State Plan Document

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

Part I - Comprehensive Medical and Hospitalization coverage
Part II - Flexible Benefits and Parking/Transportation Expense Plan

2021

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PART I
COMPREHENSIVE MEDICAL AND HOSPITALIZATION PROGRAM

INTRODUCTION

This part of the Plan Document applies to the State of Tennessee Comprehensive Medical and Hospitalization Program established pursuant to Chapter 27 of Title 8 of the Tennessee Code Annotated. The Preferred Provider Organization Premier plan, Preferred Provider Organization Standard plan, Preferred Provider Organization Limited plan, CDHP/HSA, and Local CDHP/HSA 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 the different groups of eligible individuals.

Anti-Discrimination and Civil Rights Compliance
Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and Administration:

- Your name, address and phone number. You must sign your name. (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.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Benefits Administration, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 800.253.9981

Alternatively, you may contact or submit civil rights complaints to the following entities:

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
1-800-368-1019 or TTY/TDD at 1-800-537-7697

U. S. Office for Civil Rights
Office of Justice Programs
U. S. Department of Justice
810 7th Street, NW
Washington, DC 20531

Tennessee Human Rights Commission
312 Rosa Parks Avenue, 23rd Floor
William R. Snodgrass Tennessee Tower
Nashville, TN 37243

If you speak a language other than English, help in your language is available for free. This tells you how to get help in a language other than English.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-576-0029 (TTY: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-576-0029 (TTY:1-800-848-0298)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለውቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान द: य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल कर।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر بهزبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1-866-576-0029 (TTY: 1-800-848-0298).

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 State 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 or clinical 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, dental or vision benefits to continue the same insurance for a specific length of time under certain conditions pursuant to Section 4.09.

1.05 "COBRA Participant"
COBRA participant shall mean a qualified beneficiary pursuant to Section 4.09 who continues his or her health, dental and/or vision 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 State 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 of each respective plan. The State Insurance Committee is composed by law of the Commissioner of Finance and Administration, the Commissioner of Commerce and Insurance, the Commissioner of Human Resources, the Treasurer, the Comptroller of the Treasury, a representative of the Tennessee State Employees Association (TSEA) and three state employee representatives. Two of the employee representatives are elected by central government employees, and one employee representative is selected through a process adopted by the Tennessee Higher Education Commission.

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 or clinically necessary incurred expenses, as designated in Article XIII, including behavioral health, preventive services, and 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; 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

(4) 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 state 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) Any person employed by the employer, who is regularly scheduled to work at least 30 hours per week;

(B) Any person who has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204(a)(3); and

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

Individuals in positions classified as temporary appointments or performing services on a contractual basis shall not be considered to be employees **unless** they otherwise meet the definition of an eligible employee as defined in subsection (C).

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 persons who are eligible for health insurance coverage under the Plan.

1.17 "Employer"

Employer shall mean the State of Tennessee, University of Tennessee, other State of Tennessee Public Institutions of Higher Education or any agency of the State of Tennessee, which is authorized by statute to participate in the plan. The State of Tennessee, University of Tennessee, and the other public institutions of higher education are separate employers.

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 "Habilitation (Habilitative) Services"

Habilitation Services as defined in the ACA's Uniform Glossary of Health Coverage and Medical Terms means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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 “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.

1.31 "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 use 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.

1.32 "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.

1.33 "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.

1.34 "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.

1.35 "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.

1.36 "Out-of-Pocket Expenses"

Out-of-pocket expenses shall mean the sum of any copayment, 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.

1.37 "Outpatient"

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

1.38 "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.

1.39 "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.

1.40 "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.

1.41 "Plan"

Plan shall mean the applicable State of Tennessee Preferred Provider Organization Comprehensive Medical and Hospitalization Program, subject to the provisions of Section 2.09. 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.

1.42 "Plan Year"

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

1.43 "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.

1.44 "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.

1.45 "Pregnancy"

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

1.46 "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.

1.47 "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 use 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.

1.48 "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) Residential Treatment Center shall mean a facility which provides a program of intensive short term Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements: (i) it is established and operated in accordance with applicable state law for residential treatment programs; (ii) it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee; (iii) it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; (iv) it provides basic services in a 24-hour per day, structured milieu, including at a minimum room and board, evaluation and diagnosis, counseling, and referral and orientation to specialized community resources and (v) treatment services adhere to defined policies, procedures and evidenced based clinical protocols. A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

(V) 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.

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

(X) Treatment Center shall mean A facility which provides a program of intensive short term Mental Disorder Treatment/Substance Use Disorder/Dependency Treatment and meets all of the following requirements: (i) it is established and operated in accordance with any applicable state law; (ii) it provides a program of treatment approved by a Physician and the Claims Administrator;(iii) It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient; and it provides basic services including at a minimum room and board (if the Plan provides inpatient benefits at a Treatment Center), evaluation and diagnosis; counseling; and referral and orientation to specialized community resources and (iv) treatment services adhere to defined

policies, procedures and evidenced based clinical protocols. A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

(Y) 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.

1.49 "Qualified Beneficiary"

Qualified beneficiary shall mean any employee or dependent who is defined under Section 4.09 of the plan.

1.50 "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.

1.51 "Rehabilitation (Rehabilitative) Services"

Rehabilitation Services as defined in the ACA's Uniform Glossary of Health Coverage and Medical Terms means services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

1.52 "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 an optional 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, except as provided for in TCA 8-27-208. Retirees whose first employment with the state commenced on or after July 1, 2015 will not be eligible to continue insurance coverage at retirement, unless that retiree was also employed by the state or a participating local education agency, as defined in §8-27-301, before July 1, 2015, and did not accept a lump sum payment form the Tennessee Consolidated Retirement System before July 1, 2015.

1.53 "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.

1.54 "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.

1.55 "State"

State shall mean the State of Tennessee.

1.56 "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.

1.57 "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.

1.58 "Workers' Compensation Benefits"

Workers' compensation benefits shall mean benefits payable to employees injured on the job.

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

(2) For seasonal employees hired prior to July 1, 2015*, the eligibility date shall be the date of attainment of conditions relating to seasonal employees who are scheduled to work 1,450 hours per fiscal year and have 24 months of prior service as set forth in TCA 8-27-204(a)(3), provided the employee applies within 31 calendar days of meeting the 24-month requirement; or

(3) For employees transferring from the local education 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

(4) For employees experiencing any status change, including but not limited to 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

(5) For employees transferring from active coverage as an employee or dependent to retired coverage through eligibility as a TCRS or ORP retirement plan participant, the eligibility date shall be the date of the status change; or

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

*The 1,450 category does not apply to employees hired on or after July 1, 2015.

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 (hire date) and completion of one full calendar month of employment for newly hired employees; or

(2) The first day of the month following the date of attainment of conditions relating to seasonal employees hired before July 1, 2015, or the first day of the month following the date of the status change and completion of one full calendar month of employment for employees transferring from the local education or local government plan, 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 active work, 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.

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. Enrolling as an employee or head of contract provides a higher level of life insurance.

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 State 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) Special Enrollment Provision. 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 all of the following:

(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 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. Retirees may enroll in medical insurance for themselves and their eligible dependents subject to the special qualifying events, special enrollment period, and special enrollment effective date provided in this section. The retiree must have been a covered person under a state-sponsored plan at the time they retired and must be eligible to continue that coverage by virtue of age, their length of service and length of participation in the plan, as outlined in Tennessee Code Annotated § 8-27-205 and Section 4.07. A retiree who is age 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 the state commenced on or after July 1, 2015, will not be eligible to continue insurance coverage at retirement and will not be eligible for special enrollment under this provision, unless that retiree was also employed by the state or a participating local education agency, as defined in §8-27-301, before July 1, 2015, and did not accept a lump sum payment from the Tennessee Consolidated Retirement System before July 1, 2015.

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 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 State Insurance Committee or an authorized representative of the Committee.

(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.

(D) **Emergency Relief for 2020 Plan Year**. [Expires December 31, 2020] As permitted by IRS Notice 2020-20 concerning Covid-19 Guidance Under § 125 Cafeteria Plans issued on May 12, 2020, all members enrolled in a narrow network offered by the plan (Blue Cross/Blue Shield Network S or Cigna LocalPlus Network) as of May 21, 2020, have the option to change their coverage design option from the narrow network to the broad network offered by the plan (Cigna OAP Network) provided that the member's current network has lost 5 or more participating hospitals between January 1, 2020 and June 1, 2020. This is a limited one-time mid-year election for the sole purpose of permitting eligible members, affected by loss of participating hospitals, to upgrade their network selection prospectively from July 1, 2020 through the end of the 2020 plan year. This special mid-year election option must be exercised by eligible members in June 2020 within a time period to be established by Benefits Administration. Notification of this special enrollment opportunity will be provided to all members of the plans' narrow networks. Coverage for all affected and eligible members making midyear election changes pursuant to this provision will become effective on July 1, 2020 and remain effective through the end of the 2020 plan year.

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:

(1) Without completing the one full calendar month required of new employees; and

(2) Without satisfying the late applicant requirements of Section 2.08, provided the employee meets the other eligibility requirements of Section 2.01; or

(3) As otherwise specified in Section 3.07.

(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.

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 by Order of the Board of Appeals.

In the event that reinstatement of a covered person's insurance is ordered by the Board of Appeals, such reinstatement shall be completed as outlined in the order. If the order does not specify a date for reinstatement of insurance coverage, the covered person shall have the options outlined below:

(A) Coverage shall be reinstated from the period in which it was previously canceled with the requirement that the covered person pay all past due premiums; or

(B) Coverage shall be reinstated on the first of the month in which the order is signed or the first of the following month, with the employee's written authorization.

3.08 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 Person'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:

(1) Change in legal marital status – marriage, divorce, legal separation, annulment, or death of spouse;

(2) Change in number of employee's dependents – birth, adoption, placement for adoption, death of a dependent;

(3) Change in employment status that affects eligibility – spouse or dependent gains new employment, returns from unpaid leave, or changes from part-time to full-time employment;

(4) Event causing employee or employee's dependent to satisfy or cease to satisfy dependent eligibility requirements – entitlement to Medicare, Medicaid or TRICARE, attaining a specified age, judgments, decrees, or orders;

(5) Change in residence or workplace – move out of national service area;

(6) Change in coverage of spouse or dependent under another employer plan – open enrollment; or

(7) Marketplace Enrollment – Change in hours worked to less than 30 hours per week on average if the employee and covered family members enroll in another plan providing minimal essential coverage.

Unless otherwise stated in this Plan Document, a Covered Person 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 dependent shall terminate upon the earliest to occur of the following:

(1) The last day of the month in which the employee separates employment with the State*;

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

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

(4) The date the plan is terminated.

*State employees only. Item (B)(1) in the above section does not apply to Higher Education.

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) If an employee or retiree requests to terminate coverage of a dependent spouse while a divorce case is pending, such termination will be subject to laws and court orders related to the divorce or legal separation. This includes the requirements of Tennessee Code Annotated Section 34-4-106 and the requirement that the employee or retiree provide notice of termination of health insurance to the covered dependent spouse under Tennessee Code Annotated Section 56-7-2366. It is the responsibility of the employee or retiree to make sure that any request to terminate a dependent spouse is consistent with those legal requirements.

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

(A) If a covered employee dies, dependents covered at the time of the employee's death are entitled to six months of extended coverage without charge. 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 4.09.

(B) Health insurance may be continued for eligible surviving dependents after the six months extended coverage if the employee met the eligibility criteria to continue retiree group health coverage as outlined in section 4.06 or 4.07 at the time of their passing.

(1) If the employee was a member of the Tennessee Consolidated Retirement System (TCRS), election of a monthly pension benefit from the TCRS is required for insurance continuation. The covered dependents do not have to be the pension beneficiaries, but election of a lump sum pension payout by either the employee or the employee's designated pension beneficiary, will forfeit continuation of retiree insurance coverage for the surviving dependents. If insurance is continued, premiums will be deducted from the deceased employee's monthly TCRS pension check. Covered surviving dependents must submit insurance premiums directly to Benefits Administration if the pension check is insufficient to cover the premiums or if the beneficiary of the monthly pension is not a covered dependent.

(2) If the employee was not a member of the TCRS, including Optional Retirement Program (ORP) participants, non-elects, and state employees on federal appointment, election of a monthly pension option is not a requirement. Monthly premiums must be submitted directly to Benefits Administration.

(C) Group health coverage will not be continued beyond the six months extended coverage if the employee did not meet the eligibility criteria to continue group health as a retiree at the time of their passing. COBRA will be offered.

(D) In all cases, dependents must continue to meet all eligibility requirements in order to continue insurance coverage.

4.04 Continuation of Dependent's Participation upon Employee's Death in The Line of Duty.

If an employee who had elected family coverage dies while performing in the line of duty, the dependents are eligible to continue coverage pursuant to TCA 8-27-207. Coverage will continue for such dependents electing this continued coverage until one of the following occurs:

(A) The dependent ceases to be an eligible dependent pursuant to Section 1.11;

(B) A dependent spouse is remarried and obtains insurance coverage through the subsequent marriage;

(C) Any dependents become entitled to Medicare; or

(D) The coverage is canceled for non-payment of premium.

Should the surviving spouse lose eligibility, dependent children may continue coverage provided they meet the dependent eligibility requirements and the spouse is unable to secure insurance coverage for the dependent children. If coverage under this section is extended until the occurrence of (A), (B) or (C) and the period of extension is less than 36 months, the surviving spouse or dependent may elect continuation of coverage under COBRA for the remainder of the 36-month period beginning with the employee's date of death. The contribution for this coverage will be the same as the premium paid by active employees. The employer shall continue to make employer contributions.

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

An employee who leaves the employer's payroll because of a work-related injury, who qualifies for total, temporary disability benefits (lost time pay) from the Division of Claims Administration or its representative, 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, pursuant to TCA 8-27-204 (c). In the event the requirements of the preceding sentence are met, the employer shall pay for the total cost of such coverage. The employer is still responsible for paying premiums even though the employee may have terminated employment.

