Coverage during Leave of Absence. 25
3.02 Coverage for Spouse Who Is an Employee on Leave of Absence 25
3.03 Suspension of Coverage During Leave of Absence. 25
3.04 Reinstatement of Coverage Following Suspension of Coverage. 25
3.05 Reinstatement of Coverage Following Termination of Employment. 26
3.06 Coverage Reinstatement Following Voluntary Cancellation. 26
3.07 Reinstatement for Military Personnel Returning from Active Service 26
ARTICLE IV COVERAGE TERMINATION AND CONTINUATION 28
4.01 Termination of Covered Employee's Participation. 28
4.02 Termination of Dependent Participation. 28
4.03 Continuation of Dependent's Participation upon Death of a Covered Employee. 28
4.04 Continuation after Covered Employee's Work-Related Injury. 29
4.05 Continuation of Coverage for Disabled Employees 29
4.06 Continuation of Coverage for Retirees. 31
4.07 Limited Continuation of Coverage (COBRA). 35
4.08 Conversion Privileges. 37
ARTICLE V COORDINATION OF MEDICAL BENEFITS 39
5.01 General. 39
5.02 Definitions. 39
5.03 Effects on Benefits. 40
5.04 Subrogation. 42
5.05 Right of Reimbursement. 42
5.06 Recovery of Payment. 43
5.07 Dependents Previously Covered as Employees and Employees Previously Covered as Dependents. 43
5.08 Plan Purpose. 43
ARTICLE VI PLAN ADMINISTRATION AND FIDUCIARIES 44
6.01 General. 44
6.02 Liability of the Committee. 44
6.03 Authority and Powers of the Committee. 44
6.04 Fiduciary Duties and Responsibilities. 44
6.05 Appeals Provision. 45
ARTICLE VII CLAIM PROVISIONS 46
7.01 Proof of Claim. 46
7.02 Payment of Benefits. 46
7.03 Examination of Claimants. 46

7.04 Disputed Claim. 46
7.05 Liability for Benefits. 47
7.06 Overpayments and Incorrect Payments. 47
ARTICLE VIII CONTRIBUTIONS. 48
8.01 Employee Contributions. 48
8.02 Employer Contributions. 48
8.03 Funding Medium. 48
ARTICLE IX AMENDMENT AND TERMINATION 50
9.01 Plan Modification and Amendment of Plan. 50
9.02 Plan Termination. 50
9.03 Local Education Agency Termination. 50
ARTICLE X PRIVACY OF PROTECTED HEALTH INFORMATION 52
10.01 Local Education Insurance Committee Certification of Compliance. 52
10.02 Purpose of Disclosure to Local Education Insurance Committee. 52
10.03 Restrictions on Local Education Insurance Committee Use and Disclosure of Protected Health Information. 52
10.04 Adequate Separation between the Local Education Insurance Committee and the Plan. 53
ARTICLE XI MEDICAL BENEFITS 55
11.01 Amount of Benefits. 55
11.02 Deductible Amount. 55
11.03 Coinsurance. 56
11.04 Emergency Room Visit Copayment. 58
11.05 Stop Loss Provision. 58
11.06 Maximum Benefits. 58
11.07 Utilization Management Program(s). 59
ARTICLE XII MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS 64
12.01 Amount of Benefits. 64
12.02 Deductible Amount. 64
12.03 Coinsurance. 65
12.04 Benefits for Detoxification. 66
12.05 Stop Loss. 66
12.06 Maximum Benefits. 66
12.07 Utilization Management. 66
ARTICLE XIII COVERED EXPENSES AND EXCLUSIONS AND LIMITATIONS 68
13.01 Conditions. 68
13.02 Covered Expenses - Generally. 68
13.03 Other Covered Expenses. 74
13.04 Exclusions and Limitations. 80
ATTACHMENT A SCHEDULE OF BENEFITS 85
Attachment A.1 Schedule of Partnership PPO Benefits. 86
Attachment A.2 Schedule of Standard PPO Benefits 91
Attachment A.3 Schedule of Limited PPO Benefits 96
Attachment A.4 Schedule of HealthSavings CDHP Benefits 100
ATTACHMENT B OPTIONAL SECOND SURGICAL OPINION PROCEDURES 103
ATTACHMENT C LIST OF DURABLE MEDICAL EQUIPMENT 105

INTRODUCTION

The State of Tennessee Comprehensive Medical and Hospitalization Program was established pursuant to Chapter 27 of Title 8 of the Tennessee Code Annotated. The Preferred Provider Organization Partnership plan, Preferred Provider Organization Standard plan, Preferred Provider Organization Limited plan, Wellness HealthSavings CDHP and HealthSavings CDHP are healthcare options available as part of a comprehensive medical and hospitalization program for eligible individuals. The availability of the different healthcare options is subject to the specific eligibility criteria and participation requirements in effect at the time of enrollment, reenrollment or continuation of coverage. Health care options and offerings may vary between different groups of eligible individuals. This document contains the terms and conditions of the plans. Covered persons should also review their member handbooks for additional information.

Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in its health programs and activities or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability. If you have a complaint regarding discrimination, please call 866.576.0029 or 615.741.4517.

If you think you have been treated differently, please mail the following to Benefits Administration, Civil Rights Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102:

- Your name, address, phone number and signature. If you write for someone else, include your name, address, phone number and how you are related to that person (for instance wife, lawyer or friend.); and
- The name and address of the program you think treated you in a different way; and
- How, why and when you think you were treated in a different way; and
- Any other key details

If you need free language help or have a disability and need free help or an auxiliary aid or service, for instance Braille or large print, please call 800.253.9981.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 800.368.1019 or TTY/TDD at 800.537.7697.

The following provisions shall be administered as specified below, unless a different meaning or provision is prescribed in the applicable section attached hereto.

Assignment.

Except for assignments of reimbursement payable for coverage for hospital, surgical or medical charges, no assignment of any rights or benefits under the plan shall be of any force. To the full extent permitted by law, all rights and benefits accruing under the plan shall be exempt from execution, attachment, garnishment or other legal or equitable process, for the debts or liabilities of any employee.

Choice of Laws.

This plan shall be governed, construed, administered and regulated in all respects under the laws of the State of Tennessee, except insofar as they shall have been superseded by the provisions of federal law.

Conflict of Provisions.

If any provision or term of this plan is deemed to be substantively at variance with, or contrary to, any law of the United States or applicable state law, the provision of the law shall be deemed to govern.

Execution of the Plan.

This document may be executed in any number of counterparts and each fully executed counterpart shall be deemed an original.

Fraud.

Fraudulent acts (e.g., misrepresentation of claims, etc.) may subject a covered person to disciplinary action including, but not limited to, the recommendation of the employee's termination of employment, termination of insurance coverage, and/or criminal prosecution.

Liability of Employer.

No covered person or qualified beneficiary shall have any right or claim to any benefit under the plan except in accordance with its provisions.

Plan Is Not a Contract of Employment.

The plan shall not be deemed to constitute a contract between the employer and any employee or to be a consideration for, or an inducement or condition of, the employment of an employee. Nothing in the plan shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the employer with the bargaining representative of any employees.

ARTICLE I
DEFINITIONS

As used herein, the following words and phrases shall have the meaning indicated unless otherwise defined or required by the context:

1.01 "Benefit Analysis"
Benefit analysis shall mean the process of insurance benefit review by the claims administrator.

1.02 "Benefits Administration"
Benefits Administration, a division of the Department of Finance and Administration, shall mean the staff of the Local Education Insurance Committee. The staff is responsible for certain administrative functions necessary for administering the plan and may be designated as the committee's representative.

1. 03 "Claims Administrator"
Claims administrator shall mean the entity/organization contractually designated by the state to provide claims adjudication and/or medical management program review and/or provider contracting and/or such other services necessary to assure the proper and efficient administration of the plan.

1. 04 "COBRA"
COBRA (Consolidated Omnibus Budget Reconciliation Act) shall mean the federal and state laws that allow employees, spouses, and/or dependents who are losing their health or dental benefits to continue the same insurance for a specific length of time under certain conditions pursuant to Section 4.07.

1. 05 "COBRA Participant"
COBRA participant shall mean a qualified beneficiary pursuant to Section 4.07 who continues his or her dental and/or health care coverage under the provisions of the federal guidelines in the Consolidated Omnibus Budget Reconciliation Act of 1985 and Public Health Service Act as amended and state COBRA law..

1. 06 "Committee"
Committee shall mean the individuals comprising the Local Education Insurance Committee to whom the administrative duties and responsibilities of the plan are delegated pursuant to Section 6.01 and shall include any authorized representative of the committee. The committee shall be the plan administrator. The Local Education Insurance Committee is composed by law of the Commissioner of Education as designated by the Governor, Commissioner of Finance and Administration, the Commissioner of Commerce and Insurance, the Treasurer, the Comptroller of the Treasury, a representative of local school boards to be selected by the Tennessee School Board Association and three teachers elected to represent the three grand divisions under the procedure contained in TCA 8-34-302.

1. 07 "Coverage(s)"

Coverage(s) shall mean:

(A) Employee Only/Retiree Only – Single coverage for the employee only or retiree only.

(B) Family - Coverage for the employee or retiree and his/her spouse and/or dependents. Family premium tiers for employees include employee + child(ren), employee + spouse, and employee + spouse + child(ren).

Family premium tiers for retirees include retiree + child(ren), retiree + spouse, retiree + spouse + child(ren), spouse only, child(ren) only, and spouse + child(ren).

1.08 "Covered Expenses"

Covered expenses shall mean the maximum allowable, medically necessary incurred expenses, as designated in Article XIII, including surgical and medical care expenses required for diagnosis and treatment of injury or illness.

1.09 "Covered Person"

Covered person shall mean any employee, retiree, COBRA participant or dependent who is covered hereunder.

1.10 "Custodial Care"

Custodial care shall mean services for personal care such as help in walking and getting out of bed, assistance in bathing, dressing, feeding, using the toilet, supervision over medication which can usually be self-administered and services which do not entail or require the continuing attention of trained medical or paramedical personnel. Other examples of custodial care include changing of dressings, diapers, protective sheets, administration of oxygen, care or maintenance in connection with casts, braces or other similar devices, feeding by tube, including cleaning and care of the tube site and care in connection with ostomy bags or devices or indwelling catheters.

1.11 "Dependents"

Dependents shall mean:

(A) A legally married spouse; individual agencies may deny eligibility to the spouses of employees who are eligible for group health insurance through the spouse's employers; or

(B) A child under the age of 26 who meets at least one of the following criteria without consideration of factors such as financial dependency, marital status, enrollment in school, or residency:

(1) employee or retiree's natural (biological) child; or

(2) employee or retiree's adopted child (including a child placed for adoption in anticipation of adoption); or

(3) child for whom the employee/retiree is the legal guardian; or

(5) employee or retiree's child for whom the plan has received a qualified medical child support order requiring the child to be enrolled in a health insurance plan pursuant to State or Federal statutes.

(C) An employee/retiree or spouse's stepchild under the age of 26 for whom the employee/retiree or spouse is providing care or support.

(D) Dependents over the age of 26 who meet at least one of the criteria in 1.11 (B) or (C) of this section and who are incapacitated (mentally or physically incapable of earning a living regardless of age, provided the dependent is incapable of self-sustaining employment). This provision applies only when the incapacity existed before the dependent's 26th birthday and they were already insured by a state-sponsored plan. The child must meet the requirements for dependent eligibility listed in this section. A request to continue coverage due to incapacity must be provided to Benefits Administration prior to the dependent's 26th birthday. Annual proof may also be required. Approval is subject to review of the claims administrator. Coverage will not continue and will not be reinstated once the dependent is no longer incapacitated.

(E) Dependents not eligible for coverage include:

(1) Foster children;

(2) Dependents not listed in the above definitions;

(3) Parents of the employee or spouse;

(4) Ex-spouse; and

(5) Live in companions who are not legally married to the employee.

An employee may not be enrolled as both head of contract and dependent within the local education plan.

1.12 "Durable Medical Equipment"

Durable medical equipment shall mean equipment, which is:

(A) Primarily and customarily used to serve the medical purpose for which prescribed;

(B) Not useful to the patient or other person in the absence of illness or injury; and

(C) Appropriate for use within the home.

The purchase or rental of durable medical equipment must be medically necessary as determined by the claims administrator and prescribed by a physician. Attachment C located at the back of the *Plan Document* provides a list of durable medical equipment.

1.13 "Eligibility Date"

Eligibility date shall mean the date on which an employee or dependent becomes eligible to participate in the plan pursuant to the applicable provision of Article II, hereof. Effective date is defined in Section 2.03 (B).

1.14 "Emergency"

Emergency shall mean a medical condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the

health of the individual in serious jeopardy (or, with respect to pregnant women, the health of her unborn child), serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or danger to self (including psychiatric conditions and intoxication).

1.15 "Employee"

Employee shall mean:

(A) A teacher as defined in TCA 8-34-101-(46);

(B) An interim teacher whose salary is based on the local school system's schedule;

(C) A regular full-time employee not defined above who is regularly scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;

(D) A non-certified employee that has completed 12 months of employment with a local education agency that participates in the plan and works a minimum of 25 hours per week. A resolution passed by the school system's governing body authorizing the expanded 25-hour rule for the local education agency must be submitted to Benefits Administration prior to enrollment. In the case of a county school system, the county's chief legislative body (county commission) must also approve the school system's change in the eligibility provisions;

(E) School board members; or

(F) All other individuals cited in state statute, approved as an exception by the Local Education Insurance Committee, or defined as full-time employees for health insurance purposes by federal law.

Employees not eligible to participate in the plan are:

(A) Any employee who does not meet the definitions outlined above;

(B) Substitute teachers and other individuals in positions classified as temporary appointments, or performing services on a contractual basis, **unless** they otherwise meet the definition of an eligible employee as defined in subsection (F).

1.16 "Employee Assistance Program (EAP) Services Administrator"

Employee assistance program (EAP) services administrator shall mean the entity/organization contractually designated by the state to provide counseling services and/or referral services to all persons who are eligible for health insurance coverage under the Plan. Employees, retirees and COBRA participants must be enrolled in the health Plan.

1.17 "Employer"

(A) Employer shall mean a local education agency, pursuant to TCA 49-3-302, that participates in this plan.

(B) <u>Employer's Additional Requirements for Plan Participation:</u>

(1) The participating employer must agree to have monthly premiums deducted from their bank account via automated clearinghouse (ACH) debit process;

(2) A minimum of 50 percent plus one of all eligible employees must participate in the Local Education Plan;

(3) The participating employer must agree to provide eligibility information on all employees, enroll employees in the plan, adhere to all plan provisions as set forth by the Local Education Insurance Committee and collect applicable premiums according to established procedures;

(4) The participating employer must designate one individual (the local education agency's benefits coordinator) to serve as liaison with Benefits Administration for the purpose of carrying out the responsibilities of plan administration;

(5) The participating employer must offer to eligible employees only those health insurance options sponsored by the Local Education Insurance Committee;

(6) The participating employer must agree to complete and return a Memorandum of Understanding (MOU) as required in Section 1.36 of the Plan Document and must abide by all conditions of the local education memorandum of understanding (MOU); and

(7) A minimum of two years participation in the Local Education Plan is required; if the employer ceases to participate, a 60-day notice indicating the agency's intent to cancel participation is required and that employer is prohibited from rejoining the plan for 24 months from the date of their termination.

(C) Employer's Effective Date of Participation who satisfies the conditions set forth in Section 1.19(A) and 1.19(B) shall be the later of the following:

(1) The first day of the month following the approval of the employer as an eligible participant in the plan by the committee, or its representative; and

(2) The first date of the month following the enrollment period for all eligible employees in the plan.

1.18 "Family and Medical Leave"

Family and medical leave shall mean a leave of absence granted for a period not to exceed 12 work weeks in a 12 month period for an employee's serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. Individuals on family and medical leave shall continue to receive the state support of their health insurance premium. Initial approval for family and medical leave is at the discretion of each agency head. Employees must have completed a minimum of 12 months of employment and worked 1250 hours in the 12 months immediately preceding the onset of leave.

1.19 "Formulary"

Formulary, or preferred drug list (PDL), shall mean a listing of prescription medications which are preferred for use by the plans and which will be dispensed by participating pharmacies to covered employees and their covered dependents. Such a list is subject to periodic review and modification by the pharmacy benefits manager (PBM).

1.20 "Grandfathered"

Grandfathered shall mean:

(A) Active employees – When an agency joins the plan for the first time, the plan may enroll any active employee of the agency who does not meet the plan's definition of employee if that employee is on the agency payroll and was insured on the agency medical insurance the month prior to the agency enrolling in the plan. The agency must provide to the plan a copy of the billing from the previous medical insurance carrier when requesting a grandfather status for the active employee. After approval, if the active employees' medical coverage on the plan lapses for any reason, the employee is no longer eligible for the grandfather status and may rejoin the plan under the provisions of Sections 1.17 and 2.08.

(B) Dependents – Dependents of active employees who do not meet the plan's definition of dependent may be enrolled when the agency joins the plan for the first time. The agency must provide a copy of the dependent definition from the previous carrier and proof of former coverage to the plan when requesting approval for a grandfathered status for the dependent.

(C) Retirees – When an agency joins the plan for the first time, the plan may enroll any retired employee and their dependent(s) under the age of 65 in the medical plan on the date of the agency's initial enrollment if those individuals were participating with the agency's employee group medical plan in the month prior to the date the agency joins the plan. Retirees and dependents of any age who are never eligible for Medicare may also be enrolled in the medical plan if they were participating with the agency's employee group medical plan in the month prior to the date the agency joins they plan. The agency must provide to the plan a copy of the billing from the previous medical insurance carrier when requesting a grandfather status for the retired employee or their dependent(s). If the coverage lapses for any reason other than agency termination, the retiree and their dependent(s) may not rejoin the plan under retiree coverage.

All coverages for grandfathered retirees and their dependents will cease if their former employer ceases to participate in the plan or premiums are not paid when due.

Retirees or their spouses over the age of 65 who are Medicare eligible will not be grandfathered into the medical plan. The retiree may, however, request enrollment in the Medicare Supplement for themselves and their eligible dependent(s) subject to meeting all eligibility rules for that plan as defined in State law and the Medicare Supplement Plan Document. Medical underwriting will be waived for eligible individuals.

Retirees whose first employment with a participating agency commenced on or after July 1, 2015 will not be grandfathered into the medical plan and those retirees are not eligible for enrollment in the Medicare Supplement plan. It shall be the employer's responsibility to assist ineligible retirees and their dependent(s) with finding other coverage.

1.21 "HIPAA"

HIPAA (Health Insurance Portability and Accountability Act) shall mean the federal and state laws pertaining to portability between health plans, governing special enrollment provisions that may allow employees, spouses, and/or dependents to enroll under certain conditions pursuant to Section 2.08(A).

1.22 “Illness”

Illness shall mean sickness or disease, including mental infirmity, which requires treatment by a physician. For purposes of determining benefits, “illness” includes pregnancy.

1.23 “Injury”

Injury shall mean any bodily injury sustained by any covered person, which requires treatment by a physician, or is ordered by a physician and is determined to be medically necessary by the claims administrator.

1.24 “Inpatient”

Inpatient shall mean an individual who is treated as a registered bed patient in a hospital, alcohol or drug dependency treatment facility, or skilled nursing facility and for whom a room and board charge is made and who is confined for more than a 23 hour period.

1.25 “In-Network”

In-network shall mean the services received and the reimbursement level available when rendered by doctors, caregivers, and medical facilities participating in an agreement with the state’s contracted claims administrators. Services provided are subject to specific terms and rates. The benefit level when using providers in a health plan’s network is referred to as “in-network” on the benefit summary chart.

1.26 “Joint Custody”

Joint custody shall mean that the employee or spouse has joint custody of a child together with the ex-spouse, as evidenced by the spouse’s divorce decree.

1.27 “Leave of Absence”

Leave of absence shall mean an employer authorized temporary absence from employment or duty with intention to return.

1.28 “Legal Custody”

Legal custody shall mean that the employee or spouse has sole custody of a child.

1.29 “Legal Guardian”

Legal guardian shall mean a person lawfully invested with the power, and charged with the duty, of taking care of a person.

1.30 “Local Education Agency (LEA)”

Local education agency (LEA) shall mean a local education agency pursuant to TCA 49-3-302.

1.31 "Maximum Allowable Charge"

Maximum allowable charge shall mean the highest dollar amount of reimbursement allowed by either the primary or secondary plan for a particular covered service. Such amount is based on the fees negotiated between the claims administrator and certain physicians, health care professionals or other providers and whether covered services are received from providers contracting with the claims administrator or not contracting with the claims administrator.

1.32 "Medically Necessary" or "Clinically Necessary"

Medically necessary or clinically necessary shall mean services or supplies, which are determined by a physician to be essential to health and are:

(A) Provided for the diagnosis or care and treatment of a medical, mental health/substance abuse or surgical condition;

(B) Appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition;

(C) Within standards of medical practice recognized within the local medical community;

(D) Not primarily for the convenience of the covered person, nor the covered person's family, physician or another provider; and

(E) Performed in the most appropriate, cost effective and safe setting or manner appropriate to treat the covered person's medical condition. The fact that a physician has prescribed, performed, ordered, recommended or approved a service or treatment does not, in and of itself, make it medically necessary and appropriate. The claims administrator will determine if an expense is medically necessary and/or clinically necessary.

1.33 "Medical Supplies"

Medical supplies shall mean reusable or disposable supplies, which are:

(A) Prescribed by the patient's physician;

(B) Medically necessary and/or clinically necessary, as determined by the claims administrator, for treating an illness or injury;

(C) Consistent with the diagnosis;

(D) Recognized as therapeutically effective; and

(E) Not for environmental control, personal hygiene, comfort or convenience.

Examples of supplies that are covered under the medical benefit include oxygen facemasks, sheepskin (lambs wool pads), and sitz bath. Examples of supplies covered under the pharmacy benefit include glucose test strips and lancets.

1.34 "Medicare"

Medicare shall mean Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as now constituted or as hereafter amended.

1.35 "Member Handbook"

Member Handbook shall mean the applicable handbook for the specific medical coverage enrollment made by a covered person with regard to plan option and claims administrator. The handbook explains many features of the plan in support of the Plan Document. It also contains benefit details for covered services and exclusions which may change from one plan year to another. The member handbook is mailed annually to a covered person's home address. Electronic versions are posted on the Benefits Administration website. Covered persons are responsible for reviewing the handbooks and complying with the stated rules and limitations of the plan.

1.36 "Memorandum of Understanding (MOU)"

Memorandum of Understanding shall mean the document which defines the administrative responsibilities of the Tennessee Department of Finance and Administration, Benefits Administration (BA) and participating employers.

Participating employers shall be responsible for completing and returning a MOU prior to enrolling in the plan, within thirty (30) days of notification of modification or amendment of a previous MOU, or as otherwise requested by Benefits Administration. A modified or amended MOU, presented by the committee or Benefits Administration acting as the committee's representative, supersedes and replaces all prior MOUs. A participating employer failing to complete and return a MOU as provided in this section, or failing to abide by all provisions of the MOU, shall be subject to administrative action as specified in TCA 8-27-303 or the MOU, up to and including, delayed enrollment, suspension of claims payment for persons covered through the employer, and an employer's termination from the plan. Benefits Administration reserves the authority to determine appropriate action for a participating employer's non-compliance or to extend compliance deadlines based on extenuating circumstances.

