

The background of the page features a large, faint, circular seal of the State of Tennessee. The seal contains the text "THE GREAT SEAL OF THE STATE OF TENNESSEE" around the perimeter, with "1796" at the bottom. In the center, there is a plow, a sheaf of wheat, and a cotton plant, with the word "AGRICULTURE" above and "COMMERCE" below. The year "XVI" is at the top.

Local Government Plan Document

2027

The legal publication that defines eligibility, enrollment, benefits and administrative rules of the State of Tennessee Group Insurance Program and the Local Government Health Insurance Plan

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INTRODUCTION

1. This Plan Document

applies to the State of Tennessee Group Health Insurance Plan for local government agencies, 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, Preferred Provider Organization Copay Plan, and Local CDHP/HSA are health Plans available to eligible individuals. The health Plans are subject to the specific eligibility criteria and participation requirements in effect at the time of enrollment, reenrollment or continuation of Coverage. This Plan Document does not govern the State Plan, Local Education Plan, or voluntary benefit Plans authorized by Tenn. Code Ann. §8-27-702(c).

2. Assignment.

Except for assignments of reimbursement payable for Coverage for hospital, surgical or medical charges required by applicable law, no assignment of any rights, appeals, or benefits under this 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 Covered Person

3. Choice of Laws.

This Plan shall be governed, construed, administered and regulated by the law of the State of Tennessee and applicable provisions of federal law.

4. Conflict of Provisions.

If any provision of this Plan with Tennessee law or applicable federal law, the applicable law shall control.

5. Fraud.

Fraud or misrepresentation by a Covered Person may result in disciplinary action including, termination of employment, termination of insurance Coverage, and/or criminal prosecution.

6. Plan Document Is Not a Contract of Employment.

This Plan Document is not an employment contract between the Employer and any Employee, or a consideration for, or inducement or condition of the employment of an Employee. Nothing in the Plan grants any Employee the right to be retained in the service of the Employer or an expectation of continued Employment or a basis to interfere with the right of the Employer to discharge any Employee.

7. Litigation/Settlements with Third Parties.

No Employer participating in this Plan shall initiate or participate in any third-party litigation or settlements related to claims paid by the Plan or premiums paid to the Plan without prior notice to and approval from BA. The Employer must provide sufficient notice for BA to conduct a review of the proposed litigation/settlement, but not less than 30 days prior to initiating or participating in such activity. If a participating Employer receives any sums resulting from third-party litigation or settlement related to such claims or premiums, it must immediately notify BA of such receipt and comply with BA's directives regarding use of said sums for the benefit of the Plan.

8. Anti-Discrimination Compliance and Civil Rights Complaint Procedures.

Benefits Administration does not support any practice that excludes participation in its health programs or activities or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability.

If you think you have been denied services or treated differently for these reasons, you may submit a complaint to the Tennessee Department of Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov.

Please include the following information in your email:

- Your name, address and phone number. You must provide 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

Email to FA.CivilRights@tn.gov or Mail to:

State of Tennessee,

Department of Finance and Administration, Civil Rights Coordinator,

312 Rosa L. Parks Avenue,

William R. Snodgrass Tennessee Tower, 19th Floor

Nashville, TN 37243

F & A Policy No. 36. Non-Discrimination Policy and Complaint procedure which is available on the F&A Policies webpage at www.tn.gov/finance/looking-for/policies/.

You may also contact the:

U.S. Department of Health & Human Services Region IV Office for Civil Rights

Sam Nunn Atlanta Federal Center, Suite 16T70 61 Forsyth Street, SW

Atlanta, Georgia 30303-8909

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 Office of Attorney General and Reporter

Civil Rights Enforcement Division

P.O. Box 20207

Nashville, TN 37202

9. Language/Communication Assistance.

Do you speak a language other than English, and need free language help? Do you have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please request assistance by emailing benefits.assistance@tn.gov or calling 800-253-9981. If you think you have been denied free language or communications assistance, please call 615-532-9617 for the F&A Civil Rights Coordinator or follow the F & A complaint procedures in F & A Policy No. 36. Non-Discrimination Policy and Complaint Procedure which is available on the F&A Policies webpage at www.tn.gov/finance/looking-for/policies/.

Spanish

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

Arabic

1-866-576-0029 مقرب لصلتا. ن اجمالاب لكل رفاوتت ةيوجلللا ةدعاسملا تامدخ نإف، ةغلللا ركذا ثدحتت تنك اذإ: ةطوحم
مكبللاو مصللا فتاه مقر (1-800-848-0298).

Chinese

注意：如果會說中文，則提供免費的語言協助服務。請致電 1-866-576-0029 (電傳打字機：1-800-848-0298)。

Vietnamese

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

Korean

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

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

Laotian

ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີເມັດມີຢູ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

German

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

Gujarati

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

Japanese

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

Tagalog

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).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

Russian

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

Persian

اب. دشاب یم مهارف امش یراب ناگیار تروصب ینابز تالی هست، دینک یم وگتفگ یراف نابز م رگا: هجوت
دیری گب سامت 1-866-576-0029 (TTY: 1-800-848-0298)

SECTION 1 DEFINITIONS

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

1.01 Agency Benefits Coordinator (ABC)

is a designated and trained Employee of the Employer who serves as a liaison between the Employer and BA for purposes of facilitating enrollment, terminations, and assisting Covered Persons and Employees related to health benefits. Upon approval of BA, the ABC may be a designated and trained employee of the city, county, or State that oversees benefit enrollment and benefit premium payments for the participating LGA.

1.02 Anatomic Impairment

is the loss or abnormality of a body structure or function, encompassing conditions like loss of a limb, paralysis, or other structural or functional deficits and does not include psychological disorders or impairments related to mental or emotional functioning.

1.03 Benefits Administration (BA)

is a division of the Department of Finance and Administration which performs administrative functions for the State Insurance Committee and the Plan.

1.04 Center of Excellence Program (COE)

A plan-approved bundled service program with Providers who are selected to perform specified services. The Center of Excellence Program and its Providers that perform those specific services shall act as the TPA for all purposes regarding those services.

1.05 COBRA (Consolidated Omnibus Budget Reconciliation Act)

is the federal law that allows Employees, spouses, and Dependents to extend their insurance for a specified length of time after losing Coverage if certain conditions are satisfied..

1.06 Committee

is the Local Government Insurance Committee as defined in Tenn. Code Ann. §8-27-701.

1.07 Coverage

is an entitlement to insurance benefits under the Plan. Coverage may be either:

- (A) Employee Only or Retiree Only - Single Coverage for the Employee only or Retiree only.
- (B) Family Coverage - Coverage for the Employee or Retiree and spouse and/or Dependents. Coverage levels are set forth in Attachment A of this Plan Document.

1.08 Covered Expenses

are the maximum allowable, Medically Necessary or Clinically Necessary expenses, incurred by a Covered Person and designated as covered in Section 12.

1.09 Covered Person

is any Employee, Retiree, COBRA participant or Dependent who is currently enrolled and in good standing on the Plan.

1.10 Custodial Care

is services for personal care such as assistance with walking; getting out of bed; bathing; feeding; using the toilet; supervising medication which can usually be self-administered; and other services which do not involve or require continued attention of trained medical or paramedical personnel. Custodial Care also includes changing dressings, diapers, or protective sheets; administering oxygen, care and maintenance in connection with casts, braces or other similar devices; feeding by tube (including cleaning and care of the tube site); and assisting with ostomy bags or devices or indwelling catheters.

1.11 Dependent

is:

- (A) A legally married spouse;
- (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);
- (C) An Employee/Retiree or spouse's stepchild under the age of 26;
- (D) A person under age 26 who is placed with the HOC by a valid order of guardianship, custody, or conservatorship (or legally equivalent order) by a court of competent jurisdiction ("placement order") as provided below:
 - (1) The HOC must provide certification upon enrollment and upon request that: (a) the placement order is in effect and has not expired by subsequent court order or by operation of law, and (b) the HOC shall immediately notify BA when the placement order terminates or expires.
 - (2) If a placement order terminates or expires due to the person attaining the legal age of majority, the person may remain an eligible Dependent until age 26 if the HOC certifies that the following requirements in (a), (b) and (c) are met:
 - (a) The HOC and the person has a relationship as set forth in 26U.S.C. §152(d)(2), which includes the following relationships:
 - (i) The person is a descendant of a son/daughter, stepson/stepdaughter of the HOC;
 - (ii) The person is a brother/sister, half-brother/half-sister, stepbrother/stepsister, son/daughter-in-law, brother/sister-in-law, or niece/nephew of the HOC; or
 - (iii) The person has the same principal place of abode as the HOC and is a member of the HOC's household; and
 - (b) The HOC provides over one-half of the person's financial support for the calendar year in which the HOC's taxable year begins; and
 - (c) The person is a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada.
 - (3) Additional documents and certifications may be requested to establish that the person is an eligible Dependent.
- (E) 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 the Dependent was enrolled in the State Group Insurance Program prior to and on their 26th birthday. A request to continue Coverage due to incapacity must be provided to BA prior to the Dependent's 26th birthday as provided in Section 2.04(D).

(F) Dependents not eligible for Coverage include:

- (1) Children in the care, custody or guardianship of the Tennessee Department of Children's Services or equivalent placement agency, who are placed with the HOC for temporary or long-term foster care, but not including a person who is placed with the HOC for the purpose of adoption;
- (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 HOC and Dependent within the State Plan.

1.12 Durable Medical Equipment

is equipment that 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 TPA and prescribed by a physician. Attachment B provides a list of Durable Medical Equipment.

1.13 Effective Date

is the date on which Employee or Dependent Coverage begins pursuant to the applicable provision of Section 2.

1.14 Eligibility Date

is the date on which an Employee or Dependent becomes eligible to participate in the Plan pursuant to the applicable provision of Section 2.

1.15 Emergency

is 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).

1.16 Employee

shall mean:

- (A) Any person employed by the Employer, who is regularly scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;
- (B) A member of the chief legislative body of the county or municipal government;

- (C) All other individuals cite in State statute, approved as an exception by the Local Government Insurance Committee, or defined as full-time Employees for health insurance purposes by federal law; or
- (D) Utility board members appointed or elected pursuant to TCA 7-82-307, but only during their term of service; or
- (E) County officials as defined in TCA 8-34-101(9)(A) and (B), regardless of whether the agency participates in the Plan, pursuant to TCA 8-27-704.

Individuals performing services on a contractual basis are not considered to be Employees unless they otherwise meet the definition of an eligible Employee as defined in subsection (C).

1.17 Employee Assistance Program (EAP) Services Administrator

is the entity/ contractually designated by the State to provide short term counseling services and referral services to persons who are eligible for health insurance Coverage under the Plan.

1.18 Employer

- (A) Employer is a Tennessee local government, or quasi-governmental organization as defined by Tenn. Code Ann. § 8-27-702 that participates in the Local Government Plan. Each participating government or organization shall be considered a separate Employer.
- (B) Tenn. Code Ann. § 8-27-702 defines a quasi-governmental organization as one that can demonstrate the following three factors:
 - (1) That it was created by an act of the general assembly or by an ordinance or similar enactment of a local government;
 - (2) That it performs governmental functions; and
 - (3) That it is under governmental supervision by having government officials on its governing board, that it is subject to audit by the comptroller of the treasury, or that it is subject to review by a committee of the general assembly.
- (C) An entity is not a qualified quasi-governmental organization by being a party to a services contract with the State or any of its agencies unless it also satisfies the three factors listed in (B) above.
- (D) Employer's Additional Requirements for Plan Participation:
 - (1) The participating Employer must agree to have monthly premiums deducted from their bank account via automated clearinghouse (ACH) debit process;
 - (2) A minimum of 50 percent plus one of all eligible Employees must participate in the Local Government Plan. Agencies with fewer than 20 Employees must have 50 percent of all eligible Employees enroll;
 - (3) The participating Employer must agree to provide eligibility information on all Employees, enroll Employees in the Plan, adhere to all Plan provisions as set forth by the Local Government Insurance Committee and collect applicable premiums according to established procedures;
 - (4) The participating Employer must designate one individual (the Local Government Agency's benefits coordinator) to serve as liaison with BA for the purpose of carrying out the responsibilities of Plan administration;
 - (5) The participating Employer must offer to eligible Employees only those health insurance options sponsored by the Local Government Insurance Committee;

- (6) The participating Employer must agree to complete and return a Memorandum of Understanding (MOU) as required in Section 1.39 of the Plan Document and must abide by all conditions of the Local Government Memorandum of Understanding (MOU);and
 - (7) A minimum of two years participation in the Local Government Plan is required; if the Employer ceases to participate, a 60-day notice indicating the agency's intent to cancel participation is required and that Employer is prohibited from rejoining the Plan for 24 months from the date of their termination.
- (E) Employer's Effective Date of Participation who satisfies the conditions set forth in Section 1.18(A) and 1.18(B) shall be the later of the following:
- (1) The first day of the month following the approval of the Employer as an eligible participant in the Plan by the Committee, or its representative; and
 - (2) The first date of the month following the enrollment period for all eligible Employees in the Plan.

1.19 Family and Medical Leave

is a Leave of Absence granted pursuant to 29 U.S.C. 2601, et seq.

1.20 Formulary

or preferred drug list (PDL) is a listing of prescription medications which are preferred for use by the Plan, and which will be dispensed by participating pharmacies to Covered Persons. Such a list is subject to periodic review and modification by the Pharmacy Benefits Manager(PBM).

1.21 Grandfathered

Grandfathered shall mean:

- (A) Active Employees – When an agency joins the Plan for the first time, the Plan may enroll any active Employee of the agency who does not meet the Plan's definition of Employee if that Employee is on the agency payroll and was insured on the agency medical insurance the month prior to the agency enrolling in the Plan. The agency must provide to the Plan a copy of the billing from the previous medical insurance carrier when requesting a Grandfathered status for the active Employee. After approval, if the active Employees' medical Coverage on the Plan lapses for any reason, the Employee is no longer eligible for the grandfather status and may rejoin the Plan as provided in Section 2.
- (B) Dependents – Dependents of active Employees who do not meet the Plan's definition of Dependent may be enrolled when the agency joins the Plan for the first time. The agency must provide a copy of the Dependent definition from the previous carrier and proof of former Coverage to the Plan when requesting approval for a Grandfathered status for the Dependent.
- (C) Retirees:
 - (1) When an agency joins the Plan for the first time, it will be required to make the choice about providing Retiree Coverage specified in section 4.05 of this Plan Document. If the agency opts to offer Retiree Coverage the agency may enroll any retired Employee and their Dependent(s) under the age of 65 in the medical Plan on the date of the agency's initial enrollment if those individuals were participating with the agency's Employee group medical Plan in the month prior to the date the agency joins the Plan and provided that they are not eligible for Medicare. Retirees and Dependents of any age who are never eligible for Medicare may also be enrolled in the medical Plan if they were participating with the agency's Employee group medical Plan in the month prior to the date the agency joins the Plan. The agency must provide to the Plan a copy of the billing from the previous medical insurance carrier when requesting to enroll the retired Employee or

their Dependent(s). If the Coverage lapses for any reason other than agency termination, the Retiree and their Dependent(s) may not rejoin the Plan under Retiree Coverage. All Coverages for Retirees and their Dependents enrolled under this Section 1.21(C) will cease if their former Employer ceases to participate in the Plan or premiums are not paid when due.

- (2) Retirees or their Dependents will not be eligible for Retiree Coverage if the agency has elected to opt out of Retiree Coverage. Retirees of the new agency may continue Retiree Coverage if the agency elects to continue to provide Coverage for its existing Retirees at the time of joining the local government Plan, provided that the existing Retirees are under age 65 and not eligible for Medicare or any age and never eligible for Medicare.
- (3) Retirees or their Dependents of any age who are Medicare eligible will not be enrolled in the Plan. The Retiree may, however, request enrollment in The Tennessee Plan (supplemental medical insurance for Retirees with Medicare) for themselves and their eligible Dependent(s) subject to meeting all eligibility rules for that Plan as defined in State law and The Tennessee Plan (supplemental medical insurance for Retirees with Medicare) Plan Document. Medical underwriting will be waived for eligible individuals.

Retirees whose initial employment with a qualifying Employer commenced on or after July 1, 2015, are not eligible for enrollment in The Tennessee Plan (supplemental medical insurance for Retirees with Medicare). It shall be the Employer's responsibility to assist ineligible Retirees and their Dependent(s) with finding other Coverage.

1.22 Habilitation (Habilitative) Services

are 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 Outpatient settings.

1.23 Head of Contract (HOC)

is a Covered Person who elects Coverage and has authority to change Coverage elections on the Plan.

1.24 HIPAA (Health Insurance Portability and Accountability Act)

is the federal law governing portability between health Plans, special enrollment provisions, and privacy and security of protected health information.

1.25 Illness

is sickness or disease, including mental infirmity, which requires treatment by a physician. For purposes of determining benefits, Illness includes pregnancy.

1.26 Immediate Relative

is a husband or wife; parent, child, or sibling by law or marriage; grandparent or grandchild; and spouse of a grandparent or grandchild. Immediate Relative also includes biologically or legally related persons that share a common domain with the patient as part of a single-family unit.

1.27 Injury

is any bodily Injury sustained by any Covered Person, which requires treatment by a physician, or for which treatment is ordered by a physician that is determined to be Medically Necessary by the TPA.

1.28 Inpatient

is 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, unless specifically stated otherwise.

1.29 In-Network

are the services received and the benefit level available when rendered by doctors, caregivers, and medical facilities participating in an agreement with the State's contracted TPAs.

1.30 Leave of Absence

is an Employer authorized temporary absence from employment or duty with intention to return.

1.31 Local Government Agency (LGA)

is a Local Government Agency pursuant to TCA 8-27-702.

1.32 Maximum Allowable Charge

is the highest dollar amount of reimbursement allowed by either the primary or secondary plan for a particular covered service

1.33 Medically Necessary or Clinically Necessary

are services or supplies, which are prescribed by a physician as 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 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 TPA will determine if an expense is Medically Necessary and/or Clinically Necessary based upon the above factors for all services and supplies other than those performed through a Center of Excellence Program as defined herein..

1.34 Medical Supplies

are reusable or disposable supplies, which are:

- (A) Prescribed by the patient's physician;
- (B) Medically Necessary and/or Clinically Necessary, as determined by the TPA, 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 (lamb's wool pads), and sitz bath. Examples of supplies covered under the pharmacy benefit include glucose test strips and lancets.

1.35 Medicare

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

1.36 Member Handbook

is the applicable handbook for the specific medical Coverage enrollment made by a Covered Person. The handbook contains a schedule of benefits and benefit details for services and programs available to enrolled members which may change from one Plan Year to another. Electronic versions are posted on the BA website, and print versions are available upon request. If any information in the Member Handbook conflicts with provisions in this Plan Document, the Plan Document controls.

1.37 Memorandum of Understanding

is the document which defines the administrative responsibilities of the Employers as defined herein. Employers shall be responsible for completing and returning a MOU prior to enrolling in the Plan, within thirty (30) days of notification of modification or amendment of a previous MOU, or as otherwise requested by BA. The MOU must be executed by the ABC as defined herein; the Head of Agency; and the individual acting as the fiscal officer of the Employer. For purposes of executing the MOU, the fiscal officer is defined as the person who oversees a participating agency's financial transactions and has the authority to agree to the financial terms of the MOU on behalf of the participating agency. Fiscal officer oversight may include but is not limited to payment of benefit premiums, payroll deductions, receipt of funds, preparation of budget documents, and financial reporting to governing bodies. A modified or amended MOU, presented by the Committee or BA, replaces all prior MOUs. An Employer failing to complete and return a MOU as provided in this section or failing to abide by all provisions of the MOU, shall be subject to administrative action as specified in § TCA 8-27-703 or the MOU, up to and including, delayed enrollment, suspension of claims payment for persons covered through the Employer, and an Employer's termination from the Plan. BA may extend compliance deadlines based on extenuating circumstances.

1.38 Out-of-Network

are the services received and the benefit level available when rendered by doctors, caregivers, medical facilities, and pharmacies that do not participate in an agreement with the TPAs for provision of services at specific terms and rates.

