State Plan Document

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

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

2023

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PART I
COMPREHENSIVE MEDICAL AND HOSPITALIZATION PROGRAM

INTRODUCTION

This part of the Plan Document applies to the State of Tennessee Comprehensive Medical and Hospitalization Program established pursuant to Chapter 27 of Title 8 of the Tennessee Code Annotated. The Preferred Provider Organization Premier plan, Preferred Provider Organization Standard plan, Preferred Provider Organization Limited plan, CDHP/HSA, and Local CDHP/HSA are healthcare options available as part of a comprehensive medical and hospitalization program for eligible individuals. The availability of the different healthcare options is subject to the specific eligibility criteria and participation requirements in effect at the time of enrollment, reenrollment or continuation of coverage. Health care options and offerings may vary between the different groups of eligible individuals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ध्यान द: य द आप हदी बोलते ह तो आपके लिए 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 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با تماس بگیرید.

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

Assignment.

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

Choice of Laws.

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

Conflict of Provisions.

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

Execution of the Plan.

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

Fraud.

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

Liability of Employer.

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

Plan Is Not a Contract of Employment.

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

ARTICLE I
DEFINITIONS

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

1.01 "Benefit Analysis"

Benefit analysis shall mean the process of insurance benefit review by the TPA.

1.02 "Benefits Administration"

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

1.03 "COBRA"

COBRA (Consolidated Omnibus Budget Reconciliation Act) shall mean the federal and state laws that allow employees, spouses, and/or dependents who are losing their health, dental or vision benefits to continue the same insurance for a specific length of time under certain conditions pursuant to Section 4.09.

1.04 "COBRA Participant"

COBRA participant shall mean a qualified beneficiary pursuant to Section 4.09 who continues his or her health, dental and/or vision care coverage under the provisions of the federal guidelines in the Consolidated Omnibus Budget Reconciliation Act of 1985 and Public Health Service Act as amended and state COBRA law.

1.05 "Committee"

Committee shall mean the individuals comprising the State Insurance Committee to whom the administrative duties and responsibilities of the plan are delegated pursuant to Section 6.01 and shall include any authorized representative of the committee. The committee shall be the plan administrator of each respective plan. The State Insurance Committee is composed by law of the Commissioner of Finance and Administration, the Commissioner of Commerce and Insurance, the Commissioner of Human Resources, the Treasurer, the Comptroller of the Treasury, a representative of the Tennessee State Employees Association (TSEA) and three state employee representatives. Two of the employee representatives are elected by central government employees, and one employee representative is selected through a process adopted by the Tennessee Higher Education Commission.

1.06 "Coverage(s)"

Coverage(s) shall mean:

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

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

1.07 "Covered Expenses"

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

1.08 "Covered Person"

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

1.09 Custodial Care

Custodial care includes services for personal care such as help in walking and getting out of bed, assistance in bathing, dressing, feeding, using the toilet, supervision over medication which can usually be self-administered and services which do not entail or require the continuing attention of trained medical or paramedical personnel. Other examples of custodial care include changing of wound dressings, diapers, protective sheets, administration of oxygen, care or maintenance in connection with casts, braces or other similar devices, feeding by tube or gastrostomy, including cleaning and care of the tube site and care in connection with ostomy bags or devices or indwelling catheters. Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

1.10 Dependent

A Dependent is:

(A) A legally married spouse; or

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

   (1) Employee or Retiree's natural (biological) child; or

   (2) Employee or Retiree's adopted child (including a child placed for adoption in anticipation of adoption)

(C) An Employee/Retiree or spouse's stepchild under the age of 26.

(D) A person under age 26 who is placed with the Head of Contract by a valid order of guardianship, custody, or conservatorship (or legally equivalent order) by a court of competent jurisdiction ("placement order").

   (1) The HOC must provide certification upon enrollment and upon request that: (a) the placement order is in effect and has not expired by subsequent court order or by operation of law, and (b) the HOC shall immediately notify Benefits Administration when the placement order terminates or expires.

(2) If a placement order terminates or expires due to the person attaining the legal age of majority, the person may remain an eligible dependent until age 26 if the HOC certifies that the following requirements in (a), (b) and (c) are met:

a. The HOC and the person has a relationship as set forth in 26 U.S.C. §152(d)(2), which includes the following relationships:

i. The person is a descendant of a son/daughter, stepson/stepdaughter of the HOC;

ii. The person is a brother/sister, half-brother/half-sister, stepbrother/stepsister, son/daughter-in-law, brother/sister-in-law, or niece/nephew of the HOC; or

iii. The person has the same principal place of abode as the HOC and is a member of the HOC's household; and

b. The HOC provides over one-half of the person's financial support for the calendar year in which the HOC's taxable year begins; and

c. The person is a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada.

(3) Additional documents and certifications may be requested to establish that the person is an eligible dependent.

(E) Dependents over the age of 26 who meet at least one of the criteria in 1.10(B) or (C) of this section and who are incapacitated (mentally or physically incapable of earning a living regardless of age, provided the Dependent is incapable of self-sustaining employment). This provision applies only when the incapacity existed before the Dependent's 26th birthday and the Dependent was enrolled in the state's group insurance program prior to and on their 26th birthday. A request to continue coverage due to incapacity must be provided to Benefits Administration prior to the dependent's 26th birthday as provided in Section 2.04(D).

(F) Dependents not eligible for coverage include:

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

(2) Dependents not listed in the above definitions;

(3) Parents of the employee or spouse;

(4) Ex-spouse; and

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

An employee may not be enrolled as both Head of Contract and Dependent within the state plan.

1.11 "Durable Medical Equipment"

Durable medical equipment shall mean equipment, which is:

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

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

(C) Appropriate for use within the home.

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

1.12 "Eligibility Date"

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

1.13 "Emergency"

Emergency shall mean a medical condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy (or, with respect to pregnant women, the health of her unborn child), serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or danger to self (including psychiatric conditions and intoxication).

1.14 "Employee"

Employee shall mean:

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

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

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

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

1.15 "Employee Assistance Program (EAP) Services Administrator"

Employee assistance program (EAP) services administrator shall mean the entity/organization contractually designated by the state to provide counseling services and/or referral services and/or other services necessary to ensure the proper and efficient administration of the plan's EAP benefits.

1.16 "Employer"

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

1.17 “Family and Medical Leave”

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

1.18 “Formulary”

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

1.19 “Habilitation (Habilitative) Services”

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

1.20 Head of Contract

Head of Contract (HOC) is the Employee, Retiree, or surviving Dependent enrolled in the Plan who elects coverage and has authority to change coverage elections.

1.21 “HIPAA”

HIPAA (Health Insurance Portability and Accountability Act) shall mean the federal and state laws pertaining to portability between health plans, governing special enrollment provisions that may allow employees, spouses, and/or dependents to enroll under certain conditions pursuant to Section 2.06 (A).

1.22 “Illness”

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

1.23 Immediate Relative

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

1.24 “Injury”

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

1.25 “Inpatient”

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

1.26 “In-Network”

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

1.27 “Joint Custody”

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

1.28 “Leave of Absence”

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

1.29 “Legal Custody”

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

1.30 “Legal Guardian”

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

1.31 “Maximum Allowable Charge”

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

1.32 “Medically Necessary” or “Clinically Necessary”

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

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

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

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

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

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

1.33 “Medical Supplies”

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

(A) Prescribed by the patient’s physician;

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

(C) Consistent with the diagnosis;

(D) Recognized as therapeutically effective; and

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

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

1.34 “Medicare”

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

1.35 “Member Handbook”

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

1.36 "Out-of-Network"

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

1.37 "Out-of-Pocket Expenses"

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

1.38 "Outpatient"

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

1.39 "Outpatient Surgery"

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

1.40 "ParTNers for Health Wellness Program"

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

1.41 "Pharmacy Benefits Manager (PBM)"

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

1.42 "Plan"

Plan shall mean the applicable State of Tennessee Preferred Provider Organization Comprehensive Medical and Hospitalization Program, subject to the provisions of Section 2.09. Plan may also mean specific group plans within the larger comprehensive plan, such as the State Plan, the Local Education Plan, or the Local Government Plan.

1.43 "Plan Year"

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

1.44 “Positive Pay Status”

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

1.45 “Preferred Provider Organization (PPO)”

Preferred Provider Organization (PPO) shall mean the State of Tennessee Preferred Provider Organization Medical and Hospitalization Program. This is a health insurance plan where PPO plan participants choose in-network or out-of-network providers. A network provider accepts a maximum allowable charge. The participant is responsible for a fixed copayment for some services and a deductible and percentage or coinsurance of the maximum allowable charge for other services as indicated in Attachment A of the applicable section. A participant utilizing an out-of-network provider is responsible for a larger share of the cost, which is reflected in increased copayments, coinsurance, and deductible amounts as well as charges above the maximum allowable charge.

1.46 “Pregnancy”

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

1.47 “PCP” or “Primary Care Physician”

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

1.48 “Prior Authorization”

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

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

Out-of-network providers are not contracted. Therefore, there is no mechanism for holding covered persons harmless when out-of-network providers fail to obtain authorization. When a covered person receives medically or clinically necessary care from an out-of-network provider, the covered person should verify with the TPA that prior authorization has been requested and approved in advance of receiving care. When prior authorization is required but not obtained, benefits for medically or clinically necessary services received out-of-network will be reduced by half, subject to the maximum allowable charge. The covered person will be responsible for all other charges.

1.49 "Provider"

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

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

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

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

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

(B) Ambulatory Surgical Center shall mean a health care facility, which provides surgical services but usually does not have overnight accommodations. Such a facility must be licensed as an ambulatory surgical facility by the state in which it is located or must be operated by a hospital licensed by the state in which it is located.

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

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

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

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

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

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

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

(5) Maintains clinical records on all patients; and

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

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

(G) Health Service Practitioners (HSP) shall mean psychologists defined and licensed as health service providers (TCA 63-11-101 et seq.). This definition includes four levels of psychological practice: psychological examiner, senior psychological examiner, psychologist, and certified psychological assistant (TCA 63-11-201). The psychological examiner, senior psychological examiner, and the psychologist are covered under the plan provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

(P) Pharmacist (TCA 63-10-204) shall mean an individual health care provider licensed by the State of Tennessee to practice the profession of pharmacy, involving but not limited to, interpretation, evaluation and implementation of medical orders and prescription orders, responsibility for compounding and dispensing prescription orders, patient education and counseling, and those professional acts, professional decisions or professional services necessary to maintain all areas of a patient's pharmacy-related care.

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

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

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

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

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

(V) Skilled Nursing Facility shall mean an institution, or distinct part of an institution, that provides skilled nursing services to its patients. It must provide more than custodial care and be licensed by the state.

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

(X) Treatment Center shall mean A facility which provides a program of intensive short term Mental Disorder Treatment/Substance Use Disorder/Dependency Treatment and meets all of the following requirements: (i) it is established and operated in accordance with any applicable state law; (ii) it provides a program of treatment approved by a Physician and the TPA; (iii) It has or maintains a written,

specific and detailed regimen requiring full-time residence and full-time participation by the patient; and it provides basic services including at a minimum room and board (if the Plan provides inpatient benefits at a Treatment Center), evaluation and diagnosis; counseling; and referral and orientation to specialized community resources and (iv) treatment services adhere to defined policies, procedures and evidenced based clinical protocols. A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

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

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

1.50 "Qualified Beneficiary"

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

1.51 "Qualifying Event"

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

(A) The death of a covered employee;
(B) A covered employee's termination of employment or reduction in work hours of an employee's employment;
(C) The divorce or legal separation of a covered employee and his/her spouse;
(D) A covered employee becoming entitled to Medicare Part A; or
(E) A covered dependent child ceasing to meet the definition of an eligible dependent.