4.06 Continuation of Coverage for Disabled Employees.

Employees whose first employment with the state commenced on or after July 1, 2015, are not eligible to continue insurance coverage at retirement unless that retiree was also employed by the state or a participating local education agency, as defined in §8-27-301, before July 1, 2015, and did not accept a lump sum payment from the Tennessee Consolidated Retirement System before July 1, 2015.

(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, copayment, 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 covered employee incurs a work-related injury which results in a 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 ORP (Optional Retirement Program) participants and other 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 ORP participants and other non-TCRS participants, the employer must also submit written certification that the disability is the result of a work-related injury. The contribution for continued coverage in the State 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) The State Plan will permit any employee who is approved for a retirement benefit based on total and permanent disability as the result of an on-the-job injury who sustained the injury prior to the date on which their coverage was effective as a new hire, to enroll for coverage as a retiree, even though that coverage as an active employee was never in effect. This provision also applies to employees who have qualified under HIPAA to establish coverage prior to the date of their on-the-job injury. The former employee may continue coverage as outlined in section 4.07 of the *Plan Document*. The former employee would not be eligible for a waiver of life insurance premiums because the employee was not actively at work on the day the coverage would have begun.

(D) Disability retirees who were participants in a state-sponsored plan at the time of the 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 4.07(B) for TCRS participants or 4.07(D) for ORP (Optional Retirement Program) participants and other non-TCRS participants or by having at least five years of employment with the employer immediately prior to final termination due to disability. Upon eligibility for Medicare, disability retirees and eligible dependents may continue in the plan to the point at which Medicare eligibility would have been attained had the disability not occurred, 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.

Disabled 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 state employment may reinstate that medical coverage by meeting the requirements of Section 4.07(B) for TCRS participants or 4.07(D) for ORP (Optional Retirement Program) participants and other 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 state coverage ceased. Disabled retirees whose coverage has lapsed from their last period of state 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 state employees ceased are not eligible for reinstatement of medical coverage.

4.07 Continuation of Health Coverage for Retirees.

Retirees whose first employment with the state commenced on or after July 1, 2015, are not eligible to continue insurance coverage at retirement unless that retiree was also employed by the state or a participating local education agency, as defined in §8-27-301, before July 1, 2015, and did not accept a lump sum payment from the Tennessee Consolidated Retirement System before July 1, 2015.

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 this Section 4.07. Subject to meeting all eligibility requirements upon the spouse's termination of employment, the retiree may be covered on retiree group health insurance under their own retiree record or as a dependent under the spouse's retiree record if the spouse has qualified to continue health insurance as a retiree.

Retirees who are not eligible to continue insurance coverage because of the service requirements may continue coverage pursuant to Section 4.09 (COBRA) or convert to a direct payment plan offered by the claims administrator at retirement, pursuant to Section 4.10.

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 the State of Tennessee or any agency participating in the state or local education plans. For purposes of this plan, accumulated unused sick leave is defined as employment with the employer. When eligible for retiree coverage by combining creditable state service and local education service, the retiree will be classified as a retiree in the plan from which employment ended immediately preceding retirement. When eligible for retiree coverage without combining creditable service, the retiree may choose to be classified as a retiree in the plan in which he or she first satisfied eligibility criteria, or in the plan from which the employment ended immediately preceding retirement.

For the purpose of this plan, the following are ***not*** defined as state 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.

"Optional Retirement Program" is defined as a contribution plan offered to certain employees in higher education.

"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, as defined in Section 1.52, or their dependents may not continue coverage in the plan if eligible for Medicare, except as provided below:

(1) Any retired state 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 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 copayment or deductible and coinsurance amount listed in Attachment A of the applicable section 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.

(2) Any dependent covered by a retired state 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 yet eligible for Medicare. The plan shall pay secondary benefits to Medicare after the copayment or deductible and coinsurance amount listed in Attachment A of the applicable section has been satisfied.

(3) 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 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 a state-sponsored insurance 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 state plan and becoming insured by an agency participating in one of the other state-sponsored health plans;

(b) The retiree with 20 or more total years of employment with the employer with one year of insurance coverage in a state-sponsored insurance 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 state plan and becoming employed by an agency participating in one of the other state-sponsored health plans, resulting in no lapse in coverage on a state plan. If more than five years, retirees and eligible dependents would have to meet the late applicant requirements of Section 2.08 before being 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 coverage only if qualified through the late applicant requirements of Section 2.08 or through the provision of COBRA under Section 4.09. 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.

(D) Retirees who participated in an ORP, non-elects and state employees on federal appointment (not eligible for federal insurance programs) must elect to continue coverage within one full calendar month of meeting the conditions to continue insurance coverage as outlined below, 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. 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.

Employees who elected to participate in an optional retirement program (ORP), non-elects and state employees on federal appointment (not eligible for federal insurance programs) must meet one of the following conditions to continue insurance coverage:

(1) Attainment of age 55 at final termination and at least ten but less than 20, total years of employment with the employer, with three continuous years of insurance coverage in a state-sponsored insurance 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 a state-sponsored insurance plan immediately prior to final termination.*

(3) Twenty-five years of service with the employer with one year of insurance coverage in a state-sponsored insurance plan immediately prior to final termination.*

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 plan and becoming employed by an agency participating in one of the other state-sponsored health plans, resulting in no lapse in coverage on a state plan. 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) Premiums.

(1) Individuals who participated in an optional retirement program (ORP), non-elects and state employees on federal appointment (not eligible for federal insurance programs) are not required to start a monthly pension benefit to be eligible to continue insurance. They must submit their premiums directly to Benefits Administration each month.

(2) TCRS retirees must receive a monthly benefit from the Tennessee Consolidated Retirement System and shall have premiums deducted from their benefit check. Retirees whose insurance premium exceeds their monthly benefit shall submit their premiums directly to Benefits Administration each month.

(F) Medicare.

(1) When a retiree is no longer eligible for the plan because he/she is entitled to Medicare by virtue of age, he/she may elect to continue coverage for eligible dependents. Subject to a retiree's election to continue coverage for dependents, such dependent coverage shall continue until the dependents no longer meet the eligibility requirements or until the dependents are entitled to Medicare by virtue of age.

(2) When coverage is discontinued for a retiree due to Medicare entitlement by virtue of age, the retiree shall be given an opportunity to enroll in The Tennessee Plan (supplemental medical insurance for retirees with Medicare) if they receive a monthly pension from TCRS or are a higher education optional retirement plan participant. The retiree's initial employment with the state or other qualifying employer must have commenced prior to July 1, 2015, to be eligible for The Tennessee Plan. Dependents will not be allowed to enroll in The Tennessee Plan if the retiree is not enrolled or enrolling in The Tennessee Plan. The plan will suspend coverage on any participating state plan retiree who will not provide information to Benefits Administration concerning Medicare eligibility upon request.

(G) Dependents.

(1) If a covered retiree dies, dependents covered at the time of the retiree's death are entitled to up to six months of extended coverage without charge. The contribution for this coverage is the sole responsibility of the plan. Participation in the plan during the six months of extended coverage shall be in addition to continued coverage available through the provisions of COBRA pursuant to Section 4.09.

(2) Insurance may be continued for eligible surviving dependents after the six months extended coverage provided the dependents continue to meet all eligibility requirements.

(a) A retiree's eligible surviving spouse and dependent(s) are not required to continue the deceased retiree's pension.

(b) If the retiree was a member of the Tennessee Consolidated Retirement System, and a pension benefit is continued for surviving dependents, premiums will be deducted from the deceased retiree's monthly TCRS pension check. Premiums must be submitted directly to Benefits Administration if the pension check is insufficient to cover the premiums or if the beneficiary of the monthly pension is not a covered dependent.

(c) If the retiree was not a member of the TCRS, including Optional Retirement Program (ORP) participants, non-elects, and state employees on federal appointment, monthly premiums must be submitted directly to Benefits Administration.

(3) 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 conversion to a direct payment plan offered by the claims administrator regardless of his/her present health condition. There should be no lapse in coverage.

(4) In all cases, dependents must continue to meet all eligibility requirements in order to continue insurance coverage.

(H) When a state employee was ***involuntarily*** transferred prior to July 1, 2006 to a local government Community Service Agency that participates in the Local Government Plan ***and*** in TCRS, the time worked at the state may be counted as time worked for the purpose of qualifying the employee for continuation of insurance coverage as a retiree.

*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 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.

4.08 Continuation of Coverage of Retired General Assembly Members and Former Governor.

Pursuant to TCA 8-27-208, upon retirement from the general assembly, any senator or representative, and upon completion of a term of office, a former governor may elect to continue coverage by paying the portion of premium required. The surviving spouse or dependent children of any member of the General Assembly who shall die in office or who is a member of the TCRS may elect to participate in the plan by continuing to pay the monthly contribution attributable to the deceased senator, representative, or governor's service. Should the surviving spouse or dependent children be ineligible to receive a retirement benefit, such spouse may participate in the plan by making payment for the required cost to Benefits Administration. Continued participation in the plan pursuant to this Section 4.08 shall be in lieu of continued participation under any other provision of the plan during the period that continued participation under this Section 4.08 is effective. This provision does not apply to any senator, representative, governor or their dependents when first election to any of these offices did not occur before July 1, 2015.

4.09 Limited Continuation of Coverage (COBRA).

For purposes of this Section 4.09, 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 4.09 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 4.09(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 4.09(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 4.09(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 4.09(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 4.09 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 4.09(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.

4.10 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 4.09. Provided, however, that any person obtaining a converted policy must satisfy the conditions of Section 4.10. 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 4.09, 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 stepparent with custody shall be the primary plan.

(iii) If the natural parent and the stepparent 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 8-27-201, *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 or their authorized representative 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 or their authorized representative should exhaust the internal complaint or grievance process available through the claims administrator before initiating an external level of appeal. The covered person or their authorized representative should first call the claims administrator at the telephone number listed on the Covered Person's insurance card. If the covered person has received correspondence pertaining to an inquiry, the covered person or their authorized representative should ask for the correspondent by name to discuss the issue. If the covered person's complaint cannot be resolved on an informal basis, the Covered Person or their authorized representative may submit a formal complaint in a manner designated by the claims administrator. The claims administrator may require the covered person or authorized representative 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 Contributions by Covered Persons.

Contributions by Covered Persons are required as a condition of participating in the plan. By completing an enrollment application, a Covered Person shall authorize deduction of the Covered Person's share of the monthly cost from his/her pay or retirement pension.

Covered Persons who do not receive employee pay or a retiree pension or whose retirement pension is insufficient to cover the required contribution shall submit payment for the monthly cost of coverage. If such payment is returned by the Covered Person's financial institution, the Covered Person may be required to resubmit payment in the form of a money order or cashier's check within the time period specified. Should Covered Person 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 premium deferral period of a full calendar month for premiums being billed directly instead of through payroll deduction. If the premium is not paid within the deferral period, coverage will be canceled retroactive to the last month for which the premium was paid.

When coverage for Covered Persons who are billed directly has been canceled for failure to pay within the deferral period, the plan permits a one-time opportunity for coverage reinstatement. Covered Persons seeking reinstatement of coverage must request reinstatement within 30 days of being notified that coverage was canceled. The Covered Person must sign and return the required documentation, and all current and past due premiums must be received within a 30-day deadline.

8.02 Employer Contributions.

For employees defined in Section 1.15, the state shall pay a percent of the cost for the type of medical coverage elected pursuant to Section 1.08 (except as may be otherwise indicated herein) based on an amount determined pursuant to TCA 8-27-203.

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.

ARTICLE X
PRIVACY OF PROTECTED HEALTH INFORMATION

10.01 State of Tennessee 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 State of Tennessee Insurance Committee (sponsor) unless the State of Tennessee 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 State of Tennessee 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 State of Tennessee Insurance Committee only to permit the State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee Insurance Committee for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the State of Tennessee Insurance Committee.

10.03 Restrictions on State of Tennessee Insurance Committee Use and Disclosure of Protected Health Information.

(A) The State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee Insurance Committee.

(D) The State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee Insurance Committee shall report to the group health plan any security incident of which it becomes aware.

10.04 Adequate Separation between the State of Tennessee Insurance Committee and the Plan.

(A) The following employees or classes of employees or other workforce members under the control of the State of Tennessee 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 State of Tennessee Insurance Committee.

This list includes the class of employees or other workforce members under the control of the State of Tennessee 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 State of Tennessee Insurance Committee by the plan only to perform the plan administration functions that the State of Tennessee 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 State of Tennessee Insurance Committee in its capacity as plan sponsor in breach or violation of or noncompliance with the provisions of this article. The State of Tennessee 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 deductible 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 local government or local education 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 use 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-network provider, is paid as if a network expense. The covered person is responsible for expenses determined not to be medically or clinically 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 or clinical 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 or clinically 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 clinical condition or 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. Hospital-based providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists and pathologists. In the event of covered expenses incurred with hospital-based providers at an in-network facility, 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 such providers. Covered Persons will be responsible for expenses exceeding the maximum allowable charge for hospital-based providers at an out-of-network facility unless the claims administrator determines that the expenses were for emergency care.

(G) Emergency Out-of-State. In the event of covered expenses for emergency care as outlined in Section 1.14 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 1.14, 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-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 or coinsurance 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 or Coinsurance.

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 or coinsurance 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 or coinsurance 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 or coinsurance 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. The covered person is only responsible for the in-network deductible and 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 USE 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 use services or employee assistance services. For mental health/substance use 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 use, 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 use, 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 deductible 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 local government or local education 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 use 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. Benefits for mental health and substance use 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 use utilization review organization, the Covered Person's 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 use utilization review organization, the Covered Person's 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 use utilization review organization not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

(B) Outpatient. Benefits for mental health and substance use 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 use 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 use 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 use 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 persons eligible for health insurance coverage under the plan, even if they have waived enrollment, including employees and retirees and their dependents. COBRA participants are also eligible, but they must be enrolled in the health plan. Services consist of short-term counseling (up to five sessions per problem episode) for problems such as marital or family, emotional, substance use, stress, job and financial loss. Legal and financial consultations via telephone 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 use inpatient, residential treatment, partial hospitalization/day treatment programs, intensive outpatient therapy,

outpatient psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45 to 50 minutes in duration with or without medication management, Applied Behavior Analysis, 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 use 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 use 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. 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, or for preventive services.