1.39 Out-of-Pocket Maximum

is the most a Covered Person must pay for covered services in a Plan Year. 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.

1.40 Outpatient

is any person receiving medical treatment or services on a basis other than as an Inpatient.

1.41 Outpatient Surgery

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

1.42 Pharmacy Benefits Manager (PBM)

is the entity contractually designated by the State to provide claims adjudication; pharmacy management program review; Provider contracting; and other services necessary to ensure the proper and efficient administration of the Plan pharmacy benefits.

1.43 Plan

is the Local Government Health Insurance Plan authorized by the Local Government Insurance Committee pursuant to Tenn. Code Ann. § 8-27-302(a)(1). Plan does not include life, disability, dental, vision, State, or Local Education insurance Plans.

1.44 Plan Document

is the legal publication that defines eligibility, enrollment, benefits, covered and excluded services, and administrative rules of the Plan.

1.45 Plan Year

is the 12-month period beginning January 1 and ending December 31.

1.46 Prior Authorization

is the process by which a Provider requests approval from the TPA for Medically Necessary or Clinically Necessary medical or behavioral health/substance use; Inpatient admissions, prescriptions, procedures, tests, services, or supplies other than those provided by the Center of Excellence Program as defined herein in advance of extending such treatment or care to a Covered Person. Prior Authorization is designed to encourage the delivery of Medically Necessary 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. Other than services and supplies provided by the Center of Excellence Program as defined herein, no benefits will be provided for services which are not Medically Necessary or Clinically Necessary as determined by the TPA. Covered Persons should review their current year Member Handbook or contact the TPA for a list of benefits that require Prior Authorization. Maternity admissions and Emergency situations do not require Prior Authorization.

1.47 Provider

is one of the following:

- (A) Alcohol or Drug Treatment Facility. a facility that is:
 - (1) affiliated with a hospital under a contractual agreement with an established system for patient referral;
 - (2) licensed, certified or approved as an alcohol or other drug dependency treatment center by the State of Tennessee Department of Mental Health and Substance Abuse Services, or equivalent State licensing body; and
 - (3) accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations.
- (B) Ambulatory Surgical Center is a health care facility which provides surgical services and is either licensed as an ambulatory surgical facility by the state in which it is located or operated by a hospital licensed by the state in which it is located. An Ambulatory Surgical Center generally does not provide accommodations exceeding 12 hours.
- (C) Audiologist is 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 is a designated facility licensed in the state in which it is located, appropriately equipped and staffed by physicians, to aid pregnant mothers in the delivery of a baby.

- (E) Convenience Clinic or Retail Clinic is an accessible healthcare facility that is freestanding or located inside a grocery store, pharmacy or retailer, providing fast and affordable basic medical care for minor Illnesses or Injuries, vaccinations, physicals, and preventive care, staffed with advanced nurse practitioners or physician's assistants and licensed in the state in which it is located.
- (F) Emergency Room is a hospital department, designated and staffed for the medical/surgical treatment of patients.
- (G) Health Service Practitioner (HSP) is a psychologist, licensed as a health service Provider in the state in which services are received, acting in the capacity of a psychological examiner, senior psychological examiner, psychologist or a certified psychological assistant. 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 is a public agency or private organization licensed in the state in which services are received and operated according to the laws governing agencies that provide services in a Covered Person's home.
- (I) Home Health Care Aide is 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 is a facility or designated service licensed in the state in which services are received, approved by the TPA, and staffed and medically supervised for the care and treatment of terminally ill patients.
- (K) Hospital is an institution legally operating as a hospital and licensed in the state in which it is located and which:
 - (1) Is primarily engaged in providing 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 a hospital by the Joint Commission on Accreditation of HealthCare Organizations; and
 - (4) Does not include any institution that operates principally as a rest or nursing home, 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) is a clinical social worker, licensed in the state in which services are received, who is qualified by education and experience to treat mental health disorders resulting from social and psychological stress or health impairment.
- (M) Licensed Professional Counselor (LPC) is a professional counselor, licensed in the state in which services are received, who is qualified by education and experience to treat mental health disorders resulting from social and psychological stress or health impairment.
- (N) Midwife is an individual who is certified, in the state in which services are received, in the art of aiding in the delivery of children in a health care facility licensed in the state in which it is located.
- (O) Nurse Practitioner is a duly certified practitioner as defined in TCA 63-7-123 working under the direct supervision of a physician.
- (P) Oral/Maxillofacial Surgeon is a physician or dentist, licensed in the state in which services are received, with specialty training in head, face, or oral surgery.

- (Q) Pharmacist is an individual health care Provider, licensed in the state in which services are received, 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.
- (R) Physician is a 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.) licensed in the state in which services are received.
- (S) Physician Assistant (P.A.) is a graduate of a professional academic center as a P.A., working under a physician's supervision, and licensed under applicable State law.
- (T) Registered Nurse Clinical Specialist (RNCS) is a nurse practitioner providing mental health services and licensed as a registered nurse in the state in which services are received, with an appropriate master's or doctorate degree with preparation in specialized practitioner skills and possessing current national certification as a clinical specialist.
- (U) Rehabilitation Center is a dedicated and approved/accredited facility (either freestanding or a distinct part of an institution), licensed in the state in which it is located, staffed, and medically supervised in the care and treatment of the physical restorative needs of patients.
- (V) Residential Treatment Center is 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:
- (1) it is established and operated in accordance with applicable State law for residential treatment programs;
 - (2) it provides a program of treatment under the active participation and
 - (3) direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee;
 - (4) it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; it provides basic services in a 24-hour per day, structured environment , including at a minimum room and board, evaluation and diagnosis, counseling, and referral and orientation to specialized community resources and
 - (5) 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 and not a Residential Treatment Facility.
- (W) Skilled Nursing Facility is 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 in which it is located, and it must:
- (1) Be under the medical supervision of a physician or a registered nurse;
 - (2) Require 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) Provide for nursing service continuously for 24 hours of everyday;
 - (4) Provide facilities for the full-time care of five or more patients; and
 - (5) Not be an institution or part thereof primarily devoted to the care of the aged.

- (X) Therapist includes physical, occupational, respiratory and speech therapists registered and licensed in the state in which services are received.
- (Y) Treatment Center is A facility which provides a program of intensive short term Mental Disorder Treatment/Substance Use Disorder/Dependency Treatment and meets all the following requirements:
 - (1) is established and operated in accordance with any applicable state law;
 - (2) provides a program of treatment approved by a Physician and the TPA;
 - (3) has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient; and 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
 - (4) provides treatment services that adhere to defined policies, procedures and evidenced based clinical protocols.

Not all licensed individuals in categories listed in these definitions are covered under the Plan as Providers. Not all services rendered by eligible Providers are covered under the Plans.

1.48 Rehabilitation (Rehabilitative) Services

are 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.

1.49 Retiree

is a former Employee who has retired from the Employer and receives a benefit from the Tennessee Consolidated Retirement System (TCRS Retiree), or a former Employee as otherwise described in Section 4. Retirees of agencies electing to opt in to Retiree Coverage, or to opt out of Retiree Coverage but continue to provide Coverage for Retirees on the Plan at the effective date of the opt out must meet the applicable guidelines in Section 4 to continue to participate in the Plan.

1.50 State

is the State of Tennessee and the sponsor of the Plan.

1.51 State Health Plans

is all three separate Plans administered by BA:

- (1) this Plan (the State Plan);
- (2) the Local Education Plan; and
- (3) the Local Government Plan.

The term “State Health Plans” does not include life, disability, vision, or dental insurance Plans.

1.52 Tennessee Consolidated Retirement System (TCRS)

is the defined benefit Plan component of the State of Tennessee’s retirement program that provides retirement, survivor, and/or disability benefits to eligible Retirees and their eligible Dependents.

1.53 Third Party Administrator (TPA)

is an entity that provides claims adjudication; medical or clinical management program review for medical or behavioral and substance use services; Provider contracting; and other services necessary to assure the proper and efficient administration of the Plan.

1.54 Urgent Care

is 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 Provider for treatment advice on Urgent Care situations.

1.55 Workers' Compensation Benefits

are benefits payable to Employees injured on the job.

SECTION 2 ELIGIBILITY AND ENROLLMENT

2.01 Employee Eligibility, Enrollment and Effective Date of Coverage.

- (A) Eligibility. All Employees defined by Section 1.16 shall be eligible for Coverage. The Eligibility Date is the hire date or the last day of the LGA's probationary period, if the LGA applies a probationary period.
- (B) Enrollment. BA shall provide an Employee with enrollment access through enrollment forms or the Edison Employee Self-Service (ESS) feature.
 - (1) Enrollment access shall be provided on the hire date or within five calendar days after the hire date or otherwise becoming eligible, and enrollment must be completed and submitted to BA within 30 calendar days. The 30 days includes the hire date or other date the Employee becomes eligible. This provision does not apply to SQEs discussed in Section 2.06.
 - (2) Employees are encouraged to enroll as quickly as possible and to enroll through the Edison ESS feature. If access to ESS is unavailable, Employees must complete and return an enrollment form to the ABC indicating the desired health care option and appropriate type of Coverage as defined in Section 1.07. Regardless of the method of enrollment, newly hired Employees (including Employees coming from the Local Education, Local Government, and Institutions of Higher Education) and newly eligible Employees must complete and submit the enrollment form to BA within 30 calendar days of the hire date or date of becoming eligible.
 - (3) All documentation required to support an enrollment must be submitted to BA no later than 10 calendar days after the 30-day enrollment period.
- (C) Effective Date of Coverage for an Employee. The Effective Date of Coverage for an eligible Employee who has enrolled according to the requirements of this section shall be:
 - (1) Newly Hired Employee (including Employees moving between LGAs, or coming from LEAs, the State, or Higher Education Institutions): the first day of the month following the Eligibility Date.
 - (2) Existing Employee gaining eligibility for Coverage: the first day of the month after gaining eligibility for Coverage (including part-time to full-time employment) **and** the Employee's submission of a completed enrollment form to BA.

2.02 Re-hired Employees.

An Employee may not be terminated and then re-hired by the same Employer within 60 calendar days and be eligible for insurance Coverage as a newly hired Employee, except as outlined in Section 2.06 or Section 3.05.

2.03 Dependent Eligibility, Enrollment and Effective Date of Coverage.

- (A) Eligibility. Each Dependent defined in Section 1.11 shall be eligible for Coverage. Dependents are eligible on the later of the following:
 - (1) The date the Employee is eligible; or
 - (2) The date the Dependent is acquired:
 - (a) if Dependent is a legally married spouse - date of marriage;
 - (b) if Dependent is a natural child of the Employee - birthdate;
 - (c) if Dependent is a legally adopted child – the date of adoption (or date of legal custody in anticipation of adoption);

- (d) if Dependent is a child for whom the Employee is the legal guardian – date specified in the court order granting guardianship and requiring financial support and insurance Coverage;
 - (e) if Dependent is a stepchild of the Employee – date of marriage establishing relationship;
 - (f) if Dependent is a child named as an alternate recipient under a qualified medical child support order as defined in Section (D) – the entry date of the order unless another date is specified in the order.
- (B) Enrollment.
 - (1) Employees must enroll Dependents pursuant to Section 2.01(B), 2.06, or 2.07.
- (C) Effective Date of Coverage for a Dependent.
 - (1) The Effective Date of Coverage for an eligible Dependent shall be the later of the following:
 - (a) The Effective Date of the Employee’s Coverage as provided in Section 2.01(C); or
 - (b) The Effective Date of Coverage as provided in 2.06(A)(5), (B)(3), (C)(4) and (C)(5); or
 - (c) The Effective Date of Coverage as provided in 2.07(D) and 2.07(E).
- (D) If the State is served with a National Medical Support Notice of a qualified medical child support order as defined by federal law that requires an Employee or Retiree’s child to be enrolled in This Plan, the child will be enrolled, and the insurance will become effective according to the terms of the Order.

2.04 Substantiation of Dependent Eligibility.

- (A) In order to add a Dependent, the HOC must provide sufficient documentation to substantiate the Dependent’s eligibility for the Plan no later than 10 calendar days past the enrollment deadline. The required documentation may include marriage certificates, birth certificates, adoption orders, legal guardianship orders, divorce decrees, federal income tax returns (listing Dependent spouse), social security number or card; or other documentation requested by BA. No Dependent will be added to the insurance Plan unless the requested information is provided.
- (B) From time to time, BA may require members to submit documentation listed in (A) above, to substantiate eligibility of Dependents on the Plan, or to facilitate reporting and other operational requirements of the Plan. Failure to provide the requested information within 90 days of BA’s request may result in termination of Coverage unless the member can demonstrate that despite good faith efforts to secure the requested documentation from an Employer, insurer, or governmental agency within the expiration of the 90-day deadline, the documentation has not been received.
- (C) A Dependent who is not properly added or whose Coverage is terminated may only be enrolled in the Plan during the next annual enrollment period or by compliance with the special enrollment provisions of Section 2.06.
- (D) A request to continue Coverage for a Dependent beyond age 26 as defined in Section 1.11(E) must be received before the Dependent’s 26th birthday
 - (1) BA will determine if all Plan requirements have been met by:
 - (a) Confirming if the TPA’s review of the submitted documentation establishes incapacity of the Dependent; and
 - (b) Participating in annual reviews as required by BA or the TPA to confirm continued incapacity.

- (2) Coverage will be terminated and shall not be reinstated if it is determined that the Dependent is not, or is no longer, incapacitated or that other Plan requirements are not satisfied.
- (3) A Dependent who has attained age 26 and whose Coverage under this Plan has been terminated will not be enrolled again as an incapacitated Dependent.
- (4) Dependents whose Coverage is terminated may qualify for COBRA subject to the provisions of Section 4.06.

2.05 Enrollment Provisions when Employee and Spouse are Both Employed by the Employer.

- (A) If two eligible Employees are married without children, each Employee may separately enroll in a State-sponsored Plan, or they may enroll in family Coverage (Employee + spouse) with one Employee as HOC and the other Employee as a Dependent.
- (B) If two eligible Employees are married with children, they may either:
 - (1) enroll in family Coverage for all eligible family members – Employee + spouse + child(ren), or
 - (2) one Employee can enroll in Employee only Coverage and the other Employee can enroll in family Coverage (Employee + child(ren)) to cover that Employee and the eligible Dependent children.
- (C) A Dependent child shall not be enrolled as a Dependent by more than one eligible Employee including divorced parents and never-married parents who both work for the Employer.
- (D) An Employee shall not be enrolled as both Head of Contract and a Dependent on this Plan.
- (E) A newly hired Employee can enroll an Employee spouse who originally declined Coverage as an Employee. An Employee spouse who is added as a Dependent pursuant to this section is not required to meet the provisions of Section 2.06.

2.06 Special Enrollment.

Without regard to the dates or circumstances on which an individual would otherwise be able to enroll in the Plan, current Employees and Dependents as defined in Section 1.11 of this Plan Document are permitted to enroll in Coverage under this Plan if the Employee or Dependent meets the following conditions of a Special Qualifying Event (SQE) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable law, as stated in Section A or B below:

- (A) Loss of Eligibility for Other Coverage.
 - (1) An Employee or Dependent, otherwise eligible to enroll in a benefit Plan, may be enrolled through this Special Enrollment provision provided that they:
 - (a) Declined Coverage when it was previously offered during their initial eligibility period as outlined in Section 2.01(B) for Employees and 2.03(A) for Dependents, or during a subsequent annual enrollment period as outlined in Section 2.07(A);
 - (b) Had Coverage under any group health insurance Plan at the time Plan Coverage was previously offered; **and**
 - (c) Experience a loss of eligibility for other health insurance Coverage for reasons including the following (but not for a failure to pay premiums or termination for cause):
 - (i) Death;
 - (ii) Divorce;
 - (iii) Legal separation;

- (iv) Cessation of Dependent status;
 - (v) Termination of employment (voluntary and non-voluntary);
 - (vi) Employer's discontinuation of contribution to insurance Coverage (total contribution, not partial);
 - (vii) Reduction in number of work hours of employment;
 - (viii) Spouse maintaining Coverage that has reached their lifetime maximum (if legally permitted);
 - (ix) The loss of eligibility due to an HMO's failure to provide benefits in the area where the individual lives, works, or resides if the requirements of HIPAA are satisfied; or
 - (x) Loss of TennCare or Children's Health Insurance Program (CHIP) Coverage other than non-payment of premium, or expiration of COBRA Coverage.
- (2) If an Employee satisfies all three requirements of A (1) above, the Employee and all Dependents of the Employee are eligible for special enrollment to the Plan.
 - (3) If a Dependent satisfies all three requirements of A (1) above, only that Dependent, the Employee, and other Dependents satisfying the requirements of A (1) above are eligible for special enrollment to the Plan.
 - (4) All Special Enrollment requests for Loss of Eligibility for Coverage including required documentation must be submitted to and received by ABC/BA within **sixty (60) calendar days** of the loss of eligibility for other Coverage.
 - (5) The Effective Date of Coverage for a Special Enrollment for Loss of Coverage shall be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment.
 - (6) Substantiation of Loss of Coverage. If requesting special enrollment based on loss of eligibility for other Coverage, the Employee must submit appropriate documentation to substantiate all of the following:
 - (a) That the Employee or Dependent was covered by any other group health insurance Plan at the time they declined the offer of Coverage from This Plan; and
 - (b) That the Employee experienced an event resulting in the Employee or Dependent's loss of eligibility for Coverage under the other group health insurance Plan, and the date of the Employee or Dependent's loss of eligibility.
- (B) New Eligibility for Premium Subsidy under a State CHIP or Medicaid Program.
- (1) An Employee or Dependent may be enrolled through this Special Enrollment Provision if they become newly eligible to receive premium assistance under a State Children's Health Insurance Program (CHIP) or Medicaid.
 - (2) All Special Enrollment requests for new eligibility for premium assistance including required documentation must be submitted to and received by ABC/BA within sixty (60) calendar days of receipt of notice of gaining eligibility for the premium assistance.
 - (3) The Effective Date of Coverage for a Special Enrollment for new eligibility for a premium subsidy shall be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment.
 - (4) If requesting special enrollment based on new eligibility for a premium subsidy appropriate documentation to substantiate the eligibility for premium assistance must be submitted.

(C) Acquisition of New Dependents.

- (1) When an Employee acquires a new Dependent by marriage, birth, adoption, placement for adoption, the Employee, Spouse, and any Dependent may be enrolled by Special Enrollment. When an Employee acquires a new Dependent by a legal guardianship order placing child in the custody of the Employee and requiring Employee to provide insurance Coverage for the new Dependent, only the Employee and new Dependent may be enrolled by Special Enrollment.
- (2) Any Coverage changes made as a result of a Special Enrollment that are not required by HIPAA shall be on account of and correspond with the change in status that affected eligibility for Coverage under the Plan, such as acquiring a new Dependent through legal guardianship.
- (3) All Special Enrollment applications based upon the acquisition of a new Dependent must be submitted to and received by ABC/BA within **sixty (60) calendar days** of the acquisition date. (SEE IMPORTANT EFFECTIVE DATE RULES BELOW REGARDING ACQUISITION OF CHILD THROUGH BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION).
- (4) The Effective Date of Coverage for a Special Enrollment for acquiring a new child by birth, adoption, placement for adoption, shall be:
 - (a) retroactive to the date of the birth, adoption, or placement for adoption if the Special Enrollment application is submitted to and received by the **ABC/BA WITHIN THIRTY (30 DAYS)** from the date of birth, adoption, or placement for adoption. The thirty-day period begins on the day after birth, adoption, or placement for adoption.
 - (b) prospective only from the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment if the Special Enrollment application is submitted to and received by the **ABC/BA BETWEEN THIRTY- ONE (31) AND SIXTY (60) DAYS** from the date of birth, adoption, or placement for adoption.
- (5) The Effective Date of Coverage for a Special Enrollment for acquiring a new Dependent Spouse, child pursuant to an order of guardianship, and new stepchild acquired by marriage shall be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment.
- (6) Substantiation of Acquiring a New Dependent. If requesting enrollment based on acquiring a new Dependent, the Employee must submit appropriate documentation as listed on the enrollment application form to substantiate the following:
 - (a) The date of birth of a child; or
 - (b) The date of the order of adoption or of the order placing the child in custody for adoption;
 - (c) The date of guardianship specified by the order granting guardianship of the person and requiring financial support and insurance Coverage; or
 - (d) The date of marriage.