1.52 "Rehabilitation (Rehabilitative) Services"

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

1.53 "Retiree"

Retiree shall mean a former employee who has retired from the employer and receives a benefit from the Tennessee Consolidated Retirement System, or a former employee who has retired from the employer and participated in an optional retirement plan, or a former employee who has retired from the employer and has been approved for a disability benefit based on total and permanent disability; all categories of retirees must meet the applicable guidelines in Article IV to continue to participate in the plan. An individual cannot be classified as a retiree and maintain insurance as an active employee under the plan, except as provided for in TCA 8-27-208. Retirees whose first employment with the state commenced on or after July 1, 2015 will not be

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

1.54 “Shared Parenting”

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

1.55 “Specialist”

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

1.56 “State”

State shall mean the State of Tennessee.

1.57 Third Party Administrator (TPA)

Third Party Administrator is an entity that provides claims adjudication, medical or clinical management program review, provider contracting; and other services necessary to assure the proper and efficient administration of the Plan.

1.58 “Urgent Care”

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

1.59 “Utilization Review Organization”

Utilization review organization shall mean

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

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

1.60 “Workers’ Compensation Benefits”

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

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.01 Employee Eligibility, Enrollment and Effective Date of Coverage.

(A) Eligibility. All employees defined by Section 1.14 shall be eligible for coverage.

(B) Enrollment. BA shall provide an Employee with enrollment access through enrollment forms or the Edison Employee Self-Service (ESS) feature.

(1) Enrollment access shall be provided on the hire date or within five business days after otherwise becoming eligible, and enrollment must be completed and submitted to BA within 30 calendar days. The 30 days includes the hire date or other date the Employee becomes eligible. This provision does not apply to SQEs discussed in Section 2.06.

(2) Employees are encouraged to enroll as quickly as possible and to enroll through the Edison ESS feature. If access to ESS is unavailable, Employees must complete and return an enrollment form to the ABC indicating the desired health care option and appropriate type of coverage as defined in Section 1.06. Regardless of the method of enrollment, newly hired Employees (including Employees coming from the Local Education, Local Government, and Institutions of Higher Education) and newly eligible Employees must complete and submit the enrollment form to BA within 30 calendar days of the hire date or date of becoming eligible.

(3) All documentation required to support an enrollment must be submitted to BA no later than 10 calendar days after the 30-day enrollment period.

(C) Effective Date of Coverage for an Employee. The effective date of coverage for an eligible Employee who has enrolled according to the requirements of this section shall be:

(1) Newly Hired Employee (including Employees coming from the Local Education or Local Government Plans, or from Higher Education Institutions, or Employees moving between Higher Education Institutions): the first day of the month following the hire date and completion of one calendar month of employment with the new Employer.

(2) Seasonal Employee Hired Prior to July 1, 2015: the first day of the month following the date the Employer certifies that the Employee has met the requirements of TCA 8-27-204(a)(3) and the employee submits a completed enrollment form to BA.

(3) Existing Employee with at Least One Calendar Month of Employment Followed by gaining eligibility for coverage: the first day of the month following gaining eligibility for coverage (including part-time to full-time employment and emergency appointment to permanent appointment) **and** the employee's submission of a completed enrollment form to BA.

2.02 Re-hired Employees.

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

2.03 Dependent Eligibility, Enrollment and Effective Date of Coverage.

(A) Eligibility. Each Dependent defined in Section 1.10 shall be eligible for coverage. Dependents are eligible on the later of the following:

(1) The date the Employee is eligible; or

(2) The date the Dependent is acquired:

(a) if Dependent is a legally married spouse - date of marriage;

(b) if Dependent is a natural child of the Employee - birth date;

(c) if Dependent is a legally adopted child – the date of adoption (or date of legal custody in anticipation of adoption);

(d) if Dependent is a child for whom the Employee is the legal guardian – date specified in the court order granting guardianship and requiring financial support and insurance coverage;

(e) if Dependent is a stepchild of the Employee – date of marriage establishing relationship;

(f) if Dependent is a child named as an alternate recipient under a qualified medical child support order as defined in Section (D) – the entry date of the order unless another date is specified in the order.

(B) Enrollment.

(1) Employees must enroll Dependents pursuant to Section 2.01(B), 2.06, or 2.07.

(C) Effective Date of Coverage for a Dependent.

(1) The effective date of coverage for an eligible Dependent shall be the later of the following:

(a) The effective date of the Employee's coverage as provided in Section 2.01(C); or

(b) The effective date of coverage as provided in 2.06(A)(5) and (B)(4) and (5); or

(c) The effective date of coverage as provided in 2.07(D).

(D) If the State is served with a National Medical Support Notice of a qualified medical child support order as defined by federal law that requires an Employee or Retiree's child to be enrolled in This Plan, the child will be enrolled, and the insurance will become effective according to the terms of the Order.

2.04 Substantiation of Dependent Eligibility.

(A) In order to add a Dependent, the HOC must provide sufficient documentation to substantiate the Dependent's eligibility for the plan no later than 10 business days past the enrollment deadline. The required documentation may include marriage certificates, birth certificates, adoption orders, legal guardianship orders, divorce decrees, federal income tax returns (listing Dependent spouse), social security card; or other documentation requested by BA. No Dependent will be added to the insurance plan unless the requested information is provided.

(B) From time to time, BA may require members to submit documentation listed in (A) above, to substantiate eligibility of Dependents on the Plan, or to facilitate reporting and other operational requirements of the Plan. Failure to provide the requested information may result in termination of coverage.

(C) A Dependent who is not properly added or whose coverage is terminated may only be enrolled in the Plan during the next annual enrollment period or by compliance with the special enrollment provisions of Section 2.06.

(D) A request to continue coverage for a Dependent beyond age 26 as defined in Section 1.10(E) must be received before the Dependent's 26th birthday.

(1) BA will determine if all Plan requirements have been met by:

(a) Confirming if the TPA's review of the submitted documentation establishes incapacity of the Dependent; and

(b) Participating in annual reviews as required by BA or the TPA to confirm continued incapacity.

(2) Coverage will be terminated and shall not be reinstated if it is determined that the Dependent is not, or is no longer, incapacitated or that other Plan requirements are not satisfied.

(3) A Dependent who has attained age 26 and whose coverage under this Plan has been terminated will not be enrolled again as an incapacitated Dependent.

(4) Dependents whose coverage is terminated may qualify for COBRA subject to the provisions of Section 4.09.

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

(A) If two eligible Employees are married without children, each Employee may separately enroll in a state-sponsored Plan or they may enroll in family coverage (Employee + spouse) with one Employee as HOC and the other Employee as a Dependent. (Enrolling as an Employee provides a higher level of life insurance than enrolling as a Dependent spouse).

(B) If two eligible Employees are married with children, they may either:

(1) enroll in family coverage for all eligible family members – Employee + spouse + child(ren), or

(2) one Employee can enroll in Employee only coverage and the other Employee can enroll in family coverage (Employee + child(ren)) to cover that Employee and the eligible Dependent children.

(C) A Dependent child shall not be enrolled as a Dependent by more than one eligible Employee including divorced parents and never-married parents who both work for the Employer.

(D) An Employee shall not be enrolled as both Head of Contract and a Dependent on this Plan.

(E) A newly hired Employee can enroll an Employee spouse who originally declined coverage as a Dependent. An Employee spouse who is added as a Dependent pursuant to this section is not required to meet the provisions of Section 2.06.

2.06 Special Enrollment.

Without regard to the dates or circumstances on which an individual would otherwise be able to enroll in the Plan, current Employees and Dependents as defined in Section 1.10 of this Plan Document are permitted to enroll in coverage under this Plan if the Employee or Dependent meets the following conditions of a Special Qualifying Event (SQE) pursuant to the Health Insurance Portability and Accountability Act of 1966 (HIPAA), as stated in Section A or B below:

(A) Loss of Eligibility for Other Coverage.

(1) An Employee or Dependent, otherwise eligible to enroll in a benefit plan, may be enrolled through this Special Enrollment provision provided that they:

(a) Declined coverage when it was previously offered during their initial eligibility period as outlined in Section 2.01(B) for employees and 2.03(A) for dependents, or during a subsequent annual enrollment period as outlined in Section 2.07(A);

(b) Had coverage under any group health insurance plan at the time Plan coverage was previously offered; **and**

(c) Experience a loss of eligibility for other health insurance coverage for reasons including the following (but not for a failure to pay premiums or termination for cause):

(i) Death;

(ii) Divorce;

(iii) Legal separation;

(iv) Cessation of dependent status;

(v) Termination of employment (voluntary and non-voluntary);

(vi) Employer's discontinuation of contribution to insurance coverage (total contribution, not partial);

(vii) Reduction in number of work hours of employment;

(viii) Spouse maintaining coverage that has reached their lifetime maximum (if legally permitted);

(ix) The loss of eligibility due to an HMOs failure to provide benefits in the area where the individual lives, works, or resides if the requirements of HIPAA are satisfied; or

(x) Loss of TennCare or Children's Health Insurance Program (CHIP) coverage other than non-payment of premium, or expiration of COBRA coverage.

(2) If an Employee satisfies all three requirements of A (1) above, the Employee and all Dependents of the Employee are eligible for special enrollment to the Plan.

(3) If a Dependent satisfies all three requirements of A (1) above, only that Dependent, the Employee, and other Dependents satisfying the requirements of A (1) above are eligible for special enrollment to the Plan.

(4) All Special Enrollments for Loss of Eligibility for Coverage must be submitted to and received by ABC/BA within **sixty (60) calendar days** of the loss of eligibility for other coverage.

(5) The effective date of coverage for a Special Enrollment for Loss of Coverage shall be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment.

(6) Substantiation of Loss of Coverage. If requesting special enrollment based on loss of eligibility for other coverage, the Employee must submit appropriate documentation to substantiate all of the following:

(a) That the Employee or Dependent was covered by any other group health insurance plan at the time they declined the offer of coverage from This Plan; and

(b) That the Employee experienced an event resulting in the Employee or Dependent's loss of eligibility for coverage under the other group health insurance plan, and the date of the Employee or Dependent's loss of eligibility.

(B) Acquisition of New Dependents.

(1) When an Employee acquires a new Dependent by marriage, birth, adoption, placement for adoption or legal guardianship, the Employee, Spouse, and any Dependent may be enrolled by Special Enrollment.

(2) Any coverage changes made as a result of a Special Enrollment that are not required by HIPAA shall be on account of and correspond with the change in status that affected eligibility for coverage under the plan, such as acquiring a new dependent through legal guardianship.

(3) All Special Enrollment applications based upon the acquisition of a new Dependent must be submitted to and received by ABC/BA within **thirty (30) calendar days** of the acquisition date.

(4) The effective date of coverage for a Special Enrollment for acquiring a new Dependent Spouse, child pursuant to an order of guardianship, and new stepchild acquired by marriage shall be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment.

(5) The effective date of coverage for a Special Enrollment for acquiring a new child by birth, adoption, placement for adoption, shall be the date of the birth, adoption, or placement for adoption.

(6) Substantiation of Acquiring a New Dependent. If requesting enrollment based on acquiring a new Dependent, the Employee must submit appropriate documentation as listed on the enrollment application to substantiate the following:

(a) The date of birth of a child; or

(b) The date of the adoption or the order placing the child in custody for adoption;

(c) The date of guardianship specified by the order granting guardianship and requiring financial support and insurance coverage; or

(d) The date of marriage.

