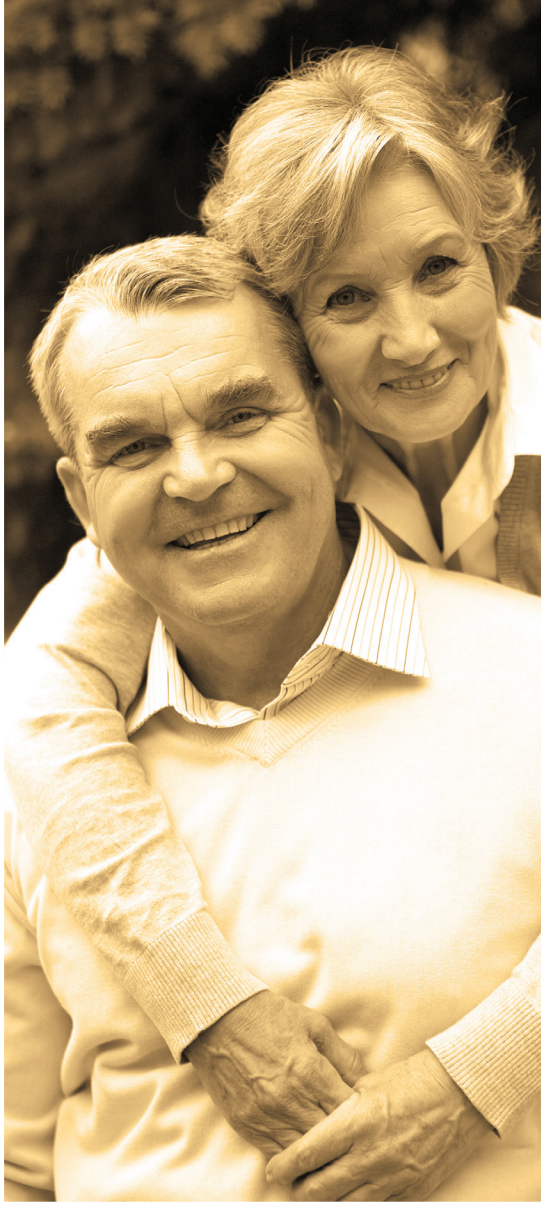

THE TENNESSEE PLAN HANDBOOK | 2016

The State of Tennessee Medicare Supplement Plan for Retirees

POMCO®

EXPERIENCE. EXCELLENCE.

Quick Information:

The Tennessee Plan **ID number printed on your POMCO ID card is:**

_____

The effective (beginning) date of your coverage is:

_____

Website:
www.TheTennesseePlan.com

If you have questions concerning eligibility and claims payment, please contact POMCO's customer service department for *The Tennessee Plan,* Monday–Friday 7 a.m. to 5 p.m. CST (8 a.m. to 6 p.m. EST) at:

1.888.477.9307

Please send claims submissions or correspondence to:
POMCO
P.O. Box 118
Syracuse, NY 13206

POMCO®
EXPERIENCE. EXCELLENCE.

Frequently Asked Questions About *The Tennessee Plan*

Who do I call with questions on my premiums?
You can call the State of Tennessee, Benefits Administration at 1.800.253.9981 with questions on your premiums.

Does POMCO offer an online service where I can access *The Tennessee Plan*, including eligibility status and claims inquiry?
Yes, you can log onto www.TheTennesseePlan.com to access claim status, view and print Explanation of Benefits (EOBs), as well as other important information about your eligibility and coverage.

What do I need to do when I go to the doctor or a health care provider?
When you receive services from a health care provider, or are admitted to a hospital, show both your Medicare card and your *Tennessee Plan* identification card.

I lost my *Tennessee Plan* identification card. How do I get another one?
You can call the POMCO customer service office for *The Tennessee Plan* at 1.888.477.9307 Monday–Friday, 7 a.m. to 5 p.m. CST (8 a.m. to 6 p.m. EST), to request an additional card. TTY/TDD users, call 1.866.256.7256.

How can I reach Medicare if I have a question regarding how Medicare paid my claim?
You can contact Medicare at 1.800.MEDICARE (1.800.633.4227).

How do I know my *Tennessee Plan* effective date?
The Tennessee Plan effective date is shown on your POMCO member identification (ID) card.