2.07 Annual Enrollment Elections.

- (A) The Plan's designated annual enrollment period will be announced in an annual enrollment newsletter and will be published on the Plan's website. All timely submitted annual enrollment elections and revisions will become effective on January 1 of the upcoming Plan Year and remain in effect through December 31 of the upcoming Plan Year unless a mid-year enrollment change is permitted by this Plan Document.

- (B) Employees may make Coverage elections during annual enrollment, may choose between any Plan design option for which the Employee is eligible, and may add or drop eligible Dependents. If no new elections are received by BA during annual enrollment, the Coverage in effect immediately prior to annual enrollment is deemed to be elected for the upcoming Plan Year.
- (C) When adding new Dependents during annual enrollment, eligibility documentation must be submitted prior to December 1 of the current Plan Year or as otherwise directed by BA. In no event will annual enrollment documentation be accepted after December 31 of the current Plan Year.
- (D) During annual enrollment a Retiree is not eligible to enroll in new Coverage, but a covered Retiree may add or drop an eligible Dependent and make changes to existing Coverage. A Retiree carrying Dependent only Coverage is not eligible to enroll in new coverage or add new Dependents.
- (E) During annual enrollment a surviving Dependent may make changes to existing Coverage but is not eligible to enroll in new Coverage or add Dependents. For annual enrollment for COBRA participants, see Section 4.06.
- (F) Employees who are eligible for Coverage under this Plan and another of the State Health Plans may switch their Coverage (and Coverage for their Dependents) to or from the other plan during the designated annual enrollment period of the applicable plan.
- (G) Once the Plan's designated annual enrollment period has closed, active Employees and eligible Retiree HOCs have one opportunity to revise annual enrollment elections provided that requests are submitted to BA no later than 4:30 CT on December 1 of the current Plan Year.

SECTION 3

PARTICIPATION DURING APPROVED LEAVE AND REINSTATEMENT TO PLAN UPON RETURN

3.01 Family Medical Leave Act (FMLA) Continuation of Coverage during Leave of Absence.

- (A) If the HOC is on paid FMLA leave, the HOC's Coverage elections will continue on a Salary Reduction basis during the leave.
- (B) If the HOC is on unpaid FMLA leave, the HOC may choose to continue their Coverage elections with after-tax dollars through direct billing or suspend their Coverage by submitting forms provided by BA on the BA website. If the HOC continues Coverage while on unpaid FMLA leave, the Employer will continue to maintain the Coverages on the same terms and conditions as if the HOC were still an active Employee. If the HOC elects to continue their Coverage while on leave, the Employer will continue to pay its share of the premiums. If the HOC fails to pay the Employee share of the premium payments, their Benefits will be suspended.
- (C) If a HOC's Coverage is suspended while on FMLA leave (by voluntary suspension or due to non-payment of premiums), the Coverage will be reinstated upon return from leave with the same elections in place at the commencement of the FMLA leave subject to any changes in benefit levels that may have taken place during the period of FMLA leave. The HOC will be enrolled in the same Plan options they were previously enrolled in upon notice of return from FMLA, with Coverage becoming effective the first day of the month following receipt of the notice of return. Within 30 days of their return from FMLA leave, the HOC may elect retroactive Coverage to the date that Coverage was suspended provided payment is made for all retroactive premiums.
- (D) If a Covered Person experiences a mid-year benefit election change event while on FMLA leave and seeks a change in benefit elections, the HOC must submit an election change request form within 60 days of the election change event or upon return to work from leave, whichever is later. Effective Dates of new benefit elections are governed by applicable provisions of Section 2 and Section 4 of this Plan.

3.02 Non-Family Medical Leave Act (Non-FMLA) Approved Leave of Absence.

- (A) An Employee on an approved Leave of Absence that is not covered under FMLA may continue Coverage as described in this subsection. An Employee on an approved non-FMLA Leave of Absence may continue Coverage under the Plan for a period not to exceed two continuous years provided they pay the Employee share of the premium during paid leave and the full monthly premium (both the Employer and Employee portions as described in Section 8) during periods of unpaid approved leave.
- (B) If the HOC is on paid non-FMLA leave, the HOC's Coverage elections will continue on a Salary Reduction basis during the leave.
- (C) If the HOC is on unpaid non-FMLA leave, the HOC may choose to continue their health Coverage with after-tax dollars through direct billing or to suspend their Coverage by submitting forms provided by BA on the BA website. If an HOC continues to pay premiums while on unpaid non-FMLA leave, their premium reduction election shall be reinstated upon their return to work unless a status change occurs allowing an election change as provided in Section 2 or 4 of this Plan.
- (D) If the HOC fails to make premium payments while on unpaid non-FMLA leave, Coverage may be involuntarily terminated retroactive to the last month that premiums were paid. If Coverage is terminated during a non-FMLA Leave of Absence due to failure to pay, Covered Persons will not be eligible for COBRA Coverage.

- (E) If the HOC's Coverage is terminated while on non-FMLA leave (by voluntary suspension or due to non- payment of contributions), their Coverage elections will be reinstated prospectively upon notice of return from leave with the same elections in place at the commencement of the non-FMLA leave subject to any changes in benefit levels that may have taken place provided that the HOC continues to meet all Plan eligibility requirements.
- (F) If a Covered Person experiences a mid-year benefit election change event while on non-FMLA leave and seeks a change in benefit elections, the HOC must submit an election change request form within 60 days of the election change event or upon return to work from leave, whichever is later. Effective Dates of new benefit elections are governed by applicable provisions of Section 2 and Section 4 of this Plan.

3.03 Effective Date of Reinstated Coverage after Return from Leave.

- (A) When Coverage has been suspended, the Effective Date for reinstated Coverage upon return from non- Military, non-FMLA leave that is six months or less is the first day of the calendar month following the date the Employee returns to work.
- (B) When Coverage has been suspended, the Effective Date for reinstated Coverage upon return from non- Military, non-FMLA leave that is more than six months is the first day of the month following one full calendar month after return to work.
- (C) The Coverage Effective Date for return to work following FMLA leave is as provided in Section 3.01(C).
- (D) The Coverage Effective Date for return to work following Military leave is as provided in Section 3.07.

3.04 Return from Two Year Leave of Absence.

If the HOC returns to work after a two-year (24 consecutive months) Leave of Absence they must be in a positive pay status for one full calendar month before they may be eligible for continued Coverage on the Plan during a subsequent Leave of Absence. If the HOC does not return to active work status after completion of a two-year Leave of Absence, Coverage will terminate on the last day of the month of leave, and COBRA continuation Coverage will not be offered.

3.05 Reinstatement of Coverage Following Termination of Employment.

If the HOC terminates employment with the Employer and returns to work with the Employer within sixty (60) days of termination, the Employee's insurance elections shall be reinstated provided that all other eligibility requirements are met. If the Employee has experienced a mid-year Coverage change event as provided in Section 2.06 or Section 4.01 and wants to change Coverage elections, the Employee must submit the election change request and all required documentation to BA at the time of return to employment.

3.06 Reinstatement for Military Personnel Returning from Active Service.

If a HOC's Coverage is suspended while on Military leave, the Coverage will be reinstated upon return from leave with the same elections in place at the commencement of the Military leave subject to any changes in benefit levels that may have taken place during the period of leave. The HOC will be enrolled in the same Plan options they were previously enrolled in upon notice of return, effective the first day of the month following the notice of return (prospective). Alternatively, the HOC may elect an Effective Date of the first day of the month of their return (retroactive). No waiting period requirements will apply to this reinstatement.

SECTION 4 COVERAGE TERMINATION AND CONTINUATION

4.01 Termination of Covered Person's Participation.

- (A) Voluntary Termination of Coverage. Employees. Voluntary cancellation of active HOC or Dependent Coverage outside of Annual Enrollment is prohibited unless the HOC or Dependent experiences one of the events listed below. For all events the Insurance Cancel Request Application Form and required documentation must be received by BA within 60 days from the date of the event. If the status change event is new entitlement to Medicare or Medicaid, the Insurance Cancel Request Application Form must be received by BA within 60 days from the date of the HOC/Dependent's receipt of notice of the new entitlement. The Effective Date of voluntary Coverage termination is the first day of the calendar month following BA's receipt of the Insurance Cancel Request Application Form and required documentation. Permissible voluntary Coverage termination events are as follows:
- (1) New eligibility for group health insurance/benefits through spouse or Dependent's employer;
 - (2) Annual enrollment into a spouse, former spouse, or Dependent's employer's group health plan;
 - (3) Marketplace eligibility and enrollment;
 - (4) New entitlement to Medicare or Medicaid;
 - (5) Termination of child support order of Dependent child provided by National Medical Support Notice; or
 - (6) Change of residence out of the national service area
- (B) Voluntary Termination of Coverage. Retirees. Voluntary cancellation of Retiree HOC or Dependent Coverage outside of annual enrollment is prohibited unless the HOC or Dependent experiences an event listed in (A) above and submits the Insurance Request Cancel Request Application Form to BA. The Effective Date of voluntary Coverage termination is the first day of the calendar month following BA's receipt of the Insurance Cancel Request Application Form and required documentation.
- (C) Involuntary Termination of Coverage. Coverage terminates involuntarily when a Covered Person ceases to satisfy Coverage eligibility requirements of the Plan or fails to make premium payments in the manner required by BA. Unless otherwise expressly provided in the Plan, involuntary termination is effective as follows:
- (1) Coverage of the HOC shall terminate upon the earliest to occur of the following:
 - (a) The last day of the month for which the Employee's last contribution was applied;
 - (b) The date the Plan is amended to terminate the Coverage of a class of Employees of which the Employee is a Covered Person;
 - (c) The date the Plan is terminated; or
 - (d) The last day of the month in which the Local Government Agency participates in the Local Government Plan.
 - (2) Coverage of Dependents 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 immediately notify the Employer or BA (if the HOC is a Retiree) of a status change event causing a Dependent to become ineligible for Coverage. When failure to notify the Employer or BA results in claims paid for ineligible Dependents, all claim amounts will be recovered from the HOC.

- (D) Pending Divorce Actions. If a HOC submits a timely request to terminate Coverage of a Dependent for any of the above listed mid-year change events or drops Coverage of a Dependent during annual enrollment while a divorce case is pending, the termination will be processed and final. Court orders in matters to which the Plan is not a party have no application to the Plan and do not entitle the HOC to rescind a termination request or to permit re-enrollment of a Dependent.
- (1) It is the responsibility of the HOC to comply with all applicable law regarding termination of health insurance while a divorce action is pending. Neither BA nor the Plan is responsible for said compliance or for the HOC's failure to comply.
 - (2) BA may rely upon the direction, information, or election of a HOC to remove a Dependent while a divorce action is pending as being proper and in compliance with all legal requirements and the Plan shall not be responsible for removal of a Dependent if it is determined that the HOC's request was in violation of court orders or applicable law, or if proper notice was not provided by the HOC to the Dependent.
 - (3) A former or ex-spouse is not eligible for Coverage on the Plan even if a court order requires the HOC to provide health insurance Coverage to a former/ex-spouse. If a spouse ceases to be eligible due to divorce from a Covered Person, that spouse shall be eligible to continue Coverage through COBRA as provided in Section 4.06 and any other applicable state law.

4.02 Continuation of Dependent's Health Insurance 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 (6) months of extended Coverage without charge. Participation in the Plan during the six (6) months of extended Coverage due to death shall be in addition to continued Coverage available through the provisions of COBRA pursuant to Section 4.06.
- (B) Health insurance may be continued for eligible surviving Dependents after the six (6) months extended Coverage if the agency elected to opt in to Retiree Coverage, and the Employee met the eligibility criteria to continue Retiree group health Coverage as outlined in section 4.04 or 4.05 at the time of death, provided the Dependent enrolls within 60 days of the termination date of free coverage provided in Section 4.02(A) above.
- (1) If the Employee was a vested member of the TCRS, election of a monthly benefit payment from the TCRS is required for insurance continuation. The covered Dependents do not have to be the TCRS 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 Coverage for the surviving Dependents. If Coverage is continued, premiums will be deducted from the deceased Employee's TCRS monthly benefit payment. Covered surviving Dependents must submit the entire monthly insurance premiums directly to BA if the TCRS monthly benefit payment is insufficient to cover the premiums or if the beneficiary of the TCRS monthly benefit payment is not a covered Dependent.
 - (2) If the Employee was not a vested member of the TCRS, premiums must be submitted directly to BA.
- (C) Coverage will not be continued beyond the six (6) months extended Coverage if the Employee did not meet the eligibility criteria to continue Coverage as a Retiree at the time of death. COBRA will be offered.
- (D) In all cases, Dependents must continue to meet all eligibility requirements to continue Coverage.

4.03 Continuation of Coverage During Temporary Disability of a Covered Employee.

Continuation of Coverage During Temporary Disability of a Covered Employee. An Employee who leaves the Employer's payroll because of a work-related injury and receives workers' compensation temporary disability benefits, and who was participating in the Plan at the time the work-related injury occurred, may continue participation in the Plan during the period of such temporary disability. If the temporary disability benefits cease, the Employee may continue Coverage as described at 3.01. The Plan shall pay no medical expenses incurred because of a work-related injury or illness which qualifies the employee for workers compensation benefits.

4.04 Continuation of Coverage for Disabled Employees.

- (A) Disabled Employees. If a covered Employee of an Employer that has "opted-in" to offer Retiree Coverage incurs an injury or illness which results in a total and permanent disability while enrolled in the Plan and employment is terminated, the former Employee may continue Coverage as a disabled Retiree if they are approved for a retirement benefit based on total and permanent disability by TCRS pursuant to Tenn. Code Ann. Title 8, Chapter 36, Part 5 or by the Social Security Administration (SSA), according to the terms provided below:
- (1) There can be no lapse between Plan Coverage as an active Employee and as a disabled Retiree unless the lapse in coverage results from awaiting approval of the disability determination by TCRS or SSA, and TCRS or SSA determines the date of the disability retirement to be on or before the date employment terminated.
 - (2) Retirees Eligible for Medicare will be terminated from Retiree Coverage. Dependents of Retirees Eligible for Medicare may continue with Retiree Coverage until they no longer satisfy Coverage eligibility requirements.
 - (3) **TCRS participants** must be determined to be totally and permanently disabled due to an illness or injury by the TCRS medical panel and must remain eligible for a TCRS monthly disability benefit. The required proof must show total and permanent disability existed on or before the date employment terminated. If the disability results from a work-related injury or illness, the Retiree must also submit written documentation that the disability is the result of a work-related injury. The contribution for continued Coverage is the same premium as required for a non-disabled Retiree and is deducted from the TCRS monthly benefit. If the TCRS monthly benefit payment is insufficient to cover the premium, then the premium payment is the responsibility of the former Employee.
 - (4) **Non-TCRS Participants** must establish total and permanent disability by submitting an award letter from SSA. The required proof must show total and permanent disability existed on or before the date employment terminated. If the disability results from a work-related injury or illness, the Employer must also submit written certification that the disability is the result of a work-related Injury. The contribution for continued Coverage is the responsibility of the former Employee and shall be the same premium as required for a Retiree. A Non-TCRS Participant must have been employed with the Employer at which the injury or illness became disabling for five (5) or more years prior to final termination of employment due to permanent and total disability to continue Coverage as a disabled Retiree.
 - (5) Employees who are granted a TCRS service retirement, but who are also disabled and seek continuation of Coverage as a disabled Retiree, must establish that total disability existed at the time of retirement and that their TCRS or SSA disability approval date is on or before the date on which their active state coverage ceased.

- (B) Disabled Dependents. A Retiree's disabled Dependent who is in receipt of SSA disability shall discontinue Retiree Coverage upon eligibility for Medicare.

4.05 Continuation of Coverage for Retirees.

- (A) Continued Coverage on the Plan is available to Retirees as provided in TCA § 8-27-705 and this Section if the Retiree's Employer at the time of retirement has opted-in to provide Retiree Coverage.
- (B) Each Local Government Agency must elect, in writing, whether to offer Retiree Coverage to its Employees ("opt-in" or "opt-out"). All agencies must elect one of the following choices in writing by the deadline specified in the Retiree Coverage Election form (election form):
 - (1) Provide Coverage for Retirees (or "opt in"). The election to opt in to providing Retiree Coverage shall be effective as of June 30 of the year in which the agency signs the election form and shall entitle the agency to offer Retiree Coverage to active Employees and to continue to offer Retiree Coverage to current Retirees on the Plan. An agency election to opt in will continue to be effective until such election is changed in writing at the time designated for submitting such notice; or
 - (2) Not offer Coverage for Retirees (or "opt out"). The election to opt out of providing Retiree Coverage is effective as of June 30 of the year in which the agency signs the election form. Agency elections to opt out of offering Retiree Coverage in the State sponsored Plan are permanent and no Employees or Retirees shall be eligible to enroll in Retiree Coverage or to continue in Retiree Coverage after June 30 of the year of the agency's election to opt out. Once an election has been made to opt out, the agency may not reinstate Retiree Coverage; or
 - (3) Opt out as in (2) above, as to active Employees only (or "limited opt out"). The limited election opt-out prohibits the agency from offering Retiree Coverage to active Employees after June 30 of the year in which the agency signs the election form. The agency may continue to offer Retiree Coverage to its Retirees that have insurance Coverage on the Retiree Plan effective on or before June 1 of that year. Coverage starts on the first day of the month, and June 1 of the year in which the election form is signed is the last Effective Date which will qualify a Retiree as a current Retiree eligible to continue Coverage prior to the June 30 opt out date. As in (2) above, once an election has been made to opt out for active Employees the agency may not reinstate active Retiree Coverage. However, an agency may elect to opt out of continuing Coverage for current Retirees by selecting "opt-out" (section 4.05 (A)(2)) status in a subsequent Plan Year by timely submission of the election form.
 - (4) Annually, BA's website shall display a list of agencies that have selected option (1) above to opt in to provide Retiree Coverage, and a list of agencies that have selected option (3) above to continue to offer Retiree Coverage to existing Retirees for that Plan Year.
- (C) Retirees and their Dependents may not continue to participate in Retiree Coverage if the Employer elects to "opt out" of Retiree Coverage and not cover existing Retirees, or if the Retiree or Dependent is eligible for Medicare.
- (D) Definitions. For purposes of Section 4.05, the following definitions apply:
 - (1) Continuous Coverage is participation in the Plan without any break in Coverage. COBRA participation that both immediately follows and immediately precedes periods of employment with any entity covered on the Plan constitutes participation in the Plan for purposes of Continuous Coverage to bridge one period of employment to another period of employment with agencies participating in the Local Government Plan.