2.07 Annual Enrollment Elections.

(A) The Plan's designated annual enrollment period will be announced in an annual enrollment newsletter and will be published on the Plan's website.

(B) The HOC may make coverage elections during annual enrollment and may choose between any Plan design option for which the HOC is eligible. If no new elections are received by BA, the coverage in effect immediately prior to annual enrollment is deemed to be elected for the upcoming Plan Year.

(C) Employees who are eligible for coverage under This Plan and either the Local Education or Local Government Plan may switch their coverage (and coverage for their Dependents) to the other Plan during the Plan's designated annual enrollment period. In no case may an Employee switch to the Local Education or the Local Government Plan while remaining on This Plan.

(D) All annual enrollment elections, including new elections received by BA and those deemed as elected during the Plan's designated annual enrollment period, shall be effective from January 1 through December 31 of the upcoming Plan Year.

(E) Once the Plan's designated annual enrollment period has closed, Employees have one opportunity to revise annual enrollment elections provided:

(1) Requests are submitted to BA no later than 4:30 CT on December 1 of the current Plan year; and

(2) Timely submitted revisions will become effective on January 1 of the upcoming Plan Year.

ARTICLE III

PARTICIPATION DURING APPROVED LEAVE AND REINSTATEMENTS

3.01 Continuation of Coverage during Leave of Absence.

An employee on an approved leave of absence that is not covered under the Family and Medical Leave Act of 1993 (as amended) may continue coverage as described in this subsection. An employee on an approved leave of absence may continue coverage under the plan for two continuous years provided he/she pays the full monthly premium (both the employer and employee portions as described in Article VIII) during such leave of absence. Employees who return to work after a two-year leave of absence must be in a positive pay status for one full calendar month before they may be eligible for a subsequent leave of absence to continue coverage. If an employee does not return to active work status and has completed a two-year leave of absence, coverage will be discontinued, and COBRA continuation coverage will not be offered.

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

If an employee and his/her spouse both work for the employer and are both covered under a state sponsored plan, and one spouse goes on a leave of absence, the spouse, as a covered person may change his/her type of coverage pursuant to Section 1.06 in order to cover his/her spouse as a dependent. The employee adding his/her spouse must contact his/her benefits coordinator and change to family coverage by completing the enrollment change application.

3.03 Suspension of Coverage during Leave of Absence.

If the employee decides not to continue coverage while on leave, he/she must apply to suspend coverage by signing the leave without pay insurance options form while the coverage is still active, and premiums are current. Coverage will terminate on the last day of the month in which the employee has paid his/her premium(s). When the employee returns from leave, to re-enroll in coverage, the benefits coordinator must be contacted by the employee and enrollment forms completed and the insurance premium paid. The employee has one full calendar month from the end of the leave to reinstate the coverage; otherwise, the employee will be subject to the late applicant requirements of Section 2.06.
Individuals returning from military leave shall have 90 calendar days from the end of their leave of absence to reinstate coverage.

3.04 Reinstatement of Coverage Following Suspension of Coverage.

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

(A) If an employee returns to covered employment with the employer during a time period equal to or less than six months of the date coverage previously suspended, he/she shall have his/her coverage reinstated on the first day of the calendar month following the date the employee returns to work:

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

(2) Without satisfying the late applicant requirements of Section 2.06, provided the employee meets the other eligibility requirements of Section 2.01; or

(3) As otherwise specified in Section 3.06.

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

3.05 Reinstatement of Coverage Following Termination of Employment.

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

3.06 Reinstatement by Order of the Board of Appeals.

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

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

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

3.07 Reinstatement for Military Personnel Returning from Active Service.

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

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

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

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

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

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

SECTION 4
COVERAGE TERMINATION AND CONTINUATION

4.01 Termination of Covered Person's Participation.

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

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

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

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

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

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

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

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

Unless otherwise stated in this Plan Document, a Covered Person who wishes to re-enroll at a later date will be subject to the late applicant requirements in Section 2.06.

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

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

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

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

(4) The date the plan is terminated.

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

4.02 Termination of Dependent Participation.

(A) Except as otherwise expressly provided in the plan, participation in the plan by a dependent (as a dependent) shall terminate at the end of the month in which the dependent ceases to be an eligible dependent as defined in Section 1.10. It is the responsibility of the employee to notify the committee's

representative of any event that would cause a dependent to become ineligible for coverage. Claims paid in error for any reason will be recovered from the employee.

(B) If an employee or retiree requests to terminate coverage of a dependent spouse while a divorce case is pending, such termination will be subject to laws and court orders related to the divorce or legal separation. This includes the requirements of Tennessee Code Annotated Section 36-4-106 and the requirement that the employee or retiree provide notice of termination of health insurance to the covered dependent spouse under Tennessee Code Annotated Section 56-7-2366. It is the responsibility of the employee or retiree to make sure that any request to terminate a dependent spouse is consistent with those legal requirements.

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

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

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

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

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

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

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

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

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

(A) The dependent ceases to be an eligible dependent pursuant to Section 1.10;

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

(C) Any dependents become entitled to Medicare; or

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

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

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

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

4.06 Continuation of Coverage for Disabled Employees.

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

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

(B) If a covered employee incurs a work-related injury which results in a total and permanent disability, the former employee may continue medical coverage if they are approved for a retirement benefit based on total and permanent disability as the result of an on-the-job injury. There can be no lapse in medical coverage with the state-sponsored plan, and disabled retirees under age 65 who are eligible for Medicare must maintain at least Part B coverage. TCRS participants must be approved by the Tennessee Consolidated Retirement System medical panel as being totally and permanently disabled due to a work-related injury and must remain eligible for a disability allowance. For ORP (Optional Retirement Program) participants and other non-TCRS participants, proof of total and permanent disability must be shown by submitting an award letter from the Social Security Administration or approval by TCRS based on physician review of the medical records documenting the disability. The required proof must show total and permanent disability existed on or before the date employment terminated. For ORP participants and other non-TCRS participants, the employer must also submit written certification that the disability is the result of a work-related injury. The contribution for continued coverage in the State Plan is the responsibility of the former employee and shall be the same premium as required for a retiree. This coverage may be continued until such time as the retiree is eligible for Medicare based on his/her age.

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

(D) Disability retirees who were participants in a state-sponsored plan at the time of the injury or illness which resulted in their disability may continue coverage provided that no lapse in medical coverage has occurred by meeting either the requirements of Section 4.07(B) for TCRS participants or 4.07(D) for ORP (Optional Retirement Program) participants and other non-TCRS participants or by having at least five years of employment with the employer immediately prior to final termination due to disability. Upon eligibility for Medicare, disability retirees and eligible dependents may continue in the plan to the point at which Medicare eligibility would have been attained had the disability not occurred, provided the retired employee remains eligible for disability allowance and Part B of Medicare is retained. Employees who are granted a service retirement, but are also disabled, must prove that total disability exists at the time of retirement. Proof of total disability must be shown by submitting an award letter from the Social Security Administration or approval by the TCRS medical panel based on physician review of medical records documenting the disability. The required proof must show total disability existed at the time of termination of employment. Medicare will be the primary coverage and the plan the secondary carrier. Coverage will terminate once the retiree reaches the normal age for Medicare.

Disabled retirees who are awaiting approval of the employer-sponsored retirement plan for disability benefits and whose medical coverage has lapsed from their last period of state employment may reinstate that medical coverage by meeting the requirements of Section 4.07(B) for TCRS participants or 4.07(D) for ORP (Optional Retirement Program) participants and other non-TCRS participants or by having at least five years of employment with the employer immediately prior to final termination due to disability and provided that the employer-sponsored retirement plan determines their date of disability retirement to be on or before the date on which their active state coverage ceased. Disabled retirees whose coverage has lapsed from their last period of state employment and whose effective date of disability retirement has been determined by the employer-sponsored retirement plan to be after the date on which their coverage as full-time state employees ceased are not eligible for reinstatement of medical coverage.

4.07 Continuation of Health Coverage for Retirees.

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

Upon retirement, if the retiree's spouse is an active employee of the employer, participating in the plan, the active employee may insure the retiree under his/her coverage until such time as that employee leaves employment. Upon the spouse's termination of employment, the retiree would revert his/her participation to the retiree group under the provisions of this Section 4.07. Subject to meeting all eligibility requirements upon the spouse's termination of employment, the retiree may be covered on retiree group health insurance under their own retiree record or as a dependent under the spouse's retiree record if the spouse has qualified to continue health insurance as a retiree.

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

Definitions used in interpreting these policies are as follows:

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

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

For the purpose of this plan, the following are ***not*** defined as state employment with the employer: military service that did not interrupt employment, educational leave, leave of absence or service with a local government

agency. Also, if a person cashes out previous service and does not buy it back, they cannot count that service as employment with the employer to establish insurance eligibility.

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

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

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

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

(A) Retirees, as defined in Section 1.53, or their dependents may not continue coverage in the plan if eligible for Medicare, except as provided below:

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

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

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

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

(1) For individuals who terminate employment, one of the following conditions must be met for continuation in the plan:

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

(b) The retiree with 20 or more total years of employment with the employer with one year of insurance coverage in a state-sponsored insurance plan immediately prior to final termination for retirement.* For such retirees, the period of time between the employee's final termination date and the date retirement benefits commence (retirement date) may be up to five years in length. The five-year requirement for commencement of retirement benefits will be waived for employees leaving the state plan and becoming employed by an agency participating in one of the other state-sponsored health plans, resulting in no lapse in coverage on a state plan. If more than five years, retirees and eligible dependents would have to meet the late applicant requirements of Section 2.06 before being insured.

(C) Retirees eligible to continue insurance coverage in the plan, pursuant to this section, must apply to continue coverage within one full calendar month of the expiration date of active insurance coverage or within one full calendar month of meeting the conditions to continue insurance as outlined in this section.* However, when a retiree has 20 or more years of service and there is an allowed gap of up to five years between the date of termination and the date retirement benefits commence according to retirement statutes (retirement date), the retiree must apply to continue coverage within one full calendar month of the retirement date or within one full calendar month of meeting the eligibility conditions. The effective date of insurance coverage will be the first of the month following the retirement date. At the expiration of the application period, eligible retirees may continue coverage only if qualified through the late applicant requirements of Section 2.06 or through the provision of COBRA under Section 4.09. In order to enroll through the late applicant requirements, the retiree must have had medical coverage at the time they retired and be eligible to continue that coverage by virtue of age, their length of service and length of participation in the plan.

(D) Retirees who participated in an ORP, non-elects and state employees on federal appointment (not eligible for federal insurance programs) must elect to continue coverage within one full calendar month of meeting the conditions to continue insurance coverage as outlined below, or the date of final termination from employment with the employer, whichever is later.* When the retiree has 20 or more years of service and there is an allowed gap of up to five years between the date of termination and the date insurance benefits commence, the retiree must apply to continue coverage within one full calendar month of meeting conditions for continuing coverage. Subject to timely submission of an enrollment

application, the effective date of coverage will be the first of the month following attainment of conditions for continuing coverage. If application is made after the expiration of the application period, the eligible retiree may continue coverage only if qualified through one of the late applicant requirements of Section 2.06 or through the provision of COBRA. In order to enroll through the late applicant requirements, the retiree must have had medical coverage at the time they retired and be eligible to continue that coverage by virtue of age, their length of service and length of participation in the plan.