(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 tests, laboratory tests, and x-ray services in addition to office visit charges 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 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, or for treatment by a licensed acupuncturist 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. Covered Persons or their provider must obtain prior authorization and coverage is subject to utilization management review.

(L) Charges for the taking and or the reading of an x-ray, CAT scan, MRI PET or laboratory procedure, including physician charges and hospital charges. Covered persons or their provider must obtain prior authorization prior to incurring charges for use of this advanced imaging technology.

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

(N) Preventive screening lab charges and associated office visits for pap smears covered 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.

(O) 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.

(P) 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) Limited prescription agents and over-the-counter nicotine replacement therapies (e.g., gum, patches, lozenges, and oral and nasal inhalers) provided for assistance in tobacco cessation. 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) Medically necessary insulin, the related syringes, home blood glucose monitors and related supplies for the treatment of diabetes as prescribed or recommended by a physician;

(6) 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;

(7A) 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;

(7B) 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.

(7C) 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.

(8) 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;

(9) 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

(10) "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;

(11) 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);

(12) 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;

(13) 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(P)(7C), 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;

(14) 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. Covered Persons or their provider must obtain prior authorization;

(15) Bone anchored hearing aid devices determined to be medically necessary by the claims administrator. Covered Persons or their provider must obtain prior authorization;

(16) 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;

(17) 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;

(18) 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;

(19) Other preventive care as recommended, including but not limited to:

(a) adult annual physical exam;

(b) Alcohol misuse counseling;

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

(d) cholesterol screening;

(e) Colorectal screenings;

(f) depression screening for adolescents and adults;

(g) healthy diet counseling;

(h) mammogram screenings;

(i) over the counter, generic forms of aspirin (prescription required);

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

(k) routine women's health (including various screenings);

(l) tobacco use counseling.

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

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

13.03 Other Covered Expenses.

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

(1) A physician recommends skilled nursing facility care for rehabilitation or recovery of a covered illness or injury;

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

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

(4) Services were preauthorized by the claims administrator.

Eligible charges for 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 skilled nursing facility care 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 applicable 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 determined to be medically necessary by the claim administrator using FDA-approved cochlear implants. Covered Persons or their provider must obtain prior authorization.

(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. Covered services are limited to 125 visits per plan year.

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) Therapy. Speech, physical, and/or occupational. The plan shall provide preauthorized inpatient therapy benefits and medically necessary outpatient therapy benefits. Habilitative and rehabilitative services as defined in Article I of this Plan Document are covered. Specific to rehabilitation therapy, coverage is available for conditions resulting from an illness or injury, or when prescribed immediately following surgery related to the condition. No therapy services will be covered if the claims administrator determines services are not medically necessary or if the covered person is no longer progressing toward therapy goals.

Cardiac rehabilitation services will be a covered expense when determined to be medically necessary by the claims administrator.

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 or damage to sound natural teeth and/or jaw. Treatment of accidental injury as described in this section does not include injury from eating or chewing. Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a covered person's ability to masticate and maintain a healthy weight. Services are 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). Treatment will not be covered

if the claims administrator determines services are cosmetic or otherwise not medically necessary.

(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, only at Medicare-approved facilities. 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 and determined to be medically necessary 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.

(K) Well-Child Checkups and Immunizations. Physician office visits for routine check-ups and immunizations are covered expenses. 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 screenings annually (per plan year) as recommended. Covered persons should consult their current year member handbook for recommended coverage details.

(M) Bariatric Surgery (weight reduction). The plan will cover preauthorized surgical procedures for the treatment of morbid obesity. The claims administrator will determine if all the criteria have been met before approving surgery.

(N) 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 for adults (annually per plan year) 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.

(O) Hearing Impairment Screening and Testing. The plan will cover, as determined by the claims administrator, medically necessary hearing impairment screening (annually per plan year) 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.

(P) 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.

(Q) 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.

(R) 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.

(S) Certain preferred anti-obesity medications (as determined by the pharmacy benefits manager), subject to prior authorization.

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 use 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(P)(2) and 13.02(P)(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 pursuant to 13.02(P)(13):

   (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, sun or heat lamps, air conditioners, air purifiers and exercise devices;

(24) Non-surgical services for weight control or reduction (obesity), including prescription medication. Certain preferred anti-obesity medications and preventive screenings, counseling, treatment, healthy diet counseling, ParTNers for Health sponsored programs, certain surgical services, and participation in an integrated clinical program as part pf the bariatric surgery benefit are not excluded;

(25) Medical or surgical procedures and prescription drugs determined by the claims administrator to be experimental, investigational, or unproven;

(26) Organ transplants involving artificial organs and non-human organs unless determined to be medically necessary by the claims administrator, 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 other than psychological treatment or counseling;

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

(31) Midwife services outside a licensed health care facility.

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

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

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

(35) 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;

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

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

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

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

(40) Diapers (incontinent pads);

(41) Cranial prosthesis (wig);

(42) Nutritional supplements, vitamins, and oral nutritional formulas for infants and adults which can be obtained at retail or over the counter without a written prescription. **Nutritional treatment of inborn errors of metabolism, Enteral Nutrition (EN), and Total Parenteral Nutrition (TPN) are not excluded under this clause as noted in Section 13.03(P);**

(43) 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*;

(44) Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, collection and handling fees;

(45) 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;

(46) 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;

(47) Ecological or environmental medicine, diagnosis and/or treatment;

(48) Examinations and services provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes; related expenses for reports, including report presentation and preparation; vocational therapy, vocational rehabilitation, education therapy, and recreational therapy;

(49) Services given by a pastoral counselor;

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

(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 Use Expenses. In addition to relevant exclusions noted in Section 13.04(A), the following are specifically excluded under the mental health/substance use benefit:

(1) Services for disorders not included in the *American Psychiatric Association Diagnostic & Statistical Manual*, 5th Edition, on Axis I or II.

(2) 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.

ATTACHMENT A
SCHEDULE OF BENEFITS

ATTACHMENT A.1
SCHEDULE OF PPO BENEFITS

Table 1: PPO PLANS - Services in this table ARE NOT subject to a deductible. $ = your copayment amount; % = your coinsurance percentage; 100% covered or No charge = you pay $0 in-network.

PPO HEALTHCARE OPTION	PREMIER		STANDARD	
COVERED SERVICES	In-Network [1]	Out-of-Network [1]	In-Network [1]	Out-of-Network [1]
PREVENTIVE CARE — OFFICE VISITS				
• Well-baby, well-child visits as recommended • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended • Annual hearing and non-refractive vision screening • Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	$45	No charge	$50
OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA				
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 • Inc surgery in office setting and initial maternity visit	$25	$45	$30	$50
Specialist Office Visit • Including surgery in office setting • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	$45	$70	$50	$75
Behavioral Health and Substance Use [2] Including virtual visits	$25	$45	$30	$50
Telehealth (approved carrier programs only)	$15	N/A	$15	N/A
Allergy Injection Without Office Visit	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Chiropractic and Acupuncture • Limit of 50 visits of each per year	Visits 1-20: $25 Visits 21-50: $45	Visits 1-20: $45 Visits 21-50: $70	Visits 1-20: $30 Visits 21-50: $50	Visits 1-20: $50 Visits 21-50: $75
Convenience Clinic	$25	$45	$30	$50
Urgent Care Facility	$45	$70	$50	$75
Emergency Room Visit	$150		$175	
PHARMACY				
30-Day Supply generic | preferred brand | non-preferred	$7 | $40 | $90	copay plus amount exceeding MAC	$14 | $50 | $100	copay plus amount exceeding MAC
90-Day Supply generic | preferred brand | non-preferred (90-day network pharmacy or mail order)	$14 | $80 | $180	N/A - no network	$28 | $100 | $200	N/A - no network
90-Day Supply generic | preferred brand | non-preferred (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 | $40 | $160	N/A - no network	$14 | $50 | $180	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	In-Network = 10%; minimum $50; maximum $150 Out-of-Network = NA – no network			

[1], [2], [3] See footnotes at the bottom of Table 2

Table 2: PPO PLANS: Services in this table ARE subject to a deductible unless noted with a [5]. % = your coinsurance percentage.

PPO HEALTHCARE OPTION	PREMIER		STANDARD	
COVERED SERVICES	In-Network [1]	Out-of-Network [1]	In-Network [1]	Out-of-Network [1]
PREVENTIVE CARE — OUTPATIENT FACILITIES				
• Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No charge[5]	40%	No charge[5]	40%
OTHER SERVICES				
Hospital/Facility Services [4] • Inpatient care; outpatient surgery • Inpatient behavioral health/ substance use [2] [6]	10%	40%	20%	40%
Maternity - Global billing for labor and delivery and routine services beyond initial office visit	10%	40%	20%	40%
Home Care [4] • Home health; home infusion therapy	10%	40%	20%	40%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4]; outpatient • Outpatient IN-NETWORK physical, occupational and speech therapy [5]	10%	40%	20%	40%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) [5]	10%		20%	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	10%	40%	20%	40%
All Reading, Interpretation and Results [5]	10%		20%	
Ambulance (air and ground)	10%		20%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10%	40%	20%	40%
Also Covered	Certain dental benefits, hospice care and out-of-country charges - See Member Handbook for details.			
DEDUCTIBLE				
Employee Only	$500	$1,000	$1,000	$2,000
Employee + Child(ren)	$750	$1,500	$1,500	$3,000
Employee + Spouse	$1,000	$2,000	$2,000	$4,000
Employee + Spouse + Child(ren)	$1,250	$2,500	$2,500	$5,000
OUT-OF-POCKET MAXIMUM – medical and pharmacy combined – eligible expenses, including deductible, count toward the out-of-pocket maximum				
Employee Only	$3,600	$4,000	$4,000	$4,500
Employee + Child(ren)	$5,400	$6,000	$6,000	$6,750
Employee + Spouse	$7,200	$8,000	$8,000	$9,000
Employee + Spouse + Child(ren)	$9,000	$10,000	$10,000	$11,250

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 (MAC) will not be counted. 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

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge unless otherwise noted in this Plan Document or the Member Handbook.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient", prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis), depression and osteoporosis medications.

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

[5] Deductible DOES NOT apply.

[6] Select Substance Use Treatment Facilities are preferred with an enhanced benefit – members won't have to pay a deductible or coinsurance for facility-based substance use treatment; Copays will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

ATTACHMENT A.2
SCHEDULE OF CDHP/HSA BENEFITS

Table 1: CDHP/HSA PLAN: Services in this table ARE subject to a deductible with the exception of in-network preventive care and 90-day supply maintenance medications. % = your coinsurance percentage.

CDHP/HSA HEALTHCARE OPTION	CDHP/HSA	
COVERED SERVICES	In-Network [1]	Out-of-Network [1]
• Well-baby, well-child visits as recommended • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended • Annual hearing and non-refractive vision screening • Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	40%
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 • Inc surgery in office setting and initial maternity visit	20%	40%
Specialist Office Visit • Including surgery in office setting • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	20%	40%
Behavioral Health and Substance Use [2] Including virtual visits	20%	40%
Telehealth (approved carrier programs only)	20%	N/A
Allergy Injection Without Office Visit	20%	40%
Chiropractic and Acupuncture • Limit of 50 visits of each per year	20%	40%
Convenience Clinic	20%	40%
Urgent Care Facility	20%	40%
Emergency Room Visit	20%	
PHARMACY		
30-Day Supply generic | preferred brand | non-preferred	20%	40% plus amount exceeding MAC
90-Day Supply generic | preferred brand | non-preferred (90-day network pharmacy or mail order)	20%	NA – no network
90-Day Supply generic | preferred brand | non-preferred (certain maintenance medications from 90-day network pharmacy or mail order) [3]	10% without first having to meet deductible	NA – no network
Specialty Medications (30-day supply from a specialty network pharmacy)	20%	NA – no network

[1], [2], [3] See footnotes at the bottom of Table 2

Table 2: CDHP/HSA PLAN: Services in this table ARE subject to a deductible with the exception of in-network preventive care. % = your coinsurance percentage.

CDHP HEALTHCARE OPTION	CDHP/HSA	
COVERED SERVICES	In-Network [1]	Out-of-Network [1]
PREVENTIVE CARE — OUTPATIENT FACILITIES		
• Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No charge	40%
OTHER SERVICES		
Hospital/Facility Services [4] • Inpatient care; outpatient surgery • Inpatient behavioral health and substance use [2] [5]	20%	40%
Maternity - Global billing for labor and delivery and routine services beyond initial office visit	20%	40%
Home Care [4] • Home health; home infusion therapy	20%	40%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4]; outpatient	20%	40%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	20%	40%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	20%	40%
All Reading, Interpretation and Results	20%	
Ambulance (air and ground)	20%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	20%	40%
Also Covered Subject to applicable deductible and coinsurance	Certain dental benefits, hospice care and out-of-country charges - See Member Handbook for details.	
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 – medical and pharmacy combined – eligible expenses, including deductible, count toward the out-of-pocket maximum		
Employee Only	$2,500	$4,500
Employee + Child(ren)	$5,000	$9,000
Employee + Spouse	$5,000	$9,000
Employee + Spouse + Child(ren)	$5,000	$9,000
CDHP HEATH SAVING ACCOUNT (HSA) CONTRIBUTION		
State contribution made to HSA for individuals enrolled in the CDHP/HSA - State and Higher Education only	$250 for employee only $500 for all other coverage levels	

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 (MAC) will not be counted. The deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied for the family. Coinsurance is after deductible is met unless otherwise noted.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient" prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis), depression and osteoporosis medications.

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

[5] Select Substance Use Treatment Facilities are preferred with an enhanced benefit – members must meet their deductible first, then coinsurance is waived. Deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

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

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.

PART II

FLEXIBLE BENEFITS AND PARKING/TRANSPORTATION EXPENSE PLAN

INTRODUCTION

Information contained in this part of the Plan Document applies to the Flexible Benefits Plan and the parking & transportation plan. If you have any questions regarding these benefits, contact your Agency Benefits Coordinator (ABC). If you have questions about your medical Flexible Spending Account (FSA), Dependent Care Flexible Spending Account (DC-FSA), or Limited Purpose Flexible Spending Account (L-FSA), you may contact the claims administrator.