- (2) Employment with the Employer. Only employment with the Local Government Agency from which the Employee is retiring may be considered Employment with the Employer. Service with any other State, Local Education Agency, or Local Government Agency is not considered Employment with the Employer. Accumulated unused sick leave is included in Employment with the Employer.
- (a) For all TCRS vested members, Employment with the Employer is employment upon which contributions to TCRS are made by the Employee or by the Local Government Agency from which the Employee is retiring on behalf of the Employee. For non-TCRS Participants, Employment with the Employer is employment in a position with the Local Government Agency from which the Employee is retiring, where the Employee qualified for Coverage with the Plan.
 - (b) Military service that did not interrupt employment, educational leave, Leave of Absence, employment with an agency participating in the State or Local Education Plans, or service with another Local Government Agency shall not be considered as Employment with the Employer.
 - (c) Service for which an Employee received a lump sum TCRS retirement payment is not considered Employment with the Employer unless the Employee repurchases the service from TCRS before the Termination Date.
 - (d) BA will calculate Employment with the Employer for all Employees who participated in TCRS and apply for Retiree Coverage by consulting TCRS records. The Employer will certify Employment with the Employer to BA for Employees in non-TCRS Employment who apply for Retiree Coverage.
- (3) Non-TCRS Participant is an Employee that is not vested in the TCRS retirement program so as to be entitled to draw a TCRS retirement benefit
- (4) Retirement Date is, with respect to vested TCRS participants, the date retirement benefits commence as determined by TCRS.
- (5) Termination Date is an Employee's last paid day or last day of leave, from the Employer, whichever is later. A "final" Termination Date is an Employee's last paid day or last day of leave from an agency participating in one of the State Health Plans, whichever is later.
- (E) Employees who retire from Employment with the Employer are eligible to elect continuation of Coverage under the Plan as a Retiree provided the Employer has elected to opt in to Retiree Coverage and that one of the following conditions is met.
- (1) **For TCRS vested members** who terminate employment, one of the following conditions must be met for continuation in the Plan:
- (a) The Retiree must have at least ten (10) or more years of Employment with the Employer, be age 55, and have Continuous Coverage for three (3) years immediately prior to the Termination Date. The requirement to have three (3) years of Continuous Coverage is waived for individuals retiring from an agency who joined the plan for the first time less than three (3) years immediately prior to the individual's Termination Date. The Retirement Date must be on or before the date on which active Coverage has ceased unless the Employee is leaving the Plan and becoming employed by an agency participating in one of the State Health Plans resulting in no lapse in coverage on a state-sponsored plan. The Effective Date of Retiree Coverage will be the first of the month following the Retirement Date or termination of active Coverage, whichever is later.

- (i) The Retiree must apply to continue Coverage within one (1) full calendar month of the expiration of active Coverage or the date of the TCRS notice of retirement letter, whichever is later.
 - (ii) If the Employee does not enroll within the time period specified in (1)(a) above, Retirees and eligible Dependents must meet the special enrollment provisions of Section 2.06 to enroll. To enroll through the special enrollment provisions, the Retiree must have had Coverage on one of the State Health Plans at the final Termination Date and otherwise have satisfied and continue to satisfy eligibility requirements for Retiree Coverage. If the Retiree is no longer eligible for Coverage, the Retiree may not enroll Dependents through the special enrollment provisions of Section 2.06.
- (b) The Retiree must have 20 or more total years of Employment with the Employer, be age 55, and have one (1) year of Continuous Coverage immediately prior to the Termination Date. The requirement to have one year of Continuous Coverage is waived for individuals retiring from an agency who joined the plan for the first time less than one (1) year immediately prior to the individual's Termination Date. The Retirement Date must be on or before the date on which active Coverage has ceased unless the Employee is leaving the Plan and becoming employed by an agency participating in one of the State Health Plans resulting in no lapse in coverage on a state-sponsored plan. The Effective Date of Retiree Coverage will be the first of the month following the Retirement Date or termination of active Coverage, whichever is later.
 - (i) The Retiree must apply to continue Coverage within one (1) full calendar month of the expiration of active Coverage or the date of the TCRS notice of retirement letter, whichever is later.
 - (ii) If the Employee does not enroll within the time period specified in (1)(b) above, Retirees and eligible Dependents must meet the special enrollment provisions of Section 2.06 to enroll. To enroll through the special enrollment provisions, the Retiree must have had Coverage on one of the State Health Plans at the final Termination Date and otherwise have satisfied and continue to satisfy eligibility requirements for Retiree Coverage. If the Retiree is no longer eligible for Coverage, the Retiree may not enroll Dependents through the special enrollment provisions of Section 2.06.
- (c) The Retiree must have 30 or more years of Employment with the Employer and have one (1) year of Continuous Coverage immediately prior to the Termination Date. The requirement to have one (1) year of Continuous Coverage is waived for individuals retiring from an agency who joined the plan for the first time less than one (1) year immediately prior to the individual's Termination Date. The Retirement Date must be on or before the date on which active Coverage has ceased unless the Employee is leaving the Plan and becoming employed by an agency participating in one of the State Health Plans resulting in no lapse in coverage on a state-sponsored plan. The Effective Date of Retiree Coverage will be the first of the month following the Retirement Date or termination of active Coverage, whichever is later.
 - (i) The Retiree must apply to continue Coverage within one (1) full calendar month of the expiration of active Coverage or the date of the TCRS notice of retirement letter, whichever is later.

- (ii) If the Employee does not enroll within the time period specified in (1)(c) above, Retirees and eligible Dependents must meet the special enrollment provisions of Section 2.06 to enroll. To enroll through the special enrollment provisions, the Retiree must have had Coverage on one of the State Health Plans at the final Termination Date and otherwise have satisfied and continue to satisfy eligibility requirements for Retiree Coverage. If the Retiree is no longer eligible for Coverage, the Retiree may not enroll Dependents through the special enrollment provisions of Section 2.06.
- (2) **Non-TCRS Participants.** For Non-TCRS Participants who terminate employment, one of the following conditions must be met for continuation in the Plan:
 - (a) The Retiree must have ten (10) or more years of Employment with the Employer, be age 55, and have three (3) years of Continuous Coverage immediately prior to the Termination Date. The requirement to have three (3) years of Continuous Coverage is waived for individuals retiring from an agency who joined the plan for the first time less than three (3) years immediately prior to the individual's Termination Date. The Termination Date must be on or before the date on which active Coverage has ceased unless the Employee is leaving the Plan and becoming employed by an agency participating in one of the State Health Plans resulting in no lapse in coverage on a state-sponsored plan. The Effective Date of Retiree Coverage will be the first of the month following the final Termination Date or termination of active Coverage, whichever is later.
 - (i) The Retiree must apply to continue Coverage within one (1) full calendar month of the expiration of active Coverage.
 - (ii) If the Employee does not enroll within the time period specified in (2)(a) above, Retirees and eligible Dependents must meet the special enrollment provisions of Section 2.06 to enroll. To enroll through the special enrollment provisions, the Retiree must have had Coverage on one of the State Health Plans at the final Termination Date and otherwise have satisfied and continue to satisfy eligibility requirements for Retiree Coverage. If the Retiree is no longer eligible for Coverage, the Retiree may not enroll Dependents through the special enrollment provisions of Section 2.06.
 - (b) The Retiree must have 20 or more years of Employment with the Employer, be age 55, and have one year of Continuous Coverage immediately prior to final the Termination Date. The requirement to have one (1) year of Continuous Coverage is waived for individuals retiring from an agency who joined the plan for the first time less than one (1) year immediately prior to the individual's Termination Date. The Termination Date must be on or before the date on which active Coverage has ceased unless the Employee is leaving the Plan and becoming employed by an agency participating in one of the State Health Plans resulting in no lapse in coverage on a state-sponsored plan. The Effective Date of Retiree Coverage will be the first of the month following the Termination Date or termination of active Coverage, whichever is later.
 - (i) The Retiree must apply to continue Coverage within one (1) full calendar month of the expiration of active Coverage.
 - (ii) If the Employee does not enroll within the time period specified in (2)(b) above, Retirees and eligible Dependents must meet the special enrollment provisions of Section 2.06 to enroll. To enroll through the special enrollment provisions, the Retiree must have had Coverage on one of the State Health Plans at the final

Termination Date and otherwise have satisfied and continue to satisfy eligibility requirements for Retiree Coverage. If the Retiree is no longer eligible for Coverage, the Retiree may not enroll Dependents through the special enrollment provisions of Section 2.06.

- (c) The Retiree must have 30 or more years of Employment with the Employer and have one (1) year of Continuous Coverage immediately prior to the Termination Date. The requirement to have one (1) year of Continuous Coverage is waived for individuals retiring from an agency who joined the plan for the first time less than one (1) year immediately prior to the individual's Termination Date. The Termination Date must be on or before the date on which active Coverage has ceased unless the Employee is leaving the Plan and becoming employed by an agency participating in one of the State Health Plans resulting in no lapse in coverage on a state-sponsored plan. The Effective Date of Retiree Coverage will be the first of the month following the Termination Date or termination of active Coverage, whichever is later.
 - (i) The Retiree must apply to continue Coverage within one full calendar month of the expiration of active Coverage.
 - (ii) If the Employee does not enroll within the time period specified in (2)(c) above, Retirees and eligible Dependents must meet the special enrollment provisions of Section 2.06 to enroll. To enroll through the special enrollment provisions, the Retiree must have had Coverage on one of the State Health Plans at the final Termination Date and otherwise have satisfied and continue to satisfy eligibility requirements for Retiree Coverage. If the Retiree is no longer eligible for Coverage, the Retiree may not enroll Dependents through the special enrollment provisions of Section 2.06.
- (3) Police Officers and Firefighters Not Participating in TCRS. Retiree Coverage is available to public safety Employees (police officers and firefighters) who are age 50 or older and have 25 or more years of service within the agency they are retiring from, provided that the agency participates in a retirement system other than TCRS and the Employee is not qualified for a reduced retirement benefit. The Employee must have at least one (1) full year prior of Continuous Coverage prior to Termination Date and the Local Government Agency must have "opted in" to provide Retiree Coverage and agreed by resolution to offer early retirement eligibility as provided by this section. Continuation of Retiree Coverage must commence immediately following termination of active Coverage resulting in no lapse in Coverage.
- (4) Utility board members must have at least 20 years of service with the participating utility district from which they are retiring, be age 55, and have at least one (1) year of Continuous Coverage immediately preceding termination of service as a board member, provided that the agency has opted in to offer Retiree Coverage. The one (1) year rule will be waived if the agency has not participated in the Plan for one (1) year. Continuation of Retiree Coverage must immediately follow the termination of active insurance, unless the Retiree goes to work for an agency participating in a State Sponsored Plan resulting in no lapse in coverage on a State Sponsored Plan; OR.

Must have at least 30 years of service with the participating utility district from which they are retiring AND at least one (1) year of Continuous Coverage immediately preceding termination of service as a board member, provided that the agency has opted in to offer Retiree Coverage. Continuation of Retiree Coverage must immediately follow the termination of active Coverage, unless the Retiree goes to work for an agency participating in a State Sponsored Plan resulting in no lapse in Coverage on a State Sponsored Plan.

- (F) Premiums.
- (1) TCRS Participants. If the Retiree is responsible for the entire monthly premium, it shall be deducted from the Retiree's TCRS monthly benefit payment. TCRS Retirees whose insurance premiums exceed their monthly benefit payment shall submit their entire monthly premiums directly to BA.
 - (2) Non-TCRS Participants who are responsible for the entire monthly Retiree premium must submit their premiums directly to BA each month.
 - (3) Agencies that elect to pay all or a portion of their Retiree's premiums will be billed by BA for the entire premium. The Retiree is responsible for paying their portion of the premium to the agency from which they retired.
- (G) Impact of Eligibility for Medicare.
- (1) Retirees and their Dependents may not continue Coverage in the Plan if eligible for Medicare. This prohibition includes persons who were previously ineligible for Medicare and become eligible for Medicare Part A by virtue of a spouse's eligibility, subsequent employment, or for any other reason. The Plan will suspend Coverage for a Retiree who will not provide information to BA concerning Medicare eligibility upon request.
 - (2) If a Retiree and Dependents were grandfathered into the Plan by the Local Government Education Insurance Committee based on Plan provisions in effect when the Retiree's agency joined the Plan for the first time, they may continue Coverage in the Plan even if eligible for Medicare.
 - (3) Eligible Retirees who lose Coverage by becoming eligible for Medicare may apply for coverage in The Tennessee Plan which provides supplemental medical insurance for Retirees with Medicare.
 - (4) Dependent-only Coverage is allowed when a Retiree is removed from the Plan due to Medicare eligibility. A Retiree may continue Dependent-only Coverage until the Dependent no longer meets eligibility requirements.
 - (5) All Retirees must provide information to BA concerning Medicare eligibility upon request to continue Plan Coverage.
- (H) Continuation of Coverage for Surviving Dependents.
- (1) If a covered Retiree dies, Dependents covered at the time of the Retiree's death may retain Coverage for a period up to six (6) months after the date of the Retiree's death without charge. Participation in the Plan during the six (6) months of extended Coverage shall be in addition to continued Coverage available through the provisions of COBRA pursuant to Section 4.06. After expiration of the six (6) months free Coverage provided by this Section, eligible surviving Dependents may apply to continue Coverage as the new HOC. Each surviving Dependent must continue to meet all eligibility requirements to continue Coverage under this Section.
 - (a) A deceased Retiree's surviving eligible Dependents are not required to receive the deceased Retiree's TCRS monthly benefit to continue Coverage.
 - (b) If the Retiree's eligible Dependents receive the deceased Retiree's TCRS monthly benefit payments, the premiums will be deducted from the TCRS benefit payments. The Covered Dependent must submit full premiums directly to BA if the TCRS monthly benefit payments are insufficient to cover the premiums or if the beneficiary of the monthly pension is not a covered Dependent.

- (c) Eligible surviving Dependents of Non-TCRS Participants must submit monthly premiums directly to BA.
 - (2) If Coverage is discontinued for a Retiree's surviving Dependent child because of the Plan's eligibility requirements, the Dependent may be eligible for continued Coverage through COBRA as permitted by federal law.
 - (3) In all cases, surviving Dependents must continue to meet all eligibility requirements in order to continue insurance Coverage other than through COBRA.
- (I) **Retiree Spouse as Active Employee.** At the Termination Date, if the Retiree's spouse is an Employee of an agency participating in one of the State Health Plans, the Retiree may enroll on the active Employee spouse's coverage as a Dependent if the spouse Employee is employed and eligible for active Coverage. Upon the spouse's termination of Coverage or other SQE, the Retiree may enroll in Retiree Coverage as HOC in this Plan if all eligibility criteria of Section 4.05 are met (including meeting applicable Retirement Date and Section 2.06 late enrollment application deadlines). Alternatively, the Retiree may continue as a Dependent on the spouse's Retiree Coverage if the spouse is eligible to continue Coverage as a Retiree.
- (J) **Reinstatement Following Voluntary Cancellation of Coverage.** If a Retiree voluntarily cancels Coverage, that Coverage can be reinstated if all the following conditions are met:
- (1) Premiums are paid current on the Coverage termination date;
 - (2) Retirees and Dependents continue to meet the eligibility requirements; and
 - (3) Retiree submits a written request for reinstatement within one full calendar month of termination of Coverage.

4.06 Limited Continuation of Coverage (COBRA).

- (A) **Definitions.** For purposes of Section 4.06, the following definitions apply:
- (1) **Covered Employee.** An individual who is or was covered under the Plan by virtue of being or having been an Employee.
 - (2) **Eligible.** The state of being qualified to obtain Medicare benefits or continuation of Coverage under this Section of the Plan regardless of whether such benefits are being accessed or received.
 - (3) **Entitled.** The state of being eligible and being enrolled in/accessing available Medicare benefits or continuation of Coverage under this Section of the Plan.
 - (4) **Qualified Beneficiary.** With respect to a Covered Employee under the Plan, any other individual who, on the day before the COBRA Qualifying Event for that Covered Employee, is a Dependent on the Plan as the spouse of the Covered Employee, the dependent child of the Covered Employee, or a child who is born to or placed for adoption with the Covered Employee during the period of continuation Coverage under this Section of the Plan.
 - (5) **COBRA Qualifying Event.** For a Covered Employee, a COBRA Qualifying Event is the termination of the Covered Employee's employment for reasons other than gross misconduct, or the reduction of a Covered Employee's work hours to less than 30 hours per week. For Qualified Beneficiaries, a COBRA Qualifying Event is one of the following:
 - (a) the termination of the Covered Employee's employment for reasons other than gross misconduct, or the reduction of a Covered Employee's work hours to less than 30 hours per week;

- (b) the death of the Covered Employee;
 - (c) a divorce or legal separation from the Covered Employee; or
 - (d) a Dependent child ceasing to be a Dependent as defined by the Plan.
- (B) Continuation of Coverage. Covered Employees and Qualified Beneficiaries may elect to continue Coverage under this Plan for up to 18 months after experiencing a COBRA Qualifying Event which results in loss of Coverage. The following events may extend the period of continued Coverage up to a maximum of 36 months after experiencing a COBRA Qualifying Event:
 - (1) Medicare. If a Qualifying Event occurs less than 18 months after a Covered Employee becomes eligible for benefits under title XVIII of the Social Security Act, the period of continued Coverage for Qualified Beneficiaries shall not terminate before the close of the 36-month period beginning on the date of the Covered Employee's COBRA Qualifying Event.
 - (2) Disability. If a Covered Employee or 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, the Covered Employee or Qualified Beneficiary may elect an additional 11 months (total of up to 29 months from the date of the COBRA Qualifying Event). 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 Eligible for COBRA because of a COBRA Qualifying Event described in Section 4.06(A)(5). 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 COBRA Qualifying Event in Section 4.06(A)(5) must notify BA 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.
 - (3) Extension for Qualified Beneficiaries. A Qualified Beneficiary may elect to continue Coverage under this Plan for up to 36 months after the COBRA Qualifying Event, if such Qualified Beneficiary loses Coverage due to one of the following Qualifying Events:
 - (a) Death of the Covered Employee;
 - (b) Divorce or legal separation from the Covered Employee; or
 - (c) A Dependent child ceases to be a Dependent as defined by the Plan.
 - (4) Multiple Qualifying Events. 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 COBRA 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 no more than 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 COBRA Qualifying Event.
- (C) Election. To continue Coverage, the Covered Employee or Qualified Beneficiary must make written election within 60 calendar days* after the later of the following dates:
 - (1) The date the Covered Employee or Qualified Beneficiary's Coverage terminated due to a Qualifying Event; or

- (2) The date the Covered Employee or Qualified Beneficiary is sent notice of his/her right to elect COBRA continuation Coverage.

*An election is made on the date that it is uploaded to BA or the date of the postmark if mailed to BA at the address provided in the COBRA notice.

(D) Premiums.

- (1) Premium Amount. The total monthly premium for COBRA Coverage must be paid by the Covered Person or Qualified Beneficiary to BA. The monthly premium price shall be 102 percent of the premium amount for Coverage of a similarly situated Employee whose Coverage had not otherwise terminated. When a Covered Employee or Qualified Beneficiary has a special continuation period due to a disability, as described in Section 4.06(B)(2), the monthly cost during the additional 11 months shall be, 150 percent of the premium price.
- (2) Premium Payment Date. The Covered Employee or Qualified Beneficiary must pay the premium 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 BA. The Covered Employee or Qualified Beneficiary must pay the monthly cost by the last day of each month for the following month's Coverage.
- (3) No claims will be paid pursuant to this Section until BA has received the applicable monthly premium for the Coverage.

(E) Notice. A Covered Employee or Qualified Beneficiary shall notify BA or their ABC of a COBRA 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 within 60 calendar days after the date of the COBRA Qualifying Event or the date the Qualified Beneficiary would lose Coverage on account of the COBRA Qualifying Event, whichever is later. A Covered Employee or Qualified Beneficiary who fails to provide notice as required by this Section is deemed to have waived any right to continued Coverage under COBRA.

(F) Termination. A Covered Employee or Qualified Beneficiary's COBRA Coverage shall terminate on the earliest of:

- (1) The date, after the date of the COBRA election, upon which the Covered Employee or Qualified Beneficiary first becomes covered under any other group health Plan;
- (2) The end of the applicable 18-month or 36-month period;
- (3) The end of an additional 11-month disability extension period as described in Section 4.06(B)(2), or the first day of the month that is more than 30 days after a final determination that the Covered Employee or Qualified Beneficiary is no longer disabled, whichever is earlier;
- (4) The date, after the date of the COBRA election, upon which the Covered Employee or Qualified Beneficiary first becomes eligible for Medicare benefits;
- (5) The date the Covered Employee or Qualified Beneficiary fails to make timely payment of the monthly premiums in the manner prescribed by BA; or
- (6) The date on which the Employer ceases to provide a group health Plan (or successor plans) to any Employee.

(G) Annual Enrollment. A COBRA participant is entitled to the same benefits, choices, and services that an Employee receives under the Plan during annual enrollment to: add/drop Coverage; add/drop eligible Dependents; or switch from one benefit package to another within the Plan.