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

(1) Attainment of age 55 at final termination and at least ten but less than 20, total years of employment with the employer, with three continuous years of insurance coverage in a state-sponsored insurance plan immediately prior to final termination unless they satisfy one or more of the late applicant requirements in Section 2.06*, or

(2) Attainment of age 55 and 20 or more total years of employment with the employer, with one year of insurance coverage in a state-sponsored insurance plan immediately prior to final termination.*

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

For individuals who qualify under either (2) or (3) above, the period of time between the final termination date and the date insurance benefits are to commence may be up to five years in length. The five-year requirement for commencement of benefits will be waived for employees leaving the plan and becoming employed by an agency participating in one of the other state-sponsored health plans, resulting in no lapse in coverage on a state plan. If more than five years, the individual and eligible dependents would have to meet one of the late applicant requirements of Section 2.06 before becoming insured.

(E) Special Enrollment for Retirees. Retirees may enroll in medical insurance for themselves and their eligible dependents subject to the special qualifying events, special enrollment period, and special enrollment effective date provided in Section 2.06. The retiree must have been a covered person under a state-sponsored plan at the time they retired and must be eligible to continue that coverage by virtue of age, their length of service and length of participation in the plan, as outlined in Tennessee Code Annotated § 8-27-205 and Section 4.07. A retiree who is age eligible for Medicare is not eligible to enroll in the state-sponsored health Plan. Retirees who have lost eligibility for the health Plan may not enroll dependents in the health Plan. Retirees whose first employment with the state commenced on or after July 1, 2015, will not be eligible to continue insurance coverage at retirement and will not be eligible for special enrollment under this provision, unless that retiree was also employed by the state or a participating local education agency, as defined in §8-27-301, before July 1, 2015, and did not accept a lump sum payment from the Tennessee Consolidated Retirement System before July 1, 2015.

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

(F) Premiums.

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

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

(G) Medicare.

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

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

(H) Dependents.

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

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

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

(b) If the retiree was a member of the Tennessee Consolidated Retirement System, and a pension benefit is continued for surviving dependents, premiums will be deducted from the

deceased retiree's monthly TCRS pension check. Premiums must be submitted directly to Benefits Administration if the pension check is insufficient to cover the premiums or if the beneficiary of the monthly pension is not a covered dependent.

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

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

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

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

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

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

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

4.09 Limited Continuation of Coverage (COBRA).

For purposes of this Section 4.09, a qualified beneficiary is any individual who, on the day before a qualifying event, is covered under the plan by virtue of being on that day either the covered employee, the spouse of the covered employee, or a dependent child of the covered employee.

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

A covered employee for purposes of this Section 4.09 is any individual who is (or was) provided coverage under this group health plan by virtue of being or having been an employee.

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

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

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

In the case of a qualifying event described in Section 4.09(A)(1) or (2) above that occurs fewer than 18 months after the date the covered employee became entitled (enrolled) to benefits under title XVIII of the Social Security Act, the period of coverage for qualified beneficiaries other than the covered employee shall not terminate before the close of the 36-month period beginning on the date the covered employee became so entitled. The 36-month time period excludes any time covered under a retiree's coverage.

If a qualified beneficiary is determined to have been disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 calendar days of COBRA continuation coverage, any qualified beneficiary will be entitled to elect an additional 11 months (total of up to 29 months from the date of the qualifying event) of COBRA continuation coverage. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 calendar days of COBRA continuation coverage is measured from the date of birth or placement for adoption. This same 11-month disability extension applies to each qualified beneficiary entitled to COBRA because of a qualifying event described in Section 4.09(A)(1) or (2) above. To qualify for this extension of coverage, the qualified beneficiary must have been disabled within the time periods described above and must obtain a social security determination to that effect. The qualified beneficiaries affected by the qualifying event in Section 4.09(A)(1) or (2) must notify the committee's representative of the disability determination within 60 calendar days after the date the determination is issued and prior to the expiration of the initial 18-month period.

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

(1) Death of the covered employee;

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

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

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

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

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

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

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

(C) Premiums. The monthly cost of COBRA coverage must be paid by the qualified beneficiary to Benefits Administration. The monthly cost shall be 102 percent of the cost to the plan for coverage of a similarly situated employee whose coverage had not otherwise terminated. When a qualified beneficiary has a special continuation period due to a certified disability, as described in subsection 4.09(A), the monthly cost during the additional 11 months shall be, in general, 150 percent of the cost to the plan.

The qualified beneficiary must pay the required costs for the initial continuation of coverage period within 45 calendar days of the date of the election. The monthly cost for coverage ***following*** the period after the initial election must be made in monthly payments in the manner prescribed by the committee or its representative. Without further notice from the employer, the qualified beneficiary must pay the monthly cost by the last day of each month for the following month's coverage. No claims will be paid pursuant to this Section 4.09 until Benefits Administration receives the applicable monthly premium for the qualified beneficiary's coverage.

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

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

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

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

(3) The end of an additional 11-month disability extension period as described in subsection 4.09(A). The continuation period shall not exceed the first day of the month following one full calendar month after a final determination that the qualified beneficiary is no longer disabled;

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

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

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

SECTION 5
COORDINATION OF MEDICAL BENEFITS

5.01 General.

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

5.02 Definitions.

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

(A) **Allowable Expense(s)** is any necessary healthcare charge, at least a portion of which is covered under at least one or more of the Other Plans covering the person for whom claim is made. When the Other Plans provide benefits in the form of services, the reasonable cash value of each service rendered is deemed to be both an Allowable Expense and a benefit paid.

(B) **Claim Determination Period** is the calendar year (January 1 through December 31);however, it does not include any part of a year during which a person has no coverage under the Plan.

(C) **Other Plans** means any plan providing benefits or services for medical care or treatment including but not limited to:

(1) Group, blanket or franchise insurance coverage (including State of Tennessee Local Government Plan and State of Tennessee Local Education Plan);

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

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

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

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

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

(D) **Primary Plan** is the policy that pays its full allowance of benefits first without regard to other coverages or Other Plans.

(E) **Secondary Plan** is a policy that is not the Primary Plan.

(F) **This Plan** is the State Insurance Plan created by Tenn. Code Ann. § 8-27-202(a)(1).

5.03 Order of Benefits Rules.

(A) General. When there is a basis for a claim under This Plan and Other Plans, This Plan is a Secondary Plan which has its benefits determined after those of the Other Plan, unless:

(1) The Other Plan has rules coordinating its benefits with those of This Plan; and

(2) both those rules and This Plan's rules, in subparagraph (B) below, require This Plan to be the Primary Plan.

(B) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-dependent/Dependent. The benefits of a plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) shall be the Primary Plan and a plan that covers such person as a dependent shall be the Secondary Plan.

(a) Medicare Exception. The order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the Other Plan covering the person as a dependent is the Primary Plan when the Covered Person is a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

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

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

(2) Dependent Child/Parents Not Separated or Divorced. If This Plan and Other Plan(s) cover the same child as a dependent of different persons, called "parents":

(a) the benefits of a plan which covers the parent whose birthday comes first in the calendar year shall be the Primary Plan and the plan which covers the parent whose birthday comes later in that year shall be the Secondary Plan;

(b) if both parents have the same birthday, the plan which covered the parent longer shall be the Primary Plan and the plan which covered the other parent for a shorter period shall be the Secondary Plan;

(3) Dependent Child/Separated or Divorced Parents. If parents are divorced or separated and there is a court decree which establishes financial responsibility for medical expenses for the dependent, the plan covering the dependent of the parent who has that financial responsibility shall be considered the Primary Plan. If there is no court decree, the plan which covers the dependent of the parent with primary custody, shall be the Primary Plan. If there is no court decree and the parent with primary custody has remarried, the order of benefits shall be as follows:

(a) The plan of the parent with primary custody shall be the Primary Plan.

(b) If the parent with primary custody does not have medical plan coverage, then the plan of the spouse of the parent with primary custody shall be the Primary Plan.

(c) If neither the parent or spouse with primary custody has medical plan coverage, then the plan of the parent without primary custody shall be the Primary Plan.

(4) Active/Inactive Employee. The plan covering an individual as an employee (or as the employee's dependent) who is neither laid-off nor retired shall be the Primary Plan. The plan covering that individual as a laid-off or retired employee (or as that individual's dependent) shall be the Secondary Plan. If the Other Plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule shall be ignored.

(5) Longer/Shorter Length of Coverage. As to plans for which rules (1) through (4) do not establish an order of benefit determination, the benefits of a plan which has covered the person for whom Allowable Expenses are being coordinated for the longer period of time shall be the Primary Plan and the plan which has covered such person the shorter time shall be the Secondary Plan.

(C) COBRA. When an individual has simultaneous COBRA coverage and coverage as an employee or a dependent of the employee, the plan covering the individual as an employee, or adependent of the employee, is the Primary Plan, and COBRA is the Secondary Plan. In the event of conflicting coordination provisions between This Plan and any Other Plan(s), This Plan shall be the Primary Plan for an individual only if This Plan has provided coverage for a longer period. If the Other Plan(s) does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule shall be ignored.

(D) Medicare Eligible.

(1) Upon attaining age 65 or otherwise becoming entitled to Medicare benefits, benefits for active employees shall continue under This Plan and Medicare shall be considered the Secondary Plan for:

(a) Active employees; and

(b) Dependent spouses of active employees.

(2) For individuals who were covered by This Plan as a Covered Person and became Medicare eligible due to end stage renal disease, This Plan shall be the Primary Plan for a period not to exceed 30 months.

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

5.04 Effect on the Benefits of This Plan

(A) This section applies when, in accordance with Section 5.03 Order of Benefits Rules, This Plan is a Secondary Plan as to one or more Other Plans. The benefits of This Plan will be reduced when the sum of the following two amounts exceed the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the Other

Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

(B) When the sum of (1) and (2) above exceeds the Allowable Expenses in a Claim Determination Period, benefits will be reduced so that the benefits under This Plan and the benefits payable under the Other Plans do not total more than the Allowable Expenses. When the benefits of This Plan are reduced, each benefit is reduced in proportion and is then charged against any applicable benefit limit of This Plan. This Plan will determine its liability for benefits payable in absence of the Other Plan and pay the lesser of: (a) This Plan's Allowable Expenses minus the Other Plan's payment; or (b) This Plan's original liability. In both (a) and (b), the Covered Persons' copayments and deductible/coinsurance under This Plan shall apply.

(C) Benefits payable under Other Plan(s) include the benefits that would have been payable had the claim been duly made therefor. In the case of a person eligible for, but not enrolled in Medicare, benefits payable under Other Plans shall include benefits that would have been payable under Parts A and B of Medicare had the person duly enrolled.

5.05 Subrogation Rights.

(A) The plan assumes and is subrogated to a Covered Person's rights to recovery of any payments made by it for medical expenses where the Covered Person's illness or injury resulted from the action or fault of a third party. Medical expenses shall include all Covered Expenses paid by the Plan. The Plan has the right to recover all amounts equal to its payments from the insurance company of the injured party, from the person who caused the illness or injury or his/her insurance company, or from any other source such as uninsured motorist coverage. The Plan's right to recovery may be exercised by agreement, litigation or settlement.