POMCO®
EXPERIENCE. EXCELLENCE.

Table of Contents

Welcome to *The Tennessee Plan* **4–5**

Basic Terms **6–8**

Plan Benefits **9–11**

Duplicate Coverage and Coordination of Benefits **12–13**

Subrogation **14–15**

Termination of Coverage **16**

Suspension of Coverage:
Medicaid (TennCare) Entitlements **16**

Coverage Changes **17**

Claims and Appeals **17–18**

Welcome to *The Tennessee Plan*

This handbook contains important details about your State of Tennessee Medicare Supplement Plan for Retirees coverage. Please take the time to read this booklet carefully and keep it in a place where you can reference it as needed.

You may also find important information in the official "Plan Documents and Summary Plan Description for The Tennessee Plan (Medicare supplemental benefit plan)" available on the Benefits Administration website at tn.gov/finance/ins on the publications page.

Understanding Your *Tennessee Plan* Medicare Supplement
It is important that you understand the terms of your *Tennessee Plan* supplemental coverage, offered to you by the State of Tennessee and administered by POMCO. Since this is a self-funded plan provided to you by the State of Tennessee, it is not issued or insured by POMCO.

As you read through this handbook, remember that the words "we," "us," and "our" refer to the State of Tennessee, the Plan administrator. The words "you" and "your" indicate you, the Plan subscriber. And POMCO, as a claims administrator of *The Tennessee Plan*, will be referred to often by name, or as the "claims administrator."

About Your *Tennessee Plan* Coverage
The Tennessee Plan ("Plan") coverage provides a program of hospital, skilled nursing facility and medical benefits for individuals enrolled in Medicare. The program is designed to supplement Medicare coverage—that is, to pay certain deductible and coinsurance amounts not covered by Medicare.

The Plan also covers additional days of care in the hospital, along with other medical services not paid by Medicare Part A or Part B.

In return for the payment of monthly premiums by or on your behalf as a subscriber, the State of Tennessee agrees to the terms and benefits described in this plan of coverage.

Right to Return Policy
If you are not satisfied with *The Tennessee Plan*, you can cancel it within 30 days after receipt. You will receive a refund of any premiums paid in advance. Any claims paid during this period will be recovered.

Confidentiality and Privacy
The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality, integrity, security and privacy of individually identifiable health information. When you enroll in the Plan, you give consent for the Plan and those administering it to use or disclose your protected health information in order to facilitate treatment and/or payment and processing of your claims. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan and those administering it agree to implement administrative, physical and technical safeguards that protect the information that it creates, receives, maintains or transmits on your behalf.

You are encouraged to call one of the POMCO member service representatives if you have questions about privacy policies and practices.

Welcome to *The Tennessee Plan*

POMCO
EXPERIENCE. EXCELLENCE.

Receiving Services and Filing Claims
Whenever you receive services from a health care provider, or are admitted to a hospital, be sure to show both cards: your Medicare card and your *Tennessee Plan* identification card.

- If the doctor or facility accepts Medicare assignment, their billing office will file your Medicare claim for you.
- Once Medicare processes the claim, they will usually forward the payment details to POMCO for consideration of any additional benefits available under the Tennessee Plan

Tip: Remind your provider to include your* Tennessee Plan *identification number on your Medicare claim to avoid any delays or questions.

If you receive services from a health care provider or hospital that does not accept Medicare assignment, or if the doctor will not file your *Tennessee Plan* claims for you, you need to:

- File your claim first with Medicare.
- If 30 days have passed from your claim filing with Medicare and after you have received a bill from your provider, send a copy of your Medicare Explanation of Benefits form (or MEOB), with your Medicare Health Insurance Claim (HIC) number found on your Medicare card on it, to the following address:

  POMCO
  P.O. Box 118
  Syracuse, NY 13206

No additional claim form is needed for your *Tennessee Plan* claim submissions.

If You Need More Information
If you have questions about your *Tennessee Plan* benefits, you can go to the Plan's website, www.TheTennesseePlan.com, or call POMCO at 1.888.477.9307, Monday through Friday, 7 a.m. to 5 p.m. CST (8 a.m. to 6 p.m. EST), to speak to a POMCO customer service representative. TTY/TDD users call 1.866.256.7256.

Basic Terms

The following are some basic terms and descriptions that will help you understand your coverage.

