THE TENNESSEE PLAN
Supplemental Medical Insurance for Retirees with Medicare

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

the legal publication that explains administrative provisions and benefits for covered retirees and their covered dependents

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INTRODUCTION

This document is a description of The Tennessee Plan (the Plan) sponsored by the State of Tennessee (Plan Administrator). No oral interpretations can change this Plan. The Plan described is designed to help fill in the coverage holes in Medicare Part A and Part B coverage and is comparable to coverage offered in a Medicare Gap National Association of Insurance Commissioners (NAIC) Model D Benefit Plan. This is a summary of Plan eligibility and benefits effective July 1, 2023. For eligibility and expenses incurred before July 1, 2023, refer to previous publications relative to the State offered The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare).

The Tennessee Plan is a supplemental medical insurance plan for retirees with Medicare authorized under the provisions of Tennessee Code Annotated (TCA) 8-27-209. Funds collected for the purpose of the operation of the Plan are maintained by the State of Tennessee in a discrete account.

Coverage under the Plan will take effect for an eligible Retiree and designated dependents when the Retiree and such dependents satisfy all the eligibility requirements of the Plan. The Plan is only available to qualified Retirees and their eligible dependents when the retiree's initial employment with the state or other qualifying employer commenced prior to July 1, 2015.

The Plan Administrator may make changes to the Plan, including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility or terminate the Plan at any time upon due authorization from the insurance committee. If the Plan is terminated, amended, or benefits are eliminated, the benefits available to Plan Participants are limited to Covered Charges incurred before termination, amendment or elimination.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or the inability to enroll in coverage. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, medical necessity, failure to timely file claims, or lack of coverage.

The Plan will pay benefits only for the eligible expenses incurred while this coverage is in force. No benefits are payable for expenses incurred prior to the coverage effective date or after the coverage has terminated. An expense for an eligible service or supply is incurred on the date the service or supply is provided.

If an appeal is made, no recovery action (legal or otherwise) shall be initiated under any section of this Plan until the appeal process has been exhausted and the Plan benefits requested in such appeals have been denied in whole or in part.

Fraudulent acts may subject the participant to disciplinary action including, but not limited to, the recommendation of the participant's termination of insurance coverage, and/or criminal prosecution.

DEFINED TERMS

The terms used in this document that describe covered medical benefits carry the same meaning as those services defined under Medicare Part A and Medicare Part B.

The following terms have special meaning and when used in this Plan Document will be capitalized.

Allowed Charges The Plan will consider the Allowed Charge to be Medicare's Part A or Medicare's Part B approved amount for those covered services billed by a covered Provider. The Medicare approved amount is the amount recognized as reasonable by Medicare for health care expenses of the kinds covered by Medicare. The Medicare approved amount also includes amounts considered payable under the Medicare B fee schedule. The Plan will not pay charges that exceed Medicare's approved amounts. For covered services under the Plan and excluded under Medicare Part A or Medicare Part B, the Allowed Charge will be the Usual, Reasonable, and Customary Charges as determined by the Claims Administrator. The Plan will not pay charges that exceed Allowed Charges. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Benefit Period A Benefit Period begins when a Plan Participant enters a hospital as an inpatient. Successive stays in one or more hospitals or skilled nursing facilities count as one Benefit Period unless sixty (60) days or more elapse between the day of discharge and the next admission. When a Plan Participant enters a hospital after sixty (60) days have elapsed since the last discharge from the hospital or skilled nursing facility, a new Benefit Period begins.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator is the entity designated by the State Insurance Committee to adjudicate claims under the plan of benefits; to respond to inquiries from employees, Retirees and Plan Participants; to exchange eligibility and claims payment information with Medicare and to perform other services as determined by the State Insurance Committee and the Plan Administrator.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary or clinically necessary services or supplies that are covered under this Plan.

Employer shall mean the State of Tennessee, University of Tennessee, State of Tennessee Public Institutions of Higher Education, agency of the State of Tennessee, any Local Education or Local Government agency within the State of Tennessee which is authorized by statute or action by the State, Local Education, or Local Government Insurance Committees to participate in this Plan. The State of Tennessee, University of Tennessee, and the other public institutions of higher education are separate employers.

Enrollee is a retiree or dependent of a retiree who has met all the eligibility requirements of the Plan and has been enrolled into the Plan.

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

Incurred means those services or supplies provided to or received by a Plan Participant. Such expenses shall be considered to have been incurred at the time or date the service or supply is actually provided.

Injury means a physical injury to the body caused by unexpected external means.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of a child and managing the property and rights of that child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations for Covered Charges. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Medically Necessary or clinically necessary shall mean services or supplies, which are determined by a physician to be essential to health and are:
(A) Provided for the diagnosis or care and treatment of a medical, behavioral health/substance abuse or surgical condition;
(B) Appropriate and necessary for the symptoms, diagnosis or treatment of a medical, behavioral health/substance abuse or surgical condition;
(C) Within standards of medical practice recognized within the local medical community;
(D) Not primarily for the convenience of the covered person, nor the covered person's family, physician or another Provider; and
(E) Performed in the most appropriate, cost effective and safe setting or manner appropriate to treat the covered person's medical, behavioral health/substance abuse or surgical 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 or clinically necessary and appropriate. The Claims Administrator will determine if an expense is medically necessary and/or clinically necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Plan means The Tennessee Plan, a benefits plan for eligible Retirees and their eligible dependents as described in this document.

Plan Administrator is the State of Tennessee acting through the State Insurance Committee. The State Insurance Committee shall determine the benefits available to Plan Participants, set the monthly premiums necessary to fund the Plan's anticipated expenses, provide for the administration of the Plan and establish eligibility criteria for participation in the Plan.

Plan Participant is a Retiree or Retiree's dependent who meets the Plan's eligibility requirements, has applied for and qualified for coverage and who has paid the Plan premium. Plan Participants are certified by the Plan Administrator to the Claims Administrator.

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

Provider means 1. any legally licensed physician or any physical therapist, speech therapist, occupational therapist, or other health care providers performing a covered service ordered by a physician; 2. any licensed independent laboratory, hospital, skilled nursing facility, rehabilitation facility, hospice agency, home health care agency; or other facility/agency included for Plan coverage; 3. urgent care facilities and other health centers or clinics performing covered services given by covered physicians or other healthcare providers that would otherwise be covered by the Plan. To be covered, a Provider must meet Medicare criteria as a covered provider, meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

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

Refund means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

Retiree is a former employee who has retired from the Employer and receives a benefit from the Tennessee Consolidated Retirement System (TCRS), or an employee who has retired from the employer and participates in a higher education optional retirement plan (ORP).

Shared Parenting means a court approved parenting plan, describing the role each parent will have in the child's life, including a residential schedule indicating the times and places where the child will reside.

Pursuant to TCA 36-6-410, the parenting plan shall designate the parent with whom the child is scheduled to reside a majority of the time as the custodian of the child solely for the purpose of all other state and federal policies and any applicable policies of insurance that require a designation or determination of custody. The statute further provides that if there is no designation in the plan, the parent with whom the child is determined to reside the majority of the time shall be deemed the custodian for the purposes of such statutes.

Sickness is a person's Illness, disease or pregnancy (including complications).

Special Qualifying Event is a personal change in status, such as divorce or termination of spouse or ex-spouse's employment, which results in the loss of group health coverage and may allow persons to enroll or change benefit elections.

Subrogation means the Plan's authority to pursue and place a lien upon the Plan Participant's claims for medical, behavioral health/substance abuse, surgical or dental charges against another party.