(B) In order to facilitate the Plan's right to subrogation, the Covered Person shall promptly notify Benefits Administration if the Covered Person's illness or injury resulted from the action or fault of a third party. The Covered Person shall also provide all information requested by Benefits Administration or its representative and sign all documents requested by Benefits Administration or its representative in order to assist the Plan with asserting its subrogation rights. If the Covered Person hires an attorney to represent them in legal proceedings relating to any injury or illness for which the sums have been or may be paid by the Plan, the Covered Person must inform the attorney of the Plan's subrogation rights and notify Benefits Administration within 7 business days that an attorney has been hired. The Covered Person shall answer all documentation requests related to the subrogation claims.

(C) If the Covered Person fails to cooperate or proceeds to negotiate settlements of any claim without the written consent of Benefits Administration, the Plan shall be entitled to recover an amount equal to all medical expense payments made by the Plan plus reasonable attorney's fees and court costs incurred in recovering said amounts from the Covered Person. Failure to comply with this provision, may result in the disenrollment of the Covered Person and their dependents from the Plan. A State Employee who submits false information to the Committee or its representatives may also be subject to disciplinary action.

5.06 Right of Reimbursement.

(A) If a Covered Person receives payment from a third party specifically for the medical expenses which have been paid by the Plan, the Covered Person shall reimburse the Plan, up to the amount paid by the Plan, from the money such Covered Person (or such Covered Person's family) received. The Covered Person shall reimburse the Plan the amount of money recovered for medical expenses through judgment or settlement from a liable third party (or the insurer of the third party). The Covered Person agrees to cooperate with Benefits Administration or its representative and answer any and all documentation requests related to the Plan's right of reimbursement. The Covered Person shall immediately notify the Plan of any pending or final judgment or settlement from a third party for medical expenses. Failure to respond to Benefits Administration's requests for information or failure to reimburse the Plan for money received for medical expenses, may result in disenrollment of the Covered Person and eligible dependents from the Plan. A State Employee who submits false information to the Committee or its representatives may also be subject to disciplinary action.

(B) If the Plan makes an error in administering benefits under this Plan, the Plan may provide additional benefits to, or recover any overpayments from any person, insurance company or plan. No such error may be used by a Covered Person to demand benefits greater than those otherwise due under this Plan. The Covered Person shall assist the Plan in enforcing its rights under this provision by signing or delivering all documents requested by Benefits Administration or its representative.

5.07 Recovery of Payment.

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

(A) Any person to, or on behalf of whom such payments were made;

(B) Any insurance company; or

(C) Any other appropriate organization or entity.

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

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

SECTION 6
PLAN ADMINISTRATION

6.01 General.

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

6.02 Liability of the Committee.

(A) The State Insurance Committee is an arm of the state government and is entitled to all immunities and defenses from liability applicable to the State of Tennessee.

(B) Members of the State Insurance Committee are considered "state officers" or "employees" as the meaning is set forth in TCA 8-42-101(3) and are entitled to all applicable immunities and defenses from liability.

6.03 Authority and Powers of the Committee.

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

(A) The Committee has delegated authority to perform the following administrative duties to Benefits Administration, unless otherwise required by State or Federal law or otherwise provided in this Plan Document:

(1) To interpret and explain the Plan;
(2) To decide all questions of Plan eligibility;
(3) To establish enrollment procedures for the Plan;
(4) To prepare and distribute information explaining the plan;
(5) To request information for proper administration of the plan;
(6) To receive and maintain records pertaining to the Plan;
(7) To provide recommendations to the Committee for the financing of the Plan, including benefit levels and premium rates, in consultation with contractors as needed;
(8) To perform all contract procurement functions in a manner consistent with TCA §§ 8-27-101(c) and 103 and CPO Rules and Policies, and arrive upon a proposed award recipient to recommend to the Committee for approval;
(9) To manage the contracts procured in subsection (A)(8) and serve as liaison between the Plan and the contractors; and
(10) To conduct internal BART appeals as provided in Section 6.04.

(B) The Committee may vote to delegate administrative duties not listed in (A) above to Benefits Administration.

(C) At any time, the administrative duties delegated in (A) above may be revised by a vote of The Committee.

6.04 Appeals Provision.

(A) Definitions For the purposes of this section:

(1) **Appeal** is a formal challenge to or request for review, re-consideration, or reversal of an adverse determination of benefits, payment denial, enrollment decision or premium decision under this Plan. An Appeal must be submitted by the Covered Person (with or without assistance from an Authorized Person) or a Personal Representative of the Covered Person and must follow the rules provided herein as well as any applicable provisions of a Covered Person's Member Handbook.

(2) **Personal Representative** is an individual or entity, such as a parent, guardian, conservator, representative of an estate, or an attorney, legally acting as the Covered Person. A Personal Representative must have a legal relationship to the Covered Person and does not include a Provider or an assignee of the Covered Person.

(3) **Authorized Person** is an individual or entity, such as a spouse, relative, or friend, having a Covered Person's permission to help them dispute an issue or file an appeal in the name of the Covered Person. An Authorized Person is different than a Personal Representative because an Authorized Person is not legally acting as the Covered Person. An Authorized Person may only assist the Covered Person, and the Covered Person retains all legal rights.

(4) **Payment** is the amount paid or not paid by the Plan for Medical Services.

(5) **Enrollment** is the eligibility, effective dates of coverage, or enrollment status as a Covered Person.

(6) **Medical Services** are healthcare services delivered on an outpatient or inpatient basis, prescriptions, and medical equipment.

(7) **Premium** is the amount that a Head of Contract is required to pay for Plan enrollment, and/or the unpaid amount owed by the Head of Contract.

(8) **Provider** is a person or entity that provides Medical Services to a Covered Person. A Provider has no agreement with the State of Tennessee or the Plan but may be contracted with one or more TPAs to provide Medical Services to Covered Persons.

(9) **Dispute** is an informal challenge to or request for review, re-consideration, or reversal of an adverse determination of benefits, payment denial, enrollment decision or premium decision under this Plan.

(B) Pre-Appeal Communication.

(1) To Dispute a decision regarding coverage for Medical Services or a Payment, a Covered Person with or without help from an Authorized Person or Personal Representative should call the TPA at the telephone number listed on the Covered Person's insurance card. If the Covered Person has received related correspondence the Covered Person, Authorized Person, or Personal Representative should call the number provided on the correspondence to discuss the issue. A telephone call does not constitute an Appeal, but a call should be made as soon as possible upon learning of any denial of Payment or Medical Services.

(2) To Dispute a decision regarding Enrollment or Premium, the Head of Contract with or without help from an Authorized Person or a Personal Representative should call Benefits Administration at 1-800-253-9981 or visit https://tn.gov/partnersforhealth.If the Head of Contract has received related correspondence, the Head of Contract, Authorized Person, or a Personal Representative should mention the correspondence and ask to discuss the issue. A telephone call does not constitute an Appeal, but a call should be made as soon as possible upon learning of any Enrollment or Premium issues.

(C) Appeal Deadline. To initiate an Appeal discussed in this Section the Appeal must be submitted by the Covered Person with or without help from an Authorized Person or a Personal Representative within one-hundred, eighty (180) calendar days after receipt of notification of an adverse determination.

(D) Medical Services and Payment Appeals. Medical Services and Payment Appeals are submitted to and resolved by the TPA administering the benefits of the Covered Person. In addition to the initial internal Appeal initiated within one hundred and eighty (180) calendar days after receipt of notice of an adverse determination, a Covered Person with or without help from an Authorized Person or a Personal Representative may initiate a second internal Appeal to the TPA one hundred and eighty (180) calendar days from receipt of an adverse determination of the initial Appeal. If the benefit determination involved medical judgment, a Covered Person may submit an external Appeal to an Independent Review Organization (IRO) within four months of receipt of notice of an adverse decision of an internal Appeal. The Member Handbooks provide the address where internal and external Appeals must be filed.

(E) Enrollment and Premium Appeals. A Head of Contract with or without help from an Authorized Person or Personal Representative may file an Enrollment or Premium Appeal. The Appeal is submitted to and decided by the Benefit Administration Review Team (BART)within BA. The Appeal must be timely submitted in writing (which may be electronic mail) to BA at the following address: Benefits.Administration@tn.gov, or State of Tennessee, Department of Finance and Administration, Benefits Administration, 312 Rosa L. Parks Avenue, Suite 1900 William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102.Enrollment and Premium Appeals are not decided by TPAs and no external administrative Appeal is provided. An Enrollment Appeal cannot be utilized to make mid-year benefit election changes not otherwise permitted by Sections 2.06 and 4.01of the Plan Document. A retroactive termination of enrollment that meets the definition of “rescission” under 45 CFR147.128 is appealable and shall be resolved in accordance with Federal law.

(F) Provider Appeals. The Plan does not provide an Appeal process for Providers, does not review disputes under a Provider/TPA contract, and does not permit Covered Persons to assign Appeal rights to a Provider. A Provider may assist a Covered Person to prepare an Appeal but shall not become a party to such Appeal. In the event of a conflict between this provision and applicable state or federal law explicitly requiring the Plan (as a governmental plan exempt from ERISA) to permit assignment of Appeal rights to a Provider in certain circumstances, the applicable law shall control. Providers may Appeal to TPAs on their own behalf if permitted by an agreement between the Provider and the TPA or state or federal law, and all such appeals are not an appeal or administrative remedy provided by this Plan.

SECTION 7
CLAIM PROVISIONS

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7.01 Proof of Claim.

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

7.02 Payment of Benefits.

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

7.03 Verification of Request for Medical Services.

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

7.04 Overpayments Incorrect, and Fraudulent Payments.

(A) The Plan has the authority to pursue recovery of any benefit payments made in error or in excess of contract liability. The Committee may enter into contracts to collect amounts owed to the Plan.

(B) The Plan shall pursue recovery of all payments and other losses resulting from any fraud against the Plan including misrepresentation of eligibility or expense on the part of a Covered Person. The Plan will coordinate with the Comptroller and other applicable state agencies in identifying and recovering losses due to fraud.

SECTION 8
CONTRIBUTIONS

8.01 Contributions by Covered Persons.

(A) Covered Persons are required to make premium contributions as a condition of participating in the Plan. By completing an enrollment application, a Covered Person shall authorize deduction of the Covered Person's share of the monthly premium from his/her pay or retirement pension.

(B) Covered Persons who do not receive employee pay or a retiree pension or whose retirement pension is insufficient to cover the required premium contribution shall submit payment in an amount equal to the monthly premium contribution. If such payment is returned by the Covered Person's financial institution, the Covered Person may be required to resubmit payment in the form of a money order or cashier's check within the designated timeframe. Should a Covered Person submit two consecutive payments that are not honored by their financial institution, coverage will be terminated retroactively to the last paid date with no provision for reinstatement within the current Plan Year.

(C) The Plan permits a premium deferral period of a full calendar month for premiums being billed directly to the Covered Person. If the premium is not paid within the deferral period, coverage will be canceled retroactive to the last month for which the premium was paid. If coverage for Covered Persons who are billed directly is canceled at the end of the deferral period for failure to pay, the plan permits a one-time opportunity for coverage reinstatement. Covered Persons seeking reinstatement of coverage must request reinstatement within 30 calendar days of being notified that coverage was canceled. BA must receive all signed required documentation and all premiums due must within 30 days of the request for reinstatement.

8.02 Employer Contributions.

For Employees, the state shall pay a percent of the cost for the type of medical coverage elected pursuant to Section 1.06 (except as may be otherwise indicated herein) based on an amount determined pursuant to TCA 8-27-203.

8.03 Funding Medium.

(A) The choice of insurance companies or TPAs under the Plan, the timing and amount of any fund established under the Plan, the timing and amount of any payment to such company, and the timing and amount of any contribution to any fund established under the Plan shall be at the sole discretion of the Committee.