The Plan
The Tennessee Plan coverage is sponsored by the State of Tennessee, and claims are administered by POMCO. The coverage is based on the information in this handbook, your signed application and your POMCO member ID card.

This Plan provides you certain benefits and responsibilities. These benefits and responsibilities may not be assigned or transferred to any other person.

This policy is based on the statements you gave on your application. These statements are considered to be representations, not warranties. Only your written statements on the application may be used to defend a claim based on misrepresentation.

Except where required by law, the terms of this handbook cannot be changed unless the State of Tennessee and POMCO agree in writing to the change. Any amendment or endorsement must be signed by the State of Tennessee and made a part of the contract.

The Subscriber
By subscriber, we mean the person who signed the application and in whose name the ID card is issued. The person must be enrolled in Part A of Medicare.

Medicare
Medicare refers to the two programs of health insurance provided under Title XVIII of the Social Security Act. Officially, the two programs are known as Health Insurance for the Aged and Disabled.

The first program, commonly called Part A Medicare, provides basic protection against the costs of inpatient hospital and skilled nursing facility care. For the most part, Part A Medicare is financed through the Social Security tax.

The second of the two programs, Part B Medicare, is a voluntary program which covers the cost of physicians' services, outpatient hospital services and certain other services not covered under Part A Medicare. It is funded through the monthly premiums paid by participants and contributions from the federal government.

By Medicare benefits, we mean the benefits you are eligible for, or would have been eligible for under Part A Medicare or Part B Medicare—whether or not you apply for them.

By Medicare-approved amount, we mean the amount recognized as reasonable by Medicare for health care expenses of the kinds covered by Medicare. The Medicare-approved amount also includes amounts considered payable under the Medicare Part B fee schedule.

Medicare Definitions
The terms below carry the same meaning as they do in Medicare. Please visit www.Medicare.gov to review definitions of the following words:

- Coinsurance • Deductibles
- Inpatient hospital services
- Benefit period • Physicians' service
- Outpatient hospital services
- Outpatient physical or occupational therapy services
- Independent laboratory
- Skilled nursing facility services
- Medicare fee schedule
- Medically necessary

Basic Terms

Providers
Providers does not only refer to physicians or hospitals but any professionals or facilities that can provide you with health care services. The following are the definitions of some commonly used providers:

Hospital refers to an institution that is qualified as eligible to participate in Medicare as a hospital and meets all of the following requirements:

- Provides inpatient and outpatient services and is compensated by or on behalf of its patients;
- Provides surgical and medical facilities primarily to diagnose, treat and care for the injured and sick;
- Has a staff of physicians licensed to practice medicine; and
- Provides nursing care by registered graduate nurses on duty 24 hours a day.

A hospital does not serve, other than incidentally, as a nursing home, a place for rest, the aged, drug addicts or alcoholics.

A participating hospital is a hospital which:

- Has an agreement with the Secretary of Health and Human Services of the United States to provide Medicare benefits; or
- Has an agreement with POMCO to provide hospital services to Plan subscribers.

A non-participating hospital does not have either of these agreements.

A skilled nursing facility primarily provides skilled nursing care and related services or rehabilitation services, and has an agreement with the Secretary of Health and Human Services to provide skilled nursing facility services as defined by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature if it fits the above requirements.

The title ***physician***, for identifying covered physician services, includes all of the following:

- Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) legally qualified and licensed without limitation to practice medicine and perform surgery (except interns and residents);
- Doctor of Dental Surgery (D.D.S.);
- Doctor of Dental Medicine (D.M.D.);
- Doctor of Optometry (O.D.); and
- Doctor of Chiropractic (D.C.).

Basic Terms

All physicians must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

Premiums

- ***Payment of premiums for coverage.*** The monthly premium rates for coverage under the Plan are established by the State of Tennessee. Regular payment of premiums is required. After the first payment, premiums become due as they are billed. Claims will not be paid if premiums are not paid to date.

- ***Grace period of premium payment.*** After the first payment, a deferral period of a full calendar month is allowed. If the premium is not paid within this deferral period, coverage is terminated retroactively to the last month for which premiums were paid. Coverage cannot be reinstated if it was canceled due to non-payment of premiums.