1.37 "Out-of-Network"

Out-of-network shall mean the services received and the reimbursement level available when rendered by doctors, caregivers, medical facilities, and pharmacies that are not participating in an agreement with the state's contracted claims administrators to provide services according to specific terms and rates. The benefit level when using providers who are not in a health plan's network is referred to as "out-of-network" on the benefit summary chart.

1.38 "Out-of-Pocket Expenses"

Out-of-pocket expenses shall mean the sum of any deductible or coinsurance amounts required or incurred for any covered expense under the plans. Only eligible expenses apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

1.39 "Outpatient"

Outpatient shall mean any person receiving medical treatment or services on a basis other than as an inpatient.

1.40 "Outpatient Surgery"

Outpatient surgery shall mean surgery performed in an outpatient department of a hospital, in a physician's office or in a freestanding ambulatory surgical center.

1.41 "ParTNers for Health Wellness Program"

ParTNers for health wellness program shall mean the program designed to provide assistance and support to employees wishing to adopt and/or maintain a healthy lifestyle. The program is available to eligible plan members and their covered dependents.

1.42 "Partnership Promise"

Partnership promise shall mean the annual commitment required by covered persons enrolled in the partnership PPO, whereby they agree to take certain steps to get or stay healthy. In order to remain in the partnership PPO, covered persons must meet the required commitment for the current plan year.

1.43 "Pharmacy Benefits Manager (PBM)"

Pharmacy benefits manager shall mean the entity/organization contractually designated by the state to provide claims adjudication and/or pharmacy management program review and/or provider contracting and/or such other services necessary to ensure the proper and efficient administration of the plan's pharmacy benefits.

1.44 "Plan"

Plan shall mean the applicable State of Tennessee Comprehensive Medical and Hospitalization Program, detailed in the Introduction to this document. Plan may also mean specific group plans within the larger comprehensive plan, such as the State Plan, the Local Education Plan, or the Local Government Plan.

1.45 "Plan Year"

Plan year shall mean the 12-month period beginning January 1 and continuing through December 31.

1.46 "Positive Pay Status"

Positive pay status shall mean receiving monetary compensation even if the employee is not actually performing the normal duties of their job. This is related to annual leave, sick leave, compensatory leave and any other type of approved leave with pay.

1.47 "Preferred Provider Organization (PPO)"

Preferred Provider Organization (PPO) shall mean the State of Tennessee Preferred Provider Organization Medical and Hospitalization Program. This is a health insurance plan where PPO plan participants choose in-network or out-of-network providers. A network provider accepts a maximum allowable charge. The participant is responsible for a fixed copayment for some services and a deductible and percentage or coinsurance of the maximum allowable charge for other services as indicated in Attachment A of the

applicable section. A participant utilizing an out-of-network provider is responsible for a larger share of the cost, which is reflected in increased copayments, coinsurance, and deductible amounts as well as charges above the maximum allowable charge.

There are three PPO options. The Partnership PPO requires employees and their covered spouses to fulfill a Partnership Promise. In exchange for taking a more active role in their health, Partnership PPO participants are rewarded with lower premiums and out-of-pocket costs. The Standard PPO offers the same benefits but premiums and out-of-pocket costs are higher. The Limited PPO also offers the same benefits but is a high-risk catastrophic policy.

1.48 "Pregnancy"

Pregnancy shall include prenatal care, childbirth, miscarriage or any complications arising during any pregnancy and post-natal care.

1.49 "PCP" or "Primary Care Physician"

PCP or primary care physician shall mean a general practitioner, a doctor who practices family medicine or internal medicine, an OB/GYN or a pediatrician. Nurse practitioners, physician assistants, and nurse midwives may also be considered primary-type providers when working under the supervision of a primary care provider. PCP selection is not required, but covered persons are encouraged to seek routine care from the same primary-type provider whenever possible for the purpose of establishing a medical home.

1.50 "Prior Authorization"

Prior authorization shall mean the process by which a provider requests approval from the claims administrator for medically or clinically necessary medical or behavioral health/substance abuse inpatient admissions, prescriptions, procedures, tests, services, or supplies in advance of extending such treatment or care to a covered person. Prior authorization is designed to encourage the delivery of medically or clinically necessary treatment or care in the most appropriate setting, consistent with the medical needs of the covered person and with patterns of care of an established managed care environment for treatment of a particular illness, injury, or medical condition. No benefits will be provided for services which are not medically necessary or clinically necessary as determined by the claims administrator. Covered persons should review their current year member handbook or contact the claims administrator for a list of benefits that require prior authorization. Maternity admissions and emergency situations do not require prior authorization.

Network providers are contractually obligated to obtain authorization for certain services. If a network provider fails to obtain such authorization, no benefits will be paid, and both the plan and the covered person shall be held harmless.

Out-of-network providers are not contracted. Therefore, there is no mechanism for holding covered persons harmless when out-of-network providers fail to obtain authorization. When a covered person receives medically or clinically necessary care from an out-of-network provider, the covered person should verify with the claims administrator that prior authorization has been requested and approved in advance of receiving care. When prior authorization is required but not obtained, benefits for medically or clinically necessary services

received out-of-network will be reduced by half, subject to the maximum allowable charge. The covered person will be responsible for all other charges.

1.51 "Provider"

Provider shall be one of the following as licensed by the State of Tennessee and shall mean:

(A) Alcohol or Drug Treatment Facilities. The plan will provide coverage as outlined in Article XII for services rendered on an inpatient basis at a facility which provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician; and

(1) Is affiliated with a hospital under a contractual agreement with an established system for patient referral;

(2) Is licensed, certified or approved as an alcohol or other drug dependency treatment center by the State of Tennessee Department of Mental Health and Mental Retardation, or equivalent state licensing body; and

(3) Is accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations.

(B) Ambulatory Surgical Center shall mean a health care facility, which 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 operated by a hospital licensed by the state in which it is located.

(C) Audiologist shall mean a trained graduate specializing in the identification, testing, habilitation and rehabilitation of hearing loss who is licensed as required by state law.

(D) Birthing Center shall mean a designated licensed facility, appropriately equipped and staffed by physicians, to aid pregnant mothers in the delivery of a baby.

(E) Convalescent Facility shall mean a lawfully operating institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care to patients recovering from injury or illness and which:

(1) Is under the medical supervision of a physician or a registered nurse;

(2) Requires that the health care of every patient be under the supervision of a physician and provides that a physician be available to furnish necessary medical care in emergencies;

(3) Provides for nursing service continuously for 24 hours of every day;

(4) Provides facilities for the full-time care of five or more patients;

(5) Maintains clinical records on all patients; and

(6) Is not an institution or part thereof primarily devoted to the care of the aged.

(F) Emergency Room shall mean a hospital department, designated and staffed for the medical/surgical treatment of patients.

(G) Health Service Practitioners (HSP) shall mean psychologists defined and licensed as health service providers (TCA 63-11-101 et seq.). This definition includes four levels of psychological practice: psychological examiner, senior psychological examiner, psychologist, and certified psychological

assistant (TCA 63-11-201). The psychological examiner, senior psychological examiner, and the psychologist are covered under the plan provisions.

Licensed psychologists with competencies in areas other than the delivery of health services ***are not eligible*** providers under this plan.

(H) Home Health Care Agency shall mean a public agency or private organization licensed and operated according to the laws governing agencies that provide services in a covered person's home.

(I) Home Health Care Aide shall mean an individual employed by an approved home health care agency or an approved hospice providing personal care under the supervision of a registered nurse or physical therapist.

(J) Hospice or Approved Hospice shall mean a facility or designated service, approved by the claims administrator, and staffed and medically supervised for the care and treatment of terminally ill patients.

(K) Hospital shall mean an institution legally operating as a hospital which:

(1) Is primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities for diagnosis and treatment of injury or illness or the care of pregnancy;

(2) Is operated under the medical supervision of a staff of physicians and continuously provides nursing services by registered nurses for 24 hours of every day; and

(3) Is accredited as such a facility by the Joint Commission on Accreditation of HealthCare Organizations.

In no event, however, shall such term include any institution which is operated principally as a rest or nursing home, or any institution or part thereof which is principally devoted to the care of the aged or any institution engaged in the schooling of its patients.

(L) Licensed Clinical Social Worker (LCSW) & Licensed Professional Counselor (LPC) A licensed clinical social worker (LCSW) shall mean a clinical social worker licensed by the Tennessee Board of Social Work, who is qualified by education and experience to treat mental health disorders resulting from social and psychological stress or health impairment. A licensed professional counselor (LPC) shall mean a professional counselor licensed by the Tennessee Board of Professional Counselors, who is qualified by education and experience to treat mental health disorders resulting from social and psychological stress or health impairment.

(M) Midwife shall mean an individual who is certified in the art of aiding in the delivery of children in a licensed health care facility.

(N) Nurse Practitioner shall mean duly certified practitioners as stipulated in TCA 63-7-123 working under the direct supervision of a physician.

(O) Oral/Maxillofacial Surgeon shall mean a physician or dentist licensed with specialty training in head, face or oral surgery.

(P) Pharmacist (TCA 63-10-204) shall mean an individual health care provider licensed by the State of Tennessee to practice the profession of pharmacy, involving but not limited to, interpretation, evaluation and implementation of medical orders and prescription orders, responsibility for compounding and dispensing prescription orders, patient education and counseling, and those

professional acts, professional decisions or professional services necessary to maintain all areas of a patient's pharmacy-related care.

(Q) Physician shall mean a duly licensed doctor of medicine (M.D.), osteopathy (D.O.), chiropractic (D.C.), podiatry (D.P.M.), dental surgery (D.D.S.), dental medicine (D.M.D.) or optometry (O.D.).

(R) Physician Assistant (P.A.) shall mean a graduate of a professional academic center as a P.A., working under a physician's supervision, and licensed under applicable state law.

(S) Registered Nurse Clinical Specialist (RNCS) shall mean a nurse practitioner providing mental health services and licensed as a registered nurse, with an appropriate master's or doctorate degree with preparation in specialized practitioner skills, and possessing current national certification as a clinical specialist.

(T) Rehabilitation Center shall mean a dedicated and approved/accredited facility (either freestanding or a distinct part of an institution) staffed and medically supervised in the care and treatment of the physical restorative needs of patients.

(U) Skilled Nursing Facility shall mean 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.

(V) Therapist shall include registered/licensed physical, occupational, respiratory and speech therapists.

(W) Walk-in Clinic shall mean a freestanding or hospital-based facility, with limited hours, professionally staffed and equipped to provide emergency or non-emergency medical care.

Not all individuals listed in these definitions are covered under the plans as providers nor are all services rendered by eligible providers covered under the plans.

1.52 "Qualified Beneficiary"

Qualified beneficiary shall mean any employee or dependent who is defined under Section 4.07 of the plan.

1.53 "Qualifying Event"

Qualifying event as pertaining to COBRA shall mean one of the following only if such event causes the qualified beneficiary to lose coverage under the plan:

(A) The death of a covered employee;

(B) A covered employee's termination of employment or reduction in work hours of an employee's employment;

(C) The divorce or legal separation of a covered employee and his/her spouse;

(D) A covered employee becoming entitled to Medicare Part A; or

(E) A covered dependent child ceasing to meet the definition of an eligible dependent.

1.54 "Retiree"

Retiree shall mean a former employee who has retired from the employer and receives a benefit from the Tennessee Consolidated Retirement System, or a former employee who has retired from the employer and participated in a non-TCRS retirement plan, or a former employee who has retired from the employer and has been approved for a disability benefit based on total and permanent disability; all categories of retirees must

meet the applicable guidelines in Article IV to continue to participate in the plan. An individual cannot be classified as a retiree and maintain insurance as an active employee under the plan. Retirees whose first employment with a participating agency commenced on or after July 1, 2015, will not be eligible to continue insurance coverage at retirement.

1.55 "Shared Parenting"

Shared parenting means a court approved parenting plan, describing the role each parent will have in the child's life, including a residential schedule indicating the times and places where the child will reside. Pursuant to TCA 36-6-410, the parenting plan shall designate the parent with whom the child is scheduled to reside a majority of the time as the custodian of the child solely for the purpose of all other state and federal policies and any applicable policies of insurance that require a designation or determination of custody. The statute further provides that if there is no designation in the plan, the parent with whom the child is determined to reside the majority of the time shall be deemed the custodian for the purposes of such statutes.

1.56 "Specialist"

Specialist shall mean a physician or health practitioner who is functioning in the role of rendering specialty care and services rather than primary care.

1.57 "State"

State shall mean the State of Tennessee.

1.58 "Urgent Care"

Urgent care shall mean a situation requiring immediate medical attention but which does not result from an emergency condition. Examples of urgent care situations include difficulty breathing, prolonged nosebleed, short-term high fever and cuts requiring stitches. Covered persons should contact their doctor or specialist for treatment advice on urgent care situations.

1.59 "Utilization Review Organization"

Utilization review organization shall mean

(A) The organization chosen by the committee to provide utilization management services for the PPO plans; and/or

(B) The mental health and substance review organization chosen by the committee to provide utilization management services for the PPO plans.

ARTICLE II
ELIGIBILITY AND ENROLLMENT

2.01 Employee Eligibility.

(A) Eligibility. All employees pursuant to Section 1.15 shall be eligible for coverage. Employees will have 31 calendar days from the eligibility date to submit an enrollment request.

(B) Eligibility Date.

(1) For newly-hired employees, the eligibility date shall be the hire date or no later than the end of the subsequent month; or

(2) For employees transferring from the state or local government plan, the eligibility date shall be the date of the transfer. A transfer between plans is allowed if an employee who is head of a contract in one plan loses eligibility or terminates employment and applies within one full calendar month following the termination of insurance coverage under the previous plan; or

(3) For employees experiencing a status change from part-time to full-time, the eligibility date shall be the date of the status change provided the employee has worked one full calendar month; or

(4) For interim teachers who do not elect coverage when first eligible and who accept a permanent teaching position at the same school system without a break in employment, the eligibility date shall be the date of the status change; or

(5) For non-certified employees who accept a certified position, the eligibility date shall be the date of the status change; or

(6) For employees transferring from active coverage as an employee or dependent to retired coverage, the eligibility date shall be the date of the status change; or

(7) The eligibility date shall be any other date established by the committee for a class of employees.

2.02 Eligibility of Re-hired Employees.

An employee may not be terminated and then re-hired by the same agency within 60 calendar days and be eligible for insurance coverage as a newly hired employee, except as outlined in Section 2.08 or Section 3.05.

2.03 Employee Enrollment and Effective Date of Coverage.

(A) Enrollment. The committee, or its representative, shall provide an employee with enrollment access through enrollment forms or the Edison Employee Self Service (ESS) feature. Where the eligibility date equals the hire date, enrollment access shall be provided either on the hire date or within five business days after the hire date, and enrollment must be completed within 31 calendar days after the hire date. Otherwise, enrollment access shall be provided prior to the employee's eligibility date, and enrollment must be completed prior to that date.

New hires should be encouraged to enroll as quickly as possible, and enrollment through the Edison ESS feature is the preferred method of enrollment.

In the event that access to ESS is unavailable, employees must complete and return an enrollment form to the committee's representative, indicating the desired health care option and appropriate type of coverage, pursuant to Section 1.08, prior to the employee's eligibility date or as otherwise indicated if such employee is to begin coverage as of the effective date described under subsection 2.03(B).

(B) Effective Date of Coverage for an Employee. The effective date of coverage for an employee who satisfies the conditions set forth in Section 2.01 shall be:

(1) The first day of the month following the eligibility date for newly hired employees; or

(2) The first day of the month following the date of the status change for employees transferring from the state or local government plan, or the first day of the month following the date of the status change for interim teachers accepting permanent teaching positions, or the first day of the month following the date of the status change for non-certified employees accepting certified positions, or the first day of the month following the date of the status change for employees and employee dependents transferring from active coverage to retired coverage; or

(3) The date the eligible employee returns to a positive pay status, if such employee is absent from work on the date his/her participation would otherwise take effect (other than for sickness or injury); or

(4) The first of the month or subsequent month following Benefits Administration's approval of the late applicant requirements as defined in Section 2.08; or

(5) The employee's eligibility date, in the event that an employee is injured while performing job-related duties and has been approved by the employer.

2.04 Dependent Eligibility.

(A) Eligibility. Each dependent of a covered person, as defined in Section 1.11, shall also be eligible for coverage.

(B) Eligibility Date. The eligibility date of each dependent shall be the later of the following:

(1) The eligibility date of the employee, or

(2) The date the dependent becomes an eligible dependent of the covered person.

2.05 Dependent Enrollment and Effective Date of Coverage.

(A) Enrollment. Eligible dependents of the employee on the employee's eligibility date must be included on the enrollment form submitted by the employee pursuant to Section 2.03(A). Written application to add a dependent(s) to a covered person's coverage must be made to the committee or its representative. If the addition of the dependent constitutes a change in the level of coverage, the application must be made by the employee within 60 calendar days following the date the dependent is acquired.

The date a dependent is acquired is determined as outlined below:

(1) Legally married spouse - date of marriage;

(2) Natural child - birth date;

(3) Legally adopted child - date of legal obligation or date of assumption of a legal obligation in anticipation of adoption;

(4) Child for whom an employee is the legal guardian – date legal guardianship granted;

(5) Stepchildren for whom the employee or spouse is providing care or support; and

(6) In connection with a child named as an alternate recipient under a qualified medical child support order as defined in Section 1.11 of the plan, date specified in such order or, if none, the date of the order.

(B) Effective Date of Coverage for a Dependent. The effective date of coverage for any eligible dependent, based upon receipt of application pursuant to Section 2.03(B), shall be the later of the following:

(1) The effective date of the employee's coverage hereunder pursuant to Section 2.03(B); or

(2) The date the dependent becomes an eligible dependent of the covered person

(a) If enrolled in single coverage, the employee may choose the first day of the month in which a dependent spouse was acquired or the first day of the subsequent month to elect family coverage. Family coverage based on enrolling newly acquired dependent children due to birth, adoption, or legal custody must begin on the first day of the month in which the event occurred and the children shall be eligible for coverage on the date they were acquired. Application to add a dependent must be submitted within 60 calendar days of the acquire date.

(b) In the event that the employee maintained family coverage on the date the eligible dependent was acquired, the effective date may be retroactive to the dependent's acquire date even if beyond the 60 day enrollment period. To add a dependent to family coverage more than 60 calendar days after the acquire date, the level of family coverage in effect on the date the dependent was acquired must have been sufficient to include that dependent without requiring a premium increase, and the employee must have maintained that same level of family coverage without a break.

2.06 Substantiation of Dependent Eligibility.

The insurance committee or its representative may, at its discretion, require marriage certificates, birth certificates, adoption papers, legal guardianship papers, divorce decrees, federal income tax returns (listing dependent spouse), or any other requested documentation. Failure to provide the requested information will suspend a dependent's eligibility until such information is provided to the insurance committee or its representative. In addition, dependents whose coverage has been suspended may be subject to termination. If coverage is terminated, those dependents may only be re-enrolled in the plan during the annual open enrollment period or through compliance with the late applicant requirements of Section 2.08.

2.07 Employee and Spouse Both Employed by the Employer.

In the event that two eligible employees are married, each employee may separately enroll in a state-sponsored plan, or they may enroll in family coverage - employee + spouse, where one employee is the head of contract and the other employee is a dependent.

If employees who are married to each other want to cover eligible dependent children under a state-sponsored plan, they can choose between enrolling in family coverage for all eligible family members – employee + spouse + child(ren), or one of the married employees can enroll in employee only coverage and the other parent-employee can enroll in family coverage – employee + child(ren), covering himself/herself and the eligible dependent children. However, if one parent-employee does not elect coverage, the other parent-employee must elect family coverage - employee + child(ren), if coverage is to be provided for dependent children; but, the spouse is ineligible for coverage, except as specifically provided in this Section 2.07. In no event may coverage for a dependent child or children be elected by more than one eligible employee including divorced parents or parents who were never married to each other who both work for the employer. An employee may not be enrolled as both head of contract and a dependent within the Local Education Plan.

A covered employee shall contact the committee's representative within one full calendar month of the marriage to or divorce from another employee of the employer.

In the event that one of the married covered employees terminates employment with the employer, the spouse still employed by the employer shall be required to contact the committee's representative within one full calendar month of the spouse's employment termination date in order to change to family coverage and provide coverage to his/her spouse and/or eligible child(ren) as dependents under the plan.

Employee spouse as newly hired employee. A newly hired employee can elect coverage for his or her spouse as a dependent when that spouse is also an employee who originally declined coverage. The dependent spouse is not required to apply through the late applicant requirements of Section 2.08. These employees are eligible only as dependents unless they become eligible to enroll due to the late applicant requirements of Section 2.08.

2.08 Late Applicant Requirements.

An employee or dependent who did not enroll during their initial eligibility period as outlined in Section 2.01(B) for employees and 2.04(B) for dependents, or during a subsequent open enrollment period, or a dependent whose coverage has been terminated pursuant to Section 2.06, shall be required to apply for coverage through a special enrollment provision (Section A), pursuant to the Health Insurance Portability and Accountability Act of 1996.

(A) <u>Special Enrollment Provision.</u> Per HIPAA regulations, an employee and/or their eligible dependent(s) may experience a special qualifying event (SQE) resulting in additional enrollment opportunities.

(1) Some special qualifying events allow enrollment if the event results in loss of coverage under another plan, meaning any group health plan or health insurance coverage, including any individual insurance policy that covers any person who would be eligible under this plan:

(a) Death of a spouse or ex-spouse;

(b) Divorce;

(c) Legal separation;

(d) Loss of eligibility (does not include a loss due to failure to pay premiums or termination of coverage for cause);

(e) Termination of spouse's or ex-spouse's employment (voluntary and non-voluntary);

(f) Employer's discontinuation of contribution to the spouse's, ex-spouse's, or dependent's insurance coverage (total contribution, not partial);

(g) Spouse's or ex-spouse's work hours reduced causing loss of eligibility for insurance coverage;

(h) Spouse maintaining coverage that has reached their lifetime maximum; or

(i) Loss of TennCare other than non-payment of premium.

(2) If requesting enrollment based on loss of coverage under another plan, the employee must submit appropriate documentation as listed on the enrollment application to substantiate all of the following:

(a) That a qualifying event has occurred; and

(b) That the employee and/or their dependent(s) were covered under another group health plan or medical insurance plan at the time of the event; and

(c) That the employee and/or their dependents may not continue coverage under the other plan.

(3) Other qualifying events allow enrollment for employees without coverage or with single coverage when a new dependent is acquired. These events are:

(a) A new dependent spouse is acquired through marriage; or

(b) A new dependent newborn is acquired through birth; or

(c) A new dependent is acquired through adoption or legal custody

An employee experiencing one of these events may enroll in employee only or family coverage. Previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible) may also be enrolled.

(4) If requesting enrollment based on acquiring a new dependent and adding other previously eligible dependents, the employee must submit appropriate documentation as listed on the enrollment application to substantiate:

(a) The date of birth; or

(b) The placement of adoption; or

(c) The date of marriage.

(B) Special Enrollment Period. Application based on special enrollment rules must be made to the committee's representative within 60 calendar days of the loss of the insurance coverage or within 60 calendar days of a new dependent's acquire date. If enrolling through a special enrollment provision, the employee may choose to change to another health plan, if eligible. Notwithstanding other provisions of this section, if the employee or employee's dependent(s) had COBRA continuation coverage under another plan and COBRA continuation coverage has since been exhausted, enrollment requirements shall be waived if application is received within 60 calendar days of the loss of coverage.