This document is also intended to be a cafeteria plan under Internal Revenue Code Section 125 and will be interpreted and administered to comply with the law and regulations under Code Section 125 as applied to the benefits subject to Code Section 125.

This document also constitutes the Dependent Care Flexible Spending Account that provides for reimbursement of expenses for dependent care expenses as permitted under Internal Revenue Code Section 129.

Finally, this document includes qualified transportation benefits as permitted under Internal Revenue Code Section 132.

State employees applying to enroll in the FSA or limited purpose FSA must consent to a payroll deduction agreement in Edison as a condition for being allowed to participate in either plan. This consent allows the State to make deductions from state employee wages to repay expenses that employees fail to substantiate to the claims administrator.

Who is the Claims Administrator?

All FSA benefits described in this document (except parking & transportation, which are only applicable to state employees) are administered by the state's contracted claims administrator. Contact information is: 1-866-600-4984 24 hours a day / 7 days a week or online at www.optumbank.com/Tennessee.

For parking & transportation expense questions, contact the Plan Administrator. 1-800-253-9981 Mon-Fri 8:00 am-4:30 pm CT or email Benefits.Info@tn.gov

Who is the Plan Administrator?

The plans described in this document are administered through the State of Tennessee Department of Finance & Administration, Division of Benefits Administration. Contact information is: 1-800-253-9981 Mon-Fri 8:00 am-4:30 pm CT or email Benefits.Info@tn.gov

What are the State of Tennessee Flexible Benefits Plans Available to Employees?

The State of Tennessee Flexible Benefits Plan is comprised of the following cafeteria plans authorized under IRS Section 125:

• The medical flexible spending account (FSA), which covers eligible out-of-pocket medical, behavioral health, dental, vision, and over-the-counter medical and pharmacy expenses. OTC medications and products as well as feminine hygiene products purchased on or after January 1, 2020 do not require a prescription. Visit the claims administrator's website for a list of eligible and non-eligible expenses.

• The limited purpose flexible spending account (L-FSA), which covers eligible out-of-pocket dental and vision expenses. Plan members who enroll in a consumer directed health plan (CDHP) may not elect a medical FSA but may choose to enroll in the L-FSA.

• The dependent care flexible spending account (DC-FSA), which covers certain IRS-defined dependent care (daycare) expenses for qualifying dependents.

The following fringe benefits authorized under IRC Section 132 are offered to state employees only:

• The parking & transportation/transportation expense plan (P&T) is available for state employees who wish to set aside up to $270 per month in a pre-tax funded account in order to pay for qualified parking and transportation expenses while at work or commuting to/from their place of employment. University of Tennessee and Tennessee Board of Regents employees or TBR college and university employees are not participating employers in the parking and transportation expense plan; this benefit applies only to state employees.

Internal Revenue Code Section 125 governs the Flexible Benefits Plan and Internal Revenue Code Section 132 governs the Transportation Expense Plan. Both of these plans are administered to comply with strict IRS regulations. The Employer's ability to offer these Plans to its employees depends upon the appropriate administration of the Plans.

Who is eligible for the plan?

Insurance-eligible employees of the State of Tennessee, the University of Tennessee campuses, or the various colleges, schools, and universities under the purview of the Tennessee Board of Regents are eligible to participate in the medical FSA, the DC-FSA, and the L-FSA. Only state employees may participate in the parking & transportation expense plan.

New employees who are insurance eligible must enroll in the medical FSA, L-FSA and/or DC-FSA within 31 days of their employment, re-hire, or reinstatement. Coverage is effective on the first day of the month following one full calendar month of work, (i.e., the effective date) except for the University of Tennessee, which allows coverage to begin on the hire date. The IRS generally prohibits retroactive enrollments.

If you fail to enroll for medical FSA, DC-FSA, or L-FSA during the applicable new employee enrollment period, you cannot enroll until the following Benefits Administration Open Enrollment period (usually a designated time period during the month of October), unless you have an event which constitutes a "status change.". If you enroll mid-year based on a status change, see Article I, Section 1.06 for more information. If you enroll for a plan during Open Enrollment AND you are on payroll on the following January 1, your plan coverage will begin on January 1 (i.e., the effective date). State employees may enroll in the parking & transportation expense plan at any time during the year and may cancel enrollment in the parking & transportation expense plan at any time during the year. For parking & transportation (state employees only), the effective date will be the first day of the month following the date that your parking & transportation enrollment form is received by the Division of Benefits Administration.

What if I work less than a full calendar year?

If you anticipate dropping off the payroll at any time during the calendar year, you should take special care to understand how that change will affect your participation in the plan. For instance, if you do not incur enough healthcare, dental, vision or dependent care expenses before your coverage terminates, you may forfeit your existing contributions.

Will my enrollment in this program automatically continue from year to year?

If a state employee elects to participate in the parking & transportation flex benefits plan, you will stay enrolled each year until you cancel your enrollment, and your payroll deduction amount will remain the same until you change it. However, for the medical FSA, L-FSA, or DC-FSA you must enroll during Open Enrollment for

each plan year in which you wish to participate. Re-enrollment does **not** occur automatically each year; you must take action to reenroll for the following year. State employees will elect enrollment in Edison, while Higher Education employees will elect enrollment in the claims administrator's portal.

What is the purpose of the flexible benefits and parking/transportation expense plan?
Getting the most from your paycheck—that is the idea behind the State's Flexible Benefits Plan and Parking & Transportation Plan. These plans allow you to pay for the employee-paid portions of your health and dental premiums for the state sponsored group insurance program plans, as well as certain medical, behavioral, dental, dependent care (daycare) and transportation out-of-pocket expenses, with money that is sheltered from taxes by deducting the funds from your pay before it is taxed. This means less of your pay is taxed. Your employer does not include health and dental insurance premiums as taxable income. You can further reduce your taxable income by deciding whether the medical FSA, L-FSA, DC-FSA and/or parking and transportation flex plans make sense for you and your family and enrolling in those plans that best fit your situation. Certain rules and guidelines apply to each benefit, so be sure you fully understand the programs before you choose to participate.

Are there any risks involved in participating in this plan?
YES! UNDER CERTAIN CIRCUMSTANCES, YOU RISK FORFEITING PART OR ALL OF THE MONEY YOU HAVE CONTRIBUTED. In general, you will forfeit money if you do not incur enough eligible expenses to cover your contributions or if you fail to file a complete reimbursement request by the final deadline of the plan year. This risk of forfeiture is required by federal regulations. For more information on the forfeiture risk, see the applicable sections for the medical FSA, L-FSA, and DC-FSA. Generally, participants may carry over to the next plan year any unused balance in their medical FSA and limited purpose FSA (L-FSA) of $500 or less. Please see the section titled "*If I have money left in my account at the end of the year, can it carry forward into the next year?*"

What time period does the plan cover?
This document describes the plan as of January 1, 2021. The plan year runs January 1 through December 31. Generally, employees enroll during Open Enrollment prior to the beginning of the plan year. Employees who enroll or end their participation during the plan year due to a status change have a shorter period of coverage. For further information, see the applicable sections for the medical FSA, DC-FSA, L-FSA, and parking/transportation (state employees only).

Does this plan affect my benefits from other employer benefit programs that are based on my pay (e.g. Life Insurance)?
No. All benefits from your pay-related benefit plans are based on your gross pay without regard to any salary deduction amounts under this plan.

Which plans does this booklet describe?
This booklet is a description of plan features for the Flexible Benefit Plans and the Parking/Transportation Expense Plan.

What if I have questions about the plan?
The state's contracted claims administrator for the medical FSA, L-FSA, and the DC-FSA, or your ABC can help you if you have specific questions about those plans. Their contact information is available on the Division of Benefits Administration website. You may also wish to consult with your tax advisor. Benefits Administration, the administrator of the parking/transportation plan for state employees, can answer questions about that program for state employees.

Would converting part of my pay to the Flexible Benefits Plan or Transportation Expense Plan cause my Social Security Benefits to be reduced?

Your Social Security benefits could be affected if your taxable earnings are less than the Social Security maximum covered wages. The laws affecting Social Security taxes and benefits are constantly changing, so it is difficult to predict how anyone might be affected. The decision becomes one of whether the current overall tax savings are more valuable to you than a possible reduction in Social Security benefits in the future. You may also wish to consult with the social security administration or your tax advisor.

NOTICE:

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

ARTICLE I
ACRONYMS AND DEFINITIONS

1.01 "ABC"
Agency Benefits Coordinator

1.02 "BA"
Benefits Administration (Division of Benefits Administration within State of Tennessee, Department of Finance & Administration is Plan Administrator); 1-800-253-9981 Mon-Fri 8:00-4:30 pm CT

1.03 "CDHP"
Consumer Directed Health Plan

1.04 "COBRA"
Consolidated Omnibus Budget Reconciliation Act

1.05 "DC-FSA"
Dependent Care (daycare) Flexible Spending Account

1.06 "Effective Date"
The first date on which services incurred by a member are covered and claims for benefits under the plan are payable.

(A) For new employees, the effective date is the first day of the month following completion of one full calendar month of work. For example, if you begin work on July 12th, then your benefits would begin on September 1st.

(B) For employees who experience a status change and enroll mid-year, the effective date is the first day of the month following BA's timely receipt of an enrollment form. For example, if you get married on July 12th, you have 60 days from the date of marriage to enroll. If BA receives your enrollment form in July, your benefits would begin on August 1. If BA receives your enrollment form in August, your benefits would begin on September 1. If BA receives your enrollment in September before your 60-day enrollment period expires, your benefits would begin on October 1.

(C) For employees who enroll during the Plan's Open Enrollment period, the effective date is January 1 of the next plan year. For example, if you enroll during Open Enrollment in October 2021, your benefits would begin on January 1, 2022.

(D) For employees enrolling in the parking and transportation benefit (state employees only), the effective date will be the first day of the month following BA's receipt of a parking & transportation enrollment form. For example, if your enrollment form is received on July 12th, your benefits would begin on August 1.

1.07 "FMLA"
Family Medical Leave Act

1.08 “FSA”
Healthcare Flexible Spending Account

1.09 “HIPAA”
Health Insurance Portability and Accountability Act

1.10 “HSA"
Health Savings Account

1.11 “IRC”
Internal Revenue Code

1.12 “IRS”
Internal Revenue Service

1.13 “L-FSA”
Limited Purpose Flexible Spending Account

1.14 “OTC”
Over the counter

1.15 “Plan Year”
The Plan Year is currently a calendar year from January 1 to December 31.

ARTICLE II
MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)

The Medical Flexible Spending Account (FSA) allows you to pay for certain unreimbursed medical, dental, vision, and over-the-counter expenses with up to $2,750 of pre-tax dollars. You participate in the program by enrolling during Open Enrollment. New employees must enroll within 31 days of their employment, re-hire, or reinstatement. Employees who become insurance eligible mid-year must enroll within 31 days of becoming eligible for the benefits. You must enroll each year during Open Enrollment for the following plan year in which you wish to participate. Enrollment is not automatic. You must take an active role in both re-enrolling each year and determining the contribution amount that is best for you. There is no minimum annual enrollment amount; however, the maximum enrollment amount is subject to change each year per the IRS. For 2021, the maximum contribution amount allowed by the State and Higher Education institutions is $2,750.

When you enroll in this account, you must decide how much of your wages for the year you wish to contribute to this account to pay for medical, dental, vision or certain qualified, prescribed-by-a-physician over–the-counter (OTC) expenses that would otherwise be paid out of your pocket. These expenses may be for your spouse and other tax -qualified dependents as well as for yourself. Plan your amount carefully since the amount elected is an irrevocable election for the plan year.

The funds you contribute to the FSA will be deducted before taxes and will be deducted in equal amounts from each paycheck you receive throughout the year. The full amount of your payroll deduction election will be available to you for use on January 1.

As you incur eligible medical, behavioral health, dental, vision, and qualified over-the-counter expenses for yourself, your spouse, and your qualified dependents, you can either use your FSA debit card (which will be issued to you by the state's FSA claims administrator) to instantly pay for eligible expenses or submit a claim for reimbursement by filling out a Reimbursement Request Form or completing the form on-line at the claims administrator's website or you may pay out of your own funds and request reimbursement.

2.01 What dependents are covered under the FSA?

For purposes of the FSA or L-FSA, the term "dependent" means a person who is defined as such under IRC Section 152 (as further defined under Code Section 105 (b)). Additionally, any child to whom IRS Section 152 (e) (regarding divorced or separated parents) applies shall be deemed a dependent of the employee participating in the plan. This generally means that expenses incurred by the employee, the employee's spouse, the employee's child who has not attained age 27 as of the end of the employee's taxable year, or the employee's tax dependent for health coverage purposes may be reimbursed from the FSA or L-FSA. For this purpose, a "child" is an individual who is the employee's son, daughter, stepson, stepdaughter, individuals adopted or placed for adoption with the employee, and eligible foster child.

Additionally, the FSA or L-FSA will comply with any Qualified Medical Child Support Order ("QMCSO"). The plan will have in place reasonable procedures for determining the qualified status of a medical child support order and administer those provisions.