Total Disability (Totally Disabled) in the case of a dependent child means the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Tricare is the United States Department of Defense health care program for members of the uniformed services, their families and survivors.

Usual, Reasonable and Customary Charge is a charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like service in the same area. A review of the charge will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. To calculate reimbursements, the Plan will use the actual charge billed if it is less than the Usual, Reasonable and Customary Charge. The Claims Administrator has the authority to decide whether a charge is Usual, Reasonable and Customary.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Retirees. All Retirees of the Employer who meet the eligibility requirements shown in the "Eligibility Requirements for Retiree Plan Coverage" section below.

Eligibility Requirements for Retiree Coverage. A qualified Retiree is eligible to be a Plan Participant from the first day that he or she satisfies the requirements for Retiree coverage.

Eligibility Requirements for Retiree Plan Coverage. A person is eligible to be a Plan Participant in the "Retiree Plan Coverage" provision of the Plan from the first day that he or she is:

(1) Per TCA 8-27-209, a retired state of Tennessee employee, as defined in TCA 8-27-204(a)(1); covered by Medicare benefits; an individual whose initial employment with the state or other governmental agency qualifying the person for plan membership commenced prior to July 1, 2015; and who is
   a. an eligible retired state employee, eligible retired employee of the University of Tennessee, or eligible retired employee of the state university and community college system drawing retirement benefits through the Tennessee consolidated retirement system; or
   b. an eligible retired employee of the University of Tennessee or the state university and community college system participating in any other retirement plan offered through their employment with the University of Tennessee or the state university and community college system, regardless of whether such retired employee is drawing a retirement benefit;

(2) Per TCA 8-27-307, a retired Local Education employee participating in the Tennessee consolidated retirement system provided that the retired employee is covered by Medicare benefits and is also drawing a monthly retirement allowance from the Tennessee consolidated retirement system, and whose initial employment with a participating local education agency or other qualifying employer commenced prior to July 1, 2015; or

(3) Per TCA 8-27-706, a retired county judge, county official, or employee of employer participating in the Tennessee Consolidated Retirement System who is covered by Medicare benefits, drawing a monthly retirement allowance from the Tennessee Consolidated Retirement System, and whose initial employment with a qualifying employer commenced prior to July 1, 2015.

The qualification by the Retiree could be due to the receipt of a TCRS disability benefit and participation in Medicare Part A, or the receipt of a TCRS service or disability benefit and the attainment of age 65 and participation in Medicare Part A. (Note: Local Government participants must enroll earlier than the State or Local Education participants when they become Medicare eligible. They cannot stay in the State of Tennessee sponsored health plan once they become Medicare eligible.)

An otherwise qualified Retiree shall become eligible to apply for enrollment as a late applicant in the Plan upon cancellation of participation in a Medicare Advantage Plan and enrollment in traditional Medicare (Parts A and B).

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Retiree's spouse who is eligible for Medicare Part A. The term "spouse" shall mean the person recognized as the covered Retiree's legally married spouse under the laws of the state where the covered Retiree lives. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Retiree's child(ren) who are **eligible for Medicare Part A** from birth to the limiting age of 26 years who meet at least one of the following five criteria:

   (a) Natural or adopted children regardless of where they live; adopted children, in connection with any placement for adoption of a child with any person, means the assumption of legal obligation of total or partial support of a child in anticipation of adoption. The obligation may be determined

by court records or other appropriate documentation as determined by the Plan Administrator.

(b) Stepchildren for whom the Retiree or spouse has legal custody, joint custody or Shared Parenting;

(c) Children for whom the Retiree is the Legal Guardian;

(d) A Retiree's child for whom the Plan has received a qualified medical child support order requiring the child to be enrolled in a health insurance plan pursuant to State or Federal statutes and who is also eligible for Medicare Part A;

(e) Dependents required to be covered by any applicable State or Federal law.

(3) Dependent children who meet at least one of the criteria shown above and who are incapacitated (the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health) who have qualified to participate in Medicare Part A and whose incapacitation was certified by Medicare as beginning prior to the child's 26th birthday. The child must meet the requirements for dependent eligibility listed in this section.

The Plan Administrator may require at reasonable intervals, not more than once each year, subsequent proof of the dependent's Total Disability and dependency. The Plan Administrator reserves the right to have such dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as dependents:

(1) Any dependent not eligible for Medicare Part A, even if all other eligibility requirements are met;

(2) Foster children;

(3) Dependents not listed in the above eligibility requirements:

(4) Parents;

(5) Legally divorced spouse;

(6) Other individuals living in the covered Retiree's home who are not eligible as shown in the above eligibility section;

(7) Any person who is covered under a State of Tennessee sponsored health plan as an employee or Retiree;

(8) Any person who is covered under TennCare or CoverKids; or

(9) The child of a child (grandchild) of the Retiree or of the retiree's spouse [except as noted in (2)(c) "Eligible Classes of Dependents above].

If both mother and father are covered separately under the Plan, their children will be covered as dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A qualified family member of a Retiree will become eligible for dependent coverage on the first day that the Retiree is enrolled for Retiree Plan Coverage and the family member satisfies the requirements for dependent coverage.

Verification of dependent eligibility may be required at time of enrollment. At any time, the Plan may require proof that a spouse or a child continues to qualify as a dependent as defined by this Plan.

FUNDING

Cost of the Plan. The monthly participation contribution rates for coverage under the Plan are established by the Plan Administrator.

Regular payment of Plan contributions is required. After the first payment, Plan contributions become due as they are billed. Claims will not be paid if premiums are not paid through the incurred date of the services for which the claims are submitted.

After the first payment, a deferral period of a full calendar month is allowed for premiums being billed directly or collected through ACH instead of through payroll deduction. If the Plan contribution is not paid within the deferral period, coverage is terminated retroactively to the last month for which Plan contributions were paid. When coverage for Plan Participants who are billed directly or collected through ACH has been canceled for failure to pay within the deferral period, a one-time opportunity for coverage reinstatement is allowed. Plan Participants seeking reinstatement of coverage must request reinstatement within 30 days of being notified that coverage was canceled. The Plan Participant must sign and return the required documentation, and all current and past due premiums must be received within 30 days of the request for reinstatement.

If the Plan Participant receives a State of Tennessee TCRS benefit check, the Retiree's and covered dependent's portion of the premium will be deducted automatically from the TCRS monthly benefit payment. If the Retiree's TCRS benefit is not sufficient to cover the cost for the coverage, or if there is a limitation in the TCRS benefit system on the number of allowed deductions, the Retiree will be billed directly. The Retiree may also choose automatic payment from a bank account.

The level of monthly contributions is set by the Plan Administrator. The Plan Administrator reserves the authority to change the level of Retiree contributions. Should the rate change, the Plan Administrator will notify Plan Participants in writing at least 30 days before the change goes into effect.

ENROLLMENT

Enrollment Requirements. A Retiree must enroll for Retiree only or Retiree and dependent coverage by filling out and signing an enrollment application along with the appropriate deduction authorization, if applicable.

Retirees who are eligible for Medicare at retirement may elect to enroll in the Plan at retirement. Retirees who become eligible for Medicare by virtue of age after the Retiree's retirement may elect to enroll in the Plan at the time of Medicare entitlement.