- ***Change of premium rate.*** The premium charge for coverage under this Plan is subject to change. Should the rate change, you will be notified in writing at least 30 days before it goes into effect as required by the State of Tennessee.

Coordination of Benefits (COB). The process of determining if the benefits payable under *The Tennessee Plan* are coordinated with any benefits payable under another group plan.

Recover, Recovered, Recovery or Recoveries. Refers to all monies paid to you or your dependents by way of judgment, settlement, or otherwise to compensate for all losses caused by an injury or sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

Refund. Repayment to the Plan for benefits that it has paid toward care and treatment of any injury or sickness.

Subrogation. The Plan's right to pursue and place a lien upon you or your dependents' claims for benefit charges against another person.

Third Party. Refers to any third party whatsoever, including another person or a business entity.

Plan Benefits

BENEFITS AT A GLANCE	*THE TENNESSEE PLAN* BENEFITS
Medicare Gaps for 2016 **What You Owe After Medicare Pays**	**What You Owe** **With *The Tennesee Plan***
Basic Benefits • $322/day for 61–90 days in hospital • $644/day for 60 lifetime reserve hospital days • 20% patient's share of approved medical expense • First three pints of blood	**Covered**
Skilled Nursing Coinsurance • $161.00/day for 21st–100th day	**Covered**
Part A Deductible • $1,288/hospital admission	**Covered**
Part B Deductible • $166/calendar year for medical expenses	**Not Covered**
Part B Excess • Medical expense over approved amount	**Not Covered**
Foreign Travel Emergency • Emergency care beginning during first 60 days of trip outside USA (after $250 deductible, benefits limited to $50,000/lifetime)	**Covered at 80%**
Hospice • You must meet Medicare's requirements, including a doctor's certification of a terminal illness	**Covered**
Prescription Drugs • Outpatient prescription drugs covered through Medicare Part D	**Not Covered**

Plan Benefits

This section describes, among other things, the level of coverage available to you under *The Tennessee Plan*. To receive benefits, you must be under a physician's care and the services must be recommended by your physician. These services are subject to the rules of the hospital or other institution, including regulations governing admission.

Services Covered in Part by Medicare Hospital Inpatient Care
When you are admitted to a participating hospital, benefits will be provided by *The Tennessee Plan* for the following:

- **Inpatient hospital deductible,** the amount of money you pay when admitted to a hospital as an inpatient before you can receive Medicare benefits. The deductible applies once each benefit period, as defined by Medicare. The deductible is covered by your *Tennessee Plan*.

- **Coinsurance amount** that applies to inpatient hospital services after the 60th day and before the 91st day. After you have been hospitalized for 60 days, you must share the cost of the hospital care with Medicare. This is called coinsurance and is covered by *The Tennessee Plan*. Your share of the cost is what *The Tennessee Plan* covers under this program.

- **Coinsurance amount** that applies to inpatient hospital services after the 90th day and before your 60 lifetime reserve days of inpatient care under Medicare expire. This coinsurance is also covered by *The Tennessee Plan*.

Hospital Outpatient Care. When you are treated in the outpatient department of a participating hospital, benefits are available for the 20% coinsurance amount imposed by Medicare.

Skilled Nursing Services. If you are admitted to a skilled nursing facility, benefits will be provided after the calendar year's deductible has been met for the coinsurance amount that applies to skilled nursing services after the 20th day and before the 101st day.

Medical and Other Health Services. Part B Medicare pays 80% of the Medicare-approved amount for Medicare eligible expenses. However, benefits will be provided for the 20% coinsurance amount or remaining amount, whichever is less, for these expenses.

Blood Deductible. *The Tennessee Plan* will cover the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part A or Part B.

Hospice Care

The Plan will cover services that provide hospice care for those Plan participants diagnosed with a terminal illness. The Plan pays up to $5 for each prescription drug and other similar products for pain relief and symptom control, and 5% of the Medicare–approved amount for inpatient respite care, provided:

(1) The Plan participant is eligible for Medicare Part A (hospital insurance);
(2) The Plan participant's doctor and the hospice medical director certify that the Plan participant is terminally ill and has six months or less to live if the Plan participant's illness runs its normal course;
(3) The Plan participant signs a statement choosing hospice care instead of other Medicare-covered benefits to treat the Plan Participant's terminal illness; and
(4) The Plan participant gets care from a Medicare-approved hospice program.