(C) Special Enrollment Provision Effective Date. The effective date of coverage for an employee or dependent approved through a special enrollment provision shall be one of the following:

(1) If enrollment is based on loss of other coverage:

(a) The day after the loss of other coverage; or

(b) First day of the month following loss of other coverage.

(2) If enrollment is based on acquiring a new dependent and adding other previously eligible dependents:

(a) Day on which the birth, adoption, or legal custody occurred; or

(b) Day on which the marriage occurred or first of the subsequent month

(3) The committee's representative may consider other effective date options if an administrative review results in approval of an enrollment request.

(D) Special Enrollment for Retirees. In order for a retiree to be eligible to enroll for medical insurance under the provision of the Health Insurance Portability and Accountability Act, the retiree must have been a covered person under a state-sponsored plan at the time they retired and be eligible to continue that coverage by virtue of age, their length of service and length of participation in the plan, as outlined in Section 4.06. A retiree who is eligible for Medicare is not eligible to enroll in the state-sponsored health Plan. Retirees who have lost eligibility for the health plan may not enroll dependents in the health Plan. Retirees whose first employment with a participating agency commenced on or after July 1, 2015, will not be eligible to continue insurance coverage at retirement.

Premiums for coverage type selected must be paid before the coverage can be effective. Loss of eligibility does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause.

2.09 Transferring Between Health Insurance Plans.

Employees who are eligible for coverage under more than one state-sponsored plan will be allowed to transfer ***between*** the State, Local Education, or Local Government Plans. These employees will have the opportunity to apply for a transfer during the Plan's designated enrollment transfer period with an effective date of January 1 of the following year. In no case may an employee transfer to another state-sponsored plan while remaining on the plan from which the transfer occurred.

2.10 Election of a Plan Option.

(A) Election of Option. Covered persons shall have the option of electing membership in one of the state plans. If a covered person elects membership in any one of the state sponsored plans in accordance with rules established by the committee, applicable participation in the non-elected plans for such covered persons shall terminate on the day preceding the date membership in the newly elected plan becomes effective. Covered persons may transfer between any plans for which they are eligible, during the annual enrollment and transfer period established by the committee with coverage selected to take effect the first day of the next plan year. Additional transfer periods may also be held on other dates as specified by the Local Education Insurance Committee or an authorized representative of the

Committee. Continued enrollment in the Partnership PPO option is subject to all regular terms and conditions of the plan including meeting the requirements of the Partnership Promise.

(B) Rejoining a Plan. If a covered person has elected membership in a plan and subsequently elects applicable participation under another plan, application shall be made during the annual enrollment transfer period and such applicable participation shall become effective the first day of the next plan year.

(C) Enrollment Procedures. A covered person wishing to enroll in a plan must complete an application and such other forms as may be required by the applicable committee. Covered persons who join a plan must submit the appropriate forms to the committee or its representative within one full calendar month of active service with the employer. For newly-hired employees becoming eligible on the hire date, application must be made within 31 calendar days after the hire date. Any changes in dependent coverage or changes in marital status must be in writing and submitted to the committee or its representative within 60 calendar days of the dependent's acquired date.

ARTICLE III

PARTICIPATION DURING APPROVED LEAVE AND REINSTATEMENTS

3.01 Continuation of Coverage during Leave of Absence.

An employee on an approved leave of absence that is not covered under the Family and Medical Leave Act of 1993 (as amended) may continue coverage as described in this subsection. An employee on an approved leave of absence may continue coverage under the plan for two continuous years provided he/she pays the full monthly premium (both the employer and employee portions as described in Article VIII) during such leave of absence.

Employees who return to work after a two-year leave of absence must be in a positive pay status for one full calendar month before they may be eligible for a subsequent leave of absence to continue coverage. If an employee does not return to active work status and has completed a two-year leave of absence, coverage will be discontinued and COBRA continuation coverage will not be offered.

3.02 Coverage for Spouse Who Is an Employee on Leave of Absence.

If an employee and his/her spouse both work for the employer and are both covered under a state sponsored plan, and one spouse goes on a leave of absence, the spouse, as a covered person may change his/her type of coverage pursuant to Section 1.08 in order to cover his/her spouse as a dependent. The employee adding his/her spouse must contact his/her benefits coordinator and change to family coverage by completing the enrollment change application.

3.03 Suspension of Coverage During Leave of Absence.

If the employee decides not to continue coverage while on leave, he/she must apply to suspend coverage by signing the leave without pay insurance options form while the coverage is still active and premiums are current. Coverage will terminate on the last day of the month in which the employee has paid his/her premium(s). When the employee returns from leave, to re-enroll in coverage, the benefits coordinator must be contacted by the employee and enrollment forms completed and the insurance premium paid. The employee has one full calendar month from the end of the leave to reinstate the coverage; otherwise, the employee will be subject to the late applicant requirements of Section 2.08.

Individuals returning from military leave shall have 90 calendar days from the end of their leave of absence to reinstate coverage.

3.04 Reinstatement of Coverage Following Suspension of Coverage.

In the event an employee has requested a suspension of coverage under the plan and premiums are current while on an approved leave of absence (as defined in Section 3.03), and not covered by the Family and Medical Leave Act of 1993, and such former employee returns to covered employment with the employer, his/her coverage under the plan may be reinstated subject to receipt of premium pursuant to this section. The employee must complete an enrollment application within 31 calendar days of returning to active employment with the employer.

(A) If an employee returns to covered employment with the employer during a time period equal to or less than six months of the date coverage previously suspended, he/she shall have his/her coverage reinstated on the first day of the calendar month following the date the employee returns to work without:

(1) Satisfying the waiting period required of new employees; and

(2) Satisfying the late applicant requirements of Section 2.08, provided the employee meets the other eligibility requirements of Section 2.01.

(B) If an employee returns to work with the employer after a period greater than six months of the date coverage previously suspended, he/she shall have coverage reinstated after working one full calendar month and satisfying the eligibility requirements of Section 2.01, including the applicable waiting period for new employees.

3.05 Reinstatement of Coverage Following Termination of Employment.

If employment is terminated with the employer and the employee returns to work with the employer within one full calendar month of insurance termination, the employee may reinstate his/her insurance if all other eligibility requirements are met. This reinstatement will be made and coverage will continue as previously enrolled. The benefits coordinator must be contacted and enrollment forms completed for coverage to be reinstated.

3.06 Coverage Reinstatement Following Voluntary Cancellation.

In the event that a policyholder has voluntarily canceled medical insurance coverage for themselves and/or their eligible dependents and wants the coverage reinstated, the policyholder may do so by meeting all of the following conditions:

(A) Premiums were paid current on the coverage termination date;

(B) The policyholder and/or their dependents continue to meet the eligibility requirements of the plan;

(C) The policyholder submits a written request for reinstatement within one full calendar month of the coverage termination date.

3.07 Reinstatement for Military Personnel Returning from Active Service.

An employee who returns to the employer's active payroll following active military duty may reinstate insurance coverage on the earliest of the following:

(A) The first day of the month which includes the date on which the military person was discharged from active duty;

(B) The first of the month following the date of discharge from active duty;

(C) The date on which the military person returns to the employer's active payroll; or

(D) The first of the month following the military person's return to the employer's active payroll. If coverage is reinstated before the employee's return to the employer's active payroll, the employee must pay 100 percent of the total premium, provided the leave for military duty is more than 31 calendar days. In all instances, employees must pay whole month premiums.

Reinstatement of coverage is not automatic. Returning military personnel must comply with Section 3.03 before coverage can be reinstated. No waiting period requirements will apply to this reinstatement.

ARTICLE IV
COVERAGE TERMINATION AND CONTINUATION

4.01 Termination of Covered Employee's Participation.

(A) Voluntary Coverage Termination. Voluntary cancellation of a covered person shall not be permitted outside of the annual enrollment transfer period unless the covered person experiences a special qualifying event, family status change, or other qualifying event as approved by Benefits Administration.

Unless stated in this Plan Document, an employee who wishes to re-enroll at a later date will be subject to the late applicant requirements in Section 2.08.

(B) Non-Voluntary Coverage Termination. In addition to the voluntary termination described in Section 4.01(A), and except as otherwise expressly provided in the plan, participation in the plan by a covered employee and/or dependents shall terminate upon the earliest to occur of the following:

(1) The last day of the month for which the employee's last contribution was applied;

(2) The date the plan is amended to terminate the coverage of a class of employees of which the employee is a covered person; or

(3) The date the plan is terminated; or

(4) The last day of the month in which the local education agency participates in the Local Education Plan.

4.02 Termination of Dependent Participation.

(A) Except as otherwise expressly provided in the plan, participation in the plan by a dependent (as a dependent) shall terminate at the end of the month in which the dependent ceases to be an eligible dependent as defined in Section 1.11. It is the responsibility of the employee to notify the committee's representative of any event that would cause a dependent to become ineligible for coverage. Claims paid in error for any reason will be recovered from the employee.

(B) In accordance with TCA 36-4-106, if termination is after the filing of a petition for divorce, the dependent spouse cannot be terminated without their consent or an order of the court until occurrence of one of the following:

(1) The final decree of divorce is entered;

(2) The order of legal separation is entered;

(3) The petition is dismissed;

(4) The parties reach agreement; or

(5) The court modifies or dissolves the injunction against making changes to insurance policies.

4.03 Continuation of Dependent's Participation upon Death of a Covered Employee.

Notwithstanding anything herein to the contrary, in the event of the death of an employee who elected family health coverage, the participation under the medical plan of such employee's dependent(s) (at the time of his/her death) may continue for six months after such employee's death, subject to the terms and conditions of

the plan. The contribution for this coverage is the sole responsibility of the plan. Participation in the plan during the six months of extended coverage due to death shall be in addition to continued coverage available through the provisions of COBRA pursuant to Section 4.07. If the employee dies in active service, and the employee met the eligibility criteria to continue retiree group health coverage as outlined in Section 4.05 or 4.06 at the time of their passing, the surviving dependent(s) covered at the time of the employees' passing may apply to continue coverage under the deceased employee's service and eligibility. If the employee was a member of TCRS, the covered dependents must be eligible for and must accept a lifetime monthly benefit from the Tennessee Consolidated Retirement System in order to continue coverage beyond the six months free coverage. If the employee did not meet the eligibility criteria to continue group health as a retiree at the time of their passing, COBRA may be offered. Dependents must continue to meet the definition of an eligible dependent.

If a retiree dies (already receiving monthly benefit), covered dependents may continue beyond the six months free coverage. If the dependent receives a benefit, premiums will be deducted by the Tennessee Consolidated Retirement System. If no benefit is continued or if the premium exceeds the monthly benefit, the premium must be submitted to Benefits Administration each month. Dependents must continue to meet the definition of an eligible dependent.

4.04 Continuation after Covered Employee's Work-Related Injury.

An employee who leaves the employer's payroll because of a work-related injury, and who was participating in a state-sponsored health plan at the time the work-related injury occurred, may continue participation in the plan during the period of such temporary disability. If the workers compensation benefits cease or the employer does not provide workers compensation coverage, the employee may continue coverage as described at 3.01. See applicable sections for specific plan provisions.

4.05 Continuation of Coverage for Disabled Employees.

Employees whose first employment with a participating agency commenced on or after July 1, 2015, are not eligible to continue insurance coverage at retirement.

(A) If a covered employee incurs a disability while enrolled in the PPO plan and employment is terminated, the former employee may continue coverage, for that condition only, for a period not to exceed one year. Continuation is in lieu of other continuation options under this plan and must be requested, in writing, within 30 calendar days of the date active insurance coverage is terminated. No premium contribution is required by the employee, however, deductible and coinsurance amounts will apply. This continuation of coverage will only provide benefits for claims associated with the disability as determined by the claims administrator. Pharmacy charges must be paid at the time of service and reimbursement is subject to the terms and conditions of the plan.

(B) If a participating employee with less than five years of creditable service with TCRS (or a non-TCRS retirement program sponsored by a participating local education agency) incurs a work-related injury which results in total and permanent disability, the former employee may continue medical coverage if they are approved for a retirement benefit based on total and permanent disability as the result of an

on-the-job injury. There can be no lapse in medical coverage with the state-sponsored plan, and disabled retirees under age 65 who are eligible for Medicare must maintain at least Part B coverage.

TCRS participants must be approved by the Tennessee Consolidated Retirement System medical panel as being totally and permanently disabled due to a work-related injury and must remain eligible for a disability allowance. For non-TCRS participants, proof of total and permanent disability must be shown by submitting an award letter from the Social Security Administration or approval by TCRS based on physician review of the medical records documenting the disability. The required proof must show total and permanent disability existed on or before the date employment terminated. For non-TCRS participants, the employer must also submit written certification that the disability is the result of a work-related injury. The contribution for this continued coverage in the Local Education Plan is the responsibility of the former employee and shall be the same premium as required for a retiree. This coverage may be continued until such time as the retiree is eligible for Medicare based on his/her age.

(C) Disability retirees insured through a participating local education agency at the time of an injury or illness which resulted in their disability may continue coverage provided that no lapse in medical coverage has occurred by meeting either the requirements of Section 4.06(B) for TCRS participants or 4.06(D) for non-TCRS participants or by having at least five years of employment with the employer immediately prior to final termination due to disability. Employees who qualify for disability retirement may continue coverage if they participated in the plan at the time the injury or illness occurred and, for such retirees, the date retirement benefits commence (retirement date) must be on or before the date on which their active state coverage ceased. Upon eligibility for Medicare, disability retirees may continue in the plan to the point at which Medicare eligibility would have been attained by virtue of age provided the retired employee remains eligible for disability allowance ***and*** Part B of Medicare is retained. Employees who are granted a service retirement but are also disabled, must prove that total disability exists at the time of retirement. Proof of total disability must be shown by submitting an award letter from the Social Security Administration or approval by the TCRS medical panel based on physician review of medical records documenting the disability. The required proof must show total disability existed at the time of termination of employment. Medicare will be the primary coverage and the plan the secondary carrier. Coverage will terminate once the retiree reaches the normal age for Medicare.

Disability retirees who are awaiting approval of the employer-sponsored retirement plan for disability benefits and whose medical coverage has lapsed from their last period of employment may reinstate that medical coverage by meeting the requirements of Section 4.06(B) for TCRS participants or 4.06(D) for non-TCRS participants or by having at least five years of employment with the employer immediately prior to final termination due to disability and provided that the employer-sponsored retirement plan determines their date of disability retirement to be on or before the date on which their active coverage ceased. Disabled retirees whose coverage has lapsed from their last period of employment and whose effective date of disability retirement has been determined by the employer-sponsored retirement plan to be after the date on which their coverage as full-time employees ceased are not eligible for reinstatement of medical coverage.

4.06 Continuation of Coverage for Retirees.

Retirees whose first employment with a participating agency commenced on or after July 1, 2015, are not eligible to continue insurance coverage at retirement.

Definitions used in interpreting these policies are as follows:

"Continuous Insurance Coverage" is defined as actual participation without a break in coverage for any month.

"Employment with the Employer" is defined as creditable service in a position where the incumbent qualifies for insurance coverage with a participating local education agency in Tennessee or with the State of Tennessee or a higher education institution. For purposes of this plan, accumulated unused sick leave is defined as employment with the employer.

For the purpose of this plan, the following are not defined as employment with the employer: military service that did not interrupt employment, educational leave, leave of absence or service with a local government agency. Also, if a person cashes out previous service and does not buy it back, they cannot count that service as employment with the employer to establish insurance eligibility.

"Non-Elect" is defined as individuals who declined optional membership in the Tennessee Consolidated Retirement System.

"Retirement Date" is defined as the date retirement benefits commence according to retirement statutes.

"Termination Date" is defined as the last paid day or last day of leave, whichever is later.

(A) Retirees and their dependents may not continue coverage in the plan if eligible for Medicare except as provided below:

(1) Individuals who were previously grandfathered into the plan by the Local Education Insurance Committee based on plan provisions in effect when the retiree's agency joined the plan for the first time. Benefits will be provided for individuals who were covered under their previous policy (prior to joining the plan) but who did not meet the plan eligibility requirements when their employer joined the plan for the first time. The plan shall pay secondary benefits to Medicare; or

(2) Any retired local education agency employee who is participating in the insurance plan and who is in receipt of a disability retirement allowance shall not be required to discontinue coverage in the plan upon eligibility for Medicare. The employee may continue in the plan as a retired employee to the point at which Medicare eligibility would have been attained had the disability not occurred provided that such retired employee remains eligible for the disability retirement allowance and maintains at least Medicare Part B coverage. The insurance premium shall be the same as that charged to non-disability retirees who are not yet eligible for Medicare. The plan shall pay secondary benefits to Medicare after the deductible or copayment amount listed in Attachment A has been met. Newly eligible pre-65 disabled retirees with Medicare Part A coverage not enrolled in Medicare Part B may continue coverage until the next open enrollment, which occurs in January, February and March for a July 1 effective date. If the disabled retiree does not enroll in Part B at the first

opportunity, coverage will be terminated as of the July 1 following their refusal to enroll in Part B.

(3) Any dependent covered by a retired local education employee that is in receipt of social security disability shall not be required to discontinue coverage upon eligibility for Medicare. The dependent may continue in the plan to the point at which Medicare eligibility would have been attained had the disability not occurred. The dependent must remain eligible for social security disability and must maintain Medicare Part B coverage. The insurance premium shall be the same as that for non-disability retirees who are not eligible for Medicare. The plan shall pay secondary benefits to Medicare after the copayment or deductible amount listed in Attachment A has been satisfied.

(4) A non-contributor to the Social Security Administration and therefore ineligible for Medicare. If a non-contributor becomes eligible for Medicare Part A by virtue of a spouse's eligibility, the coverage will be terminated.

(B) Employees who retire from employment with the employer are eligible to elect continuation of coverage under the plan provided the requirements of this section are met.

(1) For individuals participating in the Tennessee Consolidated Retirement System (TCRS) who terminate employment, one of the following conditions must be met for continuation in the plan:

(a) The retiree must have at least ten years of employment with the employer, with three continuous years of insurance coverage in the plan immediately prior to final termination for retirement.* For such retirees, the date retirement benefits commence (retirement date) must be on or before the date on which their active state coverage ceased. The requirement for immediate commencement of retirement benefits will be waived for employees leaving the Local Education Plan and becoming employed by an agency participating in one of the other state-sponsored health plans; or

(b) The retiree with 20 or more total years of employment with the employer with one year of insurance coverage in the plan immediately prior to final termination for retirement.* For such retirees, the period of time between the employee's final termination date and the date retirement benefits commence (retirement date) may be up to five years in length. The five-year requirement for commencement of retirement benefits will be waived for employees leaving the Local Education Plan and becoming employed by an agency participating in one of the other state-sponsored health plans. If more than five years, retirees and eligible dependents would have to meet the late applicant requirements of Section 2.08 before becoming insured.

(C) Retirees eligible to continue insurance coverage in the plan, pursuant to this section, must apply to continue coverage within one full calendar month of the expiration date of active insurance coverage or within one full calendar month of meeting the conditions to continue insurance as outlined in this section.* However, when a retiree has 20 or more years of service and there is an allowed gap of up to

five years between the date of termination and the date retirement benefits commence according to retirement statutes (retirement date), the retiree must apply to continue coverage within one full calendar month of the retirement date or within one full calendar month of meeting the eligibility conditions. The effective date of insurance coverage will be the first of the month following the retirement date. At the expiration of the application period, eligible retirees may continue only if qualified through the late applicant requirements of Section 2.08 or through the provision of COBRA. In order to enroll through the late applicant requirements, the retiree must have had medical coverage at the time they retired and be eligible to continue that coverage by virtue of age, their length of service and length of participation in the plan.

Retirees who will receive a monthly benefit from the Tennessee Consolidated Retirement System shall have premiums deducted from their benefit check. Retirees whose insurance premium exceeds their monthly benefit or who do not receive a monthly benefit from the Tennessee Consolidated Retirement System shall submit their premiums directly to Benefits Administration each month. Retirees who are non-elects shall submit their premiums directly to Benefits Administration each month.

(D) Employees who elected to participate in a retirement program sponsored by a participating local education agency (other than TCRS) must meet one of the following conditions to continue insurance coverage under the plan:

(1) Attainment of age 55 at final termination or at least ten but less than 20, total years of employment with the employer, with three continuous years of insurance coverage in the plan immediately prior to final termination unless they satisfy one or more of the late applicant requirements in Section 2.08*; or

(2) Attainment of age 55 and 20 or more total years of employment with the employer, with one year of insurance coverage in the plan immediately prior to final termination unless they satisfy one or more of the late applicant requirements in Section 2.08.* For such retirees, the time between the employee's final termination date and attainment of age 55 may be up to five years in length; or

(3) Twenty-five years of employment with the employer, with one year of insurance coverage in the plan immediately prior to final termination unless they satisfy one or more of the late applicant requirements in Section 2.08.*

For individuals who qualify under either (2) or (3) above, the period of time between the final termination date and the date insurance benefits are to commence may be up to five years in length. The five-year requirement for commencement of benefits will be waived for employees leaving the Local Education Plan and becoming employed by an agency participating in one of the other state-sponsored health plans. If more than five years, the individual and eligible dependents would have to meet one of the late applicant requirements of Section 2.08 before becoming insured.

(E) School board members are eligible to continue their coverage at the time of retirement as long as they meet the eligibility guidelines. To be eligible to continue insurance at retirement, the school board member must have at least 20 years of service as a member of the same school board from which they

retire, must be age 55 and be enrolled in the plan for one full year of coverage immediately prior to retirement or 30 years of service as a member of the same school board from which they retire and at least one full year of coverage on the plan immediately prior to retirement. The one-year rule will be waived if the agency has not participated in the plan for one year. Coverage must begin immediately upon retirement, unless the retiree goes to work for another agency participating in a state-sponsored plan. Should the school system from which the school board member retired cancel participation in the state-sponsored plan, individual retirees may no longer participate. School board members are required to pay the entire monthly premium.

(F) Individuals who participated in a retirement program sponsored by a participating local education agency will submit their premiums directly to Benefits Administration each month. These participants are not required to start their annuity benefit to be eligible to participate. Retirees who participated in a retirement program sponsored by a participating local education agency must apply to continue coverage within one full calendar month of meeting the conditions to continue insurance coverage as outlined in 4.06(D) or the date of final termination from employment with the employer, whichever is later.* When the retiree has 20 or more years of service and there is an allowed gap of up to five years between the date of termination and the date insurance benefits commence, the retiree must apply to continue coverage within one full calendar month of meeting conditions for continuing coverage. Subject to timely submission of an enrollment application, the effective date of coverage will be the first of the month following attainment of conditions for continuing coverage. If application is made after the expiration of the application period, the eligible retiree may continue coverage only if qualified through one of the late applicant requirements of Section 2.08 or through the provision of COBRA.

When a retiree is no longer eligible for the plan because he is entitled to Medicare, his/her covered dependents may continue coverage. This coverage shall continue until the dependents no longer meet the eligibility requirements or until the dependents are entitled to Medicare.

When coverage is discontinued for a retiree or dependent due to Medicare entitlement, the retiree shall be given an opportunity to convert to a Medicare supplement policy if they receive a monthly pension from TCRS. The retiree's initial employment with a qualifying employer must have commenced prior to July 1, 2015, to be eligible for the Medicare Supplement Plan. Dependents will not be allowed to enroll in the Medicare supplement if the retiree is not enrolled or enrolling in the Medicare supplement. The plan will suspend coverage on any participating Local Education Plan retiree who will not provide information to Benefits Administration concerning Medicare eligibility upon request.