Dependents eligible under this Plan Document may only enroll in the Plan if the Retiree is enrolled in the Plan. Dependents eligible for Medicare at the time of the Retiree's retirement may enroll upon the Retiree's enrollment or January 1 of the year following the Retiree's enrollment. Dependents that become eligible for Medicare after the Retiree's enrollment in the Plan may enroll in the Plan at the time of Medicare entitlement if the Retiree is still participating in the Plan.

Timely Enrollment - The enrollment will be "timely" if the completed enrollment form is received by the Plan Administrator no later than 60 days after the person is initially eligible (at retirement or Medicare entitlement) for coverage or within 60 days of the person becoming eligible under a Special Enrollment Provision (see below). Applications not received by the Plan Administrator within the initial 60-day eligibility period will be considered "late", and the Retiree and/or his eligible dependent(s) applying for coverage must answer specific health questions for review by the Claims Administrator. The Claims Administrator will review the answers to the health questions for those submitting late applications and determine if enrollment will be approved or denied. Dependents who elect the January 1 (see previous paragraph above) following retiree's enrollment as their effective date must submit enrollment application to the Plan Administrator no later than December 31 of the prior year for the application to be considered as timely enrollment; otherwise, the application will be considered "late", and the dependent will be required to answer health questions to qualify for enrollment.

Retirees and their dependents (including surviving dependents of deceased retirees) who qualify for enrollment

under the eligibility provisions of the Plan and enroll with a local education or local government agency joining

the State of Tennessee Group Insurance Program for the first time, shall not be considered as "late applicants" if:

- The retiree's initial employment with a qualifying agency (Tennessee Consolidated Retirement System eligible agency) commenced prior to July 1, 2015; and
- The dependents are eligible dependents of the retiree or eligible surviving dependents of the deceased retiree; and
- The retiree is receiving a pension from the Tennessee Consolidated Retirement System, or (if deceased) the retiree was eligible to receive a TCRS pension at the time of death; and
- The retirees and dependents (or surviving dependents of the deceased retiree) transfer from an active employee health plan, Medicare Supplement Plan, or a Medicare Advantage Plan sponsored by the joining agency.

This provision does not apply to retirees or dependents who are never eligible for Medicare and those who are not yet eligible for Medicare.

If two Retirees (legally married spouses) are covered separately under the Plan and the Retiree covering any dependent children terminates coverage, the dependent coverage may be continued by the other covered Retiree; no Waiting Period is required if coverage has been continuous.

Effective Date of Retiree Plan Coverage. A Retiree will be covered under this Plan on the date specified below upon satisfactorily completing the eligibility and enrollment requirements of the Plan:

(1) Retiree eligible for Medicare at retirement – For "timely" enrollment, the first of the month following termination of coverage in the State of Tennessee Sponsored Health Plan, if enrolled, or on the first of the month following the date of retirement, whichever is later. If the date of retirement is the later date and falls on the first of the month, the retiree's coverage may be effective on that date. Application must be received by Plan Administrator (Division of Benefits Administration) within 60 days of termination of active group health coverage or the date of retirement, whichever is later.

(2) Retiree not eligible for Medicare at retirement – For "timely" enrollment, on the date of Medicare entitlement for the Retiree. Application must be received by Plan Administrator (Division of Benefits Administration) within 60 days of Medicare entitlement.

(3) Late applicant – For approved enrollment, on the first day of a month, according to calendar established by the Plan Administrator, following approval of enrollment by the Claims Administrator

(4) Retiree transferred from new agency's active employee group or Medicare Supplement or Medicare Advantage Plan to the State's The Tennessee Plan (Supplement Medical Insurance for Retirees with Medicare) – For approved enrollment, on the first day of a month coinciding with the new agency's effective date in the State's Group Insurance Plan.

Effective Date of Dependent Coverage. A dependent's coverage under this Plan will take effect on the date specified below **upon satisfactorily completing the eligibility and enrollment requirements** of the Plan:

(1) Dependent and Retiree eligible for Medicare at the time of Retiree's retirement and Retiree applies timely to enroll self and dependent in the Plan

a. On the date of the Retiree's effective date in the Plan's Retiree Plan Coverage. Application must be received by the Plan Administrator within 60 days of termination of active group health coverage or the date of retirement, whichever is later.

(2) Dependent not eligible for Medicare when the Retiree becomes eligible for Medicare and enrolls in the Plan

a. On the date of Medicare entitlement for the dependent. Retiree must submit application to be received by the Plan Administrator within 60 days of the dependent's Medicare entitlement.

(3) Dependent eligible for Medicare before Retiree becomes eligible for Medicare and enrolls in the Plan

a. On the date of the Retiree's effective date when the retiree enrolls in the plan no later than 60 days after their initial eligibility date, or

b. January 1 of the year following the Retiree's enrollment in the plan no later than 60 days after their initial eligibility date. Application to enroll dependents must be received by the Plan Administrator no later than December 31st of the calendar year of the Retiree's enrollment.

(4) Late applicant
a. For approved enrollment, on the first day of a month, according to calendar established by the Plan Administrator, following approval of enrollment by the Claims Administrator and approved enrollment of the Retiree
b. The approved Dependent's enrollment shall be voided if the Retiree is not approved for enrollment or otherwise chooses to not enroll in the Plan

(5) Dependent transferred from new agency's active employee group or Medicare Supplement or Medicare Advantage Plan to the State's The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare) along with the eligible, enrolled Retiree associated with the dependent
a. For approved enrollment, on the first day of a month coinciding with the new agency's effective date in the State's Group Insurance Plan
b. The approved Dependent's enrollment shall be voided if the Retiree is not approved for enrollment or otherwise chooses to not enroll in the Plan.

Right to Return Policy

If you are not satisfied *with The Tennessee Plan,* you can cancel it within 30 days of the receipt of your identification card and member handbook. You will receive a refund of any premiums paid in advance. Any claims paid during this period will be recovered.

SPECIAL ENROLLMENT PROVISION

(1) Individuals Losing Other Coverage. A Retiree or dependent who would have been eligible to enroll in this plan at the time of retirement, but elected not to enroll, may enroll if all of the following conditions are met:

(a) The Retiree or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Retiree stated in writing at the time coverage was offered that other health coverage was the reason for declining enrollment.

(c) The coverage of the Retiree or dependent who lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or all Employer contributions towards the coverage were terminated.

(d) The Retiree or dependent requests enrollment in this Plan not later than 60 days after the date of exhaustion of COBRA coverage, or the termination of coverage, or Employer total contributions are terminated, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of this provision, a loss of eligibility occurs if:

(i) The Retiree or dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits.

(ii) The Retiree or dependent has a loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals.

(iii) The Retiree or dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death, termination of employment, or reduction in the

number of hours of employment or all employer contributions towards the coverage was terminated.

(iv) The Retiree or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(v) The Retiree or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

The coverage of the Retiree or dependent enrolled through a Special Enrollment Provision will be effective:

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

(b) the first day of the month following loss of other coverage;

If the Retiree or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have access to the Special Enrollment Provisions.

(2) Dependents.

The dependent may be enrolled under this Plan as a covered dependent of the covered **Retiree** if the dependent is otherwise eligible for coverage when both of the following conditions are met.

(a) The Retiree is a participant under this Plan (or is eligible to be enrolled under this Plan but failed to enroll during a previous enrollment period and is enrolling at this time), and

(b) A person becomes a dependent of the covered Retiree through marriage, birth, adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse of the covered Retiree may be enrolled as a dependent of the covered Retiree if the spouse is otherwise eligible for coverage.

The dependent Special Enrollment Provision is a period of 60 days and begins on the date of the Special Qualifying Event.