Medicare will still pay for covered benefits for any health problems that are not related to the Plan participant's terminal illness.

Worldwide Services

When you receive medically necessary emergency hospital or physicians' services outside of the United States, *The Tennessee Plan* pays 80% of the billed charges after you pay a $250 deductible, up to a lifetime maximum amount of $50,000, provided:

- The care is received within the first 60 days of a trip outside the United States;
- You are a resident of the United States and are temporarily traveling elsewhere;
- You are legally responsible for payment for the services;
- Benefits are not available under Medicare; and
- The care is needed because of a sudden and unexpected illness or injury.

United States refers to all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complications during any state of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same annual deductibles and coinsurance as other services and pre-existing waiting periods apply, if applicable.

Services Not Covered by Medicare

Additional Days of Hospital Care. After you have used up all of your days of inpatient hospital services under Medicare (including your lifetime reserve days), *The Tennessee Plan* pays the Diagnostic Related Group (DRG) day outlier per diem rate or other appropriate standard of payment for medically necessary inpatient hospital services, up to a maximum of 365 days per lifetime.

This benefit is paid only if you would have been eligible for Medicare benefits had your days of care not expired. If you stay in a private room, this Plan pays an amount up to the hospital's most prevalent semi-private room rate.

Plan Exclusions

This coverage does not provide benefits for:

- Services and supplies not covered by Medicare, except those specifically included under this Plan;
- Any expense to the extent of any benefits available under Medicare, whether or not you enroll and apply for them; and
- The Medicare Part B yearly deductible amount.

Duplicate Coverage and Coordination of Benefits (COB)

Special rules apply when you are covered by more than one group health plan. This can happen if you are covered under *The Tennessee Plan* and another plan. For example, coverage for yourself with another employer or coverage as a dependent under your spouse's health plan.

The purpose of Coordination of Benefits is to avoid duplicate payments that could exceed the actual charge of any expenses for services or supplies covered by multiple plans. One of the two or more plan(s) involved is the primary plan and the other plan(s) is the secondary plan(s). The primary plan pays benefits first without consideration of the other plans. The secondary plan(s) then makes up the difference up to the total allowable expense. No plan will pay more than it would have paid without this special provision. A plan without a coordination provision is automatically primary.

Allowable Expense
For the purposes of this provision, *The Tennessee Plan* will consider an allowable expense to be the Medicare allowable charge or the usual, customary and reasonable expense covered by at least one of the plans covering the person if the charge is covered under this Plan (but excluded under Medicare). In no event will the combined payments exceed 100% of the Medicare allowable charge, or for those services not covered by Medicare, *The Tennessee Plan's* usual Plan benefits.

Plan Benefit Payment Order
(A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

General Medicare Effect on the Order of Benefit Determination
(B) For individuals eligible for Medicare due to age (65 or over) or due to disability (other than end stage renal disease) who are covered under a plan as a person with current employment status or a dependent of a person with current employment status, the following order of benefit determination applies:

(1) Plans covering the individual as an employee, or as the dependent of an employee, with current employment status pay first.
(2) Medicare pays second. If you are not enrolled in Medicare, *The Tennessee Plan* will apply its Coordination of Benefits provisions as if you had enrolled in Medicare.
(3) Plans covering the individual as a retiree or as an employee without current employment status pay last.

For complete Medicare Secondary Payer Provisions as they apply to you, contact POMCO at 1.888.477.9307.

The Tennessee Plan is designed to be the primary Medicare supplemental coverage when the subscriber is not covered under any other plan (as defined below).

Definition of Plan
For the purposes of this COB provision, a "plan" means any plan that provides benefits or services for hospital, medical, vision, or dental care that is:

(A) A group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice, and health maintenance organizations (HMO). It also includes coverage other than school-accident- type coverage.

Duplicate Coverage and Coordination of Benefits (COB)

(B) Coverage under a governmental plan, or coverage provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan, whose benefits (by law) are in excess to those of an insurance program (e.g., TRICARE for Life).

Medicare Part C (Medicare Advantage Plans) Medicare Advantage Plans are health options that are part of the Medicare program. These include:

- Medicare Health Maintenance Organizations (HMO).
- Preferred Provider Organizations (PPO).
- Private Fee-for-Service Plans (PFFS).
- Medicare Special Needs Plans.