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

On behalf of the retired persons, the State shall establish and maintain an expendable trust fund from which benefit payments as provided under this Plan shall be made. The fund will receive, invest, and

administer all contributions made under this Plan in accordance with applicable law, the trust fund declaration, and accounting policies in effect for the receipt, investment, and disbursement of State funds. The fund, resulting from contributions, earnings, profits, increments and accruals thereon, may only be used for the exclusive benefit of Covered Persons or the payment of reasonable expenses of administering the Plan.

(B) Premium refunds.

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

(2) If an Employee provides timely notice of an enrollment change as required by this Plan, but the request is not processed properly by the employing agency, the Employee will receive a full refund of premiums paid, and the agency is limited to a refund of three months of premium contributions. If the Plan paid benefits to or on behalf of an ineligible person, the agency shall be responsible for payment of all overpayments of benefits, and the premiums paid will be applied to the overpayment of benefits before any refund is made to the agency.

(3) An agency that fails to report Employee separations or terminations is limited to a three-month refund of premium contributions. The agency shall be responsible for payment of all benefits paid to or on behalf of an ineligible separated Employee or Dependent and the premiums paid will be applied to the overpayment of benefits before any refund is made to the agency.

(4) A Retiree who fails to provide timely notice to BA of a change in insurance enrollments as required by this Plan is limited to a refund of three-months of the Retiree's portion of the premium. If the Plan paid benefits to or on behalf of ineligible Retiree or Dependents before the Retiree provided notice of the enrollment change, the Retiree shall be responsible to repay all overpaid benefits, and the premiums paid will be applied to the overpayment of benefits before any refund is made to the Retiree.

(5) When the State determines that fraud exists related to enrollment in the Plan BA will employ applicable offset procedures to the refund of the Employee or Retiree premium contribution. An impacted state agency will receive a full refund of its premium contribution.

SECTION 9
AMENDMENT AND TERMINATION

9.01 Plan Modification and Amendment of Plan.

(A) The Plan may be amended by the Committee. The Plan amendment shall be effective at the date of approval, unless another date is required by law, or expressly provided at the time of approval.

(B) If a provision in the Plan Document is determined to conflict with state or federal law, the conflicting provision of the Plan Document will have no force or effect and the Plan will operate to comply with the applicable law. BA is authorized to amend the provisions of the Plan Document when necessary for compliance with applicable law without approval of the Committee.

(C) BA is authorized to revise the Plan Document to correct spelling, grammatical, or formatting errors without submitting those revisions to the Committee for approval.

9.02 Plan Termination.

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

SECTION 10
PRIVACY OF PROTECTED HEALTH INFORMATION

10.01 Definitions.

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

(A) "Plan Sponsor" means the State of Tennessee and the State of Tennessee Insurance Committee.

(B) "Plan Administrator" and "Covered Entity" means the Division of Benefits Administration of the Department of Finance and Administration, and employees of other State of Tennessee agencies specifically authorized to perform services for the Plan Administrator, such as Agency Benefits Coordinators.

(C) "Plan" means the State Insurance Plan as administered by the "Plan Administrator".

(D) The terms "Business Associate"; "Covered Entity", and "Protected Health Information (PHI)" shall have the meaning set forth in HIPAA regulation 45 CFR §160.103.

10.02 Plan Sponsor Certification of Compliance.

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

10.03 Purpose of Disclosure to Plan Sponsor.

(A) The Plan, the Plan Administrator, TPAs and Business Associates servicing the Plan will disclose Covered Persons' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan in a manner that is consistent with the requirements of HIPAA and its implementing regulations (45 C.F.R. Parts 160- 64). Any disclosure and use of Covered Persons' PHI by the Plan Sponsor will be subject to and consistent with the provisions of Sections 10.04 and 10.05 of this Section.

(B) Neither the Plan, Plan Administrator, TPAs nor Business Associates servicing the Plan will disclose Covered Persons' PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Covered Persons.

(C) Neither the Plan, Plan Administrator, TPAs, nor Business Associates servicing the Plan will disclose Covered Persons' PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

10.04 Restrictions on Plan Sponsor Use and Disclosure of PHI.

(A) The Plan Sponsor shall not use or further disclose Covered Persons' PHI, except as permitted or required by the Plan, as amended, or as required by law.

(B) The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Covered Persons' PHI, agrees to the restrictions and conditions of the Plan, including this Section, with respect to PHI.

(C) The Plan Sponsor will not use or disclose Covered Persons' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(D) The Plan Sponsor will report any use or disclosure of Covered Persons' PHI that is inconsistent with the uses and disclosures allowed under this Section to the Plan Administrator promptly upon learning of such inconsistent use or disclosure.

(E) The Plan Sponsor will make PHI available to the Plan or to the Covered Person who is the subject of the information in accordance with 45 C.F.R § 164.524.

(F) The Plan Sponsor will make Covered Persons' PHI available for amendment and will on notice amend Covered Persons' PHI, in accordance with 45 C.F.R § 164.526.

(G) The Plan Sponsor will track disclosures it may make of Covered Persons' PHI that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(H) The Plan Sponsor will make their internal practices, books, and records relating to its use and disclosure of Covered Persons' PHI available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 C.F.R. Part 164, Subpart E "Privacy of Individually Identifiable Health Information".

(I) The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Covered Persons' PHI in whatever form or medium received from the Plan Administrator, TPAs, or Business Associates servicing the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Person who is the subject of the PHI, when the Covered Persons' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Covered Persons' PHI, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Covered Persons' PHI that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(J) The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains or transmits in connection with the approved Plan administration functions.

(K) The Plan Sponsor will ensure that any agent or subcontractor to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect the PHI.

(L) The Plan Sponsor shall immediately report any security incident of which it becomes aware to the Plan Administrator.

10.05 Adequate Separation between the Plan Sponsor and the Plan.

(A) The following employees or classes of employees or other workforce members delegated Plan Administration functions by the Plan Sponsor may be given access to Covered Persons' PHI received from the Plan, TPAs, or Business Associates servicing the Plan:

(1) Employees or contractors of the Plan Administrator.

(2) Other employees or subcontractors of the State of Tennessee Department of Finance and Administration responsible for providing legal, accounting, auditing, payroll, payment, or technical support to the Plan Administrator.

(B) The classes of employees or other workforce members identified in Section 10.05 (A) of this Section will have access to Covered Persons' PHI provided to the Plan Sponsor to perform the Plan administration functions that they provide for the Plan.

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

10.06 HIPAA Compliance

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

SECTION 11
MEDICAL, MENTAL HEALTH
AND SUBSTANCE USE BENEFITS

11.01 Amount of Benefits.

The amount of benefits is outlined in Attachment A, "Schedule of Benefits," which is attached to and made a part of the Plan. Unless otherwise specified as 100% covered, the copayment and deductible and coinsurance amounts outlined reflect a Covered Person's financial responsibility. The balance of the amount of benefits, up to 100% of the maximum allowable charge for covered expenses, is provided by the plan. The amount of benefits is further subject to the out-of-pocket maximum of Section 11.05.

11.02 Deductible Amount.

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

(A) Individual Deductible. If the Covered Person has incurred covered expenses equal to the deductible dollar amount (separate deductibles for in-network and out-of-network expenses) shown in the Attachment A in a plan year, such Covered Person shall have satisfied the deductible requirement of the plan for such plan year and shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 11.04. The deductible amount shown in Attachment A is for medical services, pharmacy, and mental health and substance use treatment services combined.

(B) Family Deductible. In the event that Covered Persons of the same family independently incur covered expenses in a plan year so that the total of which would satisfy the family deductible (separate deductibles for in-network and out-of-network expenses) outlined in Attachment A, then the deductible requirement of the plan shall have been satisfied for such plan year and each and every Covered Person of such family shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 11.04. The deductible amount shown in Attachment A is for medical services, pharmacy, and mental health and substance use treatment services combined

(C) Common Accident Deductible. If two or more Covered Persons who are enrolled together in a family plan, incur covered expenses due to injuries sustained in the same accident, only one individual deductible shall be applied to the total of their combined covered expenses related to the accident, incurred during the plan year in which such accident occurred.

11.03 Copayment.

The copayment amount is required to be paid by the Covered Person for certain covered expenses as outlined in Attachment A before the plan will pay the remainder up to the maximum allowable charge.

11.04 Coinsurance.

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

11.05 Out of Pocket Maximum.

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

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

11.06 Lifetime Maximum Benefits.

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

11.07 Expenses.

The TPA does not furnish covered services directly but rather pays benefits according to the Plan. The TPA, the committee, the employer and the Plan shall not be responsible for any claims, injuries or damages whatsoever caused by or which arise from the acts or failure to act of any provider. None of the entities listed above shall be liable for a provider's refusal or failure to render services on behalf of a Covered Person. The ultimate choice of a provider is solely up to each Covered Person. Whether a provider is in-network or out-of-network shall not be taken as a recommendation or endorsement with respect to a particular provider's qualifications, skills, or competence.

(A) In-Network Expenses. In the event of covered expenses for those services received from and payable to a Provider contracted with the network, the applicable deductible, copayment, and coinsurance

percentage shall be the in-network amount indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.04, have been followed, if applicable.

(B) Out-of-Network Expenses. In the event of covered expenses for those services received from and payable to a Provider not contracted with the network, the applicable deductible, copayment, and coinsurance percentage shall be the out-of-network amount indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.04, have been followed, if applicable.

(C) Expenses Which Are Determined Not to be Medically Necessary and/or Clinically Necessary. If an expense is determined by the TPA not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

(D) Ancillary Services. Ancillary services include emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. In the event of covered expenses incurred with ancillary service providers at in-network facilities, reimbursement will be made at the in-network level of benefits as outlined in Attachment A. The Covered Person will not be responsible for any covered expenses which exceed the maximum allowable charge for any such ancillary service providers at in-network facilities.

(E) Pharmacy Benefits. Covered Persons shall utilize a pharmacy in the network established by the TPA for pharmacy benefits. If the prescription is filled at a participating retail pharmacy, a participating mail order pharmacy, a participating retail-90 pharmacy, or a participating specialty pharmacy a copayment or coinsurance is required as outlined in Attachment A. A Covered Person should present their pharmacy insurance identification card at the time of purchase, along with the applicable copayment or coinsurance as outlined in Attachment A. When a participating pharmacy is utilized and the pharmacy insurance identification card is presented, the charges for the prescription will be electronically filed with the TPA for pharmacy benefits. If a Covered Person does not use their pharmacy identification card at a participating pharmacy, the claim can be submitted to the TPA for pharmacy benefits by the Covered Person and any amounts exceeding the maximum allowable charge in addition to the amounts listed in Attachment A, are the responsibility of the Covered Person. If a Covered Person utilizes a non-participating pharmacy for a 30- day supply, the claim can be submitted to the TPA by the Covered Person and any amounts exceeding the maximum allowable charge in addition to the amounts listed in Attachment A are the responsibility of the Covered Person. Prescriptions are generally limited to a 30-day supply with some having additional quantity limits, step therapy requirements, and prior-authorization requirements. Certain medications can be purchased through participating mail order pharmacies and certain participating retail-90 pharmacies for up to a 90-day supply with a copayment or coinsurance as outlined in Attachment A.

(F) Emergency Benefits. The TPA will determine benefits for emergency services meeting the definition of Emergency, as outlined in Section 1.14, at the level indicated in Attachment A and all applicable state and federal laws.