The coverage of the participating Retiree’s dependent enrolled through a Special Enrollment Provision will be effective:

(a) in the case of marriage, as of the date of marriage or the first of the subsequent month if the spouse is eligible for Medicare Part A;

(b) in the case of a dependent child's birth, as of the date the Medicare Part A coverage is effective; or

(c) in the case of a dependent child's adoption or placement for adoption, the date of the adoption or placement for adoption if the dependent child is also eligible for Medicare Part A.

SUSPENSION OF COVERAGE DUE TO MEDICAID (TennCare) ENTITLEMENT

A Plan Participant becoming eligible for Medicaid (TennCare) may notify in writing the Plan Administrator to suspend benefits and charges for coverage under this Plan for the period of Medicaid eligibility, not to exceed 24-months. The notice of such suspension must be received by the Plan Administrator within 90 days after determination of Medicaid eligibility.

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

Coverage under the Plan may be reinstated on the date the Retiree or eligible dependent loses eligibility to Medicaid if such loss occurs within 24 months after suspension. The Retiree must provide written notice of loss of Medicaid entitlement within 90 days after the date of such loss and pay the Plan Contribution charges for the period for which coverage is reinstated. Coverage may not be reinstated if the loss of eligibility to Medicaid occurs greater than 24 months after suspension.

TERMINATION OF COVERAGE

The Plan Administrator has the authority to cancel coverage of a Plan Participant for cause, for making a fraudulent claim, for failure to cooperate with subrogation recovery, or for an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Plan Administrator may either void coverage for the period of time coverage was in effect or may terminate coverage as of a date to be determined at the Plan's discretion. The Plan will collect reimbursement on any claims if benefits are paid in excess of the Plan Participants' paid premiums.

When Retiree Plan Coverage Terminates. Retiree coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The day the covered Retiree ceases to be in one of the Eligible Classes, including but not limited to death.

(3) The end of the month for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If A Retiree commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan Administrator may either void coverage for the Retiree and covered dependents for the period of time coverage was in effect or may terminate coverage as of a date to be determined at the Plan Administrator's discretion.

(5) A Retiree's failure to respond to the Plan's requests for information and/or pay any owed subrogation expenses to the Plan may result in termination of coverage on a date determined by the Plan Administrator. Any Retiree or dependent who has been disenrolled from the Plan pursuant to the "THIRD PARTY RECOVERY PROVISION" section of this Plan Document for failure to cooperate and/or pay outstanding medical expenses shall be ineligible to rejoin the Plan for a period of three (3) years.

(6) The end of the month in which the Plan Administrator receives a written or electronic request to terminate the policy signed and dated by the Retiree.

When Dependent Coverage Terminates. A dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or dependent coverage under the Plan is terminated.

(2) The date that the Retiree's coverage under the Plan terminates for any reason including death. (See "Survivor Dependents" section below for extension of coverage option.)

(3) The end of the month in which a covered spouse loses coverage due to loss of dependent status.

(4) The end of the month in which a dependent child ceases to be a dependent as defined by the Plan.

(5) The end of the month for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan Administrator may either void coverage for the dependent for the period of time coverage was in effect or may terminate coverage as of a date to be determined at the Plan's discretion.

(7) The end of the month in which the Plan Administrator receives a written or electronic request to terminate the policy signed and dated by the Retiree.

Premium Refunds. Premium refunds will be limited to three months from the date of notification to the Plan Administrator with the following guidelines:

(1) Retiree or designated representative fails to notify Plan Administrator of eligibility change: Retirees (or their designated representative) who do not notify the Plan Administrator about a change in their insurance enrollment eligibility within sixty (60) days of the change will receive a three month refund of their portion of the premium from the date of notification to the Plan Administrator unless the Retiree owes the Plan for claims paid inappropriately; overpaid benefits above the Retiree premium refund amount will be billed to the Retiree.

(2) Plan Administrator fails to follow through on Retiree request for change: If a Retiree (or his designated representative) notifies the Plan Administrator to change insurance enrollments within sixty (60) days of an eligibility change and the Plan Administrator fails to follow through on the request, the Retiree will receive his entire portion of the refund.

(3) Fraud cases: When the office of the State Comptroller has determined that fraud exists, the Retiree will forfeit his portion of a refund.

COVERAGE REINSTATEMENT FOLLOWING VOLUNTARY CANCELLATION

In the event that an Enrollee has voluntarily canceled coverage for himself and/or his eligible dependents and wants the coverage reinstated, the Enrollee may do so by meeting all of the following conditions:

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

(2) The policyholder and/or his dependent(s) continue to meet the eligibility requirements of the plan;

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

SURVIVOR DEPENDENTS

In the event of the death of a covered Retiree, the coverage will terminate at the end of the month in which the death occurred. If the Retiree elected family coverage, the surviving eligible and enrolled dependent(s) who were covered under the Plan at the time of the Retiree's death may continue enrollment in the Plan, subject to the terms and conditions of the Plan. The surviving dependent(s) must apply to continue coverage within 60 days of the notice of termination of coverage under the Retiree. If the dependent receives a TCRS benefit, premiums will be deducted by the Tennessee Consolidated Retirement System. If no TCRS benefit is continued or if the premium exceeds the monthly TCRS benefit, the premium payments must be submitted as determined by the Plan Administrator. Dependents must continue to meet the definition of an eligible dependent. Dependents acquired by the survivor(s) after the death of the Retired Employee will not be eligible for coverage under the Plan.

SCHEDULE OF BENEFITS

THE TENNESSEE PLAN

The Tennessee Plan is a supplemental medical insurance for Retirees with Medicare plan that is comparable to coverage offered in a Medicare Gap NAIC Model D Benefit Plan. The Plan is designed to fill in some of the coverage holes in Medicare Part A and Medicare Part B coverage. **Unless otherwise stated in this document, there is no prescription drug coverage under this plan.**

NON-DUPLICATION OF MEDICARE BENEFITS

This Plan shall not duplicate any benefits provided by Medicare.

ALLOWED CHARGES

The Plan will consider the Allowed Charge to be Medicare's Part A or Medicare's Part B approved amount for those covered services billed by a covered provider. The Medicare approved amount is the amount recognized as reasonable by Medicare for health care expenses of the kinds covered by Medicare. The Medicare approved amount also includes amounts considered payable under the Medicare Part B fee schedule. The Plan will not pay charges that exceed Medicare's approved amounts. For services covered under the Plan and excluded under Medicare Part A or Medicare Part B, the Allowed Charge will be the Usual, Reasonable, and Customary Charges as Determined by the Claims Administrator. It is the Plan Participant's responsibility for payment of any charges that exceed Medicare's approved amounts or any ineligible claims.

OUT OF COUNTRY CARE

This Plan will provide benefits for covered expenses Incurred outside the USA as shown in the Schedule of Benefit grid in this section. Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. The Plan Participant may be required to pay the provider at the time of service. If expenses outside the USA are Incurred, the Plan Participant must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where services were rendered. The Plan reserves the authority to reimburse the Plan Participant directly.

MEDICARE PART A - HOSPITAL BENEFITS

The following summary of benefits is an outline of the maximum amounts or specific limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to the sections entitled **Covered Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.