If coverage is discontinued for a retiree's dependent child because of the plan's eligibility requirements, the dependent may be eligible for continued coverage through the provisions of COBRA or convert to a direct payment plan offered by the claims administrator regardless of his/her present health condition. There should be no lapse in coverage.

If a covered retiree dies before a covered dependent, the dependent is entitled to six months of extended coverage without charge and continues to meet the dependent definition as either a spouse or

a dependent child as outlined in Section 1.11, insurance may be continued after the six months extended coverage until the dependent(s) no longer meets the definition of an eligible dependent.

Upon retirement, if the retiree's spouse is an active employee of the employer, participating in the plan, the active employee may insure the retiree under his/her coverage until such time as that employee leaves employment. Upon the spouse's termination of employment, the retiree would revert his/her participation to the retiree group under the provisions of Section 4.06.

Retirees who are not eligible to continue insurance coverage because of the service requirements may continue coverage pursuant to Section 4.07 (COBRA) or convert to a direct payment plan offered by the claims administrator at retirement, pursuant to Section 4.08.

*For the purpose of determining whether a plan participant meets the plan's length of participation criteria to continue coverage upon termination of employment for the purpose of retirement, the state-sponsored plans will consider the COBRA participation toward length of participation in the plan when the COBRA participation immediately follows and immediately precedes periods of employment with a participating employer. This provision is intended to bridge one period of employment to another period of employment with agencies of the state government, local education agencies participating in the Local Education Plan, or entities participating in the Local Government Plan.

4.07 Limited Continuation of Coverage (COBRA).

For purposes of this Section 4.07, a qualified beneficiary is any individual who, on the day before a qualifying event, is covered under the plan by virtue of being on that day either the covered employee, the spouse of the covered employee, or a dependent child of the covered employee.

A qualified beneficiary also includes any child who is born to or placed for adoption with a covered employee during the period of COBRA continuation coverage.

A covered employee for purposes of this Section 4.07 is any individual who is (or was) provided coverage under this group health plan by virtue of being or having been an employee.

(A) A qualified beneficiary may elect to continue coverage under this plan for up to 18 months after the qualifying event if such qualified beneficiary loses coverage due to one of the following qualifying events:

(1) The covered employee's employment is terminated (for reasons other than the covered employee's gross misconduct); or

(2) The covered employee's number of work hours is reduced to less than 30 hours per week.

In the case of a qualifying event described in Section 4.07(A)(1) or (2) above that occurs fewer than 18 months after the date the covered employee became entitled (enrolled) to benefits under title XVIII of the Social Security Act, the period of coverage for qualified beneficiaries other than the covered employee shall not terminate before the close of the 36-month period beginning on the date the covered employee became so entitled. The 36-month time period excludes any time covered under a retiree's coverage.

If a qualified beneficiary is determined to have been disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 calendar days of COBRA continuation coverage, any

qualified beneficiary will be entitled to elect an additional 11 months (total of up to 29 months from the date of the qualifying event) of COBRA continuation coverage. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 calendar days of COBRA continuation coverage is measured from the date of birth or placement for adoption. This same 11-month disability extension applies to each qualified beneficiary entitled to COBRA because of a qualifying event described in Section 4.07(A)(1) or (2) above. To qualify for this extension of coverage, the qualified beneficiary must have been disabled within the time periods described above, and must obtain a social security determination to that effect. The qualified beneficiaries affected by the qualifying event in Section 4.07(A)(1) or (2) must notify the committee's representative of the disability determination within 60 calendar days after the date the determination is issued and prior to the expiration of the initial 18-month period.

A qualified beneficiary (other than the covered employee) may elect to continue coverage under this plan for up to 36 months (excluding months covered as a dependent of a retiree) after the qualifying event, if such qualified beneficiary loses coverage due to one of the following qualifying events:

(1) Death of the covered employee;

(2) Divorce or legal separation from the covered employee; or

(3) A dependent child ceases to be a dependent as defined by the plan.

In the event that a qualified beneficiary becomes eligible for continuation of coverage for an 18-month period (or a 29-month period in the case of a disability extension) and subsequently experiences within that 18-month period (or within that 29-month period in the case of a disability extension) a second qualifying event which allows a 36 month extension, then the original 18-month period (or 29-month period in the case of a disability extension) is expanded to be 36 months from the date of the first qualifying event. This only applies to those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event.

(B) Election. To continue coverage, the qualified beneficiary must make written election within 60 calendar days after the later of the following dates:

(1) The date the qualified beneficiary's coverage terminated due to a qualifying event; or

(2) The date the qualified beneficiary is sent notice of his/her right to elect COBRA continuation coverage.

An election is considered to be made on the date that it is sent to Benefits Administration.

(C) Premiums. The monthly cost of COBRA coverage must be paid by the qualified beneficiary to Benefits Administration. The monthly cost shall be 102 percent of the cost to the plan for coverage of a similarly situated employee whose coverage had not otherwise terminated. When a qualified beneficiary has a special continuation period due to a certified disability, as described in subsection 4.07(A), the monthly cost during the additional 11 months shall be, in general, 150 percent of the cost to the plan.

The qualified beneficiary must pay the required costs for the initial continuation of coverage period within 45 calendar days of the date of the election. The monthly cost for coverage ***following*** the period after the initial election must be made in monthly payments in the manner prescribed by the committee or its representative. Without further notice from the employer, the qualified beneficiary must pay the monthly cost by the last day of each month for the following month's coverage. No claims will be paid pursuant to this Section 4.07 until Benefits Administration receives the applicable monthly premium for the qualified beneficiary's coverage.

(D) Notice. A covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of a qualifying event that is either a divorce or legal separation of the covered employee, or a dependent child ceasing to be a dependent as defined by the plan. Notice must be provided to the plan administrator within 60 calendar days after the later of the date of the qualifying event or the date the qualified beneficiary would lose coverage on account of the qualifying event. Failure to report a dependent becoming ineligible to continue coverage within 60 calendar days of the loss of eligibility will result in the dependent not being offered the opportunity to continue coverage under COBRA as their 60-day eligibility period will have lapsed.

(E) Termination. A qualified beneficiary's coverage under this limited continuation of coverage provision shall terminate on the earliest of:

(1) The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes covered under any other group health plan;

(2) The end of the applicable 18-month or 36-month period. These periods of time include months enrolled as a dependent of a retiree;

(3) The end of an additional 11-month disability extension period as described in subsection 4.07(A). The continuation period shall not exceed the first day of the month following one full calendar month after a final determination that the qualified beneficiary is no longer disabled;

(4) The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes eligible for Medicare benefits;

(5) The date the qualified beneficiary fails to make timely payment of the monthly premiums. Timely payment shall be considered to be receipt of payment within one full calendar month of the due date; or

(6) The date on which the employer ceases to provide a group health plan (or successor plans) to any employee.

4.08 Conversion Privileges.

(A) If an employee's participation under the plan terminates due to termination of employment, the employee may obtain from an insurance company or underwriting organization selected by the committee, an individual policy (the "converted policy"), which may or may not provide benefits identical to those provided under the plan. The conversion is subject to the conditions set forth in this section and to any other applicable provisions herein. The converted policy shall, except as herein

provided, cover the former employee and any of the former employee's dependents participating under the plan on the date of such termination of participation.

(B) A converted policy, as provided above, shall also be available to a qualified beneficiary at the end of the period of continued coverage pursuant to Section 4.07. Provided, however, that any person obtaining a converted policy must satisfy the conditions of Section 4.08. The committee must provide the qualified beneficiary with the option of electing a converted policy during the 180-day period that ends on the date that continued coverage, pursuant to Section 4.07, would end.

(C) The effective date of the converted policy shall be the day following termination of participation.

(D) The premium established by the insurance company or underwriting organization for the converted policy shall be that applicable to the ages of such persons, to the forms and amount of coverage provided, and to the class of risk to which the individual or individuals belong on the later of the effective date of the converted policy or the date application for the converted policy is made.

(E) In order to obtain a converted policy under this section, the person to whom such policy would be issued must make written application for the converted policy to the insurance company or underwriting organization and agree to pay the required premiums for the converted policy by the 31st day after such termination of participation.

ARTICLE V
COORDINATION OF MEDICAL BENEFITS

5.01 General.

The benefits subject to this article are all benefits arising from expenses or charges incurred on or after the effective date.

5.02 Definitions.

As used in this article, the following terms shall have the meanings indicated, unless the context clearly requires a different construction:

(A) "Allowable Expense" means any necessary, maximum allowable expense, at least a portion of which is covered under at least one of the other plans covering the person for whom claim is made. When another plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

(B) "Claim Determination Period" means the calendar year (January 1 through December 31), but excluding, for any person, any portion occurring prior to the later of the date this provision becomes effective and the first day the person is covered for benefits subject to this provision.

(C) "Maximum Allowable Charge" means the highest dollar amount of reimbursement allowed by either the primary or secondary plan for a particular covered service. Such amount is based on the fees negotiated between the claims administrator and certain physicians, health care professionals or other providers and whether covered services are received from providers contracting with the claims administrator or not contracting with the claims administrator. Reimbursement for services provided by non-contracting providers will be the stated percentage of the maximum allowable charge or billed charges, whichever is less. Contracting providers shall mean providers contracting with the claims administrator or one of its affiliates.

(D) "Other Plans" means any plan or plans primarily providing benefits or services for, or by reason of, medical care or treatment, which benefits or services are provided by:

(1) Group, blanket or franchise insurance coverage;

(2) Hospital service prepayment plan, a medical service prepayment plan, a group practice and other prepayment coverage, except that for which the subscription charge or premium payment is made directly by the person covered to the organization providing the coverage;

(3) Any coverage under labor-management trusted plans, union welfare plans, employer organization plans or employment benefit organization plans;

(4) Any coverage under governmental programs, including Medicare, and any coverage required or provided by any statute (an individual eligible for Part B of Medicare shall be deemed to be covered by it, whether or not actually enrolled);

(5) In the case of a child, any coverage sponsored by, or provided through, a school or other educational institution; or

(6) Any individual insurance policy that covers any covered person.

(E) "Primary Plan" means the plan that determines its benefit payments first and pays its full allowance without regard to other coverages or other plans.

(F) "Secondary Plan" means the plan that determines its benefit payments after the other plan or plans.

5.03 Effects on Benefits.

(A) This provision shall apply in determining the benefits as to a person covered under this plan during any claim determination period if, for the allowable expense incurred as to such person during such period, the sum of:

(1) The benefits that would be payable under this plan in the absence of this provision; and

(2) The benefits that would be payable under all other plans, in the absence therein of provisions of similar purpose to this provision;

would exceed such allowable expense.

(B) As to any claim determination period with respect to which this provision is applicable, the benefits that would be payable under the plan in the absence of this provision for the allowable expenses incurred as to such person during such period shall be reduced to that extent necessary so that the sum of such reduced benefits and all of the benefits payable for allowable expenses under all other plans except as provided in item (C) of this section, shall not exceed the total of such allowable expenses. Benefits payable under other plans include the benefits that would have been payable had claim been duly made therefore. In the case of a person eligible for, but not enrolled in, Medicare, benefits payable under other plans shall include benefits that would have been payable under Parts A and B of Medicare had the person duly enrolled.

(C) The order of benefit payments is determined using the first of the following rules that applies:

(1) The benefits of a plan, which does not include a coordination of benefits provision, shall be determined before the benefits of a plan that does provide a coordination of benefits provision.

(2) Subject to subparagraph (a) of this paragraph, the benefits of a plan, which covers the patient as an employee, member or subscriber (that is, other than as a dependent) shall be determined before the benefits of a plan that covers such person as a dependent.

(a) If the person is a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is

(i) secondary to the plan covering the person as a dependent, and

(ii) primary to the plan covering the person as other than a dependent (e.g., retired employee)

then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(3) The benefits of a plan which covers the patient as a dependent child of the employee, member or subscriber whose birthday comes first in the calendar year shall be determined before the benefits of a plan which covers such person as a dependent child of the employee, member or

subscriber whose birthday comes last in the calendar year, except in the case of a dependent child of separated or divorced parents.

(a) If parents are divorced or separated and there is a court decree, which establishes financial responsibility for medical expenses for the dependent, the plan covering the dependent of the parent who has that financial responsibility shall be considered the primary plan.

(b) If there is no court decree, the plan, which covers the dependent of the parent with custody, shall be the primary plan.

(c) If there is no court decree and the parent with custody has remarried, the order of benefits determination shall be as follows:

(i) First, the plan of the natural parent with custody shall be the primary plan.

(ii) If the natural parent does not have medical plan coverage, then the plan of the step-parent with custody shall be the primary plan.

(iii) If the natural parent and the step-parent with custody do not have medical plan coverage, then the plan of the parent without custody shall be the primary plan.

(4) The plan covering an individual as an employee (or as the employee's dependent) who is neither laid-off nor retired pays benefits first. The plan covering that individual as a laid-off or retired employee (or as that individual's dependent) pays benefits second. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule shall be ignored.

(5) The plan covering an individual as an employee (or as a dependent of the employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under another plan, and such other plan pays benefits second for such an individual. Conversely, this plan pays secondary benefits for any individual who is provided COBRA continuation under this plan and who also is covered simultaneously under another plan as an employee (or as a dependent of an employee). In the event of conflicting coordination provisions between this plan and any other plan, this plan will pay primary benefits for an individual only if this plan has provided coverage for a longer period of time. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule shall be ignored.

(6) As to plans for which rules (a) through (c) do not establish an order of benefit determination, the benefits of a plan which has covered the person, for whom allowable expenses are being coordinated for the longer period of time, shall be determined before the benefits of a plan which has covered such person the shorter time.

(D) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during any period, each benefit that would be payable in the absence of this provision shall be reduced either proportionately or in such other equitable manner as the committee shall determine.

(E) Upon attaining age 65 or otherwise becoming entitled to Medicare benefits, benefits for active employees shall continue under this plan and Medicare shall be considered the secondary plan for:

(1) Active employees; and

(2) Dependent spouses of active employees.

(F) For individuals who were covered by the plan as a covered employee and became Medicare eligible due to end stage renal disease, the plan will pay primary benefits for a period not to exceed 30 months.

(G) Notwithstanding the foregoing, to the extent that the provisions of the plan conflict with the Medicare secondary payer rules in effect at the time benefits are being determined under this plan, the Medicare secondary payer rules shall control.

5.04 Subrogation.

The plan assumes and is subrogated to a covered person's rights to recovery of any payments made by it for medical expenses where the covered person's illness or injury resulted from the action or fault of a third party. Medical expenses shall include all covered expenses paid by the plan. The plan has the right to recover through their right to subrogation amounts equal to its payments by suit, settlement or otherwise from the insurance of the injured party, from the person who caused the illness or injury or his/her insurance company, or any other source such as uninsured motorist coverage. The plan may also pursue a right of reimbursement against the covered person if he/she has received third party payments for medical expenses as detailed below in Section 5.05.

In order to facilitate the plan's right to subrogation, the covered person is required to provide information and assistance to the plan and sign the necessary papers required. The covered person agrees to answer any and all documentation requests related to subrogation claims sent by the plan or its vendors. If this is not done or if the covered person settles any claim without the plan's written consent, the plan will be entitled to recover from any judgment, settlement or suit all payments for medical expense made by the plan plus reasonable attorney's fees and court costs in trying to recover such payments. Failure to respond to the plan's requests for information, and to pay any owed subrogation expenses to the plan, may result in the covered person's disenrollment from the plan. Such disenrollment shall extend to any dependents who obtained coverage through the covered person.

5.05 Right of Reimbursement.

In addition to and separate from the plan's right to subrogation, the covered person agrees to reimburse the plan, up to the amount paid by the plan, from any money such covered person (or such covered person's family) receives specifically for the medical expenses. The covered person will reimburse the plan the amount of money recovered for medical expenses through judgment or settlement from a liable third party (or the insurer of the third party). The covered person agrees to cooperate with the plan and answer any and all documentation requests related to the plan's right of reimbursement sent by the plan or its vendors. The covered person also agrees to immediately notify the plan of any pending judgment or settlement from a third party for medical expenses. Failure to respond to the plan's requests for information, and to reimburse the plan

for any money received for medical expenses, may result in the covered person's disenrollment from the plan. Such disenrollment shall extend to any dependents who obtained coverage through the covered person.

If the plan makes an error in administering benefits under this plan, the plan may provide additional benefits to, or recover any overpayments from any person, insurance company or plan. No such error may be used by a covered person to demand benefits greater than those otherwise due under this plan. The covered person agrees to assist the plan in enforcing its rights under this provision by signing or delivering the necessary papers.

5.06 Recovery of Payment.

Whenever payments have been made under the plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this article, the committee shall have the right to recover such payments to the extent of such excess from one or more of the following, as the committee shall determine:

(A) Any person to, for or with respect to whom such payments were made;

(B) Any insurance companies; or

(C) Any other appropriate organizations or entities.

5.07 Dependents Previously Covered as Employees and Employees Previously Covered as Dependents.

Benefits payable on behalf of a dependent previously covered under the plan as an employee for hospital, surgical and medical expenses incurred during a period which began while the dependent was insured as an employee shall not exceed the maximum limitation of benefits that would have been payable during such period the dependent remained insured as an employee. The provisions of Section 5.05 also apply for employees previously covered by the plan as dependents.

5.08 Plan Purpose.

The purpose of the plan is to help the covered person pay his/her medical bills. It is not intended that insurance benefits from all sources exceed the medical expenses the covered person incurs. For this reason, if the covered person is covered under "other plans" as defined in this article and total benefits would exceed "allowable expenses," the medical care benefits provided under this plan will be reduced so that the total benefits the covered person receives from all plans will not exceed the actual eligible costs. In other words, the two plans coordinate benefits together and pay up to 100 percent of the eligible charges, but do ***not*** pay more than 100 percent.

ARTICLE VI
PLAN ADMINISTRATION AND FIDUCIARIES

6.01 General.

The committee shall have the responsibility for the administration of the plan pursuant to Chapter 27 of Title 8 of the Tennessee Code Annotated. The committee shall have only those specific powers, duties, responsibilities and obligations as are specifically given them under this plan. The committee shall be composed by law pursuant to TCA 8-27-301, *et seq.*

6.02 Liability of the Committee.

Members of the committee are absolutely immune from liability for acts or omissions within the scope of the committee member's office in serving the committee, except for willful, malicious, or criminal acts or omissions or for acts or omissions done for personal gain, pursuant to TCA 9-8-307(h). Committee members shall be considered "state officers" or "employees" as the meaning is set forth in TCA 8-42-101(3).

6.03 Authority and Powers of the Committee.

The committee shall exercise such authority and responsibility as it deems appropriate in order to comply with state law. The committee shall have such duties and powers as may be necessary to administer the plan, and to delegate as necessary to other representatives of the employer, including but not limited to the following duties and powers:

(A) To construe and interpret the plan, decide all questions of eligibility, and determine the amount, manner and time of payment of any benefits hereunder;

(B) To prescribe procedures to be followed by covered persons, beneficiaries or other persons filing applications for benefits;

(C) To prepare and distribute, in such manner as the committee determines to be appropriate, information explaining the plan;

(D) To receive from the employer, covered persons and other persons such information as shall be necessary for the proper administration of the plan;

(E) To receive, review and keep on file (as it deems convenient or proper) records pertaining to the plan;

(F) To provide for the financing of the plan;

(G) To establish the benefit levels and premium rates for the plan; and

(H) To appoint or employ individuals or companies to assist in the administration of the plan and any other agents it deems advisable.

6.04 Fiduciary Duties and Responsibilities.

Each fiduciary who is allocated specific duties or responsibilities under the plan, or any fiduciary who assumes such a position with the plan, shall discharge his/her duties solely in the interest of covered persons and for the exclusive benefit purpose of providing the benefits provided for in the plan to such covered persons, or defraying reasonable expenses of administering the plan. Each fiduciary, in carrying out such duties and

responsibilities, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims and in accordance with the documents and instruments governing the plan.

A fiduciary may allocate any of his/her responsibilities for the operation and administration of the plan. In limitation of this right, a fiduciary may not allocate any responsibilities as contained herein relating to the management or control of the fund except through the employment of an investment manager as agreed upon by the committee. In the event that an insurance contract is utilized to fund any portion of this plan, the insurance company shall be responsible for the management and control of that portion of the fund which is provided through such contract and a fiduciary may not allocate any responsibilities as contained herein relating to the management or control of that portion of the fund which is provided through an insurance contract.

The committee may adopt such rules as it deems necessary, desirable or appropriate. The committee shall be entitled to rely upon information or advice furnished by a covered person, qualified beneficiary, employer, legal counsel, or other agents when discharging its duties.

6.05 Appeals Provision.

A covered person may request an appeal of a decision made by the claims administrator relative to the disposition of a claim, the utilization review guidelines, or as determined by Benefits Administration, administrative decisions made on behalf of the plan. The covered person must first exhaust any and all levels of the internal complaint or grievance process available through the claims administrator before initiating an external level of appeal. The covered person should first call the claims administrator at the telephone number listed on his/her insurance card. If the covered person has received correspondence pertaining to an inquiry, the covered person should ask for the correspondent by name to discuss the issue. If the covered person's complaint cannot be resolved on an informal basis, they may submit a formal complaint in a manner designated by the claims administrator. The claims administrator may require the covered person to complete and file a "member grievance form" or other designated form. Such forms may be obtained by calling the claims administrator at the telephone number listed on the covered person's insurance card. The complaint or grievance should be filed with the claims administrator within the specified timeframe and will be reviewed by a committee as designated by the claims administrator. Within 60 calendar days of receipt of the written complaint, the claims administrator will issue a written decision to all of the parties involved and will advise them of any further appeal options, including external appeal through an Independent Review Organization (IRO).

ARTICLE VII
CLAIM PROVISIONS

7.01 Proof of Claim.

Written claim for benefits under the plan must be furnished to the claims administrator by the covered person or provider, in a format acceptable to the claims administrator.

7.02 Payment of Benefits.

Benefits shall be payable upon receipt of satisfactory, written proof covering the occurrence, character and extent of the event for which the claim is made. The claims administrator shall notify the covered person in writing as to the amount of benefit to which he/she is entitled, to whom any payment was made, and other pertinent information concerning his/her benefit. To be eligible for payment of benefits, claims must be submitted within 13 months of the date the claim was incurred.

7.03 Examination of Claimants.

The committee or its representative, at its own expense, shall have the right and opportunity to examine any person whose illness or injury is the basis of claim when and so often as it may reasonably require during the pendency of the claim.

7.04 Disputed Claim.

To ensure that payment of claims is in accordance with plan provisions and that payment reduction is not the result of errors in claim processing, miscommunication or misinterpretation of policies, the following should be followed when a covered person disagrees with a denial or reduction of benefits.

The health care provider, covered person (or representative), or the committee's representative should contact the claims administrator to determine why a claim(s) has been reduced or denied. If not a processing error, the claims administrator will explain why the claim reduction or denial occurred. If the claim(s) was incurred with a contracted provider, the claims administrator will explain the "hold harmless" provision of the contract and advise the caller of the patient's liability for the claim. If the claim(s) was with a non-contracted provider, or if there were both contracted and non-contracted claims, the caller will be advised to write the claims administrator and request a review of the claim(s). The claims administrator will review the written request and respond in writing within 60 calendar days of receipt of the request. After review, if claims are still reduced or denied, a detailed written explanation will be given to the covered person of the reasons for the reduction or denial. At this time, the covered person will be advised of any additional levels of review available to them.