SECTION 5 COORDINATION OF MEDICAL BENEFITS

5.01 General.

The benefits subject to this section are all benefits arising from expenses or charges incurred on or after the Effective Date.

5.02 Definitions.

The following definitions shall apply throughout this section, unless the context clearly requires a different construction:

- (A) **Allowable Expense(s)** is any necessary healthcare charge, at least a portion of which is covered under at least one or more of the Other Plans covering the person for whom claim is made. When the Other Plans provide benefits in the form of services, the reasonable cash value of each service rendered is deemed to be both an Allowable Expense and a benefit paid.
- (B) **Claim Determination Period** is the calendar year (January 1 through December 31); however, it does not include any part of a year during which a person has no Coverage under the Plan.
- (C) **Other Plans** means any Plan providing benefits or services for medical care or treatment including but not limited to:
 - (1) Group, blanket or franchise insurance Coverage (including State of Tennessee Local Government Plan and State of Tennessee Local Education Plan);
 - (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.
- (D) **Primary Plan** is the policy that pays its full allowance of benefits first without regard to other Coverages or Other Plans.
- (E) **Secondary Plan** is a policy that is not the Primary Plan.
- (F) **This Plan** is the State Insurance Plan created by Tenn. Code Ann. § 8-27-202(a)(1).

5.03 Order of Benefits Rules.

- (A) General. When there is a basis for a claim under This Plan and Other Plans, This Plan is a Secondary Plan which has its benefits determined after those of the Other Plan, unless:
 - (1) The Other Plan has rules coordinating its benefits with those of This Plan; and
 - (2) both those rules and This Plan's rules, in subparagraph (B) below, require This Plan to be the Primary Plan.

- (B) Rules. This Plan determines its order of benefits using the first of the following rules which applies:
- (1) Non-Dependent/Dependent. The benefits of a Plan which covers the person as an Employee, member, or subscriber (that is, other than as a Dependent) shall be the Primary Plan and a Plan that covers such person as a Dependent shall be the Secondary Plan.
 - (a) Medicare Exception. 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 when the Covered 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).
 - (2) Dependent Child/Parents Not Separated or Divorced. If This Plan and Other Plan(s) cover the same child as a Dependent of different persons, called “parents”:
 - (a) the benefits of a Plan which covers the parent whose birthday comes first in the calendar year shall be the Primary Plan and the Plan which covers the parent whose birthday comes later in that year shall be the Secondary Plan;
 - (b) if both parents have the same birthday, the Plan which covered the parent longer shall be the Primary Plan and the Plan which covered the other parent for a shorter period shall be the Secondary Plan;
 - (3) Dependent Child/Separated or Divorced Parents. 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. If there is no court decree, the Plan which covers the Dependent of the parent with primary custody, shall be the Primary Plan. If there is no court decree and the parent with primary custody has remarried, the order of benefits shall be as follows:
 - (a) The Plan of the parent with primary custody shall be the Primary Plan.
 - (b) If the parent with primary custody does not have medical Plan Coverage, then the Plan of the spouse of the parent with primary custody shall be the Primary Plan.
 - (c) If neither the parent or spouse with primary custody has medical Plan Coverage, then the Plan of the parent without primary custody shall be the Primary Plan.
 - (4) Active/Inactive Employee. The Plan covering an individual as an Employee (or as the Employee’s Dependent) who is neither laid off nor retired shall be the Primary Plan. The Plan covering that individual as a laid-off or retired Employee (or as that individual’s Dependent) shall be the Secondary Plan. 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) Longer/Shorter Length of Coverage. As to Plans for which rules (1) through (4) 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 the Primary Plan and the Plan which has covered such person the shorter time shall be the Secondary Plan.
- (C) COBRA. When an individual has simultaneous COBRA Coverage and Coverage as an Employee or a Dependent of the Employee, the Plan covering the individual as an Employee, or a Dependent of the Employee, is the Primary Plan, and COBRA is the Secondary Plan. In the event of conflicting coordination provisions between This Plan and any Other Plan(s), This Plan shall be

the Primary Plan for an individual only if This Plan has provided Coverage for a longer period. If the Other Plan(s) does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule shall be ignored.

(D) Medicare Eligible.

- (1) 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:
 - (a) Active Employees; and
 - (b) Dependent spouses of active Employees.
- (2) For individuals who were covered by This Plan as a Covered Person and became Medicare eligible due to end stage renal disease, This Plan shall be the Primary Plan for a period not to exceed 30 months.
- (3) Notwithstanding the foregoing, to the extent that the provisions of This 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 Effect on the Benefits of This Plan

- (A) This section applies when, in accordance with Section 5.03 Order of Benefits Rules, This Plan is a Secondary Plan as to one or more Other Plans. The benefits of This Plan will be reduced when the sum of the following two amounts exceed the Allowable Expenses in a Claim Determination Period:
 - (1) The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
 - (2) The benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.
- (B) When the sum of (1) and (2) above exceeds the Allowable Expenses in a Claim Determination Period, benefits will be reduced so that the benefits under This Plan and the benefits payable under the Other Plans do not total more than the Allowable Expenses. When the benefits of This Plan are reduced, each benefit is reduced in proportion and is then charged against any applicable benefit limit of This Plan. This Plan will determine its liability for benefits payable in absence of the Other Plan and pay the lesser of: (a) This Plan's Allowable Expenses minus the Other Plan's payment; or (b) This Plan's original liability. In both (a) and (b), the Covered Persons' copayments and deductible/coinsurance under This Plan shall apply.
- (C) Benefits payable under Other Plan(s) include the benefits that would have been payable had the claim been duly made therefor. 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.

5.05 Subrogation Rights.

- (A) 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 all amounts equal to its payments from the insurance company of the injured party, from the person who caused the Illness or Injury or his/her insurance

company, or from any other source such as uninsured motorist Coverage. The Plan's right to recovery may be exercised by agreement, litigation or settlement.

- (B) In order to facilitate the Plan's right to subrogation, the Covered Person shall promptly notify BA if the Covered Person's Illness or Injury resulted from the action or fault of a third party. The Covered Person shall also provide all information requested by BA or its representative and sign all documents requested by BA or its representative in order to assist the Plan with asserting its subrogation rights. If the Covered Person hires an attorney to represent them in legal proceedings relating to any Injury or Illness for which the sums have been or may be paid by the Plan, the Covered Person must inform the attorney of the Plan's subrogation rights and notify BA within 7 business days that an attorney has been hired. The Covered Person shall answer all documentation requests related to the subrogation claims.
- (C) If the Covered Person fails to cooperate or proceeds to negotiate settlements of any claim without the written consent of BA, the Plan shall be entitled to recover an amount equal to all medical expense payments made by the Plan plus reasonable attorney's fees and court costs incurred in recovering said amounts from the Covered Person. Failure to comply with this provision, may result in the disenrollment of the Covered Person and their Dependents from the Plan. A State Employee who submits false information to the Committee or its representatives may also be subject to disciplinary action.

5.06 Right of Reimbursement.

- (A) If a Covered Person receives payment from a third party specifically for the medical expenses which have been paid by the Plan, the Covered Person shall reimburse the Plan, up to the amount paid by the Plan, from the money such Covered Person (or such Covered Person's family) received. The Covered Person shall 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 BA or its representative and answer any and all documentation requests related to the Plan's right of reimbursement. The Covered Person shall immediately notify the Plan of any pending or final judgment or settlement from a third party for medical expenses. Failure to respond to BA's requests for information or failure to reimburse the Plan for money received for medical expenses, may result in disenrollment of the Covered Person and eligible Dependents from the Plan. A State Employee who submits false information to the Committee or its representatives may also be subject to disciplinary action.
- (B) 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 shall assist the Plan in enforcing its rights under this provision by signing or delivering all documents requested by BA or its representative.

5.07 Recovery of Payment.

If payments are made by the Plan in a total amount, at any time, in excess of the maximum allowable expense for a service or benefit, the Plan shall have the right to recover such overpayments to the extent of such excess from one or more of the following:

- (A) Any person to, or on behalf of whom such payments were made;
- (B) Any insurance company; or
- (C) Any other appropriate organization or entity.

5.08 Dependents Previously Covered as Employees and Employees Previously Covered as Dependents.

All maximum benefits apply to individuals insured under the Plan whether they are Employees or Dependents. If an individual transitions between Employee status and Dependent status within the Plan Year, benefit limitations will be applied without consideration of the status changes.

SECTION 6 PLAN ADMINISTRATION

6.01 General.

The State Insurance Committee administers the Plan, including determination of premiums, benefits, funding, administrative procedures, eligibility provisions and rules relating to the Plan, as authorized by Title 8, Chapter 27 of Tenn. Code Ann. The Committee may delegate administrative duties to the Division of BA as provided by Tenn. Code Ann. § 8-27-101(c).

6.02 Liability of the Committee.

- (A) The State Insurance Committee is an arm of the State government and is entitled to all immunities and defenses from liability applicable to the State of Tennessee.
- (B) Members of the State Insurance Committee are considered “State officers” or “Employees” as the meaning is set forth in TCA 8-42-101(3) and are entitled to all applicable immunities and defenses from liability.

6.03 Authority and Powers of the Committee.

The Committee shall be responsible for all duties necessary and appropriate to carry out the authority conferred by Title 8, Chapter 27 of Tenn. Code Ann. and other applicable law, including delegation of administrative duties.

- (A) The Committee has delegated authority to perform the following administrative duties to BA, unless otherwise required by State or Federal law or otherwise provided in this Plan Document:
 - (1) To interpret and explain the Plan;
 - (2) To decide all questions of Plan eligibility;
 - (3) To establish enrollment procedures for the Plan;
 - (4) To prepare and distribute information explaining the Plan;
 - (5) To request information for proper administration of the Plan;
 - (6) To receive and maintain records pertaining to the Plan;
 - (7) To provide recommendations to the Committee for the financing of the Plan, including benefit levels and premium rates, in consultation with contractors as needed;
 - (8) To perform all contract procurement functions in a manner consistent with TCA §§ 8-27-101(c) and 103 and CPO Rules and Policies, and arrive upon a proposed award recipient to recommend to the Committee for approval;
 - (9) To manage the contracts procured in subsection (A)(8) and serve as liaison between the Plan and the contractors; and
 - (10) To conduct internal BART appeals as provided in Section 6.04.
- (B) The Committee may vote to delegate administrative duties not listed in (A) above to BA.
- (C) At any time, the administrative duties delegated in (A) above may be revised by a vote of The Committee.

6.04 Appeals Provision.

(A) Definitions For the purposes of this section:

- (1) **Appeal** is a formal challenge to or request for review, re-consideration, or reversal of an adverse determination of benefits, payment denial, enrollment decision or premium decision under this Plan. An Appeal must be submitted by the Covered Person (with or without assistance from an Authorized Person) or a Personal Representative of the Covered Person and must follow the rules provided herein as well as any applicable provisions of a Covered Person's Member Handbook.
- (2) **Personal Representative** is an individual or entity, such as a parent, guardian, conservator, representative of an estate, or an attorney, legally acting as the Covered Person. A Personal Representative must have a legal relationship to the Covered Person and does not include a Provider or an assignee of the Covered Person.
- (3) **Authorized Person** is an individual or entity, such as a spouse, relative, or friend, having a Covered Person's permission to help them dispute an issue or file an appeal in the name of the Covered Person. An Authorized Person is different than a Personal Representative because an Authorized Person is not legally acting as the Covered Person. An Authorized Person may only assist the Covered Person, and the Covered Person retains all legal rights.
- (4) **Payment** is the amount paid or not paid by the Plan for Medical Services.
- (5) **Enrollment** is the eligibility, Effective Dates of Coverage, or enrollment status as a Covered Person.
- (6) **Medical Services** are healthcare services delivered on an Outpatient or Inpatient basis, prescriptions, and medical equipment.
- (7) **Premium** is the amount that a Head of Contract is required to pay for Plan enrollment, and/or the unpaid amount owed by the Head of Contract.
- (8) **Provider** is a person or entity that provides Medical Services to a Covered Person. A Provider has no agreement with the State of Tennessee or the Plan but may be contracted with one or more TPAs to provide Medical Services to Covered Persons.
- (9) **Dispute** is an informal challenge to or request for review, re-consideration, or reversal of an adverse determination of benefits, payment denial, enrollment decision or premium decision under this Plan.

(B) Pre-Appeal Communication.

- (1) To Dispute a decision regarding Coverage for Medical Services or a Payment, a Covered Person with or without help from an Authorized Person or Personal Representative should call the TPA at the telephone number listed on the Covered Person's insurance card. If the Covered Person has received related correspondence the Covered Person, Authorized Person, or Personal Representative should call the number provided on the correspondence to discuss the issue. A telephone call does not constitute an Appeal, but a call should be made as soon as possible upon learning of any denial of Payment or Medical Services.
- (2) To Dispute a decision regarding Enrollment or Premium, the Head of Contract with or without help from an Authorized Person or a Personal Representative should call Benefits Administration at 1-800-253-9981 or visit <https://tn.gov/partnersforhealth>. If the Head of Contract has received related correspondence, the Head of Contract, Authorized Person, or a Personal Representative should mention the correspondence and ask to discuss the issue. A telephone call does not constitute an Appeal, but a call should be made as soon as possible upon learning of any Enrollment or Premium issues.

- (C) **Appeal Deadline.** To initiate an Appeal discussed in this Section the Appeal must be submitted by the Covered Person with or without help from an Authorized Person or a Personal Representative within one-hundred, eighty (180) calendar days after receipt of notification of an adverse determination.
- (D) **Medical Services and Payment Appeals.** Medical Services and Payment Appeals are submitted to and resolved by the TPA administering the benefits of the Covered Person. In addition to the initial internal Appeal initiated within one hundred and eighty (180) calendar days after receipt of notice of an adverse determination, a Covered Person with or without help from an Authorized Person or a Personal Representative may initiate a second internal Appeal to the TPA one hundred and eighty (180) calendar days from receipt of an adverse determination of the initial Appeal. If the benefit determination involved medical judgment, a Covered Person may submit an external Appeal to an Independent Review Organization (IRO) within four months of receipt of notice of an adverse decision of an internal Appeal. The Member Handbooks provide the address where internal and external Appeals must be filed.
- (E) **Enrollment and Premium Appeals.** A Head of Contract with or without help from an Authorized Person or Personal Representative may file an Enrollment or Premium Appeal. The Appeal is submitted to and decided by the Benefit Administration Review Team (BART) within BA. The Appeal must be timely submitted in writing (which may be electronic mail) to BA at the following address: Benefits.Administration@tn.gov, or State of Tennessee, Department of Finance and Administration, Benefits Administration, 312 Rosa L. Parks Avenue, Suite 1900 William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102. Enrollment and Premium Appeals are not decided by TPAs and no external administrative Appeal is provided. An Enrollment Appeal cannot be utilized to make mid-year benefit election changes not otherwise permitted by Sections 2.06 and 4.01 of the Plan Document. A retroactive termination of enrollment that meets the definition of “rescission” under 45 CFR 147.128 is appealable and shall be resolved in accordance with Federal law.
- (F) **Provider Appeals.** The Plan does not provide an Appeal process for Providers, does not review disputes under a Provider/TPA contract, and does not permit Covered Persons to assign Appeal rights to a Provider. A Provider may assist a Covered Person to prepare an Appeal but shall not become a party to such Appeal. In the event of a conflict between this provision and applicable State or federal law explicitly requiring the Plan (as a governmental Plan exempt from ERISA) to permit assignment of Appeal rights to a Provider in certain circumstances, the applicable law shall control. Providers may Appeal to TPAs on their own behalf if permitted by an agreement between the Provider and the TPA or State or federal law, and all such appeals are not an appeal or administrative remedy provided by this Plan.

SECTION 7 CLAIM PROVISIONS

7.01 Proof of Claim.

Written claim for benefits under the Plan must be furnished to the TPA by the covered person or Provider, in a format acceptable to the TPA.

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 TPA shall notify the Covered Person in writing of the amount of benefit to which he/she is entitled, the recipient of the payment, 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 Verification of Request for Medical Services.

The TPAs may verify the basis for requests for medical services under the Plan including a determination of medical necessity when appropriate.

7.04 Overpayments Incorrect, and Fraudulent Payments.

- (A) The Plan has the authority to pursue recovery of any benefit payments made in error or in excess of contract liability. The Committee may enter into contracts to collect amounts owed to the Plan.
- (B) The Plan shall pursue recovery of all payments and other losses resulting from any fraud against the Plan including misrepresentation of eligibility or expense on the part of a Covered Person. The Plan will coordinate with the Comptroller and other applicable State agencies in identifying and recovering losses due to fraud.

SECTION 8 CONTRIBUTIONS

8.01 Contributions by Covered Persons.

- (A) Covered Persons are required to make premium contributions as a condition of participating in the Plan. By completing an enrollment application, Covered Person shall authorize deduction of the Covered Person's share of the monthly premium from his/her pay or retirement pension.
- (B) Covered Persons who do not receive Employee pay or a Retiree pension or whose retirement pension is insufficient to cover the required premium contribution shall submit direct payment in an amount equal to the monthly premium contribution. 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 designated timeframe. Should a 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.
- (C) The Plan permits a premium deferral period of a full calendar month for premiums being billed directly to the Covered Person. 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. If Coverage for Covered Persons who are billed directly is canceled at the end of the deferral period for failure to pay, the Covered Person has 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. BA must receive all signed required documentation and all premiums due within 30 days of the request for reinstatement.

8.02 Employer Contributions.

For Employees, the Employer (LGA) may contribute to premiums on behalf of the Employee.

8.03 Funding Medium.

- (A) The choice of insurance companies or TPAs under the Plan, the timing and amount of any payment to such company, and the timing and amount of any contribution to any fund established under the Plan shall be at the sole discretion of the Committee. The Employer may at its sole discretion, establish one or more trusts to hold such assets to fund its Other Post Employment Benefit liability for current and future retired persons.

Contributions by the Employer, covered Employees, COBRA participants and retired Employees for insurance premiums shall be made to a dedicated fund established by the State to provide funding of the Plan. All contributions under this Plan shall be applied toward the payment of benefits provided by the Plan and reasonable expenses of administering the Plan.

- (B) Premium refunds.
 - (1) An Employee who fails to provide timely notice about a change in insurance enrollments as required by this Plan is limited to a refund of three months of their portion of the premium, and the agency will receive a refund of all premium contributions. If the Plan paid benefits to or on behalf of an ineligible person before notice of the enrollment change was provided, the Employee shall be responsible to repay all overpaid benefits, and the premiums paid will be applied to the overpayment of benefits before any refund is made to the Employee.

- (2) If an Employee provides timely notice of an enrollment change as required by this Plan, but the request is not processed properly by the employing agency, the Employee will receive a full refund of premiums paid, and the agency is limited to a refund of three months of premium contributions. If the Plan paid benefits to or on behalf of an ineligible person, the agency shall be responsible for payment of all overpayments of benefits, and the premiums paid will be applied to the overpayment of benefits before any refund is made to the agency.
- (3) An Agency that fails to report Employee separations or terminations is limited to a three-month refund contributions. The agency shall be responsible for payment of all benefits paid to or on behalf of an ineligible separated Employee or Dependent and the premiums paid will be applied to the overpayment of benefits before any refund is made to the agency.
- (4) Retiree premium refunds and recoupment of benefits paid in error on behalf of Retirees and Retiree Dependents arising from Retiree enrollment notice failures shall be processed in the same manner as is provided in 8.03(B) (1), (2), or (3) above for Employees.
- (5) When the State determines that fraud exists related to enrollment in the Plan, BA will employ applicable offset procedures to the refund of the Employee or Retiree premium contribution. An impacted agency will receive a full refund of its premium contribution.