2.02 What expenses qualify for pre-tax reimbursement under the FSA?

This account enables you to be reimbursed for eligible out-of-pocket medical, behavioral health, dental, vision, and certain qualified, prescribed by a physician over-the-counter drug/medicine expenses incurred by you and your tax qualified dependents. Eligible expenses are generally those permitted by Section 213(d) of the Internal Revenue Code; that is, expenses which would qualify as a deductible expense on your income tax return. For reference, IRS Publication 502 also gives information on eligible expenses for tax returns. Remember that not all items listed in Section 213(d) are reimbursable under the FSA (e.g. insurance premiums, which were already taken out of your paycheck before taxes were calculated). In addition, the following conditions must apply:

- You cannot be reimbursed for the expense by any insurance plan or in any other manner
- You cannot deduct the expense on your income tax return
- You cannot be reimbursed for long-term care expenses
- You cannot be reimbursed for the cost of other health care coverage
- The expense must be incurred during your period of coverage

Here are some examples of expenses that may be reimbursed from your FSA:

• Deductibles and co-payments (not premiums) from the state-sponsored medical or dental plans
• Orthopedic shoes/arch supports
• Orthodontia and other dental expenses
• Transportation expenses for medical care
• Hearing aids
• Chiropractic services
• Nursing care
• Chemical dependency services
• Medical equipment and supplies
• Prescription drug copayments or coinsurance
• Wheelchairs
• Ambulance service
• Prescription eyeglasses or contact lenses
• Psychiatric care
• Contact lens cleaning solutions and supplies
• Over-the-counter drugs to treat a medical condition
• Feminine products including tampons, pads, liners, cups, sponges or similar product used by individuals with respect to menstruation or other genital-tract secretions

The following expenses are specifically excluded from reimbursement (representative list only, not meant to be all-inclusive):

- Air Conditioners (wall units or central air systems)
- Whirlpools
- Gym Memberships
- Veneers
- Teeth Whitening

Refer to eligible healthcare expenses from IRS Publication 502 or www.optumbank.com/Tennessee. Some of these may be covered with a letter of medical need from your physician

2.03 When is an expense incurred?
You incur an expense on the date that the service is provided, not when the expense was paid. .

2.04 What is my period of coverage?
Your period of coverage is the period between the effective date of coverage as defined in Article I, Section 1.06 and December 31 unless you terminate coverage before December 31. You may only be reimbursed for eligible expenses that occur between your effective date and the end of the plan year or your termination date, whichever occurs first.

2.05 Are insurance premiums eligible for pre-tax reimbursement under this account?
No. Insurance premiums are not eligible for reimbursement from the FSA. Remember that health and dental premiums deducted from your check are already taken pre-tax. The IRS prohibits insurance premiums from being reimbursed through an FSA.

2.06 Can I change the amount I am contributing to the FSA during the year?
Generally, no—you cannot begin, stop, or change your election during the year. The election you make during Open Enrollment is irrevocable and you must decide at that time how much you wish to contribute to your FSA for the upcoming year. However, there are some exceptions to this rule as specified in the federal regulations that allow a change or mid-year enrollment.

2.07 What status changes allow mid-year election changes?
According to federal rules, a status change occurs when a change in one or more of the following categories affects eligibility for insurance coverage:

(A) Change in employee's legal marital status
  (1) Marriage
  (2) Divorce, legal separation, annulment, death of spouse

(B) Change in number of employee's dependents
  (1) Birth, adoption, or placement for adoption
  (2) Death of dependent

(C) Change in employment status of employee, spouse, or dependent that affects eligibility
  (1) Termination or commencement of employment
  (2) strike or lockout
  (3) commencement of or return from an unpaid leave of absence

(4) a change in worksite
(5) switching from salaried to hourly, union to non-union or full-time to part-time (or vice versa)
(6) incurring a reduction or increase in hours of employment
(7) any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit

(D) Return to work from unpaid leave of absence (If an FSA election was made prior to the commencement of your unpaid leave of absence and you continued and paid your FSA while on the unpaid leave, that original election is reinstated upon your return to work unless another status change occurred allowing an election change.)

(E) Termination and rehire within 30 days (The original FSA election amount at time of termination is reinstated)

(F) Termination and rehire after 30 days – employee can make new elections (the new election cannot be less than the amount the employee had contributed through payroll contributions nor less than the amount the employee had been reimbursed for eligible expenses)

(G) Commencement or termination of employment by employee, spouse or dependent that triggers ineligibility (terminated employee may not decrease election). Coverage is revoked unless COBRA is elected.

(H) Event causing employee's dependent to satisfy or cease to satisfy eligibility requirements
(1) Attaining a specified age
(2) Family Medical Leave Act (FMLA) leave
(3) Judgments, decrees or orders
(4) Entitlement to Medicare or Medicaid (not Medical Assistance)

Important qualification: You may use the status change as a reason to start or adjust your contribution amount during the year if, and only if, the mid-year election change is consistent with the status change that affects eligibility for insurance coverage under the plan.

If you have an employment change that affects your benefits eligibility through the state-sponsored health insurance plans, you can submit an enrollment form to Benefits Administration. You can only make changes prospectively (going forward from the date of the event), and the change is effective on the first day of the pay period in which the form was received.

For example, if you elect $1,000 effective on January 1 and on June 1 get married and increase your election by $500, you will now have a total election of $1,500. The additional $500 can only be used for expenses incurred from June 1 through December 31. If the status change allows a reduction in
your FSA election, your new election amount cannot be less than the amount you have been reimbursed through the plan or contributed to the plan.
Further, any changes in status must be permitted under the Internal Revenue Code.

2.08 What about mid-year enrollment for new employees?

New employees who are insurance eligible must enroll within 31 days from the date of employment, re-hire, or reinstatement. Employees who become eligible mid-year must enroll within 31 days of becoming eligible.

2.09 How do I submit requests for reimbursement?

Eligible FSA expenses can be reimbursed by (1) entering reimbursement requests on-line at the FSA claims administrator's website, (2) completing the paper reimbursement request Form, or (3) using your flexible spending account debit card for automatic payment at participating vendors (remember to keep receipts, itemized statements, and explanation of benefits (EOBs) as you may be asked by the claims administrator to substantiate (prove) an expense paid using your debit card).

The first option is to enter your reimbursement request online. After entering the request online, the documentation to substantiate the request can then be uploaded to the claims administrator's website or faxed or mailed to them (see the section on acceptable documentation). All on-line claims entry must be completed, and documentation uploaded and/or received by the claims administrator by the plan year claim submission deadline of April 30th of the following year. Up to $500 (maximum) of unused funds in the medical FSA and L-FSA may be carried over into the next plan year.

If you do not upload the documentation to the website, after checking your documents for accuracy and legibility, fax or mail them to the claims administrator. Be sure to keep copies of all documents submitted. This will ensure you have adequate records to support your claim in the event of an IRS inquiry, or should your envelope be lost in the mail. Be sure to submit all necessary documentation.

If you prefer, the second option for receiving reimbursement for your eligible FSA expenses is to complete a Reimbursement Request Form. Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form either via fax or mail. Attach a statement from the provider indicating the date the service was provided, a description of the service, and the charge for the service (see the section on acceptable documentation). Reimbursement forms are available on the claims administrator's website.

If you submit requests for reimbursements either on-line or using the reimbursement form, expenses will be reimbursed to you weekly if you are a University of Tennessee employee; all other higher education and state employees are reimbursed daily. If you do not receive reimbursement within two weeks of submitting your request and you have not been notified of the denial of your claim, contact the claims administrator.

The third way to access funds is to use your flexible spending account debit card. The debit card will reimburse up to the available FSA balance, including any carried over funds, if applicable. When the card is used, the merchant is paid the full amount of the charge (not to exceed the account balance) and your FSA is reduced by the same amount. When you use your debit card for reimbursement, you are certifying that the debit card is being used only for eligible medical expenses for yourself and/or your eligible dependents and that the expenses paid with the card have not been and will not be reimbursed by another health plan. You should

not use the debit card to pay for expenses whose date of service is from a previous plan year, regardless of the billing date by the provider. If you do so in error, please contact the claims administrator for assistance.

2.10 Using the Flexible Spending Account debit card correctly

You must acquire and retain documentation for any expense paid with the debit card (e.g. itemized invoices or Explanation of Benefits statements) in case you are asked to verify the expense (per IRS Regulations). The advantage to the debit card is that you do not have to pay out of pocket and then wait for reimbursement. It does not eliminate the IRS requirement for documentation and does not make the process paperless. If you use your flexible spending account debit card for an eligible purchase and later return that item, the merchant should return the amount to that debit card. If the merchant does not credit your debit card but rather refunds you directly, you are responsible for the overpayment. You will need to contact the claims administrator to explain the situation and make arrangements to repay your account. Remember, use of the debit card for FSA eligible expenses does not absolve you of responsibility to comply with IRS rules and regulations.

2.11 Providing debit card transaction substantiation

If the claims administrator requires additional information regarding a debit card purchase, they will send you a letter requesting additional information. You will have 21 days to respond to their request. If the claims administrator does not receive a response from this first inquiry, a second request will be sent to you. You will be given an additional 21 days to respond to their second request. If you do not respond to this second request, your debit card will be de-activated. To have the debit card reactivated, you must respond to the claims administrator's letter and supply the requested information. As an IRS approved flexible benefits administrator, remember that the claims administrator is required to receive substantiating documentation from plan members for expenses before processing and allowing payment. If the requested information is not provided to the claims administrator by the timeframes described above, you will need to either repay the amount of that debit card transaction or submit a substitute claim to offset the amount.

In addition, if your card is on hold for a debit card transaction and you submit a manual claim for reimbursement, your claim will automatically be used to offset the transaction for which the card is on hold (as long as the on hold transaction and the date of service on the manual claim occurred in the same plan year). Further, if the FSA claims administrator contacts you to request substantiating documentation for a claim and you do not provide the requested information in a timely manner, your debit card may be placed on hold until such documentation is provided. This means that your debit card will not work when you attempt to use it at a pharmacy, physician's office or similar. If the substantiation, repayment, or offset is not provided, the amount may be included as wages on your W-2.

Acceptable documentation

Acceptable documentation is an itemized receipt or Explanation of Benefits (EOB) that reflects the actual date of service or product purchase, description of service or product, and patient portion of the charges. Please note that the following are not sufficient forms of documentation for most expenses: cancelled checks, copies of checks, cash register/credit card receipts, credit card

statements, predetermination or estimate of insurance benefits forms, balance forward statements, statements from your dentist or other provider that say, "estimated insurance amount," and balance due statements.

Should you lose your card, if it is stolen or if you need additional cards for dependents, a replacement card will be provided one time at no cost. You can order additional cards beyond the first replacement for a fee.

Over the Counter (OTC) Medicines

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, allows that OTC medications and products purchased on or after January 1, 2020 are reimbursable, allowed expenses that do not require a prescription in order to be covered and paid by a healthcare FSA. If your debit card is not accepted for an allowed expense, you will need to file a claim with the FSA claims administrator for reimbursement. Use the paper reimbursement form or complete the on-line request for reimbursement through the claims administrator's website. A copy of your receipt must accompany either method.

2.12 How are expenses paid through the FSA?

When you incur an eligible medical, dental, vision, or over-the-counter expense and submit the claim to the claims administrator, payment will be deducted from your account.

The plan will pay the lesser of:

• The amount of the expense you are submitting, or

• The total amount you have elected to contribute to your FSA for the year (plus applicable carry over funds), reduced by any previous claims paid from the account during the plan year.

You may only be reimbursed for eligible expenses that occur between your effective date and the end of the plan year or your termination date, whichever occurs first.

2.13 Is there a minimum reimbursement request amount?

If you are submitting requests for reimbursement either on-line or using the reimbursement form, there is no minimum reimbursement amount. The debit card also has no minimum reimbursement amount.

There is no need to wait until the end of the year to submit reimbursement requests. The entire amount for which you enrolled is available from the first day of your participation during the plan year.

2.14 Can I get cash out of my account for reasons other than expense reimbursement?

No. Under federal rules, you can only get money out of the account for reimbursement of eligible expenses. In addition, amounts deposited in one account cannot be used to reimburse expenses from another account.

2.15 What is the last date I can submit a request for reimbursement?

The deadline for submitting reimbursement requests for the current plan year, whether submitted by mail, fax, or online, is April 30th of the following year. All reimbursement requests must be entered with documentation uploaded and/or paper claims successfully faxed or mailed by this date. Requests for reimbursement postmarked or faxes received after the deadline will not be processed. If submitting your reimbursement request on the claims administrator's website, after completing the reimbursement request online, follow the directions to fax or mail

in your documentation. Be sure to keep a copy of your online confirmation of submission. All necessary documentation must be submitted to the claims administrator by the plan year deadline of April 30th.

2.16 If I have money left in my account at the end of the year, can it carry forward into the next year?
Yes, up to a certain amount. In accordance with IRS regulations and effective with the 2017 plan year, the FSA now includes a carryover feature. The IRS allows up to $500 to carry over from one plan year to the next. Therefore, if you are an active participant in the 2021 FSA plan on December 31, 2021 any funds in your account up to and including $500 of unreimbursed money will carry over from your 2021 FSA to be used in 2022. If your balance at the end of the plan year is greater than $500, any funds remaining in the account over the $500 carryover limit will be forfeited. These are IRS rules. However, if you carryover funds from one plan year to the next and participate in a CDHP in the next year, you will not be eligible to contribute to an HSA.

2.17 Should I be concerned about forfeiting money if I cannot claim it?
You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you still may come out ahead. For example, if you would otherwise pay 30 percent in federal, state, and social security taxes, it is fair to say that you save 30 percent on any expenses you pay with pre-tax dollars through this plan. Therefore, if you deposit $1,000 into your account and you forfeit $100, you are still $200 ahead because you have saved approximately $300 in taxes.

2.18 What happens to forfeited money?
IRS rules allow forfeited funds to be used by the employer to help offset the expense of administering the plan. The state's claims administrator does not profit from forfeitures. Rather, these funds remain with the employer group as the plan administrator of the FSA benefits for state employees and higher education employees. Any forfeited funds are used by the employer group for administrative costs associated with operating the FSA plans.

2.19 What if I terminate employment during the year and still have money left in my account?
If you terminate employment during the year, your period of coverage under the FSA will end on your employment termination date. Expenses incurred only during your period of coverage can continue to be submitted for reimbursement until 90 days after your termination date.

Tips to Prevent Forfeiture If You Over-Estimate
By December 31st of each year (for you and your family):
• Get eye exams
• Buy a pair of glasses or prescription eyeglasses
• Stock up on contact lenses
• Get your teeth cleaned
• Fill prescriptions early, before the end of the year if able

Expenses incurred after your termination date will not be reimbursed.

Federal regulations (COBRA), allow you to continue participation in the FSA and L-FSA by electing to continue contributions to the plan through monthly payments, on an after-tax basis. You will receive notification of your right to continue and how to make the appropriate election upon termination of employment.