If the dispute regarding the claims cannot be resolved at the claims administrator level, the covered person can initiate an appeal. Such appeal is to be made in accordance with both the policies and the rules and regulations of the committee. The committee is authorized to promulgate such rules and regulations necessary to process appeals.

7.05 Liability for Benefits.

To the extent that benefits under any part of the plan are provided by the purchase of insurance from an insurance company, only the insurance company and not the plan, the employer nor any other person or entity, shall be liable for the payment of such benefits. To the extent that benefits under any plan are not provided by the purchase of insurance from an insurance company, only the employer and any trust established by it for the purpose of funding such benefits, and not the plan nor any other person or entity, shall be liable for the payment of such benefits.

7.06 Overpayments and Incorrect Payments.

The committee, or its representative, has the responsibility and authority to recover any benefit payments made in error or in excess of contract liability from the person to, or for, or with respect to whom such payments were made, or from another insurance company or other organization, provider of service due to misrepresentation of eligibility or expense on the part of a covered person or employee.

ARTICLE VIII
CONTRIBUTIONS

8.01 Employee Contributions.

Contributions by covered employees are required as a condition of participating in the plan. By completing an enrollment application, an employee shall authorize the employer to deduct the employee's share of the monthly cost from his/her pay. The employees' share of the monthly cost shall be an amount equal to the difference between the monthly cost for the type medical coverage elected pursuant to Section 1.08 and the employer's share of the cost pursuant to Section 8.02.

Employees or dependents who submit payment for the monthly cost of coverage, and the payment is returned by the employee's or dependent's financial institution, shall be required to resubmit payment in the form of a money order or cashier's check within the time period specified. Should an employee or dependent submit two consecutive payments that are not honored by their financial institution, coverage will be terminated retroactively to the last paid date with no provision for reinstatement within the current plan year.

The plan permits a 30-day deferral of premium. If the premium is not paid at the end of that deferral period, coverage will be canceled retroactive to the day a premium was last paid with no provision for reinstatement of coverage.

8.02 Employer Contributions.

For employees defined in Section 1.15, basic education program funds shall be allocated for use at the employer's discretion pursuant to the mandates of the Education Improvement Act. Additionally, the employer (LEA) may make a contribution on behalf of the employee.

8.03 Funding Medium.

(A) The choice of insurance companies or claims administrators under the plan, the timing and amount of any payment to such company, and the timing and amount of any contribution to any trust established under the plan shall be at the sole discretion of the committee. Benefits under any part of the plan that are not fully insured, to the extent not insured, may, at the employer's sole discretion, be unfunded and may be paid by the employer solely from its general assets and the employer shall have no obligation to establish any trust or reserve in respect of such benefits, except as may otherwise be required by applicable law and regulations there under. The employer may, however, at its sole discretion, establish one or more trusts to hold such assets and such trust(s) may or may not, as determined by the employer, contain such provisions as are necessary to qualify for exemption from federal, state, local and other taxes.

Contributions by the employer, the state, covered employees, COBRA participants and retired employees shall be made to an expendable trust fund established to provide funding of the plan. All contributions under this plan shall be applied toward the payment of benefits provided by plan and reasonable expenses of administering the plan.

On behalf of the covered persons, the employer shall establish and maintain an expendable trust fund from which benefit payments as provided under this plan shall be made. The fund will receive, invest and administer all contributions made under this plan in accordance with state law and accounting policies in effect for the receipt, investment and disbursement of state funds. The fund, resulting from contributions, earnings, profits, increments and accruals thereon, may only be used for the exclusive benefit of covered persons or the payment of reasonable expenses of administering the plan.

Although it is anticipated that no insurance coverage will be utilized, the plan may be funded in whole or in part by such insurance coverage as from time to time may be authorized by the committee. In the event that any payments pursuant to the plan shall be made by any insurance company directly, such payments shall be deemed to have been made by the fund.

(B) Premium refunds will be subject to the following guidelines:

(1) Employee fails to notify agency of eligibility change: Employees who do not notify about a change in their insurance enrollments in a timely manner will receive a three month refund of their portion of the premium, from the date of notification to the agency unless the employee owes the plan for claims paid inappropriately, overpaid benefits above the employee premium refund amount will be billed to the employee. The agency will receive its entire portion.

(2) Agency fails to follow through on employee request for change: Employees who notify their employer, timely, to change insurance enrollments and the employer fails to follow through on the request will receive their entire portion of the refund. The agency will receive three months of refund from the date of notification to Benefits Administration, unless medical benefits have been provided to an ineligible patient. Amounts of overpaid benefits above the agency refund amount will be billed to the agency.

(3) Agency fails to report employment terminations: Agencies that fail to report employment terminations are limited to a three month refund from the time of notification to Benefits Administration, unless medical claims have been provided to an ineligible patient. Amounts of overpaid claims above the agency refund amount will be billed to the agency.

(4) Fraud cases: When the office of the State Comptroller has determined that fraud exists, the employee will forfeit their portion of a refund. The agency will receive its entire portion.

ARTICLE IX
AMENDMENT AND TERMINATION

9.01 Plan Modification and Amendment of Plan.

The plan may be modified and amended at any time by the committee upon its due approval of such modification or amendment. The modification or amendment shall be effective at the date of approval, as required by law, or at such later date as the committee may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the plan.

9.02 Plan Termination.

The plan may be terminated at any time by the committee upon due authorization of such termination effective as of the date of such authorization or at such later date as the committee may provide. In the event of such termination, the employer shall have no obligation under the plan beyond paying the difference between the claims incurred (even though filed up to 13 months after incurred) and expenses of the plan due up to the date of termination plus extended benefits, if any, provided under the plan and the funds available to pay such claims and expenses and extended benefits. Such claims and expenses shall be paid from the funds in the plan. In the event there shall be excess funds in the plan left after the payment of such claims and expenses, then the plan shall continue and from such funds there shall be paid in the following priority:

(A) The expenses of such continuation;

(B) Extended benefits, if any; and

(C) Current claims as the same shall arise, until the funds in the plan are ultimately exhausted.

Current claims received in any one month may be accumulated for later payment, and, in the event of such procedure and there ultimately being insufficient funds to pay in full such claims accumulated for a month after payment of expenses, then the funds remaining on hand may be distributed ratably among those claims accumulated for each month. The committee shall incur no liability for its failure to make payment of any claim or to make ratable distribution on any claim without regard to the reasons therefore, the committee having the responsibility for determining claims and directing payment thereof. The committee shall have the right to employ fiduciaries under the plan to aid it in the discharge of its duties hereunder.

9.03 Local Education Agency Termination.

An employer may terminate participation in the plan by providing written notification to the committee or its representative. Notification should be given 60 days prior to the termination date and should include benefit and premium information for the new plan to determine if the new plan is equal or superior to the Local Education Plan for continuation of state funding. TCA 8-27-303(a)(2) requires a local education agency electing to maintain their own benefits plan to demonstrate that the local plan is equal or superior to the state-sponsored plan. TCA 8-27-304 requires a local education agency to provide verification that a majority of eligible employees have agreed to enrollment in the plan. Any agency that ceases participation with the plan is prohibited from rejoining the plan for 24 months. If an agency ceases to participate in the plan, currently enrolled employees and dependents as well as COBRA participants and retirees associated with that local

education agency once again become the responsibility of that agency. Financial premium support for retired participants, as authorized in TCA 8-27-305, is not available to retirees of a local education agency not participating in the state-sponsored plan. Retired teachers and retired support staff (if participating in the Tennessee Consolidated Retirement System), lose the ability to have their insurance premium collected through deduction from their TCRS benefit check.

ARTICLE X
PRIVACY OF PROTECTED HEALTH INFORMATION

10.01 Local Education Insurance Committee Certification of Compliance.

Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Education Insurance Committee (sponsor) unless the Local Education Insurance Committee certifies that the *Plan Document* has been amended to incorporate this article and agrees to abide by this article.

10.02 Purpose of Disclosure to Local Education Insurance Committee.

(A) The plan and any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Education Insurance Committee only to permit the Local Education Insurance Committee to carry out plan administration functions for the plan not inconsistent with the requirements of HIPAA and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Local Education Insurance Committee of plan participants' protected health information will be subject to and consistent with the provisions of Sections 10.03 and 10.04 of this article.

(B) Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Education Insurance Committee unless the disclosures are explained in the privacy practices notice distributed to the plan participants.

(C) Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Education Insurance Committee for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Local Education Insurance Committee.

10.03 Restrictions on Local Education Insurance Committee Use and Disclosure of Protected Health Information.

(A) The Local Education Insurance Committee will neither use nor further disclose plan participants' protected health information, except as permitted or required by the *Plan Document*, as amended, or as required by law.

(B) The Local Education Insurance Committee will ensure that any agent, including any subcontractor, to which it provides plan participants' protected health information, agrees to the restrictions and conditions of the *Plan Document*, including this article, with respect to plan participants' protected health information.

(C) The Local Education Insurance Committee will not use or disclose plan participants' protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Local Education Insurance Committee.

(D) The Local Education Insurance Committee will report to the plan any use or disclosure of plan participants' protected health information that is inconsistent with the uses and disclosures allowed under this article promptly upon learning of such inconsistent use or disclosure.

(E) The Local Education Insurance Committee will make protected health information available to the plan or to the plan participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(F) The Local Education Insurance Committee will make plan participants' protected health information available for amendment, and will on notice amend plan participants' protected health information, in accordance with 45 C.F.R. § 164.526.

(G) The Local Education Insurance Committee will track disclosures it may make of plan participants' protected health information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(H) The Local Education Insurance Committee will make its internal practices, books, and records relating to its use and disclosure of plan participants' protected health information available to the plan and to the U.S. Department of Health and Human Services to determine the plan's compliance with 45 C.F.R. Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

(I) The Local Education Insurance Committee will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all plan participant protected health information, in whatever form or medium, received from the plan or any health insurance issuer or business associate servicing the plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any participant who is the subject of the protected health information, when the plan participants' protected health information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all plan participant protected health information, the Local Education Insurance Committee will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any plan participant protected health information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(J) The Local Education Insurance Committee will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the group health plan.

(K) The Local Education Insurance Committee will ensure that any agent, including a subcontractor to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect the electronic protected health information.

(L) The Local Education Insurance Committee shall report to the group health plan any security incident of which it becomes aware.

10.04 Adequate Separation between the Local Education Insurance Committee and the Plan.

(A) The following employees or classes of employees or other workforce members under the control of the Local Education Insurance Committee may be given access to plan participants' protected health

information received from the plan or a health insurance issuer or business associate servicing the plan:

(1) Employees within the State of Tennessee Department of Finance and Administration, Benefits Administration who have the responsibility for administering the plan.

(2) Other employees or subcontractors designated by the Local Education Insurance Committee.

This list includes the class of employees or other workforce members under the control of the Local Education Insurance Committee who may receive plan participants' protected health information relating to payment under, health care operations of, or other matters pertaining to the plan in the ordinary course of business.

(B) The classes of employees or other workforce members identified in Section 10.04 (A) of this article will have access to plan participants' protected health information provided to the Local Education Insurance Committee by the plan only to perform the plan administration functions that the Local Education Insurance Committee provides for the plan.

(C) The classes of employees or other workforce members identified in Section 10.04 (A) of this article will be subject to the appropriate personnel policies of the State of Tennessee regarding disciplinary action for any use or disclosure of plan participants' protected health information provided to those employees by the Local Education Insurance Committee in its capacity as plan sponsor in breach or violation of or noncompliance with the provisions of this article. The Local Education Insurance Committee will promptly report such breach, violation or noncompliance to the plan, as required by Section 10.03 (D), (J) and (K) of this article, and will cooperate with the plan to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.

ARTICLE XI
MEDICAL BENEFITS

Each reference to an attachment, plan, or network in this article shall mean the attachment, plan, or network applicable to an individual's healthcare elections or enrollment under this Plan. Each reference to a specific section shall mean the applicable section within this article unless otherwise specified.

11.01 Amount of Benefits.

The amount of benefits is outlined in Attachment A, "Schedule of Benefits," which is attached to and made a part of the plan. Unless otherwise specified as 100% covered, the copayment and coinsurance amounts outlined reflect a covered person's responsibility. The balance of the medical benefits, up to 100% of the maximum allowable charge for covered expenses, is provided by the plan. Upon receipt of proof of loss, the plan shall pay (unless otherwise specified herein) a percent, pursuant to Section 11.03, of covered expenses incurred within each plan year and which are in excess of the deductible requirement, as described in Section 11.02. The amount of the medical benefits is further subject to the stop loss provisions of Section 11.05.

11.02 Deductible Amount.

The deductible amount is specified in Attachment A, and is required to be paid by each covered person prior to payment of many covered expenses under the plan. Certain expenses are not subject to a deductible as indicated in Attachment A. For individuals who transfer between plans, the deductible met under the state or local government plan shall be considered when determining the maximum plan year deductible. For individuals who continue insurance coverage through retirement or the provisions of COBRA, the deductible met while an employee shall be considered when determining the maximum plan year deductible.

(A) Individual Deductible. In the event that the covered person has incurred covered expenses equal to the deductible dollar amount shown in the Attachment A in a plan year, such covered person shall have satisfied the deductible requirement of the plan for such plan year and shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 11.03. The deductible amount shown in Attachment A is for medical services and mental health and substance abuse treatment services combined.

(B) Family Deductible. In the event that covered persons of the same family independently incur covered expenses in a plan year so that the total of which would satisfy the family deductible outlined in Attachment A, then the deductible requirement of the plan shall have been satisfied for such plan year and each and every covered person of such family shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 11.03.

(C) Common Accident Deductible. If two or more individuals who are members of one family incur covered expenses as a result of injuries sustained in the same accident while coverage for medical care expense benefits pursuant to the plan is in force with respect to each of them, the applicable deductible

shall be applied only once to the total of their covered expenses incurred during the plan year in which such accident occurred.

11.03 Coinsurance.

The plan will pay a percentage (the "applicable coinsurance percentage") of covered expenses incurred within each plan year, and which are in excess of the deductible requirements of Section 11.02.

(A) Network Expenses - Hospital and Physician. In the event of covered expenses for those services received from and payable to a health care provider affiliated with the network, the applicable coinsurance percentage shall be the in-network percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met.

(B) Non-Network Expenses - Hospital and Physician. In the event of covered expenses which are not described in subparagraph (A), the applicable coinsurance percentage shall be the out-of-network percentage as indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met.

(C) Unique Care. Highly specialized treatment, which is determined not to be available through a network provider (as determined by the claims administrator), and as such may be provided by a non-PPO provider, is paid as if a network expense. The covered person is responsible for expenses determined not to be medically necessary and expenses that exceed the maximum allowable charge. These exceptions must be pre-approved by the claims administrator. For unique care exceptions, where the duration, medical complexity and/or level of professional skill, training and experience warrant highly specialized treatment as determined by the claims administrator and such treatment is determined not to be available through a network provider, the plan may, through the appeals process outlined in Section 6.05, provide benefits through a non-network provider. Upon such a determination reached through the appeals process and by the claims administrator, the benefit may be paid as if a network expense utilizing an allowable amount not to exceed 150 percent of the plan's maximum allowable charge for the service. The covered person will be responsible for expenses determined not to be medically necessary and expenses that exceed the allowable charge determined through the appeals process. The plan, through the appeals process, may establish a procedure for the periodic review of the need for the patients continuing need for the unique care exception. A continuous care exception may be granted when a covered person is undergoing an active treatment plan for a serious medical condition, including pregnancy. The claims administrator determines the time frame in which continuous care can be covered.

(D) Non-Compliance with Utilization Management Program. In the event that the guidelines of the utilization management program, as outlined in Section 11.07, have not been followed, as applicable, the applicable coinsurance percentage is the percentage as indicated in Attachment A, after the deductible has been met. Expenses incurred with non-network providers that are determined not to be

medically necessary as determined by the claims administrator will not be reimbursed by the plan, but will be the responsibility of the covered person.

(E) Non-Hospital and Non-Physician Expenses. In the event of covered expenses for non-hospital and non-physician services, the applicable coinsurance percentage is the percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met. Expenses incurred in conjunction with this subsection E include, but are not limited to the following: physical therapy, occupational therapy, speech therapy, ambulance, dialysis clinics, sitters, private duty nursing, and dentists.

(F) Hospital-Based Providers. In the event of covered expenses incurred with hospital-based providers, reimbursement will be made at the network level of benefits. The covered person will not be responsible for any expenses which exceed the maximum allowable charge for any providers of service that are hospital-based providers. Hospital-based providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists, and pathologists.

(G) Emergency Out-of-State. In the event of covered expenses for emergency care as outlined in Section 1.16 outside Tennessee, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). Out-of-network benefits will apply to non-network care if the claims administrator determines the situation was not an emergency.

(H) Emergency Inside Tennessee. In the event of covered expenses for emergency care as outlined in Section 1.16, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). Out-of-network benefits will apply to non-network care if the claims administrator determines the situation was not an emergency or if the patient is not transferred to a network facility once the medical condition allows.

(I) Out-of-State Retirees, Employees, Spouses, Dependent Children and COBRA Participants. Retirees and their dependents, COBRA participants, and spouses and dependent children who permanently reside out of state should utilize the out of area program as established by the claims administrator. This program allows covered persons of the plan to utilize participating network physicians, facilities and agencies that participate in the network established by the claims administrator within each state. Plan participants who choose a participating network provider will receive in-network benefits for covered services as outlined in Attachment A. Employees and their dependents who are stationed outside of Tennessee on a job assignment and continue to be paid as an employee should also utilize the out of area program to obtain maximum benefits under this plan. Employees and dependents who reside out of state and work in Tennessee will receive benefits as indicated in Attachment A for network and non-network expenses.

(J) Out-of-Country Benefits. In the event that expenses are incurred for medically necessary services rendered while a covered person is out of the country on business or pleasure, benefits shall be paid as indicated in Attachment A, subject to all other terms and conditions of the plan. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Should charges be incurred in a non-English speaking country, claims should be translated to standard English at the covered person's expense before being submitted to the claims administrator. The current exchange rate should also be provided.

(K) Pharmacy Program. In the event that expenses are incurred for prescription drugs, the applicable copayment shall be paid by the employee or dependent as indicated in Attachment A.

(L) Geographic Areas Where the Committee has Determined the Network to be Insufficient. The committee retains the right to determine if the covered persons in a specific geographic area do not have adequate access to network providers (either in total or specific specialties). If this determination is made at any time, the committee will direct the claims administrator to provide benefits in these areas, at a reimbursement level as determined by the committee even when non-network providers are utilized.

11.04 Emergency Room Visit Copayment.

The covered person is responsible for payment of the copayment or coinsurance amount shown in Attachment A for each visit to a hospital emergency room. This amount is waived if the visit results in an admission (of more than 23 hours) to the hospital with a bed assignment, a walk-in clinic is used, or the visit to the emergency room is subsequent to an initial visit to an emergency room for the same episode of an injury or illness within 48 hours. The waiver provision does not apply to CDHP healthcare options

11.05 Stop Loss Provision.

(A) Individual. After the maximum amount (separate cumulative maximums for in-network and out-of-network expenses) of individual (employee only) out-of-pocket expenses, as indicated in Attachment A, have been incurred by the covered person in any plan year, the plan will pay 100 percent of additional covered expenses incurred for the remainder of the plan year by that covered person, provided that the guidelines of the utilization management program, as outlined in Section 11.07 have been followed, if applicable.

(B) Family. After the maximum amount (separate cumulative maximum for in-network and out-of-network expenses) of family out-of-pocket expenses as indicated in Attachment A have been incurred by covered persons who are in one family in any plan year, the plan will pay 100 percent of additional covered expenses incurred for the remainder of the plan year by every covered person in that family, provided that the guidelines of the utilization management program, as outlined in Section 11.07 have been followed, if applicable.

11.06 Maximum Benefits.

There is no dollar amount lifetime maximum benefit for medical treatment under the plan.

11.07 Utilization Management Program(s).

The utilization management programs shall include requirements governing pre-admission certification, post-certification of emergency admissions, weekend admissions, optional second surgical opinions, mandatory outpatient procedures, home health, case management, private duty nursing, durable medical equipment and pharmacy program. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. In order to assure the necessity, appropriateness and quality of the hospital care a covered person receives, the committee shall retain a utilization review organization to review all general hospital admissions to certify medical necessity and length of stay.

Non-emergency hospital admissions are to be reviewed prior to being admitted to the hospital in accordance with the procedures found in this document.

Emergency admissions must be reviewed within 24 hours or one working day after admission. However, even if an emergency admission procedure is not followed, the hospital pre-admission certification procedure shall be deemed to have been followed if the utilization review organization later determines that the hospital admission was medically necessary as determined by the claims administrator.

In order to satisfy the guidelines of the utilization management program, the utilization review organization shall require elective admissions to begin on a weekday unless there is sufficient justification that the admission be made on a weekend.

Tests and other procedures that can be safely and effectively performed on an outpatient basis will be required to be administered in an outpatient setting to satisfy the guidelines of the utilization management program.

If the review decision differs from those of the covered person's attending physician and the differences are not resolved through the appeals process described in Section 6.05, the covered person and his/her attending physician shall be notified that the plan shall not provide benefits for the length of stay which exceeds the limits set forth by the utilization review organization. These charges will normally be the responsibility of the covered person; however, if part of the contracted network, such providers have, by separate contract with the claims administrator, agreed not to bill the covered person if the claims administrator determines that service(s) were not medically necessary, or if the network provider has not followed applicable utilization management guidelines, such as obtaining pre-admission certification. Network providers have agreed to accept the maximum allowable amount as payment in full for such services and hold the covered person harmless (from any balance of charges), except with respect to deductibles, coinsurance and non-covered expenses of the covered person's coverage.

The ultimate choice of a provider is solely up to each covered person.

The claims administrator does not furnish covered services directly but rather pays benefits according to the plan. The claims administrator, the committee, the employer and the plan shall not be

responsible for any claims, injuries or damages whatsoever caused by or which arise from the acts or failure to act of any provider. None of the entities listed above shall be liable for a provider's refusal or failure to render services on behalf of a covered person.

Whether a provider is in-network or out-of-network shall not be taken as a recommendation or endorsement with respect to a particular provider's qualifications, skills, or competence.

(B) Optional Second Surgical Opinion. The covered person may receive a second surgical opinion from a qualified surgeon, if the suggested procedure is listed in Attachment B. The second opinion must be obtained from a surgeon qualified to perform the surgical procedure but who is not in the same medical group as the physician who originally recommended surgery. The charges for the second opinion and any tests performed in obtaining the second opinion shall be paid in full by the plan regardless of whether or not the covered person's deductible has been met if utilizing a network provider. The payment in full provision does not apply to the CDHP healthcare options unless annual deductible requirements have already been met.

(C) Mandatory Outpatient Procedures. In order to satisfy the guidelines of the utilization management program, the plan shall require certain procedures be performed on an outpatient basis. The pre-admission certification process will determine which procedures should be performed in the outpatient setting. These procedures should be performed in the outpatient department of a hospital or in an ambulatory surgical center unless deemed to be medically necessary as determined by the claims administrator, and as approved by the utilization review organization, to be performed on an inpatient basis.