To join one of these plans, you must have Medicare Part A and Part B. You will pay your monthly premium to Medicare. In addition, you may have to pay a premium to the Medicare Advantage Plan for the extra benefits that are offered.

If you are currently enrolled in or you join a Medicare Advantage Plan, your *Tennessee Plan* policy will not coordinate benefits. This means it will not pay any deductibles, co-payments or other cost-sharing under your Medicare health plan.

Even though you may decide to participate in *The Tennessee Plan*, this Plan will not pay out any benefits if you are currently enrolled in or you join a Medicare Advantage Plan. Notwithstanding the above, you have the legal right to keep *The Tennessee Plan* policy.

Claims determination period. Benefits will be coordinated on a calendar year-basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A covered person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or the covered person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Subrogation

When This Provision Applies
You or your dependents may incur medical charges due to injuries which may be caused by the act or omission of a third party, or a third party may be responsible for payment. In such circumstances, you or your dependents may have a claim against that third party, or insurer, for payments of the medical (or in some cases, dental) charges. Accepting benefits under *The Tennessee Plan* for those incurred medical expenses automatically assigns to *The Tennessee Plan* any rights you or your dependents may have to recover payments from any third party or insurer. The *Subrogation and Reimbursement* right allows *The Tennessee Plan* to pursue any claim which you or your dependents have against any third party, or insurer, whether or not you or your dependents chooses to pursue that claim. *The Tennessee Plan* may make a claim directly against the third party or insurer, but in any event, *The Tennessee Plan* has a lien on any amount recovered by you or your dependents whether or not designated as payment for medical expenses. This lien shall remain in effect until *The Tennessee Plan* is repaid in full. You or your dependents:

(1) automatically assigns to *The Tennessee Plan* your/their rights against any third party or insurer when this provision applies;
2) cannot assign any rights against any third party or insurer without express written consent of *The Tennessee Plan*; and
3) must repay to *The Tennessee Plan* the benefits paid on your/their behalf out of the recovery made from the third party or insurer.

Amount Subject to Subrogation or Refund
You or your dependents agrees to recognize *The Tennessee Plan's* right to *Subrogation and Reimbursement*. These rights provide *The Tennessee Plan* with a 100%, first dollar priority over any and all recoveries and funds paid by you or your dependents relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to *The Tennessee Plan* any and all rights you or your dependents may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to *The Tennessee Plan* you or your dependents' third-party claims.

Notwithstanding its priority to funds, *The Tennessee Plan's Subrogation and Reimbursement* rights, as well as the rights assigned to it, are limited to the extent to which *The Tennessee Plan* has made, or will make, payments for medical (or in some cases, dental) charges as well as any costs and fees associated with the enforcement of its rights under *The Tennessee Plan*. *The Tennessee Plan* reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical or dental expenses from you or your dependents.

Subrogation

When a right of recovery exists, you or your dependents will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure *The Tennessee Plan's* right of subrogation as a condition to having *The Tennessee Plan* make payments. In addition, you or your dependents will do nothing to prejudice the right of *The Tennessee Plan* to subrogate and/or reimburse the Plan.

Recovery From Another Plan Under Which You or Your Dependents Are Covered

This right of refund also applies when a covered person recovers under an uninsured or underinsured motorist plan (which will be treated as third-party coverage when reimbursement or subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any other insurance coverage plan whatsoever.

Rights of Plan Administrator

The Plan administrator has a right to request reports on and approve any and all settlements.

Failure to respond to the Plan's request 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 and/or initiating collection activities. Such disenrollment shall extend to any dependents who obtained coverage through the covered person.

Any retiree or dependent who has been disenrolled from the Plan for failure to cooperate and pay outstanding medical expenses may be ineligible to rejoin the Plan for a period of three years. Coverage may be reinstated within three months of disenrollment by providing the requested information, paying premiums due and reimbursing the Plan for medical expenses subject to this subrogation policy.

Termination of Coverage

This coverage remains in effect until terminated by the State of Tennessee or by the subscriber. Cancellation of coverage must be made in writing to the plan administrator at the following address:

State of Tennessee Benefits Administration
19th Floor, 312 Rosa L. Parks Avenue
Nashville, TN 37243

Coverage will not be renewed in the event of fraud by the subscriber or member. Coverage will automatically be canceled if you fail to pay the premium charges within the grace period.