2.20 What if the account holder or employee dies during the plan year?

Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for the participant and covered eligible dependents. All claims for the participant or a dependent must be for the date of death or prior and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90-day period will be forfeited. If the covered spouse or dependent elects COBRA coverage on the FSA through the claims administrator and pays the required monthly premiums to the claims administrator, claims may continue to be incurred by the spouse and any dependents until the end of the plan year or until funds from the healthcare FSA are exhausted.

2.21 What rules apply if I choose to continue participating in the FSA after ending my employment with the State of Tennessee or a participating higher education institution?

(A) You must be qualified. The following people qualify for continuation:

An employee (and any covered dependents) whose coverage would otherwise end due to: (1) termination of employment for a reason other than gross misconduct (2) reduced hours.

An employee's surviving spouse and/or children, whose coverage would otherwise end due to the employee's death, divorce or children who lose their dependent status.

Exception: Continuation is not available to any employee, spouse, or dependent who as of the date of the status change has "overspent" the FSA. An account is overspent when more dollars have been reimbursed than have been deducted from a participant's paycheck as of the status change.

(B) You must pay the monthly cost. A person who elects continuation will be required to pay the entire cost of the continued coverage plus any administrative fees that your employer (state or higher education institution) has been paying to the claims administrator on your behalf. For instance, if you have a bi-weekly payroll deduction of $25.00 then the monthly COBRA

premium due to the claims administrator would be $50.00 plus any additional administrative fee charged by the claims administrator.

(C) Your continuation period is limited. Continued coverage under the FSA will end on the earliest of the following dates for qualified persons described above:

(1) The end of the plan year, December 31, (see exception below); or

(2) The end of the period for which a contribution is paid, if the required contribution is not paid on a timely basis; or

(3) The date this plan is terminated, if ever.

Please see the end of this section for the Formal COBRA Notice for FSA Participants.

2.22 What happens if I take a leave of absence or a voluntary reduction of hours?

If during the leave of absence, you continue to receive regular pay, sick pay, or vacation pay from the State of Tennessee or a participating higher education institution, your contributions to and coverage under the FSA will

continue. If you are in an active pay status, then you will stay enrolled until you terminate or at the end of the plan year.

When you return to work, you can change your election amount due to a qualified status change, if applicable. Otherwise, your remaining pledge balance will be recalculated based on the number of paychecks remaining in the year and payroll deductions will resume. The event of returning to work is not a qualifying reason to make a change in your election. The election change must be consistent with the status change. Your deductions will be adjusted to reflect the new amount. If you had a qualified status change and wish to change your FSA election upon returning to work, you must complete a Flexible Benefits Family Status Change Application to adjust your election. This form must be received by Benefits Administration within 31 days of your return to work date.

2.23 What will happen to my FSA when I retire?

When you retire, your period of coverage will end on your retirement date and any unclaimed funds will be forfeited. You are also eligible to enroll in COBRA. You cannot change your annual election amount at this time, and once you have retired, you cannot enroll during Open Enrollment for the following year. Details of COBRA eligibility for groups other than retirees is discussed later in this document.

If you want to extend your participation in the FSA when you retire

You can elect and pay COBRA continuation payments until you can submit expenses for the election amount. Extending your period of coverage will give you more time to incur eligible expenses, thus providing you with more opportunity to claim reimbursements from your account. If you elect to pay COBRA payments through the balance of the plan year in which you retire, you may be eligible to have up to $500 of the unused balance in your account carry over to the new plan year. In this situation, the funds may be used on dates of service up to 18 months following your retirement date, or until the funds are depleted - whichever occurs earliest.

If you choose to terminate your FSA

If you decide to terminate your account, your last day of coverage is your retirement date. If you have not incurred enough expenses to meet or exceed the balance remaining in your account, those funds will be forfeited. Expenses incurred after the period of coverage has ended are not eligible for reimbursement. (Even if you have contributed money and not used it, you cannot be reimbursed for a claim that takes place after your coverage period.)

2.24 Are pre-tax reimbursements through this plan better than tax deductions or tax credits on my tax return?

On your federal tax return, only your uninsured medical, behavioral health, dental and vision expenses in excess of 10 percent of your adjusted gross income are deductible. However, under the FSA, up to $2,750 of your uninsured medical, behavioral health, dental, vision and over-the-counter expenses can be paid with pre-tax dollars. In addition, under current law, you don’t pay Social Security taxes on dollars directed to your FSA. Therefore, if you expect to incur uninsured medical and dental expenses, paying for them through the FSA is likely to be more advantageous than taking a deduction for those expenses on your tax return – particularly if your medical expenses paid out-of-pocket do not exceed 10 percent adjusted gross income (AGI).

2.25 Who is responsible if I get reimbursed by this plan and also get reimbursed from another source and/or claim a reimbursed expense on my tax return?

You are. Duplications of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. Your employer does not monitor your personal income tax and other financial affairs and will not attempt to do so. You should maintain adequate records to support your claims in the event of inquiry by the IRS and keep copies of all documentation sent to the claims administrator.

2.26 My spouse has a High Deductible Health Plan (HDHP) and wants to contribute to an HSA with his/her employer. Can I enroll in FSA and maintain my spouse's eligibility in the HSA?

In this situation you may only enroll in a limited-purpose FSA. IRS rules surrounding a HDHP stipulate that in order to be eligible to contribute to an HSA, the individual cannot have access to, or enroll in, a FSA. You can, however, elect to have a "limited purpose" FSA (L-FSA) that can be used to reimburse up to $2,750 in eligible dental or vision expenses. This L-FSA allows your spouse to still

maintain HSA eligibility. If you want to enroll in the L-FSA, you may do so each fall during the Annual Enrollment period or within 31 days of your hire date.

In addition, if your eligible dependent is employed elsewhere and is eligible to contribute to an HSA and their expenses could potentially be submitted under your or your spouse's FSA that is not limited to dental or vision expenses through the end of the year they turn 26, your dependent is not eligible to make or receive HSA contributions.

2.27 Formal COBRA Notice for FSA Participants

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Plan will be entitled to the opportunity to elect a temporary extension of FSA coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

For the FSA and L-FSA, COBRA coverage will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the

annual limit elected by the employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for FSA or L-FSA COBRA coverage that will be charged for the remainder of the plan year.

2.28 What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right

to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

2.29 Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(A) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(B) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

2.30 What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(A) The death of a covered Employee.

(B) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(C) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(D) A covered Employee's enrollment in any part of the Medicare program.

(E) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or for retirees, in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a
Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

2.31 What is the Procedure for Obtaining COBRA Continuation Coverage?

Accept the continuation of coverage information when you receive it from the Claims Administrator and agree to pay all costs associated with COBRA continuation coverage as charged by the claims administrator.

2.32 What is the Election Period and How Long Must It Last?

The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA
coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

2.33 Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is

not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(A) The end of employment or reduction of hours of employment,

(B) Death of the employee,

(C) For retirees, commencement of a proceeding in bankruptcy with respect to the employer, or

(D) Enrollment of the employee in any part of Medicare.

The Plan Administrator will notify the Claims Administrator that the qualifying event has occurred.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

2.34 Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

2.35 When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(A) The last day of the applicable maximum coverage period.

(B) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(C) The date upon which the Employer ceases to provide any health plan reimbursement account (FSA) to any employee.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

2.36 What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

COBRA Continuation Coverage may extend up to 18 months. If you elect to continue coverage AND make all contributions for the plan year in which the Qualifying Event occurred AND have funds remaining in your account at the end of this plan year, the maximum coverage period for COBRA Continuation is 18 months after the Qualifying Event. If a qualified beneficiary on an 18-month COBRA extension is determined by the Social Security Administration (SSA) to have been disabled at any time during the first 60 days of COBRA coverage, the former employee and covered dependents may be eligible to continue coverage for an additional 11 months with an increase (150 percent of the total monthly premium) in payment after the 18th month. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage due to the same initial qualifying event, those nondisabled qualified beneficiaries will also be entitled to this 11-month disability extension. Dependents already insured may continue coverage under COBRA for 18 months based on the events listed for employees. Furthermore, dependents may continue coverage for an additional 18 months — maximum of 36 months — if coverage is lost due to one of the following events:

- The employee’s death
- The employee and spouse divorce
- A dependent child is no longer eligible as a dependent (over age 26 unless incapacitated)

For FSA and L-FSA, participants with underspent accounts can receive FSA and L-FSA COBRA coverage only through the end of the plan year in which the COBRA qualifying event occurs. However, qualified beneficiaries who continue COBRA coverage through December 31 of that plan year may carry over up to $500 of unused FSA and L-FSA amounts remaining at the end of the plan year, in accordance with the carry-over provisions set forth in this document, until the end of the 18, 29, or 36 month maximum COBRA coverage period that applies under the other medical plan or until the amounts are used up, if earlier.

2.37 Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

2.38 Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Other Than Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

2.39 What is Timely Payment for payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 45 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be
made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

2.40 How is My Participation in the FSA/L-FSA Affected?

You can elect to continue your participation in the FSA for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the FSA if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only
claimed $150, you may elect to continue coverage under the FSA. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above) to provide this benefit.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Claims Administrator.

2.41 KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

State of Tennessee
Division of Benefits Administration
312 Rosa L. Parks Ave, Suite 1900
Nashville, TN 37243

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

ARTICLE III

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DC-FSA)

The Dependent Care Flexible Spending Account (DC-FSA) allows you to pay for certain dependent care (daycare) expenses with up to $5,000 of pre-tax dollars. You participate in this program by enrolling during Open Enrollment. New employees must enroll within 31 days of employment, re-hire or reinstatement. Employees who become insurance eligible mid-year must enroll within 31 days of becoming eligible. You must enroll each year during Open Enrollment for each plan year in which you wish to participate. Re-enrollment does not occur automatically each year; you must take an active role to reenroll for the following year.

Important Note: The DC-FSA is for daycare type expenses. It does not cover medical or dental expenses for your tax-qualified dependents. Unreimbursed medical/dental expenses for your tax qualified dependents fall under the Flexible Spending Account (FSA).

When you enroll in the DC-FSA, you decide how much of your wages you wish to direct to this account to pay your dependent care (daycare) expenses while you are at work. The DC-FSA family maximum contribution is $5,000 per tax year (up to $2,500 per employee and $2,500 per spouse if filing jointly). The amount you contribute to the DC-FSA will be deducted in equal amounts from each paycheck you receive throughout the year. You may only submit dependent care eligible expense claims as funds are deducted from your paycheck and posted to your DC-FSA. In other words, the full amount of your annual payroll deduction election will not be available to you for use on January 1.

There is no minimum reimbursement amount. Special rules apply to children of divorced or separated parents and to married parents who are filing separate income tax returns. Persons in either of these circumstances should obtain the instructions to IRS Form 2441 and consult their tax advisor.

As you incur eligible dependent care (daycare) expenses, fill out a Reimbursement Request Form (found on the claims administrator's website), itemize your expenses including the name and Tax ID# of your dependent care provider (or social security number for an in-home provider), and either enter the information online, scan and upload the documentation or fax or mail it to the claims administrator. A reimbursement check will be mailed to your home or deposited directly in your bank account if you have signed up for direct deposit. (See the section titled How do I submit requests for reimbursement?)

3.01 Who is a qualified dependent under the DC-FSA?

You may incur expenses for a "Qualifying Individual"; that is

--a person under age 13 who is your qualifying child under the Internal Revenue Code (in general, the person (1) must have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling, or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);

--your spouse who is physically or mentally incapable of caring for himself or herself, has the same principal abode as you for more than half the year; or

--a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half the year, and is your tax dependent under the
Internal Revenue Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Internal
Revenue Code's definition).

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. Contact the Claims Administrator for more information.
If the expenses are incurred for a Qualifying Individual who is not under age 13 who is your qualifying child, then the Qualifying Individual must spend at least 8 hours per day in your household.
In addition, a qualified dependent must meet both of the following conditions:
1. Your home is the dependent's "principal abode" for more than one half of the year. Special rule for child of divorced or separated custodial parent. The child of a divorced or separated employee who has custody (more than 50% of the time) of the child is treated as a qualifying child of the employee.
2. He or she must be a citizen or resident of the United States or a resident of Canada or Mexico.
The qualified dependent cannot be the qualified dependent of any other taxpayer in the taxable year.

3.02 How much would the plan's tax savings increase my take-home pay?
Let's say a married employee, Pat, files jointly, and has a salary of $44,000 per year with two children. Pat's spouse also works and earns an annual salary of $38,000. Pat elects to contribute a total of $5,000 per year ($208.33 from each of 24 paychecks) to her DC-FSA. And, let's say Pat gets reimbursed for expenses equal to the amount Pat contributes during the year. The chart below illustrates Pat's savings under the plan.

Using the plan to pay dependent care (daycare) expenses on a pre-tax basis increases Pat's spendable pay by $1,485 per year. However, please note that without the plan, Pat would be eligible for a dependent care credit on her income tax return, and the tax advantages of the credit may outweigh the tax advantages of being reimbursed for dependent care expenses on a tax-free basis under this plan. See IRS Publication 503 Child and Dependent Care Expenses and/or consult with your tax advisor.

Sample Annual Tax Savings Comparison

	Without the plan	**With the plan**
Gross Salary	**$82,000**	**$82,000**
Pre-tax dependent care contribution	**-**	**(5,000)**
Adjusted gross income	**82,000**	**77,000**
Estimated income tax	**(12,617)**	**(11,514)**
Social Security (FICA) tax	**(6,273)**	**(5,891)**
Spendable income	**63,110**	**59,595**
Dependent care expenses paid	**(5,000)**	**-**

after tax		
Spendable income after taxes and dependent care expenses	**58,110**	**59,595**

3.03 What dependent care (daycare) expenses qualify?

The expenses must be necessary to permit you to be gainfully employed. If you are married, your spouse must be working in a job for pay or actively seeking employment, or be a full-time student, or be physically or mentally unable to care for himself/herself.