Note: Medicare Part A deductible and coinsurance amounts generally increase each Calendar Year. Plan payments will be based on the Medicare deductible and coinsurance in effect at the time approved expenses were Incurred.
Medicare Part A Deductible. The amount the beneficiary must pay each Benefit Period before Medicare begins to pay.
Medicare Coinsurance. The daily amount the beneficiary must pay for each day of inpatient care.
Lifetime Benefit Reserve Days. The Medicare coverage that becomes available when the beneficiary has been in a Hospital more than 90 days in a benefit period. The 60 reserve days can only be used once during the person's Lifetime.
Calendar Year. Twelve consecutive months beginning January 1 and ending December 31.

Medicare Part A Expenses	**Medicare Approved Amounts**		
	Medicare Pays	**This Plan Pays**	**You Pay**
Hospitalization			
• First 60 days per Benefit Period	All Allowed Charges but the Medicare Part A deductible	Medicare Part A deductible	**$0**
• 61st through 90th day	All Allowed Charges but the Medicare coinsurance amount	Medicare coinsurance amount	**$0**
• 91st day and after while using 60 Lifetime Benefit Reserve Days	All Allowed Charges but the Medicare coinsurance amount	Medicare coinsurance amount	**$0**
• Once Lifetime Benefit Reserve Days are used, an additional 365 benefit days	$0	100% of Medicare eligible expenses	**Usually $0**
Skilled Nursing Facility Care			
• First 20 days	All Allowed Charges	$0	**$0**
• 21st through 100th day	All Allowed Charges but the Medicare coinsurance amounts	Medicare coinsurance amount	**$0**
• 101st day and after	$0	$0	**All costs**
Blood			
• First three pints (Medicare Part A & Medicare Part B combined per Calendar Year)	$0	100% of Medicare eligible expenses	**$0**
• After three pints	All Allowed Charges	$0	**$0**
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	**$0**

MEDICARE PART B – MEDICAL BENEFITS			
The following summary of benefits is an outline of the maximum amounts or specific limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to the sections entitled **Covered Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.			
Medicare Part B Deductible. The portion of the Medicare approved amount that the beneficiary must pay each Calendar Year before Medicare begins to pay (based on the Medicare Part B deductible in effect at the time approved expenses were Incurred). **Patient Liability Coinsurance**. The portion of the Medicare approved amount (usually 20%) that the Plan Participant must pay after the Medicare deductible and Medicare coinsurance payment (usually 80%).			
Medicare Part B Expenses	**Medicare Approved Amounts**		
	Medicare Pays	**This Plan Pays**	**You Pay**
Medicare Part B Deductible	$0	$0	**All costs**
Part B Excess Charges (charges above Medicare approved amounts)	$0	$0	**All costs**
Blood • First three pints (Medicare Part A & Medicare Part B combined per Calendar Year)	$0	100% of Medicare eligible expenses	**$0**
• After three pints	First: $ 0 until you meet the Medicare Part B deductible **Then:** 80% of Allowed Charges	**First:** $ 0 until you meet the Medicare Part B deductible **Then:** 20% of Allowed Charges	**First: Medicare Part B deductible** **Then: $0**
Clinical Lab Services	All Allowed Charges	$0	**$0**
Other Covered Medicare Part B Services	Generally 80% of Allowed Charges after Medicare Part B deductible	Generally 20% of Allowed Charges	**$0** (after Medicare Part B deductible is met)

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

MEDICARE PART A & PART B – HOME HEALTH CARE EXPENSES			
The following summary of benefits is a brief outline of the maximum amounts or specific limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to the sections entitled **Covered Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.			
Medicare Part A & Part B Home Health Care Expenses	**Medicare Approved Amounts**		
	Medicare Pays	**This Plan Pays**	**You Pay**
Medicare Approved Services (Medically necessary skilled care services and medical supplies)	100% of Allowed Charges	$0	**$0**
Durable Medical Equipment	**First:** $ 0 until you meet the Medicare Part B deductible **Then:** 80% of Allowed Charges	**First:** $ 0 until you meet the Medicare Part B deductible **Then:** 20% of Allowed Charges	**First: Medicare Part B deductible** **Then: $0**

EMERGENCY CARE DURING FOREIGN TRAVEL

Coverage is available for the same services covered by Medicare for medically necessary emergency care services which begin during the first 60 consecutive days of each trip outside the USA. Outside the USA is considered to be outside all the states, the District of Columbia, The Commonwealth of Puerto Rico, the American Virgin Islands, Guam, American Samoa and the Northern Marinas Islands. If Medicare pays for the emergency care outside the USA, the Plan benefits will be limited to the Medicare Part A deductible and Medicare Part A and Medicare Part B coinsurance which is shown as being covered under this Plan. If Medicare **does not** pay for the emergency care services outside the USA, the Plan will provide *Foreign Travel Emergency Care Benefits* shown below.

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to the sections entitled **Covered Medical Benefits**, **Plan Exclusions**, and **Defined Terms**.	
Foreign Travel Emergency Care Benefit. Coverage is limited to emergency care services or supplies that would have been approved by Medicare if done in the USA. No other expenses are covered under this benefit.	
Foreign Travel Deductible. The amount of Allowed Charges that the Plan Participant must pay each Calendar Year before the Plan pays. The foreign travel Plan deductible is $250. **Coinsurance**. The 20% balance of the Allowed Charges that the Plan Participant must pay after the foreign travel Plan deductible is satisfied. **Calendar Year**. Twelve consecutive months beginning January 1 and ending December 31. **Lifetime Maximum Benefits:** Plan limits Foreign Travel Emergency Care Benefits to $50,000 per each Plan Participant's Lifetime**.** Once the Plan has paid $50,000, the Plan will no longer pay *Foreign Travel Emergency Care Benefits* for that Plan Participant.	
Approved Charges	
Plan Pays	**You Pay**
All but the foreign travel deductible and 20% of the Allowed Charges up to the Lifetime maximum benefits.	The foreign travel deductible and 20% coinsurance amounts and any charges more than the Lifetime maximum benefit.

COVERED MEDICAL BENEFITS

This Plan does not cover the Medicare Part B calendar year deductible, Medicare excess charges, and outpatient prescription drugs.

This section describes the covered medical benefits and how they apply when Covered Charges are Incurred by a Plan Participant for care of an Injury or Sickness and while the person is covered for these benefits under The Tennessee Plan. To receive benefits, a Plan Participant must be under a physician's care and the services must be recommended by the physician. These services are subject to the rules of the hospital or other covered institution, including regulations governing admission. Unless specifically shown as a covered benefit in this document, a Plan Participant is responsible for any ineligible charges or charges over the Medicare allowed amount.

COVERED CHARGES

Covered Charges are the Allowed Charges that are Incurred for the following services and supplies. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished.

MEDICARE PART A DEDUCTIBLE

When a Plan Participant is in a hospital and receives benefits under Part A of Medicare for that hospitalization, the Plan will pay the Medicare Part A deductible in each Benefit Period.

MEDICARE COINSURANCE AMOUNTS FOR HOSPITALIZATION UNDER MEDICARE PART A

When a Plan Participant is in a hospital and receives benefits under Medicare Part A for that hospitalization, the Plan will pay for the following:

(1) The Medicare coinsurance amount for the 61st through 90th day of each Benefit Period.

(2) The Medicare coinsurance amount for the Medicare 60 lifetime reserve hospital days.

ADDITIONAL HOSPITAL DAYS

If during a Benefit Period the Plan Participant has used the maximum Medicare hospital days, including Medicare lifetime reserve days, then the Plan will pay for medically necessary additional days of inpatient hospital care in the same Benefit Period. The Plan will not pay for more than 365 of such additional days during a Plan Participant's Lifetime.