The State of Tennessee can decline to renew all *Tennessee Plan* coverage. This coverage cannot be canceled solely because your health deteriorates.

As the subscriber, you can cancel the Plan for any reason at the end of the period for which charges have been paid. For whatever reason(s) the Plan is terminated, benefit coverage ends on the next payment due date.

Suspension of Coverage: Medicaid (TennCare) Entitlement

If you become eligible for Medicaid (TennCare), you may notify the State of Tennessee to suspend benefits and charges for coverage under this Plan for the period you are eligible for Medicaid, not to exceed 24 months. Your notice of such suspension must be received by the State of Tennessee within 90 days after determination of your Medicaid eligibility.

Upon receipt of timely notice to suspend coverage under this Plan, the State of Tennessee will return that portion of charges that correspond to the period of Medicaid eligibility, less the amount of any claims administered.

Coverage under *The Tennessee Plan* may be reinstated on the date you lose entitlement to Medicaid if such loss occurs within 24 months after suspension. You must provide notice of loss of Medicaid entitlement within 90 days after the date of such loss and pay premium charges for the period for which coverage is reinstated.

Coverage Changes

The terms of this coverage or the benefits may change. You will be notified in writing of any changes that occur. Your continued payment of the premium charges indicates acceptance of the change.

Benefits under this coverage will automatically be adjusted to conform to applicable changes in the Medicare deductible amounts and coinsurance percentages. Any such notice will be mailed to you at the address last shown in the records maintained by the State of Tennessee.

Claims and Appeals

If you have a claim for benefits, POMCO must receive written notice of that claim. When you are admitted to a hospital or skilled nursing facility, present your *Tennessee Plan* ID card at the admission desk and the hospital or facility personnel will notify POMCO.

In order to process your claims, POMCO may need information from the person or organization that supplied the service. As a subscriber accepting this Plan, you agree to authorize the physician, hospital or other provider to release any necessary information and records to POMCO.

Generally, the benefits will be provided as directed by you. However, POMCO has the right to pay you directly for all benefits administered under this Plan. Claims must be filed within 13 months from the date of service to be eligible for reimbursement.

POMCO will not process a claim received after the above applicable timely filing period.

Appeal Procedures
If you experience a problem relating to the Plan policies or the services provided, there are established procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

Administrative Review
To file an appeal regarding an administrative process or decision (such as effective dates of coverage issues or timely filing issues), contact the Plan administrator.

Claims and Appeals

Appealing to the Claims Administrator
If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call member services at POMCO to discuss the issue. If the issue cannot be resolved through member services, you may file a formal request for review or member grievance by completing the appropriate form, or as otherwise instructed, and returning it within the specified time frame to:

POMCO – Appeals
P.O. Box 118
Syracuse, NY 13206

When your request for review or other member grievance is received, you will get an acknowledgement letter advising you what to expect regarding the processing of your grievance. When a determination is made, you will be notified in writing and advised of any further appeal options.

Appealing to the Plan Administrator
The State of Tennessee, Benefits Administration has an appeal process that is available to you after you have exhausted the appeal process with the claims administrator. Appeals must be requested in writing within two years of the claim determination or decision.

To file an appeal at the state level, the member should send a letter and supporting documentation (such as explanation of benefit statements, decision letters, statements from health care providers, and medical records) to:

Appeals Coordinator
Benefits Administration – 19th Floor
Wm. R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue
Nashville, TN 37243

It is a good idea to maintain a copy of all correspondence you send. Specific questions regarding the appeal process may be directed to the appeals coordinator at 1.615.741.4517 or 1.866.576.0029.

The appeals coordinator in Benefits Administration will thoroughly review all information submitted to determine the exact nature of the appeal. The majority of requests for appeal require additional review by the claims administrator. The average review takes approximately 60 days to complete. Some cases may require additional time for review depending on individual circumstances. Some cases may also require review by the state's independent medical consultant.

Members will be notified in writing as to whether or not requests are approved or denied. For denial decisions, the notification letter will explain any additional appeal options.

© Copyright 2015 POMCO. All rights reserved.

1.888.477.9307 • www.TheTennesseePlan.com

POMCO®

EXPERIENCE. EXCELLENCE.