Expenses incurred while you are on paid leave, such as maternity leave, may be eligible for reimbursement under the plan if you are physically unable to care for your children while on such leave. An individual who is gainfully employed is not required to allocate expenses during short, temporary absences from work, such as for vacation or minor illness, when the care-giving arrangement requires the employee to pay for care during the absence. For this purpose, IRS regulations establish a "safe harbor" under which an absence of up to two consecutive calendar weeks is treated as a short, temporary absence.

The cost associated with kindergarten is not allowable since it is educational. Summer programs may be eligible for reimbursement under the plan as long as they are for custodial care. In general, if the institution providing the services documents them as education, they are not eligible. (A tuition charge on a bill will be deemed an educational expense.) If the institution provides you with documentation separating educational from other expenses, the childcare expenses will be eligible. Be sure to consult with the claims administrator if you have any questions about this issue. The cost of schooling for first grade or higher is not eligible for reimbursement under the plan. However, the cost of care provided before and after school is eligible.

If you have a regular dependent care (daycare) arrangement where you must pay a set weekly amount, even if you or your dependent are on vacation or are ill and your dependent is not receiving care, you may include those payments as an eligible expense under the plan. Expenses incurred for summer day camps are eligible as long as they are custodial in nature and not educational. Summer camp expenses involving any overnight stays are not eligible.

Only eligible expenses you incur during the plan year can be reimbursed.

3.04 When should I start, or increase contributions to, my DC-FSA for an expected baby?

This is an important question. If you or your spouse is pregnant during the Open Enrollment period, or if you or your spouse is a new hire, it is best not to include anticipated expenses for the child in your election. This holds true for an adoption as well. Wait to enroll in, or increase contributions to, a DC-FSA when the mother returns to work, or the adoption takes place.

Often times, parents find that their needs and plans change in unanticipated ways after the birth of a baby or adoption. For example, the mother may not return to work as soon as expected. If this happens to you, and

deductions are already coming out of your check, you may not be able to change your election and may end up forfeiting money.

3.05 When is an expense incurred?
You "incur" an expense on the date that the service is received, not when you receive or pay the bill.

3.06 What is my period of coverage?
Your period of coverage is the period between the effective date of coverage as defined in Article I, Section 1.06 and December 31 unless you terminate coverage before December 31. You may only be reimbursed for eligible expenses that occur between your effective date and the end of the plan year or your termination date, whichever occurs first.

3.07 What is the maximum amount of dependent care expenses that may be reimbursed through the DC-FSA?
The calendar year maximum for this plan is $5,000 in dependent care (daycare) expenses for one or more dependents. This is a family maximum set by the IRS, so if your spouse also participates in a dependent care expense account, your $5,000 maximum must be reduced by your spouse's dependent care contribution for the year.

If you are married and you and your spouse file separate federal income tax returns, not more than $2,500 of dependent care expense reimbursements for services provided during the year will be exempt from your tax. Any excess must be declared on your tax return as taxable income.

If you are married, reimbursements from your DC-FSA that exceed the earnings of the lower-paid spouse for the year must be reported as taxable income for that year. For example, if you receive $3,600 of dependent care reimbursements for expenses for services provided during a year and your spouse only earned $3,000 that year, the $600 excess must be declared as taxable income. This will be reported when you file your tax returns using forms 1040 and 2441.

For income tax purposes, the statement you receive each time you get a reimbursement check from the plan will show the amount you actually received from your DC-FSA for expenses incurred during the year. You should keep all receipts and you will need this information when you file your taxes and you will need to file Form 2441 with your 1040 tax return (or Schedule 2 with your 1040A return) to report the name of your care provider to the IRS.

Expenses that your spouse incurs while actively seeking employment are considered expenses that enable him or her to be gainfully employed. However, because of the statutory earned income limits, if your spouse does not find a job and has no earned income for the year, you may not qualify to receive reimbursements. And, if your spouse has worked for part of the year, the maximum income exclusion may be reduced as a result of your spouse's lack of earnings.

Here is an example: Let's say John is married to Susan, both of whom have full time jobs. John earns $60,000 per year, while Susan makes $35,000. They have always used John's employer (i.e. The State) to reimburse dependent care expenses for their child. A couple of months into the New Year, Susan is laid off. She looks for a new job but is not able to secure employment. At the end of the year, her earned income is only $2,500. However, during the year, John and Susan incurred $3,000 in child-care expenses while Susan was seeking employment and preparing resumes, contacting employers, going to job fairs, etc. Although John's DC-FSA allows him to be reimbursed for expenses incurred while actively looking for work, the statutory income limit nevertheless limits the amount that can be reimbursed to $2,500.

In order to have your dependent care (daycare) expenses reimbursed on a tax-exempt basis from this plan, you will have to give the name, address, and taxpayer identification number of your provider to the IRS when you file your federal income tax form. This requirement also applies if you are taking a dependent care credit on your personal tax return.

3.08 What qualifies as a dependent care eligible expense?

Daycare centers and private daycare providers in your home or outside of your home qualify as a provider of daycare.

In order to qualify as eligible expenses, the amounts you spend on dependent care must meet the following IRS rules:

- You may be reimbursed for charges for care services either inside or outside your home for eligible dependents under the age of 13. Services must be for the physical care of the child and must not be provided by a spouse or dependent.
- You may be reimbursed for charges for the care of a dependent adult or child who is mentally or physically incapable of self-care. To be eligible, services may not be provided by a spouse or dependent and the eligible dependent must regularly spend at least eight hours per day in your household.
- You may not use the Dependent Care Reimbursement Account to pay for a dependent's healthcare expenses. The account may not be used by a non-custodial parent to pay for childcare or child support payments.
- If you use the Dependent Care Reimbursement Account to pay for care or claim the Child or Dependent Care Tax Credit, you will need to file Form 2441 with your 1040 tax return (or Schedule 2 with your 1040A tax return) to report the name of your care provider to the IRS.

3.09 Can I change the amount I am contributing to my DC-FSA during the year?

Generally, no—you may not begin, stop, or change your contribution amount during the year. You must decide during Open Enrollment how much you wish to direct to your DC-FSA during the coming year. However, there are some specified status changes in the federal regulations that allow changes or mid-year enrollment status changes. Otherwise, flexible benefit enrollments are irrevocable during the plan year.

3.10 What status changes allow mid-year adjustments to my participation?

According to federal rules, a status change occurs when a change in one or more of the following categories affects eligibility for insurance coverage as described below:

(A) Change in employee's legal marital status

(1) Marriage

(2) Divorce, legal separation, annulment, death of spouse

(B) Change in number of employee's dependents

(1) Birth, adoption, or placement for adoption

(2) Death of dependent

(C) Change in employment status of employee, spouse, or dependent that affects eligibility

(1) Termination or commencement of employment

(2) strike or lockout

(3) commencement of or return from an unpaid leave of absence

(4) a change in worksite

(5) switching from salaried to hourly, union to non-union or full-time to part-time (or vice versa)

(6) incurring a reduction or increase in hours of employment

(7) any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit

(8) Unpaid leave

(9) Termination and rehire within 30 days (amount of election at the time of termination must be reinstated unless another event has occurred that allows a change)

(10) Termination and rehire after 30 days – employee may make new elections (the new election cannot be less than the amount the employee had contributed through payroll contributions nor less than the amount the employee had been reimbursed for eligible expenses)

(11) Commencement or termination of employment by employee, spouse, or dependent that triggers eligibility

Event causing employee's dependent to satisfy or cease to satisfy dependent eligibility requirements

- Attaining a specified age
- Becoming single or getting married
- Becoming or ceasing to be a student
- Family Medical Leave Act (FMLA) leave
- Significant dependent care cost increase or decrease – Note: No change can be made when the cost increase or decrease is imposed by a dependent care provider who is a blood relative of the employee.
- Addition or elimination of dependent care account through spouse's plan
- Change in coverage of spouse or dependent under other employer's plan (dependent care account)

Important note – Any changes in status must be permitted under the Internal Revenue Code.

3.11 What about mid-year enrollment for new employees?

New employees who are insurance eligible must enroll within 31 days of employment, re-hire, or reinstatement. Employees who become insurance eligible must enroll within 31 days of becoming eligible. The effective date of coverage is prospective. Retroactive enrollment is prohibited.

3.12 How do I submit requests for reimbursement?

Eligible DC-FSA expenses can be reimbursed by (1) entering reimbursement request on-line at the claims administrator's website or (2) completing the Reimbursement Request Form located on the claims administrator's website.

Enter your reimbursement request online and either upload the documentation to the website or fax or mail the documentation to the claims administrator. If you do not upload the documentation to the website, after checking your documents for accuracy and legibility, you may fax or mail them to the claims administrator. Be sure to keep copies of all documents submitted. All on-line claims entry must be completed, and documentation uploaded and/or received by the claims administrator by the plan year claim submission deadline of April 30th of the following year.

If you prefer, you may receive reimbursement for your eligible DC-FSA expenses by completing a Reimbursement Request Form. Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form. The Reimbursement Request Form along with documentation can be faxed or mailed to the claims administrator.

Be sure to keep copies of all documents submitted. This will ensure you have adequate records to support your claim in the event of an IRS inquiry, or should your envelope be lost in the mail.

Be sure to submit all necessary documentation so that it is received by the claims administrator by the plan year claim submission deadline of April 30th of the following year.

You cannot be reimbursed for daycare expenses until after expenses have been incurred (after the end of the week or month for which you are submitting expenses). Reimbursements will be made daily, with the exception of the University of Tennessee, which will be weekly.

You may only be reimbursed for eligible expenses that occur from your effective date until the end of the plan year or your termination date, whichever occurs first.

3.13 What is the last date I can submit requests for reimbursement?

Your final reimbursement request for expenses incurred during the plan year must be received by the claims administrator by the plan year claim submission deadline of April 30th of the following year. There is no carryover provision for the DC-FSA, so any funds remaining in your account after April 30th will be forfeited

per IRS rules. Requests for reimbursement or faxes received after the deadline will not be processed and any money remaining in your account will be forfeited as required by federal law.

3.14 How are dependent care expenses paid through the DC-FSA?

When you incur an eligible dependent care expense you can pay your provider by utilizing the claims administrator's online feature to pay your provider directly from your account. You may also pay for eligible expenses with cash, check or your personal credit card, then submit a claim to pay yourself back. You can even have your claim payment deposited directly into your checking or savings account. The claims administrator even offers a mobile app that allows you to manage your account, view alerts, and snap a photo of your receipts and upload them to submit claims.

The plan will pay the lesser of:

- The amount of the expense you are submitting, or
- The total amount that has been contributed to your DC-FSA to date, reduced by any previous claims paid from the account during the plan year.

If there is not enough money in your DC-FSA to pay all the expenses you have submitted during a payment period, the excess expenses will be carried forward and paid from the deposits you make in subsequent periods.

3.15 Can dependent care expenses be paid with the debit card?

No, the debit card may only be used to pay for eligible expenses of the medical FSA or the L-FSA.

3.16 Is there a minimum reimbursement request amount?

There is not a minimum reimbursement amount. There is no need to wait until the end of the year to submit reimbursement requests.

3.17 Can I get cash out of my account for reasons other than expense reimbursement?

No. Under federal rules, you may only get money out of the account for reimbursement of eligible expenses. Also, amounts deposited in one account cannot be used to reimburse expenses from another account.

3.18 If I have money left in my account at the end of the year, can I carry it forward into the next year?

No. Expenses incurred during one plan year cannot be reimbursed with money contributed in another plan year. Furthermore, according to federal law, any funds remaining in your account at the close of the plan year will be forfeited. (See the section titled "What is the last date I can submit a request for reimbursement?" for more detail regarding the final deadline.)

3.19 Should I be concerned about forfeiting money if I can't claim it?

You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you may still come out ahead. For example, if you would otherwise pay a total of 30 percent in federal, state, and social security taxes, it's fair to say that you save 30 percent on any expenses you pay with pre-tax dollars through this plan. Therefore, if you deposit $1,000 into your account and you forfeit $100, you're still $200 ahead because you've saved approximately $300 in taxes.

3.20 What happens to forfeited money?

Forfeited money is retained by the employer group to help offset the expense of administering the plan. The claims administrator does not profit from forfeitures.

3.21 What if I terminate employment during the year and still have money left in my account?

If you terminate employment during the year, your period of coverage under the DC-FSA will end on your employment termination date. Expenses incurred only during your period of coverage can continue to be submitted for reimbursement until 90 days after your termination date.

3.22 What will happen to my DC-FSA when I retire?

If you terminate employment while participating in a DC-FSA and you have money in your account, you will forfeit those funds. You should spend any funds in your account prior to terminating employment.

3.23 What if the account holder or employee dies during the plan year?

Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for the participant and covered eligible dependents. All dependent care claims must be on or before the participant's date of death and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90-day period will be forfeited.

3.24 What happens if I take a leave of absence?

If during the leave of absence, you continue to receive regular pay, sick pay or vacation pay, your contributions to and coverage under the DC-FSA will continue. You may discontinue DC-FSA contributions during the leave if your dependent care expenses during that time would not qualify for reimbursement. To discontinue DC-FSA contributions during your paid leave, please complete a Flexible Benefits Family Status Change Application form found on Benefits Administration's website: http://www.tn.gov/finance/article/fa-benefits-forms.

3.25 Are there any general guidelines as to whether pre-tax reimbursements through this plan are better than tax deductions or tax credits on my tax return?

Due to the increasing complexity of the Federal and state tax codes, deciding which of these two options is most advantageous is a very complex issue. Generally, the more taxable income a person has, the greater the likelihood that the DC-FSA will result in the greatest tax advantage. However, there are other factors to consider, such as the number of eligible dependents you have, or the amount of qualifying dependent care expenses you incur. If you have one eligible dependent, up to $3,000 of qualifying expenses may be used to calculate the credit, alternatively, you could set aside up to $5,000 in the DC-FSA. If you have two or more eligible dependents, up to $6,000 of qualifying expenses may be used to calculate the credit, while you can still only set aside up to $5,000 in the DC-FSA. For more information, consult with a qualified tax advisor or professional.

Your own tax advisors should be consulted to help you determine whether the tax credit or paying dependent care expenses through the plan on a pre-tax basis is better for you. Neither the plan administrator, your employer, nor the claims administrator is permitted to give advice about personal income tax matters.