The Plan's payment for each additional day of care will be limited to:

(1) those expenses that would have been paid under Medicare;

(2) short-term hospitalization in an acute care general hospital which either qualifies under Medicare or is accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator; and

(3) those days for which Medicare would have made payments if the maximum Medicare days had not been used.

POST-HOSPITALIZATION SKILLED NURSING FACILITY CARE

When a Plan Participant is confined in a skilled nursing facility following hospitalization and receives Medicare Part A benefits for that confinement, the Plan will pay the coinsurance amount (patient liability) from the 21st day through the 100th day in each Benefit Period.

BLOOD DEDUCTIBLE UNDER MEDICARE

The Plan will pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Medicare Part A or Medicare Part B each year, unless the blood is replaced in accordance with federal regulations.

PATIENT LIABILITY COINSURANCE UNDER MEDICARE PART B

When Medicare pays for a service covered under Medicare Plan B, the Plan will pay the coinsurance amount (patient liability), if any, based on the amount fixed by Medicare for the service. If Medicare pays 100% of the amount fixed by Medicare for a service covered under Medicare Part B, or Medicare determines the service is not an eligible expense, then the Plan will not provide payment. Under no circumstances will the Plan make any payments for the difference between the amount fixed by Medicare (Allowed Charge) and the actual charge to the Plan Participant for the service.

HOSPICE CARE

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

(1) The Plan Participant is eligible for Medicare Part A (Hospital Insurance); and

(2) The Plan Participant's doctor and the hospice medical director certify that the Plan Participant is terminally ill and has 6 months or less to live if the Plan Participant's illness runs its normal course; and

(3) The Plan Participant signs a statement choosing hospice care instead of other Medicare-covered benefits to treat the Plan Participant's terminal illness; and

(4) The Plan Participant gets care from a Medicare-approved hospice program.

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

EMERGENCY CARE DURING FOREIGN TRAVEL

The Plan will cover emergency care in a foreign country (the Plan Participant must be legally responsible for payment of these services) under the following terms and conditions:

(1) The Plan Participant is a resident of the United States and is temporarily traveling elsewhere.

(2) Emergency care means care needed immediately because of an Injury or Illness of sudden and unexpected onset.

(3) The Plan Participant is responsible for the payment of a deductible of $250.00 in each Calendar Year toward the expenses described in item (4) below for emergency care.

(4) The Plan will pay 80% of billed charges after payment of the deductible described in item (3) above for those expenses for necessary emergency hospital, physician and medical care in a foreign country that would be covered under Medicare if care was received within the United States.

(5) The emergency care must begin during the first sixty (60) consecutive days of each trip outside the United States.

(6) Plan payments for emergency care under this provision are subject to a Lifetime maximum of $50,000.00.

(7) The Plan will not pay for any emergency care received in a foreign country that is covered by Medicare under this benefit. If Medicare pays for the emergency care outside the USA, the Plan benefits will be limited to the Medicare Part A deductible and Medicare Part A and Medicare Part B coinsurance shown as covered under this Plan.

Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. The Plan Participant may be required to pay the provider at the time of service. If expenses outside the USA are Incurred, you must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where service was rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Claims Administrator reserves the authority to reimburse the Plan Participant directly.

PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following **is not covered**:

(1) Automobile Insurance, No-Fault Auto Insurance for which the Plan Participant is eligible to receive benefits through mandatory no fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the no-fault coverage due to its deductible or maximum payment limits will be covered under this Plan to the extent Allowed Charges would have otherwise been payable by this Plan. **Note:** No-fault and motor vehicle liability coverage is considered another plan under the Coordination of Benefits provision of this Plan.

(2) Covered expenses under Medicare Part A and/or Part B. Any expense to the extent of any benefits available (payable) under Medicare Part A and/or Medicare Part B, whether or not the Plan Participant is enrolled or applies for them.

(3) Dental or orthodontic expenses unless covered under Medicare Part A and/or Part B

(4) Excess Charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Medicare approved amount or the Usual, Reasonable, and Customary Charge.

(5) Foreign Travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(6) Government Coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(7) Government Facilities/Institutions. Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for covered expenses for the following exceptions:

- **(a)** Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.
- **(b)** State or local government owned acute care Hospital or Skilled Nursing Facility that customarily bills for its services.
- **(c)** State or local government owned mental health facility.
- **(d)** Government owned facility that otherwise meets Plan limitations for coverage as an outpatient alcohol or Substance Abuse treatment facility.
- **(e)** USA military acute care Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel.
- **(f)** Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary, or it is impossible to transfer the patient to another facility.

(8) Illegal Care. Services or supplies considered illegal according to the laws of the state of jurisdiction or according to federal law. Benefits will not be provided if these excluded services are obtained outside the USA even if these services are legal in the foreign country.

(9) Medicare Advantage Plans (Medicare Part C). If a Plan Participant is enrolled in a Medicare Advantage Plan, The Tennessee Plan will not coordinate benefits with the Medicare Advantage Plan.

(10) Medicare Part B yearly deductible. The Medicare Part B Calendar Year deductible amount.

(11) Military Service. Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.

(12) No Charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

(13) No Obligation to Pay. Charges incurred for which the Plan has no legal obligation to pay.

(14) Not covered by Medicare. Services and supplies not covered by Medicare Part A or Medicare Part B, except those specifically included under the plan.

(15) Not specified as Covered. Medical services, treatments and supplies which are not specified as covered under this Plan.

(16) Occupational. Care and treatment of an Injury or Sickness that arises from work for wages or profit including self-employment. Payment will not be made even if you or your dependents do not claim the entitled benefits.

(17) Other Plan/Benefit Penalties/Primary Care Network/HMO Network. Services or supplies to the extent such expenses were disallowed by a primary health plan due to failure by their Enrollee or participant to follow the requirements of its benefit management or managed care program, preadmission reviews, second surgical opinion, or any other reason, including failure to abide by the primary care physician network established by a health maintenance organization (HMO) that is a primary plan payer. In addition, this Plan will not coordinate with Plan Participants enrolled in a Medicare Advantage plan (Medicare Part C).

(18) Plan Design Exclusions. Charges excluded by the Plan design as specified in this document.

(19) Prescription Drugs. Outpatient prescription drugs that are eligible for coverage under a Medicare Part D plan are specifically excluded under this Plan, whether or not the Plan Participant is enrolled in a Medicare Part D plan.

(20) Services Before or After Coverage. Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(21) Subrogation/Third Party Claim. Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or actions) other than from an insurance carrier under an individual policy issued to a Plan Participant. **Exception**: Conditional payments shown in the section entitled "**Third Party Recovery Provision**".

(22) War. Any loss that is due to a declared or undeclared act of war.

CLAIM PROVISIONS

CLAIM SUBMISSION

Benefits under this Plan shall be paid only if the Claims Administrator concludes based upon provisions of the Plan Document that a Plan Participant is entitled to them.

Generally, the benefits will be provided as directed by the Plan Participant. However, the Claims Administrator has the right to pay the Plan Participant directly for all benefits administered under the Plan.

In order to process claims, the Claims Administrator may need information from the person or organization that supplied the service. A Plan Participant accepting this Plan, agrees to authorize the physician, hospital or other provider to release any information and records to the Claims Administrator.

If the doctor or facility accepts Medicare assignment, its billing office will file the Medicare claim.

Once Medicare processes the claim, Medicare will usually forward the payment details to the Claims Administrator for consideration of any additional benefits available under this Plan.