(G) Durable Medical Equipment. If it is determined that a Covered Person requires the use of durable

medical equipment, the Covered Person should have a written prescription from a network provider for such durable medical equipment. The level of reimbursement is outlined in Attachment A.

(H) Detoxification. In the event of covered expenses for a detoxification program, benefits will be paid by the applicable TPA at the level indicated in Attachment A provided that the guidelines of the utilization management program, as outlined in Section 11.04, have been followed, if applicable.

(I) EAP Benefits. Employee assistance program (EAP) services are available at no cost to all Employees eligible for health insurance coverage under the plan, even if they have waived enrollment, and to all enrolled Retirees. Eligible Dependents of Employees and enrolled Retirees are not required to be enrolled in the health plan to receive EAP services. COBRA participants are also eligible, but they must be enrolled in the health plan to receive EAP services. Services consist of short-term counseling (up to five sessions per problem episode) for problems such as marital or family, emotional, substance use, stress, job and financial loss. Legal and financial consultations via telephone are also available. If an Employee or Dependent is determined to need greater assistance, they will be referred to other resources. All EAP services must be preauthorized.

(J) Out-of-State Retirees, Employees, Spouses, Dependent Children and COBRA Participants. Covered Persons who permanently reside out of the State, who are stationed outside of the State on a job assignment, or are temporarily residing out of the State , should utilize the out of area network established by the TPA to access in-network Providers, facilities and agencies that participate in each state. Covered Persons who choose a Provider in the TPA's out of state network will receive in network benefits for covered services as outlined in Attachment A. Covered Persons who choose a provider who does not participate in the TPA's out of state network will receive out-of-network benefits for covered non-emergency services as outlined in Attachment A.

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

11.08 Unique Care.

A unique care exception may be approved when the duration, medical or clinical complexity and/or level of professional skill, training and experience warrant highly specialized treatment and such treatment is not available through a network provider as determined by the TPA. When a unique care exception is pre-approved by the TPA, unique care services may be provided by an out-of-network provider and covered expenses are paid at the in-network level of benefits. The TPA will work with the out-of-network provider to negotiate a single case agreement. Approval of a unique care exception is

not a guarantee the out-of-network provider will accept a single case agreement or the maximum allowable charge as payment in full. The Covered Person is responsible for expenses determined not to be medically or clinically necessary and expenses that exceed the maximum allowable charge if the out-of-network provider decides to bill the Covered Person for the balance of the billed charges. If a Covered Person is billed for expenses exceeding the maximum allowable charge, the Covered Person can request a reconsideration of the amount paid by the Plan. If the TPA determines additional reimbursement is consistent with the unique care provided, the TPA may reprocess the claim to pay an allowable amount up to 150 percent of the maximum allowable charge.

11.09 Continuous Care.

A continuous care exception may be approved when a Covered Person is undergoing an active treatment plan for a serious clinical condition or a serious medical condition, including pregnancy if their treating provider leaves the network. The TPA determines the medical or clinical need and the time frame for which continuous care will be covered. When a continuous care exception is pre-approved by the TPA, the Covered Person may continue to receive services from their treating provider for the approved time frame and covered expenses are paid at the in-network level of benefits. The Covered Person is responsible for expenses determined not to be medically or clinically necessary and expenses that exceed the maximum allowable charge if the provider decides to bill the Covered Person for the balance.

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

A Covered Person has the responsibility to notify his/her provider and facility that they are a Covered Person under the plan and that the plan has certification and authorization requirements. This notification by the Covered Person can be by presentation of the plan identification card by the Covered Person or if the Covered Person verbally informs the provider. If the Covered Person notifies a provider or facility that they are a Covered Person under the plan before the admission or services being rendered, it will be the provider's responsibility to contact the TPA for authorization. If a Covered Person, prior to an elective admission or service, does not notify the provider that they are a Covered Person under the plan, does not give the provider correct information or the Covered Person will not admit to being covered by the plan when asked by the provider, the plan will be held harmless if authorization is not obtained. The Covered Person will be responsible for the full payment. If benefits are reduced due to non-compliance with the procedures established for administering the utilization management program, and the Covered Person wishes to dispute such reduction, the Covered Person may follow the appeals process outlined in Section 6.04. The appeal shall ensure that Covered Persons who, in good faith, attempt to comply with the utilization management requirements are provided benefits at the same level as if those procedures had been followed.

(A) In Network Providers. If authorization is not obtained by a network provider, the plan and the Covered Person shall be held harmless from charges resulting from not satisfying the utilization management requirements. Network providers have, by separate contract with the TPA, agreed

not to bill the Covered Person if the TPA determines that service(s) were not medically necessary, or if the network provider has not followed applicable utilization management requirements, such as obtaining certification or authorization, unless the Covered Person has signed an advance beneficiary notice for the specific services rendered including the date of service, signed by the member prior to the service being rendered.

(B) Out of Network Providers. If a Covered Person uses out-of-network providers, it is the Covered Person's responsibility to confirm authorization with the TPA prior to a non-emergency admission or receiving non-emergent services. When using out-of-network providers, benefits for medically necessary nonemergent services will be reduced by half if certification or authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary as determined by the TPA, no benefits will be provided, and services will not be covered or reimbursed by the plan and expenses will be the responsibility of the Covered Person.

11.11 Utilization Management Program.

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

(A) Certifications and Authorizations. A provider may obtain certifications and authorizations by writing to the TPA (no more than 30 days in advance) or by calling the TPA on the certification toll-free line. It is the responsibility of the provider to obtain certifications and authorizations. It is also the providers responsibility to obtain extension of days for inpatient admissions unless the admission is an emergency.

The TPA will approve or deny the provider's requests, unless additional information is needed before a determination can be made. Once all the information is received by the TPA, the provider's request will be denied or approved within required timeframes.

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

When the provider's request, including a certification or Prior Authorization as defined in Section 1.48, is approved or denied, the TPA will send a letter to the Covered Person (or his/her guardian), provider and facility advising them of the approval or denial of the request. This letter will be sent within the required timeframe after the request is denied or approved. When a request is approved, the TPA will notify the provider of the timeframe for the approval and the number of days that are being certified if the approval is for an inpatient stay.

If the admission is in an in- network facility, it will be the facility's responsibility to contact the TPA if the provider wants to request additional inpatient days. If the benefits for additional inpatient days are denied, the TPA will notify the patient, the provider and facility on what date inpatient benefits will cease.

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

When determining if additional inpatient days should be certified, the TPA will review the health care services delivered during the admission to make sure they meet industry standards of quality and are consistent with the patient's needs. If the TPA determines that, after reviewing the facility records, the health care is not medically necessary, benefits for the additional inpatient days will be denied. If a Covered Person is transferred from one facility to another, certification at the second facility must be obtained under the certification guidelines in subsection 11.10(A).

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

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

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

Procedures and services that can be safely and effectively performed on an outpatient basis will be required to be administered in an outpatient setting to receive benefits under this Plan. If the TPA review decision differs from the recommendation of the Covered Person's attending physician, the Covered Person and his/her attending physician shall be notified and the Covered Person can avail themselves of the appeals process described in Section 6.04.

(C) Outpatient Procedures and Services. The Plan requires certain outpatient procedures and services to be reviewed for medical or clinical necessity and receive prior authorization to receive benefits. A prior authorization review of a medical procedure includes a determination of the most appropriate setting for the procedure to be performed (i.e., in the outpatient department of a hospital, an ambulatory surgical center, or a provider's surgical center), unless the TPA determines the procedure should be performed in an inpatient hospital setting. Prior authorization of medical services may include a review to determine if the service should be provided in a free-standing facility, provider's office, or in a home health setting.

(D) Home Health Care. Covered Persons may receive home health care benefits as outlined in

Section 12.03(F) if Prior Authorization is received from the TPA.

(E) Mental Health and Substance Use. Inpatient, residential treatment, partial hospitalization/day treatment programs, intensive outpatient therapy, psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, applied behavioral analysis and EAP services must be prior authorized by the applicable TPA to receive benefits.

(F) Case Management. Case management services provided by the TPA include the identification of and outreach to Covered Persons with high-risk, complex, and chronic conditions. Nurse case managers work with the Covered Person, Providers, and primary caregivers to establish treatment plans and coordinate the most appropriate, cost-effective care and care setting.

SECTION 12
COVERED EXPENSES
AND EXCLUSIONS AND LIMITATIONS

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

12.01 Conditions.

(A) All medical and mental health and substance use services, treatment, and expenses are Covered Expenses if:

(1) They are listed in Sections 12.02 or 12.03;

(2) They are not excluded from coverage under Section 12.04;

(3) They are determined to be medically necessary and/or clinically necessary by the TPA;

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

(5) They are consistent with Plan policies and guidelines.

(B) All medical, mental health and substance use services, treatment and expenses are Covered Expenses if required by applicable state or federal laws or regulations.

(C) The Committee or its representative shall make determinations regarding whether expenses are Covered Expenses pursuant to (A) (1) and (2) above. TPAs shall make determinations regarding whether conditions set out in (A) (3) (4) and (5) have been satisfied.

12.02 Covered Expenses - Generally.

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

(A) Preventive Services including:

(1) Adult annual physical; and

(2) Services with an A or B recommendation from the United Services Preventive Task Force, https://uspreventiveservicestaskforce.org/uspstf/home, as prescribed by a Covered Person's Physician, including but not limited to:

(a) Breast cancer screening (mammogram);

(b) Cervical cancer screening (pap smear);

(c) Colorectal cancer screening;

(d) Tobacco use screening, counseling (behavioral health interventions)

(e) Healthy diet and physical activity counseling (behavioral health interventions) for cardiovascular disease;

(f) Unhealthy drug use screening (questions, not biological testing);

(g) Unhealthy alcohol use screening and counseling (behavioral interventions);

(h) Depression screening;

(i) Low-dose, over-the-counter generic forms of aspirin (prescription required); and

(j) Osteoporosis screening

(B) Hospital room and board charges for a semi-private room up to the TPA's Maximum Allowable Charge normally based on a daily per-diem rate which includes all room, board and ancillary services for the type of care provided as authorized through the utilization review for the Plan. Additional charges for a private room will only be considered when isolation of the patient is medically necessary and/or clinically necessary as determined by the TPA to reduce the risk of receiving or spreading infection. The Plan will pay the most prevalent room rate charge when the unit or facility does not provide semi-private rooms. The physician or hospital must obtain preauthorization from the TPA.

(C) Services and supplies furnished to the eligible Covered Persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an Injury or Illness, including consultations with a physician requested by the Covered Person's physician.

(D) Charges for "surgical procedures." Surgical procedures shall mean the generally accepted operative and cutting procedures rendered by a physician for the necessary diagnosis and treatment of an Injury or Illness. During one operation, a physician may perform two or more surgical procedures through the same incision. In this situation, payment is equal to the full benefit amount for the most expensive procedure plus one-half of the benefit amount for each additional procedure.

(E) Office visits to a physician that are due to an Injury or Illness, or for preventive services.

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

(G) Charges for diagnostic tests, laboratory tests, and x-ray services in addition to office visit charges including, but not limited to laboratory examinations, metabolism tests, cardiographic examinations

and encephalographic examinations.

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

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

(J) Charges for treatment received by a licensed doctor of podiatric medicine or, for treatment by a licensed Doctor of Chiropractic, or for treatment by a licensed acupuncturist provided treatment was within the scope of his/her license, unless excluded under Section 12.04.

(K) Charges for chemotherapy and radiation therapy when medically necessary as determined by the TPA. Covered Persons or their provider must obtain prior authorization and coverage is subject to utilization management review.