SECTION 9 AMENDMENT AND TERMINATION

9.01 Plan Modification and Amendment of Plan.

- (A) The Plan may be amended by the Committee. The Plan amendment shall be effective at the date of approval, unless another date is required by law, or expressly provided at the time of approval.
- (B) If a provision in the Plan Document is determined to conflict with State or federal law, the conflicting provision of the Plan Document will have no force or effect, and the Plan will operate to comply with the applicable law. BA is authorized to amend the provisions of the Plan Document when necessary for compliance with applicable law without approval of the Committee.
- (C) BA is authorized to revise the Plan Document to correct spelling, grammatical, or formatting errors without submitting those revisions to the Committee for approval.

9.02 Plan Termination.

The Plan will continue to operate unless the General Assembly determines to terminate the Plan. In case of termination, the Plan will comply with all federal and State laws and directives of the Plan Sponsor regarding notice to Plan members and termination of the Plan.

9.03 Local Government Agency Termination.

An Employer may terminate participation in the Plan by providing written notification to the Committee or its representative. Notification should be given 60 calendar days prior to the termination date. Any agency that ceases participation with the Plan is prohibited from rejoining the Plan for 24 months. If an agency ceases to participate in the Plan, currently enrolled Employees and Dependents as well as COBRA participants and Retirees associated with that agency once again become the responsibility of that agency. In the event that a participating agency does not formally terminate participation in the Plan and does not have any active Employees that are eligible for Coverage, then the agency is deemed to have withdrawn from the Plan.

SECTION 10 PRIVACY OF PROTECTED HEALTH INFORMATION

10.01 Definitions.

For purposes of compliance with the Health Information Portability and Accountability Act (HIPAA), the following definitions apply to terms in this Section.

- (A) “Plan Sponsor” means the State of Tennessee and the Local Government Insurance Committee.
- (B) “Plan Administrator” and “Covered Entity” means the Division of Benefits Administration of the Department of Finance and Administration, and Employees of other State of Tennessee agencies specifically authorized to perform services for the Plan Administrator, such as Agency Benefits Coordinators.
- (C) “Plan” means the Local Government Insurance Plan as administered by the “Plan Administrator”.
- (D) The terms “Business Associate”, “Covered Entity”, and “Protected Health Information (PHI)” shall have the meaning set forth in HIPAA regulation 45 CFR §160.103.

10.02 Plan Sponsor Certification of Compliance.

Neither the Plan, the Plan Administrator, nor the TPAs or Business Associate servicing the Plan will disclose Covered Persons’ Protected Health Information (PHI) to the Plan Sponsor unless the Plan Sponsor certifies agreement to abide by this Section.

10.03 Purpose of Disclosure to Plan Sponsor.

- (A) The Plan, the Plan Administrator, TPAs and Business Associates servicing the Plan will disclose Covered Persons’ PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan in a manner that is consistent with the requirements of HIPAA and its implementing regulations (45 C.F.R. Parts 160- 64). Any disclosure and use of Covered Persons’ PHI by the Plan Sponsor will be subject to and consistent with the provisions of Sections 10.04 and 10.05 of this Section.
- (B) Neither the Plan, Plan Administrator, TPAs nor Business Associates servicing the Plan will disclose Covered Persons’ PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Covered Persons.
- (C) Neither the Plan, Plan Administrator, TPAs, nor Business Associates servicing the Plan will disclose Covered Persons’ PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or Employee benefit Plan of the Plan Sponsor.

10.04 Restrictions on Plan Sponsor Use and Disclosure of PHI.

- (A) The Plan Sponsor shall not use or further disclose Covered Persons’ PHI, except as permitted or required by the Plan, as amended, or as required by law.
- (B) The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Covered Persons’ PHI, agrees to the restrictions and conditions of the Plan, including this Section, with respect to PHI.
- (C) The Plan Sponsor will not use or disclose Covered Persons’ PHI for employment-related actions or decisions or in connection with any other benefit or Employee benefit Plan of the Plan Sponsor.

- (D) The Plan Sponsor will report any use or disclosure of Covered Persons' PHI that is inconsistent with the uses and disclosures allowed under this Section to the Plan Administrator promptly upon learning of such inconsistent use or disclosure.
- (E) The Plan Sponsor will make PHI available to the Plan or to the Covered Person who is the subject of the information in accordance with 45 C.F.R. § 164.524.
- (F) The Plan Sponsor will make Covered Persons' PHI available for amendment and will on notice amend Covered Persons' PHI, in accordance with 45 C.F.R. § 164.526.
- (G) The Plan Sponsor will track disclosures it may make of Covered Persons' PHI 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 Plan Sponsor will make their internal practices, books, and records relating to its use and disclosure of Covered Persons' PHI 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 Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Covered Persons' PHI in whatever form or medium received from the Plan Administrator, TPAs, or Business Associates servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Person who is the subject of the PHI, when the Covered Persons' PHI 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 Covered Persons' PHI, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Covered Persons' PHI that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.
- (J) The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains or transmits in connection with the approved Plan administration functions.
- (K) The Plan Sponsor will ensure that any agent or subcontractor to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect the PHI.
- (L) The Plan Sponsor shall immediately report any security incident of which it becomes aware to the Plan Administrator.

10.05 Adequate Separation between the Plan Sponsor and the Plan.

- (A) The following Employees or classes of Employees or other workforce members delegated Plan Administration functions by the Plan Sponsor may be given access to Covered Persons' PHI received from the Plan, TPAs, or Business Associates servicing the Plan:
 - (1) Employees or contractors of the Plan Administrator.
 - (2) Other Employees or subcontractors of the State of Tennessee Department of Finance and Administration responsible for providing legal, accounting, auditing, payroll, payment, or technical support to the Plan Administrator.
- (B) The classes of Employees or other workforce members identified in Section 10.05 (A) of this Section will have access to Covered Persons' PHI provided to the Plan Sponsor to perform the Plan administration functions that they provide for the Plan.

- (C) The classes of Employees or other workforce members identified in Section 10.05 (A) of this Section will be subject to the appropriate personnel policies of the State of Tennessee regarding disciplinary action for any use or disclosure of Covered Persons' PHI that violates or fails to comply with the provisions of this Section. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan Administrator, and will cooperate with the Plan Administrator to mitigate the impact of such violation or noncompliance upon all Covered Persons whose PHI may have been compromised by the breach, violation or noncompliance.

10.06 HIPAA Compliance

The Plan Administrator who has been delegated the authority to operate the Plan is a Covered Entity responsible for complying with HIPAA including the Privacy, Security, and Breach Notification Rules and the HITECH Act amendments. The Plan Administrator shall coordinate with the Local Government Insurance Committee on HIPAA compliance issues and report on such issues upon request.

SECTION 11 MEDICAL, MENTAL HEALTH AND SUBSTANCE USE BENEFITS

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 financial responsibility. The balance of the amount of benefits, up to 100% of the Maximum Allowable Charge for Covered Expenses, is provided by the Plan. The amount of benefits is further subject to the Out-of-Pocket Maximum 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 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. If the Covered Person has incurred Covered Expenses equal to the deductible dollar amount (separate deductibles for In-Network and Out-of-Network expenses) 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 11.04. The deductible amount shown in Attachment A is for medical services, pharmacy, 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 (separate deductibles for In-Network and Out-of-Network expenses) 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 11.04. The deductible amount shown in Attachment A is for medical services, pharmacy, and mental health and substance use treatment services combined.
- (C) Common Accident Deductible. If two or more Covered Persons who are enrolled together in a family Plan, incur Covered Expenses due to injuries sustained in the same accident, only one individual deductible shall be applied to the total of their combined Covered Expenses related to the accident, incurred during the Plan Year in which such accident occurred.

11.03 Copayment.

The copayment amount is required to be paid by the Covered Person for certain Covered Expenses as outlined in Attachment A before the Plan will pay the remainder up to the Maximum Allowable Charge.

11.04 Coinsurance.

The Plan will pay a percentage (the “applicable coinsurance percentage”) of Covered Expenses incurred within each Plan Year as outlined in Attachment A, and which are more than the deductible requirements of Section 11.02.

11.05 Out of Pocket Maximum.

- (A) Individual. After the maximum amount (separate cumulative maximums for In-Network and out-of-network expenses) of individual 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 Lifetime Maximum Benefits.

There is no dollar amount lifetime maximum benefit for medical services and mental health and substance use treatment services under the Plan.

11.07 Expenses.

The TPA does not furnish covered services directly but rather pays benefits according to the Plan. The TPA, 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. The ultimate choice of a Provider is solely up to each 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.

- (A) In-Network Expenses. In the event of Covered Expenses for those services received from and payable to a Provider contracted with the network, the applicable deductible, copayment, and coinsurance percentage shall be the In-Network amount indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.04, have been followed, if applicable.
- (B) Out-of-Network Expenses. In the event of Covered Expenses for those services received from and payable to a Provider not contracted with the network, the applicable deductible, copayment, and coinsurance percentage shall be the Out-of-Network amount indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.04, have been followed, if applicable.
- (C) Expenses Which Are Determined Not to be Medically Necessary and/or Clinically Necessary. If an expense is determined by the TPA not to be Medically Necessary and/or Clinically Necessary, the Plan will make no benefit payments.
- (D) Ancillary Services. Ancillary services include Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. In the event of Covered Expenses incurred with ancillary service Providers at In-Network facilities, reimbursement will be made at the In-Network level of benefits as outlined in Attachment A. The Covered Person will not be responsible for any Covered Expenses which exceed the Maximum Allowable Charge for any such ancillary service Providers at In-Network facilities.

- (E) **Pharmacy Benefits.** Covered Persons shall utilize a pharmacy in the network established by the TPA for pharmacy benefits. If the prescription is filled at a participating retail pharmacy, a participating mail order pharmacy, a participating retail-90 pharmacy, or a participating specialty 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 and the pharmacy insurance identification card is presented, the charges for the prescription will be electronically filed with the TPA for pharmacy benefits. If a Covered Person does not use their pharmacy identification card at a participating pharmacy, the claim can be submitted to the TPA for pharmacy benefits by the Covered Person and any amounts exceeding the Maximum Allowable Charge in addition to the amounts listed in Attachment A, are the responsibility of the Covered Person. If a Covered Person utilizes a non- participating pharmacy for a 30- day supply, the claim can be submitted to the TPA by the Covered Person and any amounts exceeding the Maximum Allowable Charge in addition to the amounts listed in Attachment A are the responsibility of the Covered Person. Prescriptions are generally limited to a 30- day supply with some having additional quantity limits, step therapy requirements, and Prior Authorization requirements. Certain medications can be purchased through participating mail order pharmacies and certain participating retail-90 pharmacies for up to a 90-day supply with a copayment or coinsurance as outlined in Attachment A.
- (F) **Emergency Benefits.** The TPA will determine benefits for Emergency services meeting the definition of Emergency, as outlined in Section 1.15, at the level indicated in Attachment A and all applicable State and federal laws.
- (G) **Durable Medical Equipment.** If it is determined that a Covered Person requires the use of Durable Medical Equipment, the Covered Person should have a written prescription from a network Provider for such Durable Medical Equipment. The level of reimbursement is outlined in Attachment A.
- (H) **Detoxification.** In the event of Covered Expenses for a detoxification program, benefits will be paid by the applicable TPA at the level indicated in Attachment A provided that the guidelines of the utilization management program, as outlined in Section 11.04, have been followed, if applicable.
- (I) **EAP Benefits.** Employee Assistance Program (EAP) services consist of short-term counseling (up to eight sessions per problem episode, per individual, per year) 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. Prior Authorization is required for all EAP services.
- (1) Services are available at no cost to all Employees and Retirees enrolled in the health Plan and their eligible enrolled or unenrolled Dependents. Enrolled COBRA participants are also eligible.
 - (2) A LGA may elect to offer EAP services to Employees who are eligible for, but not enrolled in, the health Plan. This offering shall include eight EAP visits and access to all work-life resources at no cost to the Employee; however, the agency will incur an additional expense. Prior authorization is required for all EAP services. Any LGA intending to provide this option must notify BA upon joining the Plan or no later than August 1 of the calendar year preceding the January 1 effective date of such benefits.
- (J) **Out-of-State Retirees, Employees, Spouses, Dependent Children and COBRA Participants.** Covered Persons who permanently reside out of the State, who are stationed outside of the State on a job assignment, or are temporarily residing out of the State , should utilize the out of area network established by the TPA to access In-Network Providers, facilities and agencies that

participate in each State. Covered Persons who choose a Provider in the TPA's out of State network will receive In- Network benefits for covered services as outlined in Attachment A. Covered Persons who choose a Provider who does not participate in the TPA's out of State network will receive Out-of-Network benefits for covered non-Emergency services as outlined in Attachment A.

- (K) **Out-of-Country Benefits.** If expenses are incurred for Medically Necessary non-Emergency and non- urgent services while a Covered Person is out of the country for business or pleasure, benefits shall be paid, subject to Out-of-Network cost sharing and all other terms and conditions of the Plan. Out-of- Country Medically Necessary Emergency services shall be paid according to Section 11.07 (F). No benefits will be paid if a Covered Person travels to another country for the purpose of seeking medical treatment outside the United States. All charges incurred in a non-English speaking country must be translated to standard English at the Covered Person's expense before they are submitted to the TPA. The current exchange rate should also be provided.

11.08 Unique Care.

A unique care exception may be approved when the duration, medical or clinical complexity and/or level of professional skill, training and experience warrant highly specialized treatment, and such treatment is not available through a network Provider as determined by the TPA. When a unique care exception is pre-approved by the TPA, unique care services may be provided by an Out-of-Network Provider and Covered Expenses are paid at the In-Network level of benefits. The TPA will work with the Out-of-Network Provider to negotiate a single case agreement. Approval of a unique care exception is not a guarantee the Out-of-Network Provider will accept a single case agreement or the Maximum Allowable Charge as payment in full. The Covered Person is responsible for expenses determined not to be medically or Clinically Necessary and expenses that exceed the Maximum Allowable Charge if the Out-of-Network Provider decides to bill the Covered Person for the balance of the billed charges. If a Covered Person is billed for expenses exceeding the Maximum Allowable Charge, the Covered Person can request a reconsideration of the amount paid by the Plan. If the TPA determines additional reimbursement is consistent with the unique care provided, the TPA may reprocess the claim to pay an allowable amount up to 150 percent of the Maximum Allowable Charge.

11.09 Continuous Care

A continuous care exception may be approved when a Covered Person is undergoing an active treatment Plan for a serious clinical condition or a serious medical condition, including pregnancy if their treating Provider leaves the network. The TPA determines the medical or clinical need and the time frame for which continuous care will be covered. When a continuous care exception is pre-approved by the TPA, the Covered Person may continue to receive services from their treating Provider for the approved time frame and Covered Expenses are paid at the In-Network level of benefits. The Covered Person is responsible for expenses determined not to be medically or Clinically Necessary and expenses that exceed the Maximum Allowable Charge if the Provider decides to bill the Covered Person for the balance.

11.10 Covered Person's Responsibility Regarding Certification and Authorization Requirements.

A Covered Person has the responsibility to notify his/her Provider and facility that they are a Covered Person under the Plan and that the Plan has certification and authorization requirements. 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 a Provider or facility that they are a Covered Person under the Plan before the admission or services being rendered, it will be the Provider's responsibility to contact the TPA for authorization. If a Covered Person, prior to an elective admission or service, does not notify the Provider that they are a Covered Person under the Plan, does not give the Provider correct information or the Covered Person will not admit to being covered by the Plan when

asked by the Provider, the Plan will be held harmless if authorization is not obtained. The Covered Person will be responsible for the full payment. 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, the Covered Person may follow the appeals process outlined in Section 6.04. The appeal shall ensure that Covered Persons who, in good faith, attempt to comply with the utilization management requirements are provided benefits at the same level as if those procedures had been followed

- (A) In Network Providers. If authorization is not obtained by a network Provider, the Plan and the Covered Person shall be held harmless from charges resulting from not satisfying the utilization management requirements. Network Providers have, by separate contract with the TPA, agreed not to bill the Covered Person if the TPA determines that service(s) were not Medically Necessary, or if the network Provider has not followed applicable utilization management requirements, such as obtaining certification or authorization, unless the Covered Person has signed an advance beneficiary notice for the specific services rendered including the date of service, signed by the member prior to the service being rendered.
- (B) Out of Network Providers. If a Covered Person uses Out-of-Network Providers, it is the Covered Person's responsibility to confirm authorization with the TPA prior to a non-Emergency admission or receiving nonemergent services. When using Out-of-Network Providers, benefits for Medically Necessary non-emergent services will be reduced by half if certification or authorization is required but not obtained, subject to the Maximum Allowable Charge. If services are not Medically Necessary as determined by the TPA, no benefits will be provided, and services will not be covered or reimbursed by the Plan and expenses will be the responsibility of the Covered Person.

11.11 Utilization Management Program.

The TPA shall establish procedures for administering the utilization management program. Utilization management requirements include but are not limited to certifications and authorizations, hospital admissions, Emergency admissions, Outpatient procedures and services, home health care, mental health and substance use, and case management. These programs are used to determine payment of benefits and not to supersede the physician/patient relationship. The level and duration of medical care is always the patient's decision in conjunction with his/her physician.

- (A) Certifications and Authorizations. A Provider may obtain certifications and authorizations by writing to the TPA (no more than 30 days in advance) or by calling the TPA on the certification toll-free line. It is the responsibility of the Provider to obtain certifications and authorizations. It is also the Providers responsibility to obtain extension of days for Inpatient admissions unless the admission is an Emergency. The TPA will approve or deny the Provider's requests, unless additional information is needed before a determination can be made. Once all the information is received by the TPA, the Provider's request will be denied or approved within required timeframes.

When reviewing requests for elective or Emergency admissions or services, the TPA shall use medical personnel under the direction of a physician to determine the medical necessity, timing and setting of the medical care.

When the Provider's request, including a certification or Prior Authorization as defined in Section 1.46, is approved or denied, the TPA will send a letter to the Covered Person (or his/her guardian), Provider and facility advising them of the approval or denial of the request. This letter will be sent within the required timeframe after the request is denied or approved. When a request is approved, the TPA will notify the Provider of the timeframe for the approval and the number of days that are being certified if the approval is for an Inpatient stay.

If the admission is in an in-network facility, it will be the facility's responsibility to contact the TPA if

the Provider wants to request additional Inpatient days. If the benefits for additional Inpatient days are denied, the TPA will notify the patient, the Provider and facility on what date Inpatient benefits will cease. If the admission is in a non-network facility, the TPA will contact the facility the day following the last day of certification to confirm the patient has been discharged from the facility. If the Provider requests additional Inpatient days and the extension of Inpatient benefits is denied, the TPA will notify the patient, the Provider and facility of what date Inpatient benefits will cease.

When determining if additional Inpatient days should be certified, the TPA will review the health care services delivered during the admission to make sure they meet industry standards of quality and are consistent with the patient's needs. If the TPA determines that, after reviewing the facility 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 11.10(A).

- (B) Hospital Admissions. To assure the necessity, appropriateness and quality of the hospital care a Covered Person receives, the applicable TPA shall review all hospital admissions to authorize medical necessity and length of stay.

To receive benefits for non-Emergency hospital admissions the TPA must review and approve the admission prior to being admitted to the hospital.

To receive benefits for Emergency admissions the TPA must review and approve the admission within 24 hours or one working day after admission. If Emergency hospital admission review and approval procedures are not followed, they shall be deemed to have been followed if the TPA later determines that the hospital admission was Medically Necessary.

Procedures and services that can be safely and effectively performed on an Outpatient basis will be required to be administered in an Outpatient setting to receive benefits under this Plan.

If the TPA review decision differs from the recommendation of the Covered Person's attending physician, the Covered Person and his/her attending physician shall be notified and the Covered Person can avail themselves of the appeals process described in Section 6.04.