A detailed explanation of how dependent care expenses may be used for federal tax credit purposes can be found in IRS Publication 503.

3.26 What is the federal dependent care tax credit? Can I use it as well as this plan for dependent care expenses?

This tax credit is a percentage of your eligible dependent daycare expenses, up to $3,000 per year for one dependent and $6,000 for two or more dependents. The actual percentage depends on your income level. For more information, you should consult your qualified tax professional.

3.27 What about earned income tax credits (EIC)?

Earned income tax credits are available to lower income taxpayers. Under current law, three different credit amounts apply, depending on whether the taxpayer has one, two or more, or no qualifying children.

Participating in the DC-FSA could affect the amount of your earned income credit. For more information about EIC see IRS Publication 596.

3.28 Who is responsible if I get reimbursed by this plan and also get reimbursed from another source and/or claim a reimbursed expense on my tax return?

You are. Duplications of reimbursements attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. Your employer does not have the means to monitor your personal income tax and other financial affairs and will not attempt to do so. You should maintain adequate records to support your claims in the event of inquiry by the IRS and keep copies of all documentation sent to the claims administrator.

ARTICLE IV
LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (L-FSA)

Eligible state and higher education employees may choose to enroll in a limited purpose flexible spending account. This type of FSA allows for reimbursement or payment of qualified vision and dental expenses (only). No medical payments are allowed from this type of FSA.

The limited purpose flexible spending account (L-FSA) is provided for state and higher education employees who are enrolled in the consumer directed health plan (CDHP). Eligible employees may contribute up to $2,750 in pre-tax funds in order to save on certain IRS approved vision and dental expenses. For instance, if you are enrolled in a CDHP you must pay all plan expenses up to your plan's applicable deductible and then you are responsible for coinsurance. When you enroll in a CDHP, a health savings account (HSA) is opened for you with the state group insurance program's contracted partner for HSA services. Because you and/or your employer may fund your HSA with pre-tax dollars, you are not allowed to open a regular healthcare FSA. This is called "double dipping" and it is not allowed per IRS rules. However, for plan members or those with families who anticipate large dental (e.g. orthodontia) or vision expenses during the year or possible certain vision or dental expenses not covered by insurance (e.g. LASIK), you may fund up to $2,750 in your L-FSA to pay for those expenses. The full amount of your payroll deduction election will be available to you for use on January 1.

Expenses may be paid at many dental and vision providers using your L-FSA debit card or you may go online and pay your provider by utilizing the claims administrator's online feature to pay your provider directly from your account. Or you may pay for eligible expenses with cash, check or your personal credit card, then submit a claim to pay yourself back. It is best, however, not to use your debit card to pay for vision or dental expenses at the time of service. Rather, let your provider file the claim through your insurance, then after you get an explanation of benefits (EOB) from your insurance, you can either call your provider and pay over the phone using your debit card or file a claim to pay your provider. It is best to have an EOB in case your debit card is used, in order to provide substantiating documentation to the claims administrator. You can even have your claim payment deposited directly into your checking or savings account. The claims administrator even offers a mobile app that allows you to manage your account, view alerts, and snap a photo of your receipts and upload them to submit claims.

4.01 If I have money left in my account at the end of the year, can it carry forward into the next year?

Yes, up to a certain amount. In accordance with IRS regulations and effective with the 2017 plan year, the L-FSA now includes a carryover feature. The IRS allows up to $500 to carry over from one plan year to the next. For example, if you are an active participant in the 2021 FSA plan on December 31, 2021 and contributed your full election amount, up to $500 of unreimbursed money will carry over from your 2021 L-FSA to be used in 2022. If your balance at the end of the plan year is greater than $500, any funds remaining in the account over the $500 carryover limit will be forfeited. These are IRS rules.

4.02 Should I be concerned about forfeiting money if I cannot claim it?

You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you

still may come out ahead. For example, if you would otherwise pay 30 percent in federal, state, and social security taxes, it is fair to say that you save 30 percent on any expenses you pay with pre-tax dollars through this plan. Therefore, if you deposit $1,000 into your account and you forfeit $100, you are still $200 ahead because you have saved approximately $300 in taxes.

4.03 What is my period of coverage?

Your period of coverage is the period between the effective date of coverage as defined in Article I, Section 1.06 and December 31 unless you terminate coverage before December 31. You may only be reimbursed for eligible expenses that occur between your effective date and the end of the plan year or your termination date, whichever occurs first.

4.04 What happens to forfeited money?

IRS rules allow forfeited funds to be used by the employer to help offset the expense of administering the plan. The state's claims administrator does not profit from forfeitures. Rather, these funds remain with the state as the plan administrator of the FSA benefits for state employees and higher education employees. Any forfeited funds are used by the state for administrative costs associated with operating the FSA plans.

4.05 What if I terminate employment during the year and still have money left in my account?

If you terminate employment during the year, your period of coverage under the L-FSA will end on your employment termination date. Expenses incurred only during your period of coverage can continue to be submitted for reimbursement until 90 days after your termination date. You would be eligible to continue participation under the federal COBRA benefit laws, but you would be required to pay the monthly cost associated with maintaining an open account with the claims administrator. For more details, see the earlier question "What rules apply if I choose to continue participating in the FSA after ending my employment with the State of Tennessee or a participating higher education institution?"

4.06 What if the account holder or employee dies during the plan year?

Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for the participant and covered eligible dependents. All claims for the participant or a dependent must be for the date of death or prior and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90-day period will be forfeited. If the covered spouse or dependent elects COBRA coverage on the limited purpose FSA through the claims administrator and pays the required monthly premiums to the claims administrator, claims may continue to be incurred by the spouse and any dependents until the end of the plan year or until funds from the limited purpose FSA are exhausted.

ARTICLE V

PARKING AND TRANSPORTATION REIMBURSEMENT PLAN (STATE EMPLOYEES ONLY)

The Parking & Transportation (P&T) Reimbursement Plan (for state employees only) is another way to get the most money from your paycheck. The plan allows you to pay for qualified work-related transportation expenses with money that is sheltered from taxes by deducting the funds from your pay before it is taxed. Since less of your pay is taxed, you should come out ahead at the end of the year. This plan is governed under Section 132 of the Internal Revenue code and therefore, certain rules and guidelines apply, so be sure you fully understand the program before you choose to participate.

The P&T Reimbursement Plan allows for reimbursement for eligible parking & transportation expenses for parking and mass transportation. Some examples of eligible expenses are out-of-pocket costs that you pay for parking and bus pass expenses, vanpool expenses, and/or light rail while commuting to and from work. Claims processing for the parking & transportation reimbursement program is handled by the Division of Benefits Administration.

5.01 Who is eligible for the plan?

Any State of Tennessee employee who has transportation expenses may participate in the P&T Reimbursement Account. Claims for your parking FSA and/or transportation FSA may only be incurred by yourself, as the state employee, as part of your daily parking at work or transportation to and from work. Expenses for other family members (spouse, children) are not allowed.

5.02 What is my period of coverage?

Your period of coverage is the period between the effective date of coverage as defined in Article I, Section 1.06 (D) and December 31 unless you terminate coverage before December 31. You may only be reimbursed for eligible expenses that occur between your effective date and the end of the plan year or your termination date, whichever occurs first.

5.03 How it works

Unlike Medical and Dependent Care Flexible Benefits Accounts, there is no requirement for new employees to enroll within 31 days of being hired and there is no annual enrollment period for employees. A state employee may enroll in a Transportation Account and/or a Parking Account at any time during employment.

An employee may enroll by completing the appropriate form and faxing to 615-741-8196. The form can be accessed at https://www.tn.gov/partnersforhealth/other-benefits/flexible-benefits.html.

If you sign up for the plan during Open Enrollment AND you are on payroll on January 1, you will be able to start using the plan on January 1. State employees may enroll in the parking & transportation expense plan at any time. For parking & transportation (state employees only), the effective date will be the first of the month following the date that your parking & transportation enrollment form is received by the Division of Benefits Administration.

5.04 Will my enrollment in this program automatically continue from year to year?

Yes. Once you enroll in the Parking & Transportation reimbursement program, you will stay enrolled until you decide to disenroll.

5.05 What is the monthly maximum contribution amount for parking and transportation accounts?

The maximum contribution amount is:

- $270 for the parking account, and
- $270 for the transportation account

Note: Because both accounts are pre-tax benefits, the IRS determines the maximum contribution amount and can change the limit from year to year.

5.06 What if my parking or transportation balance is greater than the monthly maximum contribution amount?

For both the parking and transportation accounts, you can't spend more than the monthly maximum contribution amount for each account. This means:

- you can't spend more than $270 of your parking account funds in a month, even if you have a balance greater than $270; and
- you can't spend more than $270 of your transportation account funds in a month, even if you have a balance greater than $270

Remember, you can change your monthly election amount or dis-enroll at any time during the plan year.

5.07 Can I combine my parking and transportation contributions?

You cannot combine the funds or move funds from one account to another. Contributions for parking and transportation accounts are separate.

5.08 Filing Claims and Getting Reimbursed

When you have incurred transportation or parking expenses, submit a Transportation and Parking Reimbursement Request Form to Benefits Administration along with a receipt from the service provider that includes the date of service, the name of the provider and the amount charged. Canceled checks, credit card statements and bank statements are not acceptable as a receipt of the service incurred. You may submit a P&T claim by emailing it to Benefits.Info@tn.gov or faxing it to 615-741-8196.

Sample Paycheck Comparison

	Without the PDA	**With the PDA**
Gross salary	$28,000	$28,000
Bus pass expenses paid	0	(300)
Taxable compensation	$28,000	$27,700
Estimated income tax (2014 Federal and State)	(3,179)	(3,118)
Social Security (FICA) tax	(2,142)	(2,119)
Compensation after tax	$22,679	$22,463
Bus pass expenses paid after tax	(300)	0
Spendable income after taxes and bus pass expenses	$22,379	$22,463

Employees who have an available account balance in a Transportation or Parking Account as of December 31st will have until April 30th of the following year to claim the remaining funds. However, the expenses must have been incurred within the year just ending. Previous year fund balances unclaimed by April 30th will be denied. Any prior year claims submitted after April 30 will be denied. Claims for a prior year that are submitted after April 30th of the following year will be denied; however, funds will not be forfeited and will continue to accrue as long as you are enrolling in a parking and/or transportation flex account. You will only forfeit the funds if you do not spend them, go past the April 30th submission deadline, and later terminate your enrollment in the plan(s).

ARTICLE VI
PAYROLL DEDUCTION ACCOUNT (PDA)

6.01 Is there a limitation on the amounts of transportation expenses that may be deducted on a pre-tax basis?
Yes, and these limits are subject to change by the IRS each year. For 2021, the limits are $270 per month for qualified parking expenses and $270 per month for qualified transportation expenses. Participants' elections will not be monitored by Benefits Administration or the State; it is your responsibility to ensure that you do not exceed the maximums allowed by law.

6.02 How are payments for payroll deducted transportation expenses handled?
For state employees, the amount of your parking and transportation flexible benefits election will be withheld from each of your paychecks throughout the year. You will submit claims to Benefits Administration by emailing it to Benefits.Info@tn.gov or faxing it to 615-741-8196.You may roll funds from one month to the next, but you may only claim funds that have been deducted from your paycheck and posted to your P&T reimbursement account.

6.03 Can I change my PDA?
Yes, you can cancel or change your participation in the PDA at any time.

6.04 How long do I have to file claims?
You must file claims for the current year by April 30th of the prior year. Any claims for the current year filed after April 30th of the following year will be denied. However, you will not lose any funds remaining in your account that are denied. They will be added to the following year's elected contribution amount for payment of future claims.

6.05 What if the account holder or employee dies during the plan year?
Eligible expenses that are incurred up to the date of a participant's death may be reimbursed for that employee. All claims for the employee must be for the date of death or prior and must be filed within 90 days after the participant's date of death. Any funds remaining in the account after the 90-day period will be forfeited.

ARTICLE VII
NOTICE OF PRIVACY PRACTICES

7.01 Privacy of Protected Health Information and HIPAA Compliance

The plan will comply with all applicable provisions of HIPAA (as amended by the HITECH Act) and its' implementing regulations with respect to the programs under this plan to which the HIPAA Administrative Simplification Rules Apply.

7.02 State of Tennessee 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 State of Tennessee Insurance Committee (sponsor) unless the State of Tennessee Insurance Committee certifies that the Plan Document has been amended to incorporate this article and agrees to abide by this article.

7.03 Purpose of Disclosure to State of Tennessee 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 State of Tennessee Insurance Committee only to permit the State of Tennessee 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 State of Tennessee Insurance Committee of plan participants' protected health information will be subject to and consistent with the provisions of Sections 7.04 and 7.05 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 State of Tennessee 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 State of Tennessee Insurance Committee for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the State of Tennessee Insurance Committee.

7.04 Restrictions on State of Tennessee Insurance Committee Use and Disclosure of Protected Health Information.

(A) The State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee Insurance Committee.

(D) The State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee 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 State of Tennessee Insurance Committee shall report to the group health plan any security incident of which it becomes aware.

7.05 Adequate Separation between the State of Tennessee Insurance Committee and the Plan.

(A) The following employees or classes of employees or other workforce members under the control of the State of Tennessee 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 State of Tennessee Insurance Committee. This list includes the class of employees or other workforce members under the control of the State of Tennessee 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 7.05 (A) of this article will have access to plan participants' protected health information provided to the State of Tennessee Insurance Committee by the plan only to perform the plan administration functions that the State of Tennessee Insurance Committee provides for the plan.

(C) The classes of employees or other workforce members identified in Section 7.05 (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 State of Tennessee Insurance Committee in its capacity as plan sponsor in breach or violation of or noncompliance with the provisions of this article. The State of Tennessee Insurance Committee will promptly report such breach, violation or noncompliance to the plan, as required by Section 7.04 (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.

Please see the State Insurance Program Notice of Privacy Practices at:
https://www.tn.gov/finance/fa-benefits.html for additional information on your HIPAA privacy rights.