(D) Home Health. Covered persons may receive home health benefits if prior approval is received from the claims administrator. These benefits should be obtained based upon a referral from the covered person's physician and should be obtained from a provider participating in the network of home health agencies established by the claims administrator.

(E) Case Management. Notwithstanding any contract provision, rider or endorsement to the contrary, the utilization review organization will consider alternative treatment plans proposed by the covered person or provider, committee or employer on behalf of a covered person and may elect to offer alternative benefits for services not otherwise specified as covered expenses hereunder.

The claims administrator and/or utilization review organization will identify potential cases, evaluate proposed alternative treatment plans, and will otherwise coordinate the delivery of alternative benefits when the committee, or its representative, upon consultation with the utilization review organization, determines that alternative treatment is medically necessary and cost effective. Such benefits will be offered only in accordance with a plan of alternative treatment with which the covered person (or the covered person's legal guardian) and the attending physician concur. Alternative benefits will be made available on a case-by-case basis to individuals. Under no circumstances does a covered person acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer of, or confirmation of, alternative benefits in one instance shall not obligate the plan to provide the same or similar benefits for any other covered person in another instance. In addition, nothing herein shall be deemed a waiver of the right of the plan to enforce this plan in strict accordance with its express terms

and conditions. No benefits of any type will be payable, however, beyond the date the contract or covered person's coverage terminates.

(F) Private Duty Nursing. The claims administrator, based upon available medical information, may determine that a covered person needs the services of private duty nursing. The claims administrator will review medical charts documenting services provided by the nursing staff and will determine the duration for which reimbursement will be provided for this service.

(G) Durable Medical Equipment. In the event that it is determined that a covered person requires the use of durable medical equipment, such equipment should be obtained through a provider in the network established by the claims administrator. The covered person should have a written prescription from a network provider for such durable medical equipment. The level of reimbursement is in Attachment A.

(H) Pharmacy Program. In order to receive maximum benefits of the pharmacy program available, covered persons should utilize the prescription home delivery program. Covered persons may also utilize a pharmacy in the network established by the claims administrator. If the prescription is filled through the home delivery program or at a participating retail pharmacy, a copayment is required as outlined in Attachment A. A covered person should present their pharmacy insurance identification card at the time of purchase, along with the applicable copayment as outlined in Attachment A. When a participating pharmacy is utilized, the charges for the prescription will be electronically filed with the claims administrator. If a participating or non-participating pharmacy is utilized and the claim is filed by the covered person, amounts exceeding the maximum allowable charge are the responsibility of the covered person. Prescriptions are generally limited to a 30-day supply at the retail pharmacy level with some having additional limitations and pre-authorization requirements. Certain medications can be purchased through the home delivery program and certain participating retail pharmacies that have agreed to the same pricing terms as the home delivery provider for up to a 90-day supply with additional copayment amounts from the covered person.

(I) Procedures. The utilization review organization shall establish procedures for administering the utilization management program and the committee shall communicate such procedures to all covered employees and qualified beneficiaries. If benefits are reduced due to non-compliance with the procedures established for administering the utilization management program, and the covered person wishes to dispute such reduction, such covered person may request that his/her claim be reconsidered pursuant to Section 7.04.

The reconsideration shall ensure that covered persons who, in good faith, attempt to comply with the utilization management program procedures are provided benefits at the same level as if those procedures had been followed.

A covered person has the responsibility to notify his/her physician and hospital that he is a covered person under the plan and of the plan's certification requirements for hospital admissions. This notification by the covered person can be by presentation of the plan identification card by the covered person or if the covered person verbally informs the provider.

If the covered person notifies the network provider that he/she is a covered person under the plan before the admission, it will be the provider's responsibility to contact the utilization review organization for certification. If certification is not obtained, the plan and the covered person shall be held harmless from the reduction resulting from not satisfying the utilization management program by the provider.

On an elective admission, if a covered person does not notify the network provider that he/she is a covered person under the plan, or does not give the network provider correct information or the covered person will not admit to being covered by the plan when asked by the network provider, the plan will be held harmless if certification is not obtained. The covered person will be responsible for the full payment.

On an emergency admission, if a covered person does not inform the hospital of his/her participation in the plan or of the utilization management program guidelines, the provision under subsection 11.07(A) shall apply and determine what benefits will be provided by the plan when certification is not obtained. If it is determined by the claims administrator that the admission was not an emergency, the plan shall be held harmless. The covered person will be responsible for the full payment.

During a stay at a network facility, if the hospital utilizes the services of a non-network hospital-based provider for the care of the covered person, the plan will provide benefits at the in-network level (see Attachment A). The covered person is only responsible for the in-network level of coinsurance (see Attachment A) and any charges above the maximum allowable charge, and the plan is held harmless, unless otherwise specified in 11.03(F).

A provider may obtain certification by writing to the utilization review organization (no more than 30 days in advance) or by calling the appropriate utilization review organization on the pre-certification toll-free line during normal business hours. If the provider contacts the utilization review organization when the office is closed, the caller will get a recorded message asking the caller to call again during office hours. It is the responsibility of the provider to call back to obtain certification or extension of days, unless the admission is an emergency.

When the call is received during office hours, the utilization review organization will approve or deny the certification at that time, unless additional information is needed before the certification is determined. Once all of the information is received by the utilization review organization, certification will be denied or approved within one working day.

When the certification is approved or denied, the utilization review organization will send a letter to the covered person (or his/her guardian), physician and hospital advising them of the approval or denial of the certification. This letter will be sent no later than one working day after the certification is denied or approved.

When determining certification for elective or emergency admissions, medical personnel under the direction of a physician will review the timing and setting of the medical care. The utilization review organization will not question the medical necessity of the care. The utilization review organization will not verify eligibility under the plan or if the benefits are eligible expenses under the plan.

When certification is approved, the utilization review organization will notify the provider of the number of days that are being certified for the inpatient stay. If the hospitalization is in a network facility, it will be the facility's responsibility to contact the appropriate utilization review organization if the physician wants to request additional days. If the benefits for additional inpatient days are denied, the utilization review organization will notify the patient, the physician and hospital on what date inpatient benefits will cease.

If the admission is in a non-network facility, the utilization review organization will contact the hospital the day following the last day of certification to confirm the patient has been discharged from the facility. If the physician requests additional days and the extension of inpatient benefits is denied, the utilization review organization will notify the patient, the physician and hospital of what date inpatient benefits will cease.

When determining if additional inpatient days should be certified, the utilization review organization will review the health care services delivered during the confinement to make sure they meet community standards of quality and are consistent with the patient's needs. If the utilization review organization determines that, after reviewing the hospital records, the health care is not medically necessary, benefits for the additional inpatient days will be denied.

If a covered person is transferred from one facility to another, certification at the second facility must be obtained under the certification guidelines in subsection 11.07(A).

ARTICLE XII
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

Each reference to an attachment, plan, or network in this article shall mean the attachment, plan, or network applicable to an individual's healthcare elections or enrollment under this Plan.. Each reference to a specific section shall mean the applicable section within this article unless otherwise specified.

For the purpose of interpreting these provisions, the following definitions will apply:
"Eligible Providers" shall mean those providers considered eligible to provide mental health/substance abuse services or employee assistance services. For mental health/substance abuse services, eligible professional providers include psychiatrists, psychologists, licensed professional counselors, registered nurse clinical specialists and licensed clinical social workers, as defined herein. For employee assistance program (EAP) services, eligible providers are those considered eligible by the claims administrator for those services.

"In-Network" shall mean a provider contracted to participate in the claims administrator's network. For all higher levels of care (i.e. inpatient, residential, partial hospitalization, and intensive outpatient care), and selected outpatient procedures such as psychological testing a referral made by the claims administrator for a covered person for treatment of mental health/substance abuse, which is determined to be medically necessary and/or clinically necessary. Such referral is made based upon a request by the covered person and made to an in-network provider.

"Out-of-Network" shall mean an eligible provider not contracted to participate in the claims administrator's network for treatment of a covered person for mental health/substance abuse, which is determined to be medically necessary and/or clinically necessary.

12.01 Amount of Benefits.

The amount of benefits is outlined in Attachment A, "Schedule of Benefits," which is attached to and made a part of the plan. Unless otherwise specified as 100% covered, the copayment and coinsurance amounts outlined reflect a covered person's responsibility. The balance of the medical benefits, up to 100% of the maximum allowable charge for covered expenses, is provided by the plan. Upon receipt of proof of loss, the plan shall pay (unless otherwise specified herein) a percent, pursuant to Section 12.03, of covered expenses incurred within each plan year and which are in excess of the deductible requirement, as described in Section 12.02. The amount of the medical benefits is further subject to the stop loss provisions of Section 12.05.

12.02 Deductible Amount.

The deductible amount is specified in Attachment A, and is required to be paid by each covered person prior to payment of many covered expenses under the plan. Certain expenses are not subject to a deductible as indicated in Attachment A. For individuals who transfer between plans, the deductible met under the state or local government plan shall be considered when determining the maximum plan year deductible. For

individuals who continue insurance coverage through retirement or the provisions of COBRA, the deductible met while an employee shall be considered when determining the maximum plan year deductible.

(A) Individual Deductible. In the event that the covered person has incurred covered expenses equal to the deductible dollar amount shown in the Attachment A in a plan year, such covered person shall have satisfied the deductible requirement of the plan for such plan year and shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 12.03. The deductible amount shown in Attachment A is for medical services and mental health and substance abuse treatment services combined.

(B) Family Deductible. In the event that covered persons of the same family independently incur covered expenses in a plan year so that the total of which would satisfy the family deductible outlined in Attachment A, then the deductible requirement of the plan shall have been satisfied for such plan year and each and every covered person of such family shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 12.03.

12.03 Coinsurance.

The plan will pay a percentage of covered expenses incurred within each plan year, and which are in excess of the deductible requirement of Section 12.02.

(A) Inpatient Benefits. The plan will pay the following benefits for mental health and substance abuse treatment received in an inpatient setting.

(1) In-Network. In the event of covered expenses for those inpatient services received from and payable to a provider affiliated with ***and*** specifically referred by the mental health and substance abuse utilization review organization the in-network coinsurance percentage is indicated in Attachment A, provided the deductible has been met.

(2) Out-of-Network. In the event of covered expenses received from and payable to an out-of-network provider that were authorized by the mental health and substance abuse utilization review organization, the plan inpatient benefit out-of-network coinsurance percentage is indicated in Attachment A, provided the deductible has been met.

(3) Services Which Are Determined Not to be Medically Necessary and/or Clinically Necessary. In the event of expenses for those inpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

(B) Outpatient. The plan will pay the following benefits for mental health and substance abuse treatment received in an outpatient setting:

(1) In-Network. In the event of covered expenses for those in-network outpatient services received from and payable to an in-network provider referred by the mental health and substance abuse utilization review organization, in-network benefits are payable as indicated in Attachment A once the deductible has been met.

(2) Out-of-Network. In the event of covered expenses for those outpatient services received from and payable to an out-of-network provider, the out-of-network plan benefits are payable as indicated in Attachment A once the deductible has been met.

(3) Services Which Are Determined Not to be Medically Necessary and/or Clinically Necessary. In the event of expenses for those outpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

12.04 Benefits for Detoxification.

In the event of covered expenses for a detoxification program, benefits will be paid at the level indicated in Attachment A.

12.05 Stop Loss.

(A) Individual. After the maximum amount (separate cumulative maximums for network and non-network expenses) of individual (employee-only) out-of-pocket expenses, as indicated in Attachment A, have been incurred by the covered person in any plan year, the plan will pay 100 percent of additional covered expenses incurred for the remainder of the plan year by that covered person, provided that the guidelines of the utilization management program, as outlined in Section 12.07 have been followed, if applicable.

(B) Family. After the maximum amount (separate cumulative maximum for network and non-network expenses) of family out-of-pocket expenses as indicated in Attachment A have been incurred by covered persons who are in one family in any plan year, the plan will pay 100 percent of additional covered expenses incurred for the remainder of the plan year by every covered person in that family, provided that the guidelines of the utilization management program, as outlined in Section 12.07 have been followed, if applicable.

12.06 Maximum Benefits.

There are no lifetime dollar maximums under the plan for mental health/substance abuse treatment.

12.07 Utilization Management.

The utilization management programs described in this Section 12.07 shall include requirements governing pre-admission certification, outpatient referrals, case management and EAP benefits. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. A utilization management function that occurs at or prior to admission to determine whether or not the admission is both medically necessary and appropriate for the individual patient. The result is a recommendation for treatment.

(B) Outpatient Referrals. The process in which a patient is introduced to a health provider for treatment.

(C) Case Management. A process that evaluates the medical necessity and appropriateness of treatment.

(D) EAP Benefits. Employee assistance program (EAP) services are available at no cost to all employees, retirees and COBRA participants enrolled in the health Plan. Eligible dependents do not have to be enrolled. Services consist of short-term counseling (up to five sessions per problem episode) for problems such as marital or family, emotional, substance abuse, stress, job and financial loss. Legal and financial consultations are also available. If an employee or dependent is determined to need greater assistance, they will be referred to other resources. All EAP services must be preauthorized.

(E) Procedures. In order to receive maximum benefits**,** all mental health and substance abuse inpatient, residential, partial hospitalization, intensive outpatient treatment, outpatient psychological testing, electroconvulsive therapy and EAP services must be preauthorized by the utilization review organization.

ARTICLE XIII
COVERED EXPENSES
AND EXCLUSIONS AND LIMITATIONS

Each reference to an attachment or plan in this article shall mean the attachment or plan applicable to an individual's healthcare elections or enrollment under this Plan.. Each reference to a specific section shall mean the applicable section within this article unless otherwise specified.

13.01 Conditions.

All medical and mental health and substance abuse services, treatment and expenses will be considered covered expenses pursuant to this plan if:

(A) They are listed in Sections 13.02 or 13.03;

(B) They are not excluded from coverage under Section 13.04;

(C) They are determined to be medically necessary and/or clinically necessary by the claims administrator;

(D) Are rendered by a participating provider or specialist or facility in the network or a nonparticipating provider or specialist or facility as provided in an applicable section and/or attachment herein;

(E) Are consistent with plan policies and guidelines; and

(F) Required by applicable state or federal laws or regulations.

The committee, or its representative, shall make determinations regarding whether expenses will be considered covered expenses pursuant to (A) and (B) above. Medical and/or mental health and substance abuse specialists shall be consulted to determine whether a service, treatment or expense is medically necessary and/or clinically necessary. All claims from a hospital, physician or other provider shall be examined to determine whether the services, treatment and expenses were medically necessary and/or clinically necessary. If the specialist determines the treatment was not medically necessary and/or clinically necessary, the physician of the covered person for whom the claim is submitted can choose to provide additional information. If after examining the additional information it is determined that the service, treatment or expense was not medically necessary and/or clinically necessary, the claim shall not be considered as a covered expense by the plan, and the covered person may be responsible for payment of all of the bills associated with that claim, subject to the appeal process as described in Section 6.05.

Covered persons should also review their member handbooks for information on covered expenses.

13.02 Covered Expenses - Generally.

Charges for the following services and supplies are eligible covered expenses under the plan:

(A) Hospital room and board charges for a semi-private room up to the claims administrator's maximum allowable charge normally based on a daily per-diem rate which includes all room, board and ancillary services for the type of care provided as authorized through the utilization review for the plan. Additional charges for a private room will only be considered when isolation of the patient is medically necessary and/or clinically necessary as determined by the claims administrator to reduce

the risk of receiving or spreading infection. The plan will pay the most prevalent room rate charge when the unit or facility does not provide semi-private rooms. Hospital services must be preauthorized by the physician or hospital.

(B) Services and supplies furnished to the eligible covered persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an injury or illness, including consultations with a physician requested by the covered person's physician.

(C) Charges for "surgical procedures." Surgical procedures shall mean the generally accepted operative and cutting procedures rendered by a physician for the necessary diagnosis and treatment of an injury or illness, including treatment of fractures or dislocations, maternity care, any diagnosis of burns and abrasions and any endoscopic procedure (i.e. sigmoidoscopy, cystoscopy, etc.). During one operation, a physician may perform two or more surgical procedures through the same incision. In this situation, payment is equal to the full benefit amount for the most expensive procedure plus one-half of the benefit amount for the other procedure.

(D) Office visits to a physician that are due to an injury or illness.

(E) Private-duty or special nursing charges (including intensive nursing care) for medically necessary and/or clinically necessary treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative, if prescribed by the attending physician.

(F) Charges by a physician, anesthesiologist or nurse anesthetist for anesthesia and its administration. This shall include acupuncture performed by a physician or a registered nurse as an anesthetic in connection with a surgical procedure.

(G) Charges for diagnostic laboratory and x-ray services including, but not limited to: laboratory examinations, metabolism tests, cardiographic examinations and encephalographic examinations.

(H) Reasonable charges for transportation (reasonable charges include round-trip coach air fare, the state standard mileage rate or actual fuel expenses for round-trip usage of a personal car or other mode of transportation if pre-approved by the claims administrator) to a hospital or between hospitals for medical services that have been authorized by the claims administrator as a unique exception under the plan (excluding any transportation from or to points outside the continental limits of the United States). Benefits will be available for one caregiver to accompany the patient.

(I) Charges for medically necessary transportation by professional ambulance service (ground and air) to and from the nearest general hospital or specialty hospital which is equipped to furnish treatment incident to such illness or injury. Air ambulance charges and all other professional ambulance charges (including ground ambulance) are covered as detailed in Attachment A of the plan.

(J) Charges for treatment received by a licensed doctor of podiatric medicine or for treatment by a licensed doctor of chiropractic provided treatment was within the scope of his/her license, unless excluded under Section 13.04.

(K) Charges for chemotherapy and radiation therapy when medically necessary as determined by the claims administrator.

(L) Charges for hemodialysis.

(M) Charges for the taking or the reading of an x-ray, CAT scan, MRI (upon approval of the claims administrator) or laboratory procedure, including physician charges and hospital charges. Positron emission tomography (PET) is a covered expense when determined to be medically necessary by the claims administrator. PET scan technology is currently considered experimental and investigative in many applications. Covered persons or their provider should verify medical necessity and benefit eligibility prior to incurring charges for use of this technology.

(N) Charges for laser procedures, other than those specifically excluded in Section 13.04.

(O) Charges for lithotripter treatment.

(P) Charges for transfusion services for autologous blood and blood components.

(Q) Annual lab charges and associated office visits for pap smears (per plan year) beginning with age 18. Testing prior to the age of 18 will also be covered if recommended by a physician and determined to be medically necessary.

(R) Cryosurgical ablation of the prostate is covered only when approved by the claims administrator.

(S) Charges for esophageal PH monitoring for the diagnosis of gastroesophageal reflux when the patient meets specific criteria as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator for these services.

(T) Continuous passive motion machine (CPMM). The following are considered eligible expenses for CPMM:

(1) Knee replacement surgery; and

(2) Anterior cruciate ligament repair.

Up to 28 days of postoperative use of the CPMM are covered. Use of the machine beyond this provision shall be dictated by medical necessity as determined by the claims administrator. All other prescriptions for and use of the CPMM shall be considered experimental/investigative until reviewed on a case-by-case basis.

(U) Percutaneous lumbar discectomy (PLD) is a covered outpatient procedure only when the patient meets specific criteria, as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator.

(V) Ketogenic diet counseling (must be enrolled in case management).

(W) Charges for the following medications, equipment, supplies and services:

(1) Single Pharmacy Limitation.

If the claims administrator or administrative services organization (ASO) has the reasonable belief that a covered person is receiving covered services in an excessive, dangerous, or medically inadvisable amount, and this belief is based upon the professional opinion of a medical doctor and a pharmacist, the claims administrator may impose a limitation on services providing that the covered person may only receive services from one specific pharmacy. The covered person must receive advance written notification of any such restriction stating the reasons for this restriction. The restriction must provide an exception for emergency services. The covered person has the right to request removal or modification of such restriction. The claims administrator will respond in writing to any written request for

removal or modification. The covered person also has the right to appeal such restriction pursuant to Section 6.05.

(2) Drugs and medicines (unless excluded under Section 13.04) requiring written prescription of a physician, approved for use by the Food and Drug Administration and dispensed by a licensed pharmacist or physician. This includes pharmacist-administered vaccines and over-the-counter drugs that require pharmacist preparation prior to patient use or where coverage has been mandated by applicable state or federal laws. Investigational new drugs (FDA designation), if published peer review literature indicates beneficial and effective patient care;

(3) FDA approved medications which are prescribed for accepted off-label indications and have supporting documentation in those settings from at least one of the nationally recognized compendia (e.g. AHFS, DrugDex);

(4) Prescription agents and over-the-counter nicotine replacement therapies (e.g., gum, patches, lozenges, and Nicotrol oral and nasal inhalers) provided for assistance in tobacco cessation. However, the following limitations apply to this benefit:

(a) The plan will only cover tobacco cessation products with a national drug code;

(b) The plan will limit coverage to a maximum of 168 days supply (two twelve-week courses of treatment) per plan year with generic nicotine replacement products;

(c) The plan will limit coverage to a maximum of 168 days supply (two twelve-week courses of treatment) per plan year with generic Zyban or Chantix; and

(d) The plan requires a written prescription by a licensed clinician as a condition for covering any or all tobacco cessation products, including over-the-counter.

(5) Surgical supplies including bandages and dressings;

(6) Insulin, the related syringes (including needle-free syringes when medically necessary as determined by the claims administrator based on the patient's age, weight, skin and medical condition and/or the frequency of injections), home blood glucose monitors and related supplies for the treatment of diabetes as approved by a physician;

(7) Initial diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to six (6) visits per plan year. Coverage for additional training and education is available when a significant change occurs in the patient's symptoms or condition which necessitates a change in the patient's self-management or when a physician determines that re-education or refresher training is needed and determined to be medically necessary;

(8) Blood plasma or whole blood;

(9A) Artificial eyes - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age 18, or as a result of injury or illness;

(9B) Artificial limbs - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age 18, or as a result of injury or illness, with the following exceptions:

(a) One additional limb prosthesis past age 18 if additional surgery has altered the size or shape of the stump; or

(b) Replacement of the original limb prosthesis if a severe medical condition to the stump could result from improper fitting of the initial prosthesis as determined by a physician. Replacement must be within 12 months of the initial purchase of the limb prosthesis and proof of medical severity must be furnished to the claims administrator. The claims administrator must furnish written approval to the covered person prior to the replacement purchase.

(9C) Replacement prosthesis - As determined by the claims administrator, benefits are available for the purchase, fitting, necessary adjustment, repairs and replacement of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances). Replacement costs will be covered only if the prosthetic appliance was used by the employee or dependent of the employee in the manner and for the purpose for which such appliance was intended and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. Benefits are not available for prosthetic appliances to replace those which are lost, damaged, stolen or prescribed as a result of improvements in technology.