- (C) Outpatient Procedures and Services. The Plan requires certain Outpatient procedures and services to be reviewed for medical or clinical necessity and receive Prior Authorization to receive benefits. A Prior Authorization review of a medical procedure includes a determination of the most appropriate setting for the procedure to be performed (i.e., in the Outpatient department of a hospital, an ambulatory surgical center, or a Provider's surgical center), unless the TPA determines the procedure should be performed in an Inpatient hospital setting. Prior Authorization of medical services may include a review to determine if the service should be provided in a free-standing facility, Provider's office, or in a home health setting.
- (D) HomeHealth Care. CoveredPersons may receivehome healthcarebenefits as outlined in Section12.03 (F) if Prior Authorization is received from the TPA.
- (E) Mental Health and Substance Use. Inpatient, residential treatment, partial hospitalization/day treatment programs, intensive Outpatient therapy, psychological testing, transcranial magnetic stimulation, electroconvulsive treatment, applied behavioral analysis and EAP services must be prior authorized by the applicable TPA to receive benefits.
- (F) Case Management. Case management services provided by the TPA include the identification of and outreach to Covered Persons with high-risk, complex, and chronic conditions. Nurse case managers work with the Covered Person, Providers, and primary caregivers to establish treatment Plans and coordinate the most appropriate, cost-effective care and care setting.

SECTION 12 COVERED EXPENSES AND EXCLUSIONS AND LIMITATIONS

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

12.01 Conditions.

- (A) All medical and mental health and substance use services, treatment, and expenses are Covered Expenses if:
 - (1) They are listed in Sections 12.02 or 12.03;
 - (2) They are not excluded from Coverage under Section 12.04;
 - (3) They are determined to be Medically Necessary and/or Clinically Necessary by the TPA;
 - (4) They 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; and
 - (5) They are consistent with Plan policies and guidelines.
- (B) All medical, mental health and substance use services, treatment and expenses are Covered Expenses if required by applicable State or federal laws or regulations.
- (C) The Committee or its representative shall make determinations regarding whether expenses are Covered Expenses pursuant to (A) (1) and (2) above. TPAs shall make determinations regarding whether conditions set out in (A) (3) (4) and (5) have been satisfied.

12.02 Covered Expenses - Generally.

Charges for the following services and supplies are eligible Covered Expenses under the Plan:

- (A) Preventive Services including:
 - (1) Adult annual physical; and
 - (2) Services with an A or B recommendation from the United States Preventive Task Force, <https://uspreventiveservicestaskforce.org/uspstf/home>, as prescribed by a Covered Person's Physician, including but not limited to:
 - (a) Breast cancer screening (mammogram);
 - (b) Cervical cancer screening (Pap smear);
 - (c) Colorectal cancer screening;
 - (d) Tobacco use screening, counseling (behavioral health interventions)
 - (e) Healthy diet and physical activity counseling (behavioral health interventions) for cardiovascular disease;
 - (f) Unhealthy drug use screening (questions, not biological testing);
 - (g) Unhealthy alcohol use screening and counseling (behavioral interventions);
 - (h) Depression screening;
 - (i) Low-dose, over-the-counter generic forms of aspirin (prescription required); and
 - (j) Osteoporosis screening

- (B) Hospital room and board charges for a semi-private room up to the TPA'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 TPA 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. The physician or hospital must obtain preauthorization from the TPA.
- (C) 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.
- (D) 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 each additional procedure.
- (E) Office visits to a physician that are due to an Injury or Illness, or for preventive services.
- (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) Unique Care Transportation Benefit. When a medical service has been authorized by the TPA as a unique care exception, the Plan provides coverage for reasonable charges for transportation to a hospital or between hospitals for that authorized medical service. This transportation benefit is not available for travel to or from locations outside the continental United States. Reasonable charges may include round-trip coach airfare or mileage reimbursement for round-trip travel in one personal vehicle, calculated at the IRS standard medical mileage rate in effect at the time of travel. Reimbursement for other modes of transportation requires pre-approval by the TPA. Reasonable transportation charges are covered for one caregiver to travel with the patient. All reimbursement requests are subject to TPA verification of documented expenses.
- (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 12.04.
- (K) Charges for chemotherapy and radiation therapy when Medically Necessary as determined by the TPA. 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 advanced imaging technology.
- (M) Charges for laser procedures, other than those specifically excluded in Section 12.04.
- (N) 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 TPA. All other prescriptions for and use of the CPMM shall be considered experimental/investigative until reviewed on a case-by-case basis.

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

- (1) Single Pharmacy Limitation.

If the TPA 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 TPA 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 TPA 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 6.04.

- (2) Drugs and medicines (unless excluded under Section 12.04) 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, Drug Dex);
- (4) Limited prescription agents and certain over the counter (OTC) therapies:
 - (a) nicotine replacement products for assistance in tobacco cessation (e.g., gum, patches, lozenges, and oral and nasal inhalers). 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; and
 - (b) Narcan for Emergency treatment of opioid overdose. The Plan does not require a prescription.
- (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;
- (7) Medically necessary prosthetic devices and supplies including artificial eyes and limbs following Injury or physical Illness that results in Anatomic Impairment, or necessitated by a congenital defect:
 - (a) initial purchase for any Covered Person;
 - (b) replacement of the original limb prosthesis if improper fitting could result in severe damage to the stump 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 TPA. The Covered Person must receive written approval from the TPA prior to the replacement purchase.
 - (c) subsequent purchases for Covered Persons through age 18 necessitated by physical growth;
 - (d) one additional limb prosthesis past age 18 due to a surgical alteration or revision of the impacted site;
 - (e) 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), as determined to be Medically Necessary by the TPA. Replacement costs will be covered only if the prosthetic device or supplies were used by the Covered Person in the manner and for the purpose for which such item was intended and the replacement costs are necessarily incurred due to normal wear and tear. Benefits are not available for prosthetic devices and supplies to replace those which are lost, damaged, stolen or prescribed because of improvements in technology.
 - (8) Orthopedic items, when Medically Necessary as determined by the TPA. 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 TPA and not otherwise excluded in Section 12.04, 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-ulcerative 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 TPA 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 12.02(O)(7)(e), 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. Covered Persons or their Provider must obtain Prior Authorization. Ear molds and services to select, fit and adjust the hearing aid are also covered;
- (15) Bone anchored hearing aid devices determined to be Medically Necessary by the TPA. 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 services limited to history, physical examination and medical supervision, genetic testing and counseling, procedures for sterilization, oral and injected contraceptives, IUDs and internally time-released implants in an office setting, diagnostic testing to establish the etiology of infertility and Medically Necessary services for the correction of underlying causes of involuntary infertility.
- (19) Routine patient care costs related to clinical trials as defined by TCA 56-7-2365;
- (20) Routine foot-care for diabetics including nail clipping and treatment for corns and calluses;
- (21) Notwithstanding any exclusion herein, medically necessary surgery, including cosmetic or reconstructive surgery, that is required to restore anatomic function lost or impaired as a result of a traumatic Injury or a physical Illness which caused or resulted in Anatomic Impairment (such as the surgical removal or impairment of a body part or organ due to cancer and associated treatments).
- (22) Medically necessary surgery, including cosmetic or reconstructive surgery, necessitated by a physical congenital anomaly or defect which caused Anatomic Impairment of a body part or organ in a Covered Person.

12.03 Other Covered Expenses.

- (A) Skilled Nursing Facility Care. The Plan shall pay for Medically Necessary expenses for room, board, and general skilled nursing facility 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 Care; and
 - (4) Services were prior authorized by the TPA.
- (B) Eligible expenses for facility room, board and general nursing care shall only include:
 - (1) Charges for a semi-private room in accordance with 12.02(B) and
 - (2) Charges up to and including the 100th day of skilled nursing facility care during any Plan Year.
 - (3) Charges for care exceeding the 100th day of skilled nursing facility care only when the TPA determines that a short-term extension of skilled nursing facility care is required for the purpose of transitioning care under the following conditions:
 - (a) The care is recommended by the attending physician and the TPA determines it is Medically Necessary;
 - (b) Covered Person is enrolled and participating in case management to ensure discharge to the next level of appropriate care as soon as clinically possible; and
 - (c) The TPA notifies BA in writing upon its approval or denial of the requested exception.
- (C) Maternity Benefits. The Plan provides maternity benefit Coverage for prenatal care, childbirth, miscarriage or any complications arising during or related to any pregnancy, delivery, and post-natal care on the same basis as any other Illness. 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 following the birth of her child.
 - (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 that has been enrolled on the Plan as a Covered Person by the HOC according to the special enrollment instructions in Section 2.06(C)(4) of the Plan, shall include but not be limited to:
 - (a) Any professional and facility charges directly related to the treatment of any medical condition of a newborn child; and
 - (b) Usual and ordinary nursery and pediatric care at birth including follow up medical appointments.

- (3) Enhanced Newborn Coverage. Short term Coverage will be provided to a newborn child who has not been enrolled on the Plan. When a HOC or Spouse of a HOC gives birth while a Covered Person on the Plan, Coverage for the newborn shall be provided according to the following terms unless the HOC submits a completed form declining Coverage to their ABC or BA:
 - (a) Coverage will begin on the child's date of birth and remain in effect for the first 31 days of life. To receive this enhanced benefit, enrollment of the newborn is not required.
 - (b) Covered Expenses of a newborn child shall include but not be limited to:
 - (i) Any professional and facility charges directly related to the treatment of any medical condition of a newborn child; and
 - (ii) Usual and ordinary nursery and pediatric care at birth including follow up medical appointments.
 - (c) The cost-sharing requirements of the Plan, including the applicable deductible and Out-of-Pocket Maximum shall be applied to the Coverage provided to the newborn child.
 - (d) The newborn Coverage benefit terminates on the 31st day after the birth of the newborn. Coverage after this time will be provided to the newborn only if the HOC enrolls the newborn according to the special enrollment instructions in Section 2.06(C)(4) of the Plan.
- (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 TPA, the Plan shall provide hospice care 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. Eligible expenses for home health care services are covered when provided by a Home Health Care Agency.
 - (1) The Plan shall provide benefits for the services of skilled or private duty nursing care in the home when provided or supervised by a registered nurse (R.N.) who is not an Immediate Relative; prescribed by the attending physician; certified as Medically Necessary; and prior authorized by the TPA. Skilled or private duty nursing in the home is subject to the following limitations:
 - (a) Coverage is limited to 125 visits, with a visit defined as a single date of service not to exceed the number of approved hours; and
 - (b) Cases that require ongoing skilled or private duty nursing care in the home that exceeds the 125- visit limit, may be granted an exception for continued Coverage by the TPA under the following conditions:
 - (i) Ongoing care is recommended by the attending physician and determined to be Medically Necessary by the TPA;
 - (ii) A case manager shall be assigned and a written treatment Plan with relevant medical records must be submitted for periodic review by the TPA, no less than every 6 months, for ongoing skilled nursing care Coverage; and
 - (iii) The TPA shall review exceptions as needed, but no less than every 6 months, and shall notify BA of the approval or denial in writing.

- (2) Home health aide care is also a covered service with the following limitations:
 - (a) No more than 30 visits per Plan Year;
 - (b) A visit shall be four or fewer hours;
 - (c) The service must be ordered by a physician;
 - (d) The Home Health Care Aide is not an Immediate Relative
 - (e) A professional nurse must conduct intermittent visits; and
 - (f) The Home Health Care Aide service is in conjunction with Medically Necessary skilled care.
 - (3) 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 Section 1 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 TPA 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 TPA. Outpatient pulmonary Rehabilitation will be covered for certain conditions when determined to be Medically Necessary by the TPA.
- (H) Sitter. A sitter who is not an Immediate Relative of the Covered Person may be used when the Covered Person is confined to a hospital as a bed patient and certification is made by a physician that either an R.N. or L.P.N. is needed and neither 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 TPA.
 - (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 TPA 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 TPA 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 TPA. 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 disability 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 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).
 - (g) Orthodontic treatment (braces) is only covered if determined to be Medically Necessary by the TPA. Benefits are **not** available for the following therapies in treatment of TMJ:
 - (i) Prosthodontic treatments (dentures, bridges);
 - (ii) Restorative treatment (fillings, crowns);
 - (iii) Full mouth Rehabilitation (restorations, extractions); and/or
 - (iv) 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 transplant-related covered service is performed.
- (1) 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 in Section 12, the TPA will review the information provided and render a decision based on acceptable medical practices on behalf of the State group insurance program. The TPA will notify BA of its decision prior to approving such services. If the service(s) or procedure(s) does not meet the TPA's accepted medical standards, the Covered Person will be notified of their option to appeal the decision as described in Section 6.04.
 - (2) If a network facility is utilized for the transplant, Medically Necessary travel expenses are covered for the transplant recipient and one travel companion for visits from the initial evaluation through one year after the transplant. The combined maximum benefit for transportation, meals, and lodging is \$15,000 per transplant. If air transportation is determined to be necessary by the TPA, it is covered at the commercial coach fare. Ground transportation

for one personal vehicle is covered at the IRS standard medical mileage rate in effect at the time of travel. Transportation charges are covered for travel 60 miles or more for each one-way trip and are not covered for travel to or from locations outside the continental United States. Meal charges are covered only if purchased at the treatment hospital or facility with no per meal dollar limit. Lodging expenses will be reimbursed at the IRS per night per person medical expense allowance in effect at the time of travel for a maximum of two persons. All requests for reimbursement are subject to TPA verification of documented expenses.

- (3) 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.
- (4) 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 TPA. 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).
- (M) Bariatric Surgery (weight reduction). Surgical procedures for the treatment of morbid obesity are covered when the procedure is determined to be Medically Necessary by the Center of Excellence Program Providers and performed pursuant to the terms of the Center of Excellence Program.
- (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 TPA 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) are 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 TPA, 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

TPA 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 TPA. 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 TPA.
- (R) Certain preferred anti-obesity medications (as determined by the Pharmacy Benefits Manager), subject to Prior Authorization.
- (S) Program Specific Travel Benefits. The Plan covers reasonable travel expenses for Covered Persons receiving treatment through a value-based benefit program offered by the Plan. Travel benefits may include coverage for transportation, meals and lodging, subject to program specific guidelines and the program administrator's determination of eligibility for such benefits.

12.04 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 12.02(O)(2) and 12.02(O)(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 Relative of the Covered Person;
 - (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 TPA, subject to all other terms and conditions of the Plan;
 - (11) Charges which the TPA determines to be more than the Maximum Allowable Charge for that procedure or supply and for charges made which are not Medically Necessary as determined

- by the TPA;
- (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 TPA;
 - (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 12.02;
 - (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 12.02 and/or 12.03);
 - (16) Charges incurred in connection with cosmetic or reconstructive surgery directed toward preserving or improving a Covered Person's appearance, including but not limited to scar revisions, rhinoplasty, implants, or injections where no Anatomic Impairment exists. This exclusion does not apply:
 - (a) when a Covered Person elects reconstructive surgery following a mastectomy pursuant to 12.02(O)(13); or
 - (b) to breast implant removal or breast capsulectomy and reconstruction with physician documented symptoms of pain, discomfort or deformity related to breast implants or when 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 sections 12.02 and 12.03, 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 TPA;
 - (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 12.03(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 and Partners for Health sponsored programs, are not excluded;
 - (25) Medical or surgical procedures and prescription drugs determined by the TPA to be experimental, investigational, or unproven;
 - (26) Organ transplants involving artificial organs and non-human organs unless determined to be Medically Necessary by the TPA, as well as any services or supplies in connection with experimental or investigational treatment, drugs, or procedures;
 - (27) 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;

- (28) 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;
- (29) Services or supplies intended to create a pregnancy, including medications that trigger or regulate ovulation, reversal of sterilization, assisted reproductive services and associated laboratory, x-ray and other testing for procedures such as invitro fertilization (IVF), gamete intrafallopian tube placement (GIFT) and zygote intrafallopian transfer (ZIFT), ovulation predictor kits and sperm testing kits, donor eggs and sperm, and cryopreservation of donor eggs, sperm or embryos.
- (30) Midwife services outside a licensed healthcare facility.
- (31) Charges because a person fails to keep a scheduled appointment, or charges to complete a claim form;
- (32) Durable Medical Equipment not specified in Sections 12.02, 12.03 or Attachment B;
- (33) 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, except for those items specifically included as an eligible medical expense;
- (34) Charges for comfort or convenience items (e.g. television, telephone, radio, air conditioner, beauty shop and barber services, guest meals and guestbeds);
- (35) Custodial Care;
- (36) Day and evening care centers (primarily for rest or for the aged);
- (37) Services of a private-duty nurse in an Inpatient setting which would normally be provided by hospitalnursing staff;
- (38) Diapers (incontinent pads);
- (39) Cranial prosthesis(wig);
- (40) 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 12.03(O);
- (41) 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;
- (42) Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, collection, and handlingfees;
- (43) 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 TPA;
- (44) 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;
- (45) Ecological or environmental medicine, diagnosis and/or treatment;
- (46) 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;

- (47) Services given by a pastoral counselor;
 - (48) Sensitivity training, educational training therapy or treatment for an education requirement.
 - (49) Any medical, mental health or substance use service, treatment or expense that is prohibited by applicable State or federal law.
 - (50) Expenses incurred for surgical procedures for the treatment of morbid obesity when performed outside of the terms of the Center of Excellence Program, unless the Center of Excellence Program has determined that an exception should apply and refers the case to the Plan's medical TPA.
- (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 12.03(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 12.03(I);
- (C) On the Job Injuries and Illnesses. Expenses for Injuries or Illnesses incurred on the job are not Covered Expenses.
- (D) Excluded Mental Health/Substance Use Expenses. In addition to relevant exclusions noted in Section 12.04(A), the following are specifically excluded under the mental health/substance use benefit:
- (1) Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
 - (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 MEMBER COSTS PPO PLANS: Services in this table ARE NOT subject to a deductible. Coverage for ALL services and medications is subject to medical necessity as determined by the Third-Party Administrator or Pharmacy Benefits Manager.

PPO HEALTHCARE OPTION	PREMIER PPO NETWORK STATUS & COST ^[1]		STANDARD PPO NETWORK STATUS & COST ^[1]		LIMITED PPO NETWORK STATUS & COST ^[1]	
COVERED SERVICES	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network
PREVENTIVE CARE — OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY						
- Well-baby, well-child visits - Adult annual physical exam - Annual well-woman exam - Immunizations - Annual hearing and non-refractive vision screening - Screenings, labs, nutritional guidance, tobacco cessation counseling	\$0	\$45	\$0	\$50	\$0	\$50
OUTPATIENT SERVICES						
Primary Care Office Visit ^[8] - Family practice, general practice, internal medicine, OB/GYN and pediatrics - Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) - Initial maternity visit - Surgery in office setting - Provider based telehealth - Allergy injections and serum	\$25	\$45	\$30	\$50	\$35	\$55
Specialist Office Visit ^[8] - Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) - Surgery in office setting - Provider based telehealth - Allergy injections and serum	\$45	\$70	\$50	\$75	\$55	\$80
Behavioral Health and Substance Use ^{[2] [8]} Including provider-based virtual visits	\$25	\$45	\$30	\$50	\$35	\$55
Telehealth Programs (MDLive/Teladoc/Talkspace)	\$15	N/A	\$15	N/A	\$15	N/A
Chiropractic and Acupuncture Annual limit of 50 visits each	\$25/visit 1-20 \$45/visit 21-50	\$45/visit 1-20 \$70/visit 21-50	\$30/visit 1-20 \$50/visit 21-50	\$50/visit 1-20 \$75/visit 21-50	\$35/visit 1-20 \$55/visit 21-50	\$55/visit 1-20 \$80/visit 21-50
Convenience Clinic	\$25	\$45	\$30	\$50	\$35	\$55
Urgent Care Facility	\$45	\$70	\$50	\$75	\$55	\$80
PHARMACY – GENERIC/PREFERRED/NONPREFERRED						
30-Day Supply	\$7 \$40 \$90	copay + amount > MAC	\$14 \$50 \$100	copay + amount > MAC	\$14 \$60 \$110	copay + amount >MAC
90-Day Supply 90-day pharmacy or mail order	\$14 \$80 \$180	N/A - no network	\$28 \$100 \$200	N/A - no network	\$28 \$120 \$220	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order ^[3]	\$7 \$40 \$160	N/A - no network	\$14 \$50 \$180	N/A - no network	\$14 \$60 \$200	N/A - no network
30-Day Supply Medications Prescribed for Obesity	25%	N/A – no network	25%	N/A – no network	25%	N/A – no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY						
Generic/Preferred/Non-Preferred	30%	N/A – no network	30%	N/A – no network	30%	N/A – no network

[1], [2], [3] and [8] - See footnotes on page 75

TABLE 2 MEMBER COSTS PPO PLANS: Services in this table ARE subject to a deductible unless noted with a [5]. Coverage for ALL services and medications is subject to medical necessity as determined by the Third-Party Administrator or Pharmacy Benefits Manager.