If a provider or hospital does not accept Medicare assignment, or if the doctor will not file the Tennessee Plan claims for the Plan Participant, the Plan Participant will need to:

(1) File the claim first with Medicare;

(2) If 30 days has passed from the claim filing with Medicare and after the Plan Participant has received a bill from the Provider, a copy of the Medicare Explanation of Benefits (or MEOB), with the Plan Participant's Health Insurance Claim Number (HIC) number (Member Identification number found on the Plan Participant's Medicare card), should be sent to the Claims Administrator .

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 13 months from date charges for the service were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Claims filed later than that date may be declined or reduced unless:

(1) it is not reasonably possible to submit the claim in that time; and

(2) this 13-month period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

APPEAL PROCEDURES

The Plan recommends that the Plan Participant keep a copy of all correspondence sent and received. There are established internal and external procedures to help a Plan Participant resolve a complaint related to the plan policies or the services provided. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

If a Plan Participant is in disagreement with a decision or the way a claim has been paid or processed, the Plan Participant or an authorized representative, acting on behalf of the Plan Participant, should first call the Claims Administrator to discuss the issue.

If the issue cannot be resolved via the telephone call to the Claims Administrator, the Plan Participant may file with the Claims Administrator a formal request for internal review or member grievance by completing the appropriate form or as otherwise instructed. The request for review must state in clear and concise terms the reason or reasons for the disagreement with the handling of the claim. The request for review must be directed to the Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

When the request for review or member grievance is received by the Claims Administrator, the Plan Participant will receive from the Claims Administrator an acknowledgement letter advising what to expect regarding the processing of the grievance.

Once a determination is made, the Claims Administrator will notify the Plan Participant in writing of the decision and advise of any further external appeal options if the appeal was denied. The Claims Administrator's written denial response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

Specific questions regarding appeal of claims decisions should be directed to the Claims Administrator. Other appeal questions may be directed to the Plan Administrator appeals coordinator at 615-741-4517 or 1-866-576-0029.

COORDINATION OF BENEFITS

Coordination of Benefits. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans, including Medicare, are paying. When a Plan Participant is covered by the Tennessee Plan and another plan, or the Plan Participant's spouse is covered by the Tennessee Plan and by another plan, or their covered children are covered under two or more plans, the multiple plans will coordinate benefits when a claim is received.

Benefit Plan. The term benefit plan means any one of the following:

(1) Group or group-type plans, including franchise, association, Multiple Employer Welfare Arrangements (MEWA), Employee Retirement Income Security Act (ERISA) plans, or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans or programs required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

When two or more plans provide benefits for the same allowable charge, benefit payment will follow the National Association of Insurance Commissioners (NAIC) model regulations for coordination of benefits. Current regulations are shown below. If these regulations change, the Tennessee Plan will automatically follow the amended regulations.

Allowable Charge. The Tennessee Plan will consider an Allowable Charge to be the Medicare Part A and Part B allowable charge, or the usual, reasonable, and customary expense covered by at least one of the plans covering the Plan Participant if the charge is covered under this Plan (but excluded under Medicare Part A and Part B). In no event will the combined payment exceed 100% of the Medicare Part A or Part B allowable charge, or for those services not covered by Medicare Part A or Part B, The Tennessee Plan's usual Plan benefits.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amounts and the Provider's charges when that Provider accepts Medicare assignment. If a Provider does not accept assignment, a beneficiary cannot be billed for charges over the limiting charge established by Medicare for that service by that Provider. However, if services are provided under the Medicare Private Contract Option [see (3)(d) Benefit Plan Payment Order], the Provider's charges can exceed the Medicare allowable fees.

Automobile Limitations. When medical payments are available under vehicle insurance, the Tennessee Plan shall consider vehicle plan deductible, and excess benefits only. The Tennessee Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

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

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or Retiree. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or Retiree. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of either a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items **(i)** and **(ii)** above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Tennessee Plan will never pay more than 50% of allowable charges when paying secondary.

(6) Medicare will pay primary, secondary or last to the extent stated in federal law (Medicare Secondary Payor rules, MSP). When Medicare is to be the primary payer, the Tennessee Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

a. **Not Enrolled in Medicare.** This coordination will apply to persons eligible for Medicare whether or not they are actually enrolled in Medicare or incur services in a Veterans Administration

Hospital/federal facility.

If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B, the Medicare benefit will be estimated and used to reduce Allowed Charges. This could result in significant reduction or denial of the Tennessee Plan benefits. Part A services will be estimated according to Medicare payment rules. Part B will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

For services Incurred in a Veterans Administration Hospital/federal facility which are not billable to Medicare, benefit integration will be estimated. Part A services will be estimated according to Medicare payment rules. Part B will be estimated, based on 80% of Usual, Reasonable, and customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

(b) Medicare Part C (Medicare Advantage). This coordination **will not apply** when a Plan Participant is enrolled in a Medicare Advantage Plan. If a Plan Participant is currently enrolled in or enrolls in a Medicare Advantage Plan, the Tennessee Plan will not coordinate benefits. This means it will not pay any deductibles, copayments or other cost-sharing under your Medicare health plan. **Even though The Tennessee Plan benefits will not coordinate (will pay no benefits) with a Medicare Part C plan, you have the legal right to keep The Tennessee plan.**

(d) Medicare Private Contract Options. This coordination will apply to persons eligible for Medicare primary benefits if Medicare benefits are not paid due to a Medicare Private Contract Option with Physicians and certain other practitioners. (When a Medicare beneficiary agrees to the terms of a Private Contract with certain Providers, Medicare will not pay. The patient is responsible for the entire charge. The Provider may bill more than the charges allowed by Medicare.) Under the Tennessee Plan, if a private contract is used, Medicare benefits will be estimated. Part A services will be estimated according to Medicare payment rules. Part B services will be estimated, based on 80% of Usual, Reasonable, and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Tennessee Plan benefits.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and the Tennessee Plan will pay second or third according to MSP rules.

(5) The Tennessee Plan will pay primary (first) to Tricare to the extent required by federal law.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this coordination of benefits provision work, the Tennessee Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give the Tennessee Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. The Tennessee Plan may repay other plans for benefits paid that the Claims Administrator determines it should have paid. That repayment will count as a valid payment under the Tennessee Plan.

Right of Recovery. The Tennessee Plan may pay benefits that should be paid by another benefit plan. In this case the Tennessee Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

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

THIRD PARTY RECOVERY PROVISION

SUBROGATION AND REFUND

When this Provision Applies. The Plan assumes and is subrogated to a covered person's authority to recover any payments made by the Plan 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 authority to recover through subrogation amounts equal to its payments by suit, settlement or otherwise from the insurance of the injured party, from the person who caused the illness or injury or his/her insurance company, or any other source such as uninsured motorist coverage. The Plan may also pursue a right of reimbursement against the covered person if he/she has received third party payments for medical expenses as detailed below. The Plan Participant may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party, or a Third Party may be responsible for payment. In such circumstances, the Plan Participant may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. The Claims Administrator may, at its option, deny all charges or authorize conditional interim benefit payments for medical or dental expenses that would otherwise be covered by the Plan. However, any advance payments are subject to the Plan's subrogation rights. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Plan Participant may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Plan Participant has against any Third Party, or insurer, whether or not the Plan Participant chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Plan Participant whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

To facilitate the Plan's authority to subrogation, the Plan Participant:

(1) is required to provide information and assistance to the plan and sign the necessary papers required;

(2) agrees to answer any and all documentation requests related to subrogation claims sent by the Plan or its vendors,

(3) automatically assigns to the Plan his or her access to payments from any Third Party or insurer when this provision applies;

(4) cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and

(5) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund. In addition to the Plan's authority to subrogation, the Plan Participant agrees to reimburse the Plan, up to the amount paid by the Plan, from any money such covered person (or such covered person's family) receives specifically for the medical expenses. The Plan Participant will reimburse the Plan the amount of money recovered for medical expenses through judgment or settlement from a third party (or the insurer of the third party). The Plan Participant agrees to cooperate with the Plan and answer any and all documentation requests related to the Plan's right of reimbursement sent by the Plan or the Claims Administrator. The Plan Participant agrees to immediately notify the Plan of any pending judgment or settlement from a third party for medical expenses. The Plan Participant agrees to recognize the Plan's authority to Subrogation and reimbursement. These provisions provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Plan Participant relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all authority the Plan Participant may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical, behavioral health/substance abuse, surgical or dental expenses automatically assigns to the Plan the Plan Participant's Third-Party Claims.