(10) Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, back braces, knee braces, surgical collars, lumbosacral supports, rehabilitation braces, fracture braces, childhood hip braces, braces for congenital defects, splints and mobilizers, corsets-back and special surgical, trusses, and rigid back or leg braces;

(11) Foot orthotics, when prescribed by a physician if medically necessary as determined by the claims administrator and not otherwise excluded in Section 13.04, including:

(a) therapeutic shoes if an integral part of a leg brace

(b) rehabilitative when prescribed as part of post-surgical or post-traumatic casting care

(c) prosthetic shoes that are an integral part of the prosthesis (limited to one pair per lifetime)

(d) ankle orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses, and

(e) therapeutic shoes (depth or custom-molded) and inserts (limited to one pair per plan year) for covered persons with diabetes mellitus **and** any of the following complications:

(i) peripheral neuropathy with evidence of callus formation; or

(ii) history of pre-ulceratic calluses; or

(iii) history of previous ulceration; or

(iv) foot deformity; or

(v) previous amputation of the foot or part of the foot; or

(vi) poor circulation

(12) "Space" or molded shoes, limited to once per lifetime, and only when used as a substitute device due to all, or a substantial part, of the foot being absent;

(13) X-ray, radium and other radioactive substances;

(14) The first contact lens or lenses or pair of eyeglasses (no tinting or scratch-resistant coating) purchased after cataract surgery (including examination charge and refraction);

(15) Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus. Intrastromal corneal ring segments (ICRS) for vision correction is also covered with a diagnosis of keratoconus when certain medical appropriateness criteria are met;

(16) If elected by the covered person following a mastectomy, coverage shall include:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses, pursuant to Section 13.02(W)(9C), and physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for mastectomy bras as medically necessary;

(17) Hearing aids for dependent children under eighteen years of age every three years, including ear molds and services to select, fit and adjust the hearing aid;

(18) The purchase or rental (not to exceed the total maximum allowable charge for purchase) of durable medical equipment as outlined in the applicable section and attachment;

(19) Immunizations, including, but not limited to, hepatitis B, tetanus, measles, mumps, rubella, pneumococcal, and influenza, unless the employer is mandated to pay for the immunization. Immunization schedules are based on the Centers for Disease Control and Prevention guidelines and are subject to change;

(20) Transrectal prostatic ultrasound, when a physical examination of the prostate indicates the presence of nodules;

(21) Vision screening (not including refractive services and supplies) and hearing screening per plan year;

(22) Family planning and infertility services including history, physical examination, laboratory tests, advice and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing and treatment for organic impotence. If fertilization services are initiated (including, but not limited to artificial insemination or in-vitro fertilization) benefits will cease;

(23) Healthy diet counseling for medical conditions other than diabetes, limited to three visits per plan year;

(24) Other preventive care as recommended by the U.S. Preventive Services Task Force, including:

(a) adult annual physical exam;

(b) cholesterol screening;

(c) CBC with differential, urinalysis, and glucose monitoring;

(d) routine osteoporosis screening (bone density scan);

(e) annual lab charges and associated office visits for pap smears;

(f) routine women's health (including various screenings).

Covered persons should consult their current year member handbook for recommended coverage details;

(25) Routine patient care costs related to clinical trials as defined by TCA 56-7-2365;

(26) Routine foot-care for diabetics including nail clipping and treatment for corns and calluses.

13.03 Other Covered Expenses.

(A) Convalescent Care. Upon receipt of proof that a covered person has incurred medically necessary expenses related to convalescent care, the plan shall pay for charges for convalescent facility room, board and general nursing care, provided:

(1) A physician recommends confinement for convalescence;

(2) The covered person is under the continuous care of a physician during the entire period of confinement;

(3) The confinement is required for other than custodial care; and

(4) Services were preauthorized by the claims administrator.

Eligible charges for convalescent facility room, board and general nursing care shall only include:

(1) Charges not to exceed the charge for its greatest number of semi-private rooms; and

(2) Charges up to and including the 100th day of confinement during any plan year.

(B) Maternity Benefits. The plan provides coverage for pregnancy, childbirth or related medical conditions on the same basis as any other illness, unless the covered person is acting as a surrogate mother (carrying a fetus to term for another woman) in which case no benefits will be payable. Hospital admissions for maternity coverage and childbirth will be available for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean delivery. No additional approval or authorization is needed for lengths of stay that fall within these timeframes. A covered person is not required to stay in the hospital for a fixed period of time following the birth of her child. New benefits will apply if transferring to another health plan prior to delivery.

(1) Pregnancy Care. Normal maternity and complications of pregnancy will be covered without being subject to any special pregnancy limitations, exclusions, extensions and benefit restrictions that might be included in this plan. Complication of pregnancy as it applies to health (medical) benefits shall mean an ectopic pregnancy, abortion as is consistent with state law, a miscarriage, a cesarean section or any condition that seriously affects the usual expected medical management of the pregnancy.

(2) Newborn Care. Coverage for a newborn child shall be provided to covered employees who have elected family coverage or coverage pursuant to Section 2.05(A).

Covered expenses of a newborn child shall include:

(a) Any charges directly related to the treatment of any medical condition of a newborn child;

(b) Any charges by a physician for daily visits to a newborn baby in the hospital when the baby's diagnosis does not require treatment;

(c) Any charges directly related to a circumcision performed by a physician; and

(d) The newborn child's usual and ordinary nursery and pediatric care at birth are covered. A newborn child who is a covered person under the PPO plan must meet the individual deductible of Section 11.02(A) or the family deductible of Section 11.02(B) of the PPO plan.

(C) Mammogram Screening. The plan provides coverage for mammogram screenings for females as recommended by the U.S. Preventive Services Task Force. Covered persons should consult their current year member handbook for recommended coverage details.

(D) Cochlear Implantation. The plan provides coverage for cochlear implantation using FDA-approved cochlear implants provided ***all*** of the following criteria are met:

Adults (Age 18+).

(1) Diagnosis of post-lingual profound deafness;

(2) Patient has achieved little or no benefit from a hearing aid;

(3) Patient is free from middle ear infection, has an accessible cochlear lumen that is structurally suited to implantation and is free from lesions in the auditory nerve and acoustic areas of the central nervous system;

(4) Patient has the cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and

(5) Patient has no contraindications to surgery.

Children (Age 2-17).

(1) Diagnosis of bilateral profound sensorineural deafness; and

(2) Patient has achieved little or no benefit from a hearing or vibrotactile aid, as demonstrated by the inability to improve on an age-appropriate closed-set word identification task.

An electrophysiological assessment should be performed to corroborate behavioral evaluation in very young children who cannot be adequately evaluated by standard audiometry tests. This assessment may consist of an auditory brain stem evoked response or similar test which would be covered when medically necessary as determined by the claims administrator.

A minimum six-month trial with appropriate amplification (hearing aid or vibrotactile aid) and rehabilitation should be performed for children to ascertain the potential for aided benefit.

(E) Hospice Care Program. When approved by the claims administrator, the plan shall provide hospice care, as provided in the applicable section, designed to provide covered persons who are terminally ill (a person whose life expectancy is six months or less) with dignified, comfortable and less costly care the few months or weeks prior to death. This program shall be administered through an approved hospice. Care provided shall include physical, psychological, social and spiritual for dying persons

and their families, rendered by a medically supervised interdisciplinary team of professionals and volunteers on a 24 hour on-call basis.

(F) Home Health Care. The plan shall provide benefits for the services of part-time or intermittent home nursing care, given or supervised by a registered nurse (R.N.), but only if the services are certified as medically necessary and preauthorized by the claims administrator. Home health aide care is also a covered service with the following limitations:

(1) No more than 30 visits per plan year;

(2) A visit shall be four or fewer hours;

(3) The service must be ordered by a physician;

(4) A professional nurse must conduct intermittent visits; and

(5) The home health aide service is in conjunction with medically necessary skilled care.

Intravenous (I.V.) therapy administered in the home during these visits is a covered service, provided the medication is approved for use by the Federal Drug Administration. Case management services will be requested by the physician, patient or employer for home health cases requiring extensive care.

(G) Rehabilitation Therapy. The plan shall provide preauthorized inpatient and/or outpatient therapy benefits for conditions resulting from an illness or injury, or when prescribed immediately following surgery related to the condition. The plan shall provide benefits for speech therapy by a licensed speech therapist to restore speech after a loss or impairment (excluding mental, psychoneurotic or personality disorders) provided there is continued medical progress. The plan shall also provide functional, physical, and occupational therapy to the extent such therapy is performed to regain use of the upper or lower extremities, or if the covered person is a child, as long as there is continued medical improvement. Outpatient benefits are limited to 90 days per plan year for speech, physical, and occupational therapies combined. Occupational therapy may include cognitive therapy but shall not include vocational therapy or vocational rehabilitation, nor educational or recreational therapy. If medically appropriate, the claims administrator and/or utilization review organization may exceed the established plan limitations on outpatient therapies for covered persons who, because of their illness, injury, loss, or impairment, require additional speech, physical and/or occupational therapy.

Phase I and Phase II (as defined below) cardiac rehabilitation services will be a covered expense provided they meet the following criteria:

(1) Phase I includes inpatient rehabilitation services that begin during hospitalization and extend until discharge; and

(2) Phase II includes supervised ambulatory services that follow discharge and extend until the patient becomes sufficiently independent to perform prescribed exercise and carry out any recommended long-term lifestyle changes. Phase II services are limited to three sessions per week for a maximum of 12 weeks.

Outpatient pulmonary rehabilitation will be covered for certain conditions when determined to be medically necessary by the claims administrator.

(H) Sitter. A sitter who is not a relative (i.e. spouse, parent, child, brother or sister by blood, marriage or adoption or member of the household) of the covered person may be used in those situations where

the covered person is confined to a hospital as a bed patient and certification is made by a physician that an R.N. or L.P.N. is needed and neither (R.N. or L.P.N.) is available.

(I) Covered Dental Expenses.

(1) Charges for orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function of a covered person. Coverage includes dental implants if implants are required for proper orthodontic care and they are medically necessary as determined by the claims administrator.

(2) Charges for extraction of impacted wisdom teeth and excision of solid based oral tumors.

(3) Charges for treatment of accidental injury to sound natural teeth (other than by eating or chewing). Treatment of accidental injury as described in this section is limited to the cost of bridgework unless the claims administrator determines that teeth implants are medically necessary (for example if implants are medically necessary to anchor or support the bridgework).

(4) Charges for the facility and related medical services when hospitalization for dental services is determined medically necessary by the claims administrator.

Benefits for ambulatory or outpatient surgery facility charges may be medically necessary when performing dental/oral surgery for:

(a) Complex oral procedures that have a high possibility of complications;

(b) Concomitant systemic diseases for which the patient is under current medical management increasing the probability of complications;

(c) Mental illness or handicap precludes dental/surgical management in an office setting;

(d) When general anesthesia is used; or

(e) For children eight years and younger benefits will be provided for anesthesia (inpatient or outpatient) and any expenses associated with a dental procedure that cannot be safely provided in the office. Benefits will be available for anesthesia regardless of whether or not the base procedure is covered by the insurance program.

(5) Temporomandibular Joint Malfunctions (TMJ). The following are considered eligible expenses for TMJ:

(a) History, exams and office visits;

(b) X-rays of the joint;

(c) Diagnostic study casts;

(d) Appliances, removable or fixed (which are designated primarily to stabilize the jaw joint and muscles and not to permanently alter the teeth);

(e) Medications; and

(f) Physical medicine procedures (i.e., surgery).

Orthodontic treatment (braces) is only covered if determined to be medically necessary by the claims administrator. Benefits are ***not*** available for the following therapies in treatment of TMJ:

(a) Prosthodontic treatments (dentures, bridges);

(b) Restorative treatment (fillings, crowns);

(c) Full mouth rehabilitation (restorations, extractions); and/or

(d) Equilibrations (shaving, shaping, reshaping teeth).

(J) Organ Transplants. Organ transplant benefits will be paid for covered medical expenses related to transplants of the: heart, heart/lung, lung, liver, kidney, pancreas, pancreas/kidney, cornea, small bowel, small bowel/kidney and certain bone marrow transplants. Transplant services or supplies require pre-authorization before any pre-transplant evaluation or any covered service is performed. Coverage will include expenses incurred for donor search and organ procurement by the transplant center or hospital facility and all inpatient and outpatient hospital/medical expenses for the transplant procedure and related pre- and post-operative care, including immunosuppressive drug therapy. Should a transplant request fall outside those addressed and covered by the *Plan Document*, the claims administrator will review the information provided and render a decision based on acceptable medical practices on behalf of the state insurance program. The claims administrator will notify Benefits Administration of its decision prior to approving such services. If the service(s) or procedure(s) does not meet the claims administrator's accepted medical standards, the covered person will be notified of their option to appeal the decision as described in Section 6.05. If a network facility is utilized for the transplant, travel and living expenses will be covered from the initial evaluation to one year after the transplant (for medically necessary visits only as determined by the claims administrator). Air transportation, if necessary, will be paid at commercial coach fare. Ground travel will be paid at the State of Tennessee approved mileage rate or for actual fuel expenses. Additionally, hotel and meal expenses will be paid up to $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.

If the donor is not a covered person, covered expenses for the donor are limited to those services and supplies directly related to the transplant itself such as testing for the donor's compatibility, removal of the organ from the donor's body, preservation of the organ, and transportation of the organ to the site of the transplant. Services are covered only to the extent not covered by other health insurance. The search process and securing the donor are also covered under this benefit. Complications of donor organ procurement are not covered. The cost of donor organ procurement is included in the total cost of the organ transplant. No benefits are payable for donor services for recipients who are not covered under the plan. These services are ineligible even when the recipient does not provide reimbursement for the donor's expenses.

Bone marrow transplantation will fall into one of three categories: syngeneic, allogeneic or autologous.

Expenses eligible for coverage include the charge to harvest bone marrow for covered persons diagnosed with any covered malignant condition or any conditions approved for coverage by the claims administrator. Coverage for harvesting, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow will be covered when re-infusion is

scheduled within three months or less. Autologous bone marrow transplantation is considered investigational in the treatment of other malignancies, including primary intrinsic tumors of the brain.

(K) Well-Child Checkups and Immunizations. Physician office visits for routine check-ups and immunizations are covered expenses for children through age five, and a total of 12 routine visits are covered. Annual checkups and immunizations as recommended by the Centers for Disease Control and Prevention (CDC) are covered for children ages 6-17.

(L) Prostate Screening. The plan will cover PSA (prostate specific antigen) and transrectal ultrasound annually (per plan year) as recommended by the U.S. Preventive Services Task Force. Covered persons should consult their current year member handbook for recommended coverage details.

(M) Biofeedback Therapy. The plan shall provide benefits for biofeedback therapy, which is determined to be medically necessary with a maximum benefit of five sessions per plan year for each of the following conditions:

(1) Chronic pain;

(2) Incontinence;

(3) Migraine headaches; and

(4) Incapacitating stress.

(N) Bariatric Surgery (weight reduction). The plan will cover surgical procedures for the treatment of morbid obesity according to the criteria outlined in member handbooks for the plan year in which surgery is performed. The claims administrator will determine if all the criteria have been met before approving surgery.

(O) Visual Impairment Screening/Exam for Medical Diseases. The plan will cover, as outlined below, examinations and screenings of the eyes for children and adults, which are medically necessary as determined by the claims administrator in the treatment of an injury or disease:

(1) Screening for all children for visual or ocular disorders (i.e. pediatric amblyopia and strabismus) at each preventive care visit beginning at birth;

(2) Visual screenings conducted by objective, standardized testing (i.e. Snellen letters, Snellen numbers, the tumbling test or HOTV test) at 3, 4, 5, 10, 12, 15 and 18 years of age; and

(3) Routine screenings among the elderly is considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

(P) Hearing Impairment Screening and Testing. The plan will cover, as determined by the claims administrator, medically necessary hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The claims administrator has determined eligibility of many of the tests/screenings to be specific to infants. Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.

(Q) Nutritional Treatment of Inborn Errors of Metabolism. The plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup

urine disease, homocystinuria, methylmalonic acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the claims administrator. . Coverage includes licensed professional medical services under the supervision of a physician and those special dietary formulas that are medically necessary for therapeutic treatment.

(R) Enteral Nutrition (EN) and Total Parenteral Nutrition (TPN). The plan will cover medically necessary nutrition prescribed by a physician and administered either through a feeding tube or central venous catheter when determined to be medically necessary by the claims administrator.

(S) Colorectal Screenings. The plan will cover colorectal screening as recommended by the U.S. Preventive Services Task Force. Covered persons should consult their current year member handbook for recommended coverage details.

13.04 Exclusions and Limitations.

Covered persons should also review their member handbooks for information on exclusions and limitations. No exclusion of benefits under this section shall apply to benefits required by applicable state or federal laws or regulations.

(A) Generally. No medical or mental health/substance abuse benefits shall be paid by the plan for:

(1) Services which are not ordered and furnished by an eligible provider;

(2) Drugs and medicines which can be obtained without a written prescription except as covered pursuant to Section 13.02(W)(2) and 13.02(W)(4);

(3) Treatment in connection with any injury or illness, which arose out of or in the course of employment;

(4) Services and supplies (notwithstanding organ donations) provided by an immediate family member of an eligible employee or covered dependent. Immediate family members include spouse, parent, child, brother or sister, by blood, marriage or adoption;

(5) Services rendered prior to the effective date of coverage;

(6) Services incurred after the covered person's coverage under this plan is terminated;

(7) Charges for ear and/or body piercing;

(8) Charges for the removal of corns or calluses, or trimming of toenails unless there is a diabetic diagnosis;

(9) Treatment of an injury or illness due to declared or undeclared war;

(10) Charges incurred outside the United States (including those for drugs and medicines subject to FDA approval and federal law) unless the charges are incurred while traveling on business or for pleasure by a covered person who is a resident of the United States and the charges are determined to be medically necessary by the claims administrator, subject to all other terms and conditions of the plan;

(11) Charges which the claims administrator determines to be in excess of the maximum allowable charge for that procedure or supply and for charges made which are not medically necessary as determined by the claims administrator;

(12) Charges for services or supplies incurred after a concurrent review determines the services and supplies are no longer medically necessary as determined by the claims administrator;

(13) Radial keratotomy, LASIK or other surgical procedures to correct refractive errors;

(14) Expenses incurred for contact lenses, eyeglasses, sunglasses or for examinations for prescription or fitting of eyeglasses or contact lenses, except as may be allowed pursuant to Section 13.02;

(15) Expenses incurred for hearing aids or for examinations for prescription or fitting of hearing aids and hearing aid accessories including batteries, cords and other assistive listening devices (except as previously defined in Section 13.02 and/or 13.03);

(16) Charges incurred in connection with cosmetic surgery directed toward preserving or improving a patient's appearance, including but not limited to: scar revisions, rhinoplasty, prosthetic penile implants, saline injections for the treatment of varicose veins and re-constructive surgery where no significant anatomic functional impairment exists. All services must be medically necessary as determined by the claims administrator. This exclusion will ***not*** apply to the following conditions:

(a) The covered person experienced a traumatic injury or illness, which requires the cosmetic surgery;

(b) It is for treatment of a congenital anomaly which severely impairs the function of a bodily organ in a covered person;

(c) If elected by the covered person following a mastectomy:

(i) Reconstruction of the breast on which the mastectomy has been performed,

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) Prostheses, pursuant to Section 13.02(W)(9C) and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for mastectomy bras as medically necessary.

(d) Breast implant removal and breast capsulectomy with reconstruction when physician documented symptoms of pain, discomfort or deformity related to breast implants or capsule contracture is present.

(17) Arch supports, corn plaster (pads, etc.), foot padding (adhesive moleskin, etc.), orthotic or orthopedic shoes and other foot orthoses (including inner soles or inserts) unless specified in the covered expenses section of this *Plan Document*, foot orthoses primarily used for cosmetic reasons or for improved athletic performance or sports participation;

(18) Elastic stockings, except Jobst or similar quality support hose, when medically necessary as determined by the claims administrator;

(19) Garter belts;

(20) Orthopedic shoes for the correction of a deformity or abnormality of the musculoskeletal system, except when one or both are an integral part of a brace;

(21) Hotel charges or travel expense incurred while receiving treatment as an inpatient or outpatient, (other than defined in Section 13.03(J) or Attachment A);

(22) Unapproved sitters;

(23) Humidifiers, dehumidifiers, air filters, whirlpools, heating pads, blood pressure kits, sun or heat lamps, air conditioners, air purifiers and exercise devices;

(24) Non-surgical services for weight control or reduction (obesity), including prescription medication. Preventive screenings, counseling, treatment, and certain surgical services are not excluded;

(25) Experimental/investigational medical or surgical procedures and prescription drugs as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency;

(26) Organ transplants involving artificial implants and non-human organs, as well as any services or supplies in connection with experimental or investigational treatment, drugs or procedures;

(27) Reversal of sterilization procedures;

(28) Services or supplies for which there is no charge to the covered person, or for which the covered person would not have been charged if not covered by this plan;

(29) Surgery or treatment for, or related to, sex transformations or sexual dysfunctions or inadequacies, including penile prosthesis due to psychogenic impotence;

(30) Services or supplies in connection with artificial insemination, in vitro fertilization or any procedure intended to create a pregnancy;

(31) Telephone consultations, except as administered through vendor programs and approved by the plan;

(32) Charges because a person fails to keep a scheduled appointment, or charges to complete a claim form;

(33) Durable medical equipment not specified in Sections 13.02, 13.03 or Attachment C;

(34) The purchase or rental of any device, mechanical aid or other contrivance which may be required for the transportation of an individual on a public conveyance; roadway or other means of transportation, with the exception of those items specifically included as an eligible medical expense;

(35) Charges for comfort or convenience items (e.g. television, telephone, radio, air conditioner, beauty shop and barber services, guest meals and guest beds);

(36) Custodial care (as defined in Section 1.12);

(37) Day and evening care centers (primarily for rest or for the aged);

(38) Services of a private-duty nurse which would normally be provided by hospital nursing staff;

(39) Diapers (incontinent pads);

(40) Cranial prosthesis (wig);

(41) Nutritional supplements and vitamins (including but not limited to oral infant formulas) which can be obtained at retail or over-the-counter without a written prescription. **Nutritional**

treatment of inborn errors of metabolism is not excluded under this clause as noted in Section 13.03(Q);

(42) Programs considered primarily educational, and materials such as books or tapes, except as stated as specifically covered in the covered expenses section of this *Plan Document*;

(43) Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, collection and handling fees, or telephone consultations.

(B) Excluded Dental Expenses.

(1) Any dental care and treatment and oral surgery relating to the teeth and gums except those specifically provided as covered expenses in Section 13.03 (I), including but not limited to dental appliances; dental prostheses such as crowns, bridges or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; treatment of dental caries, gingivitis or periodontal disease.

(2) Any other expenses incurred relating to the teeth and gums except those specifically provided as covered expenses pursuant to Section 13.03(I);

(C) On the Job Injuries and Illnesses. The plan will not be responsible for expenses for injuries or illnesses incurred on the job.

(D) Excluded Mental Health/Substance Abuse Expenses. In addition to relevant exclusions noted in Section 13.04(A), the following are specifically excluded under the mental health/substance abuse benefit:

(1) Court or employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the claims administrator.

(2) Services for disorders not included in the *American Psychiatric Association Diagnostic & Statistical Manual*, 4th Edition, on Axis I or II.

(3) Services that are non-behavioral in focus, including but not limited to education or vocational services, testing or placement, smoking cessation, sleep disorders, dementias and pain management.

(4) Conditions classified as developmental disorders such as mental retardation, learning disabilities, pervasive developmental disorders, and academic or motor skill disorders.

(5) Services or supplies which are not medically necessary and/or clinically necessary, including any confinement or treatment given in connection with a service or supply which is not medically necessary and/or clinically necessary.

(6) Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.

(7) Ecological or environmental medicine, diagnosis and/or treatment.

(8) Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes, and related expenses for reports, including report presentation and preparation.

(9) Services given by a pastoral counselor.

(10) Sensitivity training, educational training therapy or treatment for an education requirement.