PPO HEALTHCARE OPTION	PREMIER PPO NETWORK STATUS & COST ^[1]		STANDARD PPO NETWORK STATUS & COST ^[1]		LIMITED PPO NETWORK STATUS & COST ^[1]	
COVERED SERVICES	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network
PREVENTIVE CARE — OUTPATIENT FACILITIES – AS RECOMMENDED & MEDICALLY NECESSARY						
Screenings such as colonoscopy, mammogram, colorectal, lung imaging and bone density scans ^[5]	\$0	40%	\$0	40%	\$0	50%
OTHER SERVICES						
Hospital/Facility Services ^{[4][8]} • Inpatient care ^[7] ; outpatient surgery ^[7] • Inpatient behavioral health/ substance use ^{[2][6]}	15%	40%	20%	40%	30%	50%
• Emergency room services ^[7]	15%		20%		30%	
Maternity - Global billing after first visit; Routine services & labor and delivery	15%	40%	20%	40%	30%	50%
Home Care ^{[4][8]} • Home health; home infusion therapy	15%	40%	20%	40%	30%	50%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility ^[4] ; • Outpatient PT/ST/OT/ABA ^[5] ; Other therapy	15%	40%	20%	40%	30%	50%
XRay, Lab and Diagnostics (Excludes advanced studies below) ^[5]	15%		20%		30%	
Advanced XRay, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ^[4]	15%	40%	20%	40%	30%	50%
Pathology and Radiology Reading, Interpretation and Results ^[5]	15%		20%		30%	
Ambulance (air and ground)	15%		20%		30%	
Durable Medical Equipment, External Prosthetics and Medical Supplies ^[4]	15%	40%	20%	40%	30%	50%
Hospice	\$0		\$0		\$0	
Oral Surgeons	15%	40%	20%	40%	30%	50%
Non-Contracted Providers (i.e., dentists and odontologists)	15%		20%		30%	
Out-of-Country Non-emergency, non-urgent care (See also, emergency care section)	NA	40%	NA	40%	NA	50%
DEDUCTIBLE – ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE						
Employee Only	\$750	\$1,500	\$1,300	\$2,600	\$1,800	\$3,600
Employee + Child(ren)	\$1,125	\$2,250	\$1,950	\$3,900	\$2,500	\$4,800
Employee + Spouse	\$1,500	\$3,000	\$2,600	\$5,200	\$2,800	\$5,500
Employee + Spouse + Child(ren)	\$1,875	\$3,750	\$3,250	\$6,500	\$3,600	\$7,200
OUT-OF-POCKET MAXIMUM – ELIGIBLE EXPENSES - MEDICAL, BEHAVIORAL HEALTH AND NONSPECIALTY PHARMACY COMBINED, INCLUDING APPLICABLE DEDUCTIBLE EXPENSES						
Employee Only	\$3,600	\$7,200	\$4,400	\$8,800	\$6,800	\$13,600
Employee + Child(ren)	\$5,400	\$10,800	\$6,600	\$13,200	\$13,600	\$27,200
Employee + Spouse	\$7,200	\$14,400	\$8,800	\$17,600	\$13,600	\$27,200
Employee + Spouse + Child(ren)	\$9,000	\$18,000	\$11,000	\$22,000	\$13,600	\$27,200
OUT-OF-POCKET MAXIMUM — ELIGIBLE EXPENSES— SPECIALTY PHARMACY (ONLY), INCLUDING SPECIALTY PHARMACY DEDUCTIBLE EXPENSES						
Employee Only	\$2,400	N/A	\$2,400	N/A	\$2,400	N/A
Employee + Child(ren)	\$3,600	N/A	\$3,600	N/A	\$4,800	N/A
Employee + Spouse	\$4,800	N/A	\$4,800	N/A	\$4,800	N/A
Employee + Spouse + Child(ren)	\$6,000	N/A	\$6,000	N/A	\$4,800	N/A

[1], [2], [4], [5], [6], [7] and [8] - See footnotes on page 75

SCHEDULE OF PPO BENEFITS TABLE 1 AND TABLE 2 FOOTNOTES

For PPO Plans, 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 specified by State or federal law.
- [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 included, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electro-convulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor’s clinical staff.
- [3] Additional information on the maintenance drug benefit and a list of participating Retail-90 pharmacies can be found at <https://www.tn.gov/partnersforhealth/health-options/pharmacy.html>.
- [4] Prior authorization (PA) required for non-emergent services. When using out-of-network providers, benefits for non-emergent 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 to IN-NETWORK PT/ST/OT/ABA and other services as noted.
- [6] Enhanced benefit for select preferred Substance Use Treatment Facilities – PPO 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.
- [7] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.
- [8] Member cost share for medications administered by a provider is determined by the place of service at the time of administration, i.e. provider office, infusion center, inpatient, or home. assistance.

ATTACHMENT A.2 SCHEDULE OF LOCAL CDHP/HSA BENEFITS

TABLE 1 MEMBER COSTS CDHP/HSA Plan: Services in this table ARE subject to a deductible and coinsurance except for in-network preventive care and maintenance medications. Coverage for ALL services and medications is subject to medical necessity as determined by the Third-Party Administrator or Pharmacy Benefits Manager..

CDHP/HSA HEALTHCARE OPTION	LOCAL CDHP/HSA NETWORK STATUS & COST ^[1]	
COVERED SERVICES	In-Network	Out-of- Network
PREVENTIVE CARE – OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY		
- Well-baby, well-child visits - Adult annual physical exam - Annual well-woman exam - Immunizations - Annual hearing and non-refractive vision screening - Screenings, labs, nutritional guidance, tobacco cessation counseling	\$0	50%
OUTPATIENT SERVICES – SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA		
Primary Care Office Visit ^[7] - Family practice, general practice, internal medicine, OB/GYN and pediatrics - Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) - Initial maternity visit - Surgery in office setting - Provider based telehealth - Allergy injections and serum	30%	50%
Specialist Office Visit ^[7] - Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) - Surgery in office setting - Provider based telehealth - Allergy injections and serum	30%	50%
Behavioral Health and Substance Use ^{[2] [7]} Including provider-based virtual visits	30%	50%
Telehealth Carrier Programs (MDLive/Teladoc/Talkspace)	30%	N/A
Chiropractic and Acupuncture Annual limit of 50 visits each	30%	50%
Convenience Clinic	30%	50%
Urgent Care Facility	30%	50%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED		
30-Day Supply	30%	50% + amount > MAC
90-Day Supply 90-day pharmacy or mail order	30%	NA – no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order ^[3]	20% before deductible	NA – no network
30-Day Supply Medications Prescribed for Obesity	25%	NA – no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY		
Generic/Preferred/NonPreferred	30%	NA – no network

[1], [2], [3], and [7] - See footnotes on page 78

TABLE 2 MEMBER COSTS CDHP/HSA PLAN: Services in this table ARE subject to a deductible except for in-network preventive care. Coverage for ALL services and medications is subject to medical necessity as determined by the Third-Party Administrator or Pharmacy Benefits Manager.

CDHP HEALTHCARE OPTION	LOCAL CDHP/HSA NETWORK STATUS & COST ^[1]	
COVERED SERVICES	In-Network	Out-of-Network
PREVENTIVE CARE — OUTPATIENT FACILITIES – AS RECOMMENDED & MEDICALLY NECESSARY		
Screenings such as colonoscopy, mammogram, colorectal, lung imaging and bone density scans	\$0	50%
OTHER SERVICES		
Hospital/Facility Services ^{[4] [7]} • Inpatient care ^[6] ; outpatient surgery ^[6] • Inpatient behavioral health and substance use ^{[2] [5]}	30%	50%
• Emergency Room services ^[6]	30%	
Maternity - Global billing after first visit; Routine services & labor and delivery	30%	50%
Home Care ^{[4] [7]} • Home health; home infusion therapy	30%	50%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility ^[4] ; • Outpatient PT/ST/OT/ABA; Other therapy	30%	50%
XRay, Lab and Diagnostics (excludes advanced studies below)	30%	50%
Advanced XRay, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ^[4]	30%	50%
Pathology and Radiology Reading, Interpretation and Results	30%	
Ambulance (air and ground)	30%	
Durable Medical Equipment, External Prosthetics and Medical Supplies ^[4]	30%	50%
Hospice	\$0	\$0
Oral Surgeons	30%	50%
Non-Contracted Providers (i.e., dentists and orthodontists)	30%	
Out-of-Country – Nonemergency and nonurgent care (for emergency care, see sections for those services)	NA	50%
DEDUCTIBLE – ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE		
Employee Only	\$2,000	\$4,000
Employee + Child(ren)	\$4,000	\$8,000
Employee + Spouse	\$4,000	\$8,000
Employee + Spouse + Child(ren)	\$4,000	\$8,000
OUT-OF-POCKET MAXIMUM – ELIGIBLE EXPENSES - MEDICAL, BEHAVIORAL AND NONSPECIALTY PHARMACY, COMBINED, INCLUDING APPLICABLE DEDUCTIBLE EXPENSES		
Employee Only	\$5,000	\$10,000
Employee + Child(ren)	\$10,000	\$20,000
Employee + Spouse	\$10,000	\$20,000
Employee + Spouse + Child(ren)	\$10,000	\$20,000
OUT-OF-POCKET MAXIMUM — ELIGIBLE EXPENSES— SPECIALTY PHARMACY (ONLY), INCLUDING SPECIALTY PHARMACY DEDUCTIBLE EXPENSES		
Employee Only	\$2,400	N/A
Employee + Child(ren)	\$4,800	N/A
Employee + Spouse	\$4,800	N/A
Employee + Spouse + Child(ren)	\$4,800	N/A

[1], [2], [4], [5], [6] and [7] - See footnotes on page 78

SCHEDULE OF LOCAL CDHP/HSA BENEFITS TABLE 1 AND TABLE 2 FOOTNOTES

For the CDHP Plan, 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. No one family member may contribute more than \$8,700 to the in-network family out-of-pocket maximum total.

- [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, unless otherwise specified by State or federal law.
- [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, electro-convulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor’s clinical staff.
- [3] Additional information on the maintenance drug benefit and a list of participating Retail-90 pharmacies can be found at <https://www.tn.gov/partnersforhealth/health-options/pharmacy.html>.
- [4] Prior authorization (PA) required for non-emergent services. When using out-of-network providers, benefits for non-emergent 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] Enhanced benefit for select preferred Substance Use Treatment Facilities – 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.
- [6] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.
- [7] Member cost share for medications administered by a provider is determined by the place of service at the time of administration, i.e. provider office, infusion center, inpatient, or home.

ATTACHMENT A.3 SCHEDULE OF COPAY PPO BENEFITS

TABLE 1 MEMBER COSTS COPAY PPO PLAN: In-network services in this table ARE NOT subject to a deductible or coinsurance. Out-of-network services ARE subject to a deductible and coinsurance except for Emergency Care Services, Emergency Care Advanced Radiological Imaging, and Ambulance Services. Coverage for all services and medications is subject to medical necessity as determined by the Third Party Administrator or Pharmacy Benefits Manager.

HEALTH PLAN OPTION	Copay PPO Plan	
BENEFIT PLAN FEATURES:	BlueCross BlueShield Network S	
	Your Cost In-Network ^[14]	Your Cost Out-of-Network ^[1]
COVERED SERVICES		
Preventive Care Services ^[17]	Covered at 100%	50% after deductible
PRACTITIONER OFFICE SERVICES	Tier 1 Provider/ Tier 2 Provider	
Primary Care Office Visits ^[12] ^[13]	\$30 / \$80 copay	50% after deductible
Specialist Office Visits ^[13]	\$50 / \$100 copay	50% after deductible
Office Surgery ^[3] ^[4] ^[6] ^[12] ^[13]	\$30 / \$80 copay (PCP); \$50 / \$100 copay (Specialist)	50% after deductible
Allergy Injections and Allergy Serum ^[13]	\$30 / \$80 copay (PCP); \$50 / \$100 copay (Specialist)	50% after deductible
Allergy Testing	\$250 copay	50% after deductible
Routine Diagnostic Lab, X-Ray, Supplies & Injections ^[16]	\$50 copay	50% after deductible
Physical, Occupational, and Speech Therapeutic Services	\$30 copay	50% after deductible
Chiropractic and Acupuncture Services (annual limit 50 visits each)	\$30 copay	50% after deductible
Teladoc Health® Virtual Care	\$0 copay	Not Covered
SERVICES RECEIVED AT A FACILITY (INCLUDES PROFESSIONAL AND FACILITY CHARGES) ^[2] ^[7]		
Inpatient Services ^[2] ^[4]	\$2,500 copay	50% after deductible
Outpatient Surgery ^[3] ^[4] ^[6]	\$1,000 Ambulatory Surgical Center / \$2,500 Outpatient Hospital	50% after deductible
Advanced Radiological Imaging - Outpatient ^[2] ^[4] ^[7] ^[16]	\$750 copay	50% after deductible
Other Outpatient Services (per day, per service type) ^[8]	\$250 copay (\$2,500 copay maximum per service type)	50% after deductible
Convenience Clinic Services	\$30 copay	50% after deductible
Urgent Care Center Services	\$80 copay	50% after deductible
Emergency Care Services ^[9]	\$1,000 copay	\$1,000 copay
Emergency Care Advanced Radiological Imaging ^[7] ^[16]	\$750 copay	\$750 copay
Ambulance Services ^[3] ^[4]	\$1,000 copay	\$1,000 copay
Provider-Administered Specialty Drugs ^[3] ^[11]	\$200 copay	Not Covered
BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES ^[5]		
Inpatient ^[2] ^[4]	\$2,500 copay	50% after deductible
Other Outpatient Services (per day, per service type) ^[2] ^[8]	\$250 copay (\$2,500 copay maximum per service type)	50% after deductible
Outpatient Office Visits	\$30 copay	50% after deductible
Applied Behavioral Analysis ^[2]	\$30 copay	50% after deductible
Talkspace® Virtual Behavioral Healthcare	\$0 copay	Not Covered

ATTACHMENT A.3 SCHEDULE OF COPAY PPO BENEFITS

TABLE 2 MEMBER COSTS COPAY PPO PLAN: In-network services in this table ARE NOT subject to a deductible or coinsurance, except for prescribed obesity and specialty medications. Out-of-network services are subject to a deductible and coinsurance except for 30-day supply generic and brand medications. Coverage for all services and medications is subject to medical necessity as determined by the Third Party Administrator or Pharmacy Benefits Manager.

HEALTH PLAN OPTION	Copay PPO Plan	
BENEFIT PLAN FEATURES:	BlueCross BlueShield Network S	
	Your Cost In-Network ^[14]	Your Cost Out-of-Network ^[1]
MEDICAL EQUIPMENT SERVICES ^{[3] [4]}		
Durable Medical Equipment, Prosthetic or Orthotics, Hearing Aids (under age 18)	\$250 copay	50% after deductible
SKILLED NURSING & REHABILITATION FACILITY SERVICES		
Inpatient ^{[2] [4]}	\$2,500 copay	50% after deductible
Cardiac and Pulmonary Rehabilitative Therapies (outside of a facility admission)	\$30 copay	50% after deductible
Home Health Care Services (per day) ^{[3] [4]}	\$50 copay	50% after deductible
HOSPICE SERVICES		
Inpatient ^{[2] [4]} ; Outpatient ^{[3] [4]}	\$0 copay	50% after deductible
PHARMACY – GENERIC/BRAND (CVS Value Formulary)		
30-Day Supply	\$14 generics /\$50 brand	copay + amount > MAC
90-Day Supply 90-day pharmacy or mail order	\$28 generics /\$100 brand	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order	\$14 generics /\$50 brand	N/A - no network
30-Day Supply Medications Prescribed for Obesity	25% Coinsurance	N/A - no network
Specialty Pharmacy Medications – 30-Day Supply	30% Coinsurance	N/A - no network
ANNUAL DEDUCTIBLE		
Employee Only	\$0	\$9,600
Employee + Child(ren)	\$0	\$19,200
Employee + Spouse	\$0	\$19,200
Employee + Spouse + Child(ren)	\$0	\$19,200
OUT-OF-POCKET MAXIMUM ^[10] — Eligible Expenses — Medical, Behavioral, and Non-Specialty Pharmacy, Combined		
Employee Only	\$9,600	\$19,200
Employee + Child(ren)	\$19,200	\$38,400
Employee + Spouse	\$19,200	\$38,400
Employee + Spouse + Child(ren)	\$19,200	\$38,400
OUT-OF-POCKET MAXIMUM ^[10] — Eligible Expenses— Specialty Pharmacy Only		
Employee Only	\$2,400	N/A
Employee + Child(ren)	\$4,800	N/A
Employee + Spouse	\$4,800	N/A
Employee + Spouse + Child(ren)	\$4,800	N/A

ATTACHMENT A.3 SCHEDULE OF COPAY PPO BENEFITS FOOTNOTES

- [1] Subject to maximum allowable charge. The MAC is the most a plan will pay for a covered service or medication. For non-emergent care from an out-of-network provider or pharmacy who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise specified by state or federal law.
- [2] Prior authorization is required.
- [3] Certain procedures, services, medication and equipment may require prior authorization.
- [4] When using out-of-network providers, benefits for non-emergent medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge and based upon out of network coinsurance. If services are not medically necessary, no benefits will be provided.
- [5] The following behavioral health services are treated as “facility based care” for the purpose of determining member cost-sharing: residential (inpatient) treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to facility based care, prior authorization is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, psychological testing, and other behavioral health services as determined by the Contractor’s clinical staff.
- [6] Surgeries include incisions, excisions, biopsies, fracture treatments, applications of casts and splints, sutures and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).
- [7] Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
- [8] Includes services such as radiation therapy, chemotherapy, renal dialysis, infusion administration, sleep studies, wound care, observation stays, BH partial hospitalization/day treatment programs, and BH intensive outpatient therapy.
- [9] Copay, if applicable, waived if admitted to hospital.
- [10] No single family member will be subject to an out-of-pocket maximum greater than the “employee only” amount. Once two or more family members (depending on premium level) have met the total out-of-pocket maximum, it will be met by all covered family members.
- [11] To receive benefits for provider-administered specialty drugs as identified on the provider-administered specialty drug list, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for the Provider-administered specialty medication list. Cost share listed is for the medication only; providers may bill additional charges for the administering of the drug under your medical benefit.
- [12] The primary care copay applies to Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health and Health Department services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.
- [13] Tiered Copay PPO plans offer lower copays for certain practitioner services when those services are provided by a Tier 1 network provider, compared to the same services rendered by a Tier 2 network provider.
- [14] Member is responsible for the lesser of the allowable charges or the listed copay.
- [15] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.
- [16] Reading and Interpretation included with applicable service copay.
- [17] Well-baby, well-child, adult annual physical exam, well-woman exam, routine prenatal and postnatal services, immunizations, annual hearing and non-refractive vision screening, screenings, labs, nutritional guidance, tobacco cessation counseling, colonoscopy, mammogram, colorectal, lung imaging, and bone density scans.

ATTACHMENT B
LIST OF DURABLE MEDICAL EQUIPMENT

ATTACHMENT B. 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 (BiOsteogen, etc.)				X
Electrical stimulator (TENS)				X
Exercise Equipment			X	
Heater			X	
Heating Pad			X	
Heat Lamp				X
Hospital bed, twin size, standard,				X
Siderails				X
Trapeze				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

Item of Equipment	Approve Purchase	Approve Rental	Deny	Refer to Benefits Review
Mattress (any other)			X	
Monitor, SIDS (apnea)				X
Overbed table				X
Oxygentanks, 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 TPA and recognized as therapeutically effective and not meant to serve as a comfort or convenience item.

The TPA will also determine medical necessity for other items not listed.