Notwithstanding the Plan's priority to funds, the Plan's Subrogation and Refund authority, as well as the authority assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges, as well as any costs and fees associated with the enforcement of the Plan's rights under the

Plan. The Plan reserves the ability to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Plan Participant.

When the authority of Recovery exists, the Plan Participant will execute and deliver all required instruments, papers, and do whatever else is needed to secure the Plan's interest in Subrogation as a condition to having the Plan make payments. In addition, the Plan Participant will do nothing to prejudice the authority of the Plan to Subrogate.

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

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Plan Participant if a Plan Participant refuses to cooperate with the Plan's reimbursement and Subrogation procedures or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. **Failure to respond to the Plan's requests for information, and/or pay any owed subrogation expenses to the Plan, may result in the covered person's disenrollment from the Plan. Such disenrollment shall extend to any dependents who obtained coverage through the covered person. Any retiree or dependent who has been disenrolled from the Plan pursuant to the** "THIRD PARTY RECOVERY PROVISION" section of this Plan Document for failure to cooperate and pay outstanding medical expenses shall be ineligible to rejoin the Plan for a period of three (3) years.

Recovery From Another Plan Under Which the Plan Participant is Covered. This authority to a Refund also applies when a Plan Participant recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Authority of the Claims Administrator. The Claims Administrator has the authority to deny or make conditional payments, and to request reports on and approve all settlement requests with a paid value of $5,000 or less.

Authority of the Plan Administrator. The Plan Administrator has the authority to request reports on and approve all settlement requests and to disenroll from this Plan those Plan Participants and dependents who fail to provide requested information and/or fail to reimburse the Plan any subrogation or medical expenses due to the Plan under the provisions of this section of the Plan Document.

Any Retiree or dependent who has been disenrolled from the Plan pursuant to the "THIRD PARTY RECOVERY PROVISION" section of this Plan Document for failure to cooperate and pay outstanding medical expenses shall be ineligible to rejoin the Plan for a period of three (3) years.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The State of Tennessee sponsors The Tennessee Plan, a supplemental medical insurance plan for Retirees with Medicare, and is referred to as the Plan Administrator or the Plan sponsor.

The Plan Administrator may appoint another entity to be Claims Administrator and serve at the convenience of the Plan Administrator.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to determine enrollment for coverage, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation, and those of fact relating to the Plan. The decisions of the Plan Administrator shall be conveyed to the Claims Administrator prior to becoming final and binding on all interested parties.

Duties of the Plan Administrator.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the authority to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes in consultation with the Claims Administrator which may arise relative to a Plan Participant's benefit payments.

(4) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(5) To appoint a Claims Administrator to pay claims.

(6) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

CLAIMS ADMINISTRATOR AND PLAN ADMINISTRATOR ARE NOT FIDUCIARIES. The Claims Administrator and the Plan Administrator are not fiduciaries under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator, or by virtue of establishing the Plan rules.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Retiree and Dependent Plan Coverage: Funding is derived from the funds of the State of Tennessee and contributions made by the covered **Retiree**s.

The level of any Retiree contributions is set by the Plan Administrator. These Retiree contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Retiree or withheld from the Retiree's State of Tennessee TCRS benefit check.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or the Claims Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains the authority to recover the overpayment. The person or institution receiving the overpayment will be required to return money equal to the overpayment. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that a Plan Participant or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim will be denied and the Claims Administrator will recover any benefits paid to the Plan Participant and/or a Provider. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim. This paragraph does not affect the authority granted to the Plan Administrator and/or Claims Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

REFUND DUE TO OVERPAYMENT OF BENEFITS

If payment has been made for Covered services or supplies under the Plan that are more than the benefits that should have been paid, or for services or supplies that should not have been covered, according to Plan provisions, the Claims Administrator or the Plan Administrator shall have the authority to demand a full refund, or may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Plan Participant or other present or future amounts payable to such person, or recover such amounts by any other appropriate method that the Plan Administrator, in its sole discretion, shall decide. Each Plan Participant hereby authorized the deduction of such excess payment from such benefits, or other present or future benefit payments.

Payments made in error for services or supplies not covered by this Plan shall not be considered certification of coverage and will not limit the enforcement of any provision of this Plan for any and all claims submitted under the Plan.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the benefit payments made on behalf of Plan Participants are limited to expenses Incurred prior to termination.

The Plan Administrator reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

HIPAA PRIVACY COMPLIANCE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality, integrity, security, and privacy of protected health information. The Plan administrators will use and disclose protected health information only as allowed by federal law. A description of a Plan Participant's Privacy rights and how protected health information is disclosed and may be used are found in the Plan Administrator's Notice of Privacy Practices, delivered separately to each retiree in the UMR state plan handbook. An electronic copy of your rights can also be found at tn.gov/finance/fa-benefits/hipaa-notice-of-privacy-practices. The Plan administrators agree to implement administrative, physical, and technical safeguards that protect the information that it creates, receives, maintains, or transmits on behalf of the Plan Participant. If a Plan Participant has questions or concerns or requires a paper copy of the Privacy Notice, he or she should contact the Plan Administrator's HIPAA Privacy Officer at

benefits.privacy@tn.gov or 866-252-1523.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

Plan participants will be protected from discrimination in health plans on the basis of their genetic information. The Plan will not discriminate against individuals based upon their genetic information, which includes information about genetic tests, the genetic test of family members and the manifestation of a disease or disorder in family members. In addition, genetic information will be considered " protected health information" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SPECIAL NOTICE

Anti-Discrimination and Civil Rights Compliance

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

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

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

Mail to: State of Tennessee, Benefits Administration, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102

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

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

U.S. Department of Health & Human Services
Region IV Office for Civil Rights
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, Georgia 30303-8909
1-800-368-1019 or TTY/TDD at 1-800-537-7697

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded employer group health plan, and the administration is provided through a Third-Party Claims Administrator. The funding for the benefits is derived from the funds of the State of Tennessee and contributions made by covered Retirees. The Plan is not insured.

PLAN NAME: The Tennessee Plan

PLAN EFFECTIVE DATE: January 1, 1989

RESTATEMENT DATE: July 1, 2023

PLAN YEAR ENDS: December 31

PLAN ADMINISTRATOR REPRESENTATIVE: Laurie Lee, Executive Director, Benefits Administration State of Tennessee, 19000 WRS Tennessee Tower, 312 Rosa L Parks Avenue, Nashville, TN 37243, telephone number 615-741-4517.