ATTACHMENT A

SCHEDULE OF BENEFITS

ATTACHMENT A.1

SCHEDULE OF PARTNERSHIP PPO BENEFITS

TABLE 1: Services in this table ARE NOT subject to a deductible. Costs DO APPLY to the annual out-of-pocket maximums on TABLE 3, with the exception of in-network pharmacy which has a separate out-of-pocket maximum. For further benefit details and plan limits, see sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	**Out-of-Network** [1]
PREVENTIVE CARE		
Office Visits • Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, mammogram, and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No Charge	$45 copay
OUTPATIENT SERVICES		
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25 copay	$45 copay
Specialist Office Visit • Including surgery in office setting	$45 copay	$70 copay
Behavioral Health and Substance Abuse Treatment [2] (benefits managed by Magellan Health Services)	$25 copay	$45 copay
X-Ray, Lab and Diagnostics • Including reading, interpretation, and results (not including advanced x-rays, scans, and imaging)	100% covered after office copay if applicable	100% covered up to MAC after office copay if applicable
Allergy Injection	100% covered	100% covered up to MAC
Allergy Injection with Office Visit	$25 copay primary; $45 copay specialist	$45 copay primary; $70 copay specialist
Chiropractors • Limit of 50 visits per year	Visits 1-20: $25 copay Visits 21-50: $45 copay	Visits 1-20: $45 copay Visits 21-50: $70 copay
PHARMACY - Benefits managed by CVS/caremark - see your prescription card for information		
30-Day Supply	$5 copay generic; $35 copay preferred brand; $85 copay non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail-order)	$10 copay generic; $65 copay preferred brand; $165 copay non-preferred	N/A – no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$5 copay generic; $30 copay preferred brand; $160 copay non-preferred	N/A – no network
CONVENIENCE CLINCS ANDURGENT CARE		
Convenience Clinic	$25 copay	$45 copay
Urgent Care Facility	$45 copay	$70 copay

EMERGENCY CARE	
Emergency Room Visit (waived if admitted)	$125 copay (services subject to coinsurance may be extra)

ATTACHMENT A.1 (Continued)

SCHEDULE OF PARTNERSHIP PPO BENEFITS

TABLE 2: Services in this table ARE subject to a deductible with the exception of hospice. Eligible expenses DO APPLY to the annual out-of-pocket maximum. For further benefit details and plan limits, see TABLE 3 (deductible and out-of-pocket maximum amounts) and sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	Out-of-Network [1]
HOSPITAL/FACILITY SERVICES (includes professional and facility charges)		
• Inpatient care [4] • Outpatient surgery [4] • Inpatient behavioral health and substance abuse (benefits managed by Magellan Health Services) [2] [4]	10% coinsurance	40% coinsurance
MATERNITY		
• Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance
HOME CARE [4]		
• Home health • Home infusion therapy	10% coinsurance	40% coinsurance
REHABILITATION AND THERAPY SERVICES		
• Inpatient [4]; outpatient • Skilled nursing facility [4]	10% coinsurance	40% coinsurance
AMBULANCE		
• Air and ground	10% coinsurance	
HOSPICE CARE [4]		
• Through an approved program	100% covered up to MAC (even if deductible has not been met)	
EQUIPMENT AND SUPPLIES [4]		
• Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance
DENTAL		
• Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance oral surgeons	40% coinsurance oral surgeons
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
ADVANCED X-RAY, SCANS AND IMAGING		
• Including MRI, MRA, MRS, CT, CTA, PET, and nuclear cardiac imaging studies [4]	10% coinsurance	40% coinsurance
• Reading and interpretation	100% covered	100% covered up to MAC
OUT-OF-COUNTRY CHARGES		
• Non-emergency and non-urgent care	N/A – no network	40% coinsurance

[1] Out-of-Network services cost more. An out-of-network provider may charge more than the "maximum allowable charge". The MAC is the most that the plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay any applicable copay or coinsurance amount PLUS the difference between the MAC and the actual charge. For out-of-network emergency services and ambulance services, you will not be responsible for amounts exceeding the allowable (maximum amount eligible for payment) unless the claims administrator determines the situation was not an emergency or not medically necessary.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization, and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization is required.

[3] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies (needles, test strips, lancets); statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

ATTACHMENT A.1 (Continued)

SCHEDULE OF PARTNERSHIP PPO BENEFITS

TABLE 3: DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM AMOUNTS. Services detailed in TABLES 1 and 2 are subject to these out-of-pocket maximum amounts. Services detailed in TABLE 2 are subject to the deductible amounts, with the exception of hospice. No single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

	In-Network	**Out-of-Network**
DEDUCTIBLE		
Employee Only	$450	$800
Employee + Child(ren)	$700	$1,250
Employee + Spouse	$900	$1,600
Employee + Spouse + Child(ren)	$1,150	$2,050
OUT-OF-POCKET MAXIMUM		
Employee Only	$2,300	$3,500
Employee + Child(ren)	$3,200	$4,600
Employee + Spouse	$3,700	$5,800
Employee + Spouse + Child(ren)	$4,600	$7,500
separate pharmacy out-of-pocket maximum	$2,500 employee only; $5,000 all family tiers	none

ATTACHMENT A.2

SCHEDULE OF STANDARD PPO BENEFITS

TABLE 1: Services in this table ARE NOT subject to a deductible. Costs DO APPLY to the annual out-of-pocket maximums on TABLE 3, with the exception of in-network pharmacy, which has a separate out-of-pocket maximum. For further benefit details and plan limits, see sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	**Out-of-Network** [1]
PREVENTIVE CARE		
Office Visits • Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, mammogram, and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No Charge	$50 copay
OUTPATIENT SERVICES		
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$30 copay	$50 copay
Specialist Office Visit • Including surgery in office setting	$50 copay	$75 copay
Behavioral Health and Substance Abuse Treatment [2] (benefits managed by Magellan Health Services)	$30 copay	$50 copay
X-Ray, Lab and Diagnostics • Including reading, interpretation, and results (not including advanced x-rays, scans, and imaging)	100% covered after office copay if applicable	100% covered up to MAC after office copay if applicable
Allergy Injection	100% covered	100% covered up to MAC
Allergy Injection with Office Visit	$30 copay primary; $50 copay specialist	$50 copay primary; $75 copay specialist
Chiropractors • Limit of 50 visits per year	Visits 1-20: $30 copay Visits 21-50: $50 copay	Visits 1-20: $50 copay Visits 21-50: $75 copay
PHARMACY - Benefits managed by CVS/caremark - see your prescription card for information		
30-Day Supply	$10 copay generic; $45 copay preferred brand; $95 copay non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail-order)	$20 copay generic; $85 copay preferred brand; $185 copay non-preferred	N/A – no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$10 copay generic; $40 copay preferred brand; $180 copay non-preferred	N/A – no network
CONVENIENCE CLINICS AND URGENT CARE		
Convenience Clinic	$30 copay	$50 copay
Urgent Care Facility	$50 copay	$75 copay
EMERGENCY CARE		
Emergency Room Visit (waived if admitted)	$145 copay (services subject to coinsurance may be extra)	

ATTACHMENT A.2 (Continued)

SCHEDULE OF STANDARD PPO BENEFITS

TABLE 2: Services in this table ARE subject to a deductible with the exception of hospice. Eligible expenses DO APPLY to the annual out-of-pocket maximum. For further benefit details and plan limits, see TABLE 3 (deductible and out-of-pocket maximum amounts) and sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	Out-of-Network [1]
HOSPITAL/FACILITY SERVICES (includes professional and facility charges)		
• Inpatient care [4] • Outpatient surgery [4] • Inpatient behavioral health and substance abuse (benefits managed by Magellan Health Services) [2] [4]	20% coinsurance	40% coinsurance
MATERNITY		
• Global billing for labor and delivery and routine services beyond the initial office visit	20% coinsurance	40% coinsurance
HOME CARE [4]		
• Home health • Home infusion therapy	20% coinsurance	40% coinsurance
REHABILITATION AND THERAPY SERVICES		
• Inpatient [4]; outpatient • Skilled nursing facility [4]	20% coinsurance	40% coinsurance
AMBULANCE		
• Air and ground	20% coinsurance	
HOSPICE CARE [4]		
• Through an approved program	100% covered up to MAC (even if deductible has not been met)	
EQUIPMENT AND SUPPLIES [4]		
• Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	20% coinsurance	40% coinsurance
DENTAL		
• Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	20% coinsurance oral surgeons	40% coinsurance oral surgeons
	20% coinsurance non-contracted providers (i.e. dentists, orthodontists)	
ADVANCED X-RAY, SCANS AND IMAGING		
• Including MRI, MRA, MRS, CT, CTA, PET, and nuclear cardiac imaging studies [4]	20% coinsurance	40% coinsurance
• Reading and interpretation	100% covered	100% covered up to MAC
OUT-OF-COUNTRY CHARGES		
• Non-emergency and non-urgent care	N/A – no network	40% coinsurance

[1] Out-of-Network services cost more. An out-of-network provider may charge more than the "maximum allowable charge". The MAC is the most that the plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay any applicable copay or coinsurance amount PLUS the difference between the MAC and the actual charge. For out-of-network emergency services and ambulance services, you will not be responsible for amounts exceeding the allowable (maximum amount eligible for payment) unless the claims administrator determines the situation was not an emergency or not medically necessary.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization is required.

[3] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies (needles, test strips, lancets); statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

ATTACHMENT A.2 (Continued)

SCHEDULE OF STANDARD PPO BENEFITS

TABLE 3: DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM AMOUNTS. Services detailed in TABLES 1 and 2 are subject to these out-of-pocket maximum amounts. Services detailed in TABLE 2 are subject to these deductible amounts, with the exception of hospice. No single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

	In-Network	Out-of-Network
DEDUCTIBLE		
Employee Only	$800	$1,500
Employee + Child(ren)	$1,250	$2,350
Employee + Spouse	$1,600	$3,000
Employee + Spouse + Child(ren)	$2,050	$3,850
OUT-OF-POCKET MAXIMUM		
Employee Only	$2,600	$3,900
Employee + Child(ren)	$3,800	$5,900
Employee + Spouse	$4,500	$7,200
Employee + Spouse + Child(ren)	$5,200	$9,500
separate pharmacy out-of-pocket maximum applies	$3,000 for employee only; $6,000 all family tiers	none

ATTACHMENT A.3

SCHEDULE OF LIMITED PPO BENEFITS

TABLE 1: Services in this table ARE NOT subject to a deductible, with the exception of pharmacy. Costs DO APPLY to the annual out-of-pocket maximums on TABLE 3. For further benefit details and plan limits, see sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	**Out-of-Network** [1]
PREVENTIVE CARE		
Office Visits • Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, mammogram, and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No Charge	$50 copay
OUTPATIENT SERVICES		
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$35 copay	$55 copay
Specialist Office Visit • Including surgery in office setting	$55 copay	$80 copay
Behavioral Health and Substance Abuse Treatment [2] (benefits managed by Magellan Health Services)	$35 copay	$55 copay
X-Ray, Lab and Diagnostics • Including reading, interpretation, and results (not including advanced x-rays, scans, and imaging)	100% covered after office copay if applicable	100% covered up to MAC after office copay if applicable
Allergy Injection	100% covered	100% covered up to MAC
Allergy Injection with Office Visit	$35 copay primary; $55 copay specialist	$55 copay primary; $80 copay specialist
Chiropractors • Limit of 50 visits per year	Visits 1-20: $35 copay Visits 21-50: $55 copay	Visits 1-20: $55 copay Visits 21-50: $80 copay
PHARMACY - Benefits managed by CVS/caremark - see your prescription card for information		
30-Day Supply	$10 copay generic; $55 copay preferred brand; $105 copay non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail-order)	$20 copay generic; $105 copay preferred brand; $205 copay non-preferred	N/A – no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$10 copay generic; $50 copay preferred brand; $200 copay non-preferred	N/A – no network
CONVENIENCE CLINICS AND URGENT CARE		
Convenience Clinic	$35 copay	$55 copay
Urgent Care Facility	$55 copay	$80 copay
EMERGENCY CARE		
Emergency Room Visit (waived if admitted)	$165 copay (services subject to coinsurance may be extra)	

ATTACHMENT A.3 (Continued)

SCHEDULE OF LIMITED PPO BENEFITS

TABLE 2: Services in this table ARE subject to a deductible, with the exception of hospice, and eligible expenses DO APPLY to the annual out-of-pocket maximum. For further benefit details and plan limits, see TABLE 3 (deductible and out-of-pocket maximum amounts) and sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	Out-of-Network [1]
HOSPITAL/FACILITY SERVICES (includes professional and facility charges)		
• Inpatient care [4] • Outpatient surgery [4] • Inpatient behavioral health and substance abuse (benefits managed by Magellan Health Services) [2] [4]	30% coinsurance	50% coinsurance
MATERNITY		
• Global billing for labor and delivery and routine services beyond the initial office visit	30% coinsurance	50% coinsurance
HOME CARE [4]		
• Home health • Home infusion therapy	30% coinsurance	50% coinsurance
REHABILITATION AND THERAPY SERVICES		
• Inpatient [4]; outpatient • Skilled nursing facility [4]	30% coinsurance	50% coinsurance
AMBULANCE		
• Air and ground	30% coinsurance	
HOSPICE CARE [4]		
• Through an approved program	100% covered up to MAC (even if deductible has not been met)	
EQUIPMENT AND SUPPLIES [4]		
• Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	30% coinsurance	50% coinsurance
DENTAL		
• Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	30% coinsurance oral surgeons	50% coinsurance oral surgeons
	30% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
ADVANCED X-RAY, SCANS AND IMAGING		
• Including MRI, MRA, MRS, CT, CTA, PET, and nuclear cardiac imaging studies [4]	30% coinsurance	50% coinsurance
• Reading and interpretation	100% covered	100% covered up to MAC
OUT-OF-COUNTRY CHARGES		
• Non-emergency and non-urgent care	N/A – no network	50% coinsurance

[1] Out-of-Network services cost more. An out-of-network provider may charge more than the "maximum allowable charge". The MAC is the most that the plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay any applicable copay or coinsurance amount PLUS the difference between the MAC and the actual charge. For out-of-network emergency services and ambulance services, you will not be responsible for amounts exceeding the allowable (maximum amount eligible for payment) unless the claims administrator determines the situation was not an emergency or not medically necessary.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization is required.

[3] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies (needles, test strips, lancets); statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

ATTACHMENT A.3 (Continued)

SCHEDULE OF LIMITED PPO BENEFITS

TABLE 3: DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM AMOUNTS. Services detailed in TABLES 1 and 2 are subject to these out-of-pocket maximum amounts. Services detailed in TABLE 2 are subject to the deductible amounts, with the exception of hospice. No single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

	In-Network	**Out-of-Network**
DEDUCTIBLE		
Employee Only	$1,200	$2,300
Employee + Child(ren)	$1,800	$3,350
Employee + Spouse	$2,100	$3,900
Employee + Spouse + Child(ren)	$2,600	$4,950
separate pharmacy deductible applies	$100 per member	
OUT-OF-POCKET MAXIMUM		
Employee Only	$6,600	$12,700
Employee + Child(ren)	$13,200	$25,400
Employee + Spouse	$13,200	$25,400
Employee + Spouse + Child(ren)	$13,200	$25,400

ATTACHMENT A.4

SCHEDULE OF HEALTHSAVINGS CDHP BENEFITS

TABLE 1: Services in this table ARE subject to a deductible, with the exception of in-network preventive care and 90-day supply maintenance drugs from a 90-day network pharmacy or through mail order. Costs DO APPLY to the annual out-of-pocket maximums on TABLE 3. For further benefit details and plan limits, see sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	**Out-of-Network** [1]
PREVENTIVE CARE		
Office Visits • Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, mammogram, and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No Charge	50% coinsurance
OUTPATIENT SERVICES		
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	30% coinsurance	50% coinsurance
Specialist Office Visit • Including surgery in office setting	30% coinsurance	50% coinsurance
Behavioral Health and Substance Abuse Treatment [2] (benefits managed by Magellan Health Services)	30% coinsurance	50% coinsurance
X-Ray, Lab and Diagnostics • Including reading, interpretation, and results (not including advanced x-rays, scans, and imaging)	30% coinsurance	50% coinsurance
Allergy Injection	30% coinsurance	50% coinsurance
Allergy Injection with Office Visit	30% coinsurance	50% coinsurance
Chiropractors • Limit of 50 visits per year	30% coinsurance	50% coinsurance
PHARMACY - Benefits managed by CVS/caremark - see your prescription card for information		
30-Day Supply	30% coinsurance	50% coinsurance plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail-order)	30% coinsurance	N/A – no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	20% coinsurance without first having to meet deductible	N/A – no network
CONVENIENCE CLINICS AND URGENT CARE		
Convenience Clinic	30% coinsurance	50% coinsurance
Urgent Care Facility	30% coinsurance	50% coinsurance
EMERGENCY CARE		
Emergency Room Visit	30% coinsurance	

ATTACHMENT A.4 (Continued)

SCHEDULE OF HEALTHSAVINGS CDHP BENEFITS

TABLE 2: Services in this table ARE subject to a deductible and eligible expenses DO APPLY to the annual out-of-pocket maximum. For further benefit details and plan limits, see TABLE 3 (deductible and out-of-pocket maximum amounts) and sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	Out-of-Network [1]
HOSPITAL/FACILITY SERVICES (includes professional and facility charges)		
• Inpatient care [4] • Outpatient surgery [4] • Inpatient behavioral health and substance abuse (benefits managed by Magellan Health Services) [2] [4]	30% coinsurance	50% coinsurance
MATERNITY		
• Global billing for labor and delivery and routine services beyond the initial office visit	30% coinsurance	50% coinsurance
HOME CARE [4]		
• Home health • Home infusion therapy	30% coinsurance	50% coinsurance
REHABILITATION AND THERAPY SERVICES		
• Inpatient [4]; outpatient • Skilled nursing facility [4]	30% coinsurance	50% coinsurance
AMBULANCE		
• Air and ground	30% coinsurance	
HOSPICE CARE [4]		
• Through an approved program	100% covered up to MAC (after deductible has been met)	
EQUIPMENT AND SUPPLIES [4]		
• Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	30% coinsurance	50% coinsurance
DENTAL		
• Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	30% coinsurance oral surgeons	50% coinsurance oral surgeons
	30% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
ADVANCED X-RAY, SCANS AND IMAGING		
• Including MRI, MRA, MRS, CT, CTA, PET, and nuclear cardiac imaging studies [4]	30% coinsurance	50% coinsurance
• Reading and interpretation	30% coinsurance	
OUT-OF-COUNTRY CHARGES		
• Non-emergency and non-urgent care	N/A – no network	50% coinsurance

[1] Out-of-Network services cost more. An out-of-network provider may charge more than the "maximum allowable charge". The MAC is the most that the plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay any applicable copay or coinsurance amount PLUS the difference between the MAC and the actual charge. For out-of-network emergency services and ambulance services, you will not be responsible for amounts exceeding the allowable (maximum amount eligible for payment) unless the claims administrator determines the situation was not an emergency or not medically necessary.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization is required.

[3] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies (needles, test strips, lancets); statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

ATTACHMENT A.4 (Continued)

SCHEDULE OF HEALTHSAVINGS CDHP BENEFITS

TABLE 3: DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM AMOUNTS. Services detailed in TABLES 1 and 2 are subject to these out-of-pocket maximums. Those services are also subject to these deductible amounts, with the exception of in-network preventive care and 90-day supply maintenance drugs obtained from a 90-day network pharmacy or through mail order. The family deductible and out-of-pocket maximum amounts must be met by the family as a whole. Individual family members may contribute more than the individual amount toward the family total. No one family member may contribute more than $6,850 to the in-network family out-of-pocket maximum total. Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

	In-Network	Out-of-Network
DEDUCTIBLE		
Employee Only	$1,500	$3,000
Employee + Child(ren)	$3,000	$6,000
Employee + Spouse	$3,000	$6,000
Employee + Spouse + Child(ren)	$3,000	$6,000
OUT-OF-POCKET MAXIMUM		
Employee Only	$3,800	$7,600
Employee + Child(ren)	$7,600	$15,200
Employee + Spouse	$7,600	$15,200
Employee + Spouse + Child(ren)	$7,600	$15,200

ATTACHMENT B

OPTIONAL SECOND SURGICAL OPINION PROCEDURES

ATTACHMENT B

OPTIONAL SECOND SURGICAL OPINION PROCEDURES

Inclusion on this list does not imply that a procedure is automatically approved for benefits.

Procedure

- Bone and Joint Surgery of the Foot
- Cataract Extraction with and without Implant
- Cholecystectomy
- Hysterectomy
- Knee Surgery
- Septoplasty/Sub-Mucous Resection
- Prostatectomy
- Spinal and Disc Surgery
- Tonsillectomy and Adenoidectomy
- Mastectomy
- Elective C-Section

ATTACHMENT C

LIST OF DURABLE MEDICAL EQUIPMENT

ATTACHMENT C

LIST OF DURABLE MEDICAL EQUIPMENT

Item of Equipment	Approve Purchase	Approve Rental	Deny	Refer to Benefits Review
Air conditioner			X	
Air purifier, cleaner or filter			X	
Bathroom Chairs and Stools			X	
Bathtub Handrails			X	
Bedboards				X
Bedside Commode	X			
Blood Glucose Monitor	X			
Cane	X			
Compressor, Concentrator – oxygen				X
Continuous Positive Airway Pressure				X
Crutch	X			
Dehumidifier (room or central unit)			X	
Electric chair lift			X	
Electrical stimulator for bone growth (Bi-Osteogen, etc.)				X
Electrical stimulator (TENS)				X
Exercise Equipment			X	
Heater			X	
Heating Pad			X	
Heat Lamp				X
Hospital bed, twin size, standard, Siderails Trapeze				X X X
Hospital bed, twin size, electrical or deluxe				X
Hospital bed, Kinetic, Trauma bed, Roto Rest				X
Hospital bed with siderails				X
Hot Tub			X	
Hot water bottle			X	
Humidifier (room or central unit)			X	
Hydrocollator unit				X
Hydrocollator steam packs				X
Infusion Pump (insulin, chemotherapy)				X
Infusion regulating device (IVAC, etc.)				X
Iron Lung				X
IPPB Machine				X
Massage Device			X	
Massage (as part of hospital bed)				X
Mattress (air, gel or water for alternating pressure)				X
Mattress (any other)			X	
Monitor, SIDS (apnea)				X

ATTACHMENT C (Continued)

LIST OF DURABLE MEDICAL EQUIPMENT

Item of Equipment	Approve Purchase	Approve Rental	Deny	Refer to Benefits Review
Overbed table				X
Oxygen-tanks, tents, regulators, flow meters, etc.	X	X		
Paraffin bath unit, portable or standard				X
Patient lift				X
Pulse tachometer			X	
Sauna bath			X	
Sphygmomanometer with cuff			X	
Stethoscope			X	
Suction machine (gomeo)				X
Sun lamp				X
Traction		X		
Ultraviolet cabinet, stand or bulbs				X
Walker	X			
Waterbed			X	
Wheelchair, standard				X
Wheelchair, electric				X
Wheelchair, custom made				X
Whirlpool			X	

Listed items are examples only, meeting the definition of equipment which may be prescribed by a physician, and may be provided consistent with a patient's diagnosis, when medically necessary as determined by the claims administrator and recognized as therapeutically effective and not meant to serve as a comfort or convenience item.

The claims administrator will also determine medical necessity for other items not listed.