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

(M) Charges for laser procedures, other than those specifically excluded in Section 12.04.

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

(1) Knee replacement surgery; and

(2) Anterior cruciate ligament repair.

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

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

(1) <u>Single Pharmacy Limitation</u>.

If the TPA or administrative services organization (ASO) has the reasonable belief that a Covered Person is receiving covered services in an excessive, dangerous, or medically inadvisable amount, and this belief is based upon the professional opinion of a medical doctor and a pharmacist, the TPA may impose a limitation on services providing that the Covered Person may only receive services from one specific pharmacy. The Covered Person must receive advance written notification of any such restriction stating the reasons for this restriction. The restriction must provide an exception for emergency services. The Covered Person has the right to request removal or modification of such restriction. The TPA will respond in writing to any written request for removal or modification. The Covered Person also has the right to appeal such restriction pursuant to Section 6.04.

(2) Drugs and medicines (unless excluded under Section 12.04) requiring written prescription of a physician, approved for use by the Food and Drug Administration and dispensed by a licensed pharmacist or physician. This includes pharmacist-administered vaccines and over-the-counter drugs that require pharmacist preparation prior to patient use or where coverage has been mandated by applicable state or federal laws. Investigational new drugs (FDA designation), if published peer review literature indicates beneficial and effective patient care;

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

(4) Limited prescription agents and over-the-counter nicotine replacement therapies (e.g., gum, patches, lozenges, and oral and nasal inhalers) provided for assistance in tobacco cessation. The Plan requires a written prescription by a licensed clinician as a condition for covering any or all tobacco cessation products, including over-the-counter;

(5) Medically necessary insulin, the related syringes, home blood glucose monitors and related supplies for the treatment of diabetes as prescribed or recommended by a physician;

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

(7) Prosthetic devices and supplies including artificial eyes and limbs - following Injury, Illness or congenital defect:

(a) initial purchase for any Covered Person;

(b) replacement of the original limb prosthesis if improper fitting could result in severe damage to the stump as determined by a physician. Replacement must be within 12 months of the initial purchase of the limb prosthesis, and proof of medical severity must be furnished to the TPA. The Covered Person must receive written approval from the TPA prior to the replacement purchase.

(c) subsequent purchases for Covered Persons through age 18 necessitated by physical growth;

(d) one additional limb prosthesis past age 18 due toa surgical alteration or revision of the impacted site;

(e) purchase, fitting, necessary adjustment, repairs, and replacement of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances), as determined to be medically necessary by the TPA. Replacement costs will be covered only if the prosthetic device or supplies were used by the Covered Person in the manner and for the purpose for which such item was intended and the replacement costs are necessarily incurred due to normal wear and tear. Benefits are not available for prosthetic devices and supplies to replace those which are lost, damaged, stolen or prescribed because of improvements in technology.

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

(9) Foot orthotics, when prescribed by a physician if medically necessary as determined by the TPA and not otherwise excluded in Section 12.04, including:

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

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

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

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

(e) therapeutic shoes (depth or custom-molded) and inserts (limited to one pair per Plan Year) for Covered Persons with diabetes mellitus **and** any of the following complications:

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

(ii) history of pre-ulceratic calluses; or

(iii) history of previous ulceration; or

(iv) foot deformity; or

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

(vi) poor circulation

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

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

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

(13) If elected by the Covered Person following a mastectomy, coverage shall include:

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

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

(c) Prostheses, pursuant to Section 12.02(O)(7)(e), and physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Covered Person. Benefits are also provided for mastectomy bras as medically necessary.

(14) Hearing aids for Dependent children under eighteen years of age every three years. Covered Persons or their provider must obtain prior authorization. Ear molds and services to select, fit and adjust the hearing aid are also covered.

(15) Bone anchored hearing aid devices determined to be medically necessary by the TPA.

Covered Persons or their provider must obtain prior authorization;

(16) The purchase or rental (not to exceed the total Maximum Allowable Charge for purchase) of Durable Medical Equipment as outlined in the applicable section and attachment;

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

(18) Family planning services limited to history, physical examination and medical supervision, genetic testing and counseling, procedures for sterilization, oral and injected contraceptives, IUDs and internally time-released implants in an office setting, diagnostic testing to establish the etiology of infertility and medically necessary services for the correction of underlying causes of involuntary infertility.

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

(20) Routine foot-care for diabetics including nail clipping and treatment for corns and calluses;

12.03 Other Covered Expenses.

(A) Skilled Nursing Facility Care. The Plan shall pay for medically necessary expenses for room, board and general skilled nursing facility care, provided:

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

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

(3) The facility care is required for other than Custodial Care; and

(4) Services are prior authorized by the TPA.

(B) Eligible expenses for facility room, board and general nursing care shall only include:

(1) Charges for a semi-private room in accordance with 12.02(B); and

(2) Charges up to and including the 100th day of skilled nursing facility care during any Plan Year.

(3) Charges for care exceeding the 100th day of skilled nursing facility care only when the TPA determines that a short-term extension of skilled nursing facility care is required for the purpose of transitioning care under the following conditions:

(a) The care is recommended by the attending physician and the TPA determines it is medically necessary;

(b) Covered Person is enrolled and participating in case management to ensure discharge to the next level of appropriate care as soon as clinically possible; and

(c) The TPA notifies BA in writing upon its approval or denial of the requested exception.

(C) Maternity Benefits. The Plan provides coverage for pregnancy, childbirth, or related medical conditions on the same basis as any other Illness. Hospital admissions for maternity coverage and childbirth will be available for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean delivery. No additional approval or authorization is needed for lengths of stay that fall within these timeframes. A Covered Person is not required to stay in the hospital for a fixed period following the birth of her child. New benefits will apply if transferring to another health plan prior to delivery.

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

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

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

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

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

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

(D) Cochlear Implantation. The Plan provides coverage for cochlear implantation determined to be medically necessary by the claim administrator using FDA-approved cochlear implants. Covered Persons or their provider must obtain prior authorization.

(E) Hospice Care Program. When approved by the TPA, the Plan shall provide hospice care designed to provide Covered Persons who are terminally ill (a person whose life expectancy is six months or less) with dignified, comfortable and less costly care the few months or weeks prior to death. This program shall be administered through an approved hospice. Care provided shall include physical, psychological, social, and spiritual for dying persons and their families, rendered by a medically supervised interdisciplinary team of professionals and volunteers on a 24 hour on-call basis.

(F) Home Health Care. Eligible expenses for home health care services are covered when provided by a Home Health Care Agency.

(1) The Plan shall provide benefits for the services of skilled or private duty nursing care in the home when: provided or supervised by a registered nurse (R.N.) who is not an Immediate Relative; prescribed by the attending physician; certified as medically necessary; and prior authorized by the TPA. Skilled or private duty nursing care in the home is subject to the following limitations:

(a) Coverage is limited to 125 visits, with a visit defined as a single date of service not to exceed the number of approved hours; and

(b) Cases that require ongoing skilled or private duty nursing care in the home that exceeds the 125- visit limit, may be granted an exception for continued coverage by the TPA under the following conditions:

i. Ongoing care is recommended by the attending physician and determined to be medically necessary by the TPA;

ii. A case manager shall be assigned and a written treatment plan with relevant medical records must be submitted for periodic review by the TPA, no less than every 6 months, for ongoing skilled nursing care coverage; and

iii. The TPA shall review exceptions as needed, but no less than every 6 months, and shall notify BA of the approval or denial in writing.

(2) Home Health Care Aide services are also a covered service with the following limitations:

(a) No more than 30 visits per Plan Year;

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

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

(d) The Home Health Care Aide is not an Immediate Relative;

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

(f) The Home Health Care Aide service is in conjunction with medically necessary skilled care.

(3) Intravenous (I.V.) therapy administered in the home during home health care visits is a covered service, provided the medication is approved for use by the Federal Drug Administration and prior authorized as required by the TPA.

(G) Therapy. Speech, physical, and/or occupational. The Plan shall provide preauthorized inpatient therapy benefits and medically necessary outpatient therapy benefits. Habilitative and rehabilitative services as defined in Article I are covered. Specific to rehabilitation therapy, coverage is available for conditions resulting from an Illness or Injury, or when prescribed immediately following surgery related to the condition. No therapy services will be covered if the TPA determines services are not medically necessary or if the Covered Person is no longer progressing toward therapy goals. Cardiac rehabilitation services will be a Covered Expense when determined to be medically necessary by the TPA.

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

(H) Sitter. A sitter who is not an Immediate Relative of the Covered Person may be used when the Covered Person is confined to a hospital as a bed patient and certification is made by a physician that either an R.N. or L.P.N. is needed and neither is available.

(I) Covered Dental Expenses.

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

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

(3) Charges for treatment of accidental Injury or damage to sound natural teeth and/or jaw. Treatment of accidental Injury as described in this section does not include Injury from eating or chewing. Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a Covered Person's ability to masticate and maintain a healthy weight. Services are limited to the cost of bridgework unless

the TPA determines that teeth implants are medically necessary (for example if implants are medically necessary to anchor or support the bridgework). Treatment will not be covered if the TPA determines services are cosmetic or otherwise not medically necessary.

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

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

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

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

(c) Mental Illness or disability precludes dental/surgical management in an office setting;

(d) When general anesthesia is used; or

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

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

(a) History, exams and office visits;

(b) X-rays of the joint;

(c) Diagnostic study casts;

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

(e) Medications; and

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

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

(a) Prosthodontic treatments (dentures, bridges);

(b) Restorative treatment (fillings, crowns);

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

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

(J) Organ Transplants. Organ transplant benefits will be paid for covered medical expenses related to transplants of the: heart, heart/lung, lung, liver, kidney, pancreas, pancreas/kidney, cornea, small bowel, small bowel/kidney and certain bone marrow transplants, only at Medicare-approved facilities. Transplant services or supplies require pre-authorization before any pre-transplant evaluation, or any transplant-related covered service is performed.

(1) Coverage will include expenses incurred for donor search and organ procurement by the transplant center or hospital facility and all inpatient and outpatient hospital/medical expenses for the transplant procedure and related pre- and post-operative care, including immunosuppressive drug therapy. Should a transplant request fall outside those addressed and covered in Section 12, the TPA will review the information provided and render a decision based on acceptable medical practices on behalf of the state group insurance program. The TPA will notify BA of its decision prior to approving such services. If the service(s) or procedure(s) does not meet the TPA's accepted medical standards, the Covered Person will be notified of their option to appeal the decision as described in Section 6.04.

(2) If a network facility is utilized for the transplant, travel and living expenses will be covered from the initial evaluation to one year after the transplant (for medically necessary visits only as determined by the TPA). Air transportation, if necessary, will be paid at commercial coach fare. Ground travel will be paid at the State of Tennessee approved mileage rate or for actual fuel expenses. Additionally, hotel and meal expenses will be paid up to $150 per diem. The transplant recipient and one other person (guardian, spouse, or another caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.

(3) If the donor is not a Covered Person, Covered Expenses for the donor are limited to those services and supplies directly related to the transplant itself such as testing for the donor's compatibility, removal of the organ from the donor's body, preservation of the organ, and transportation of the organ to the site of the transplant. Services are covered only to the extent not covered by other health insurance. The search process and securing the donor are also covered under this benefit. Complications of donor organ procurement are not covered. The cost of donor organ procurement is included

in the total cost of the organ transplant. No benefits are payable for donor services for recipients who are not covered under the Plan. These services are ineligible even when the recipient does not provide reimbursement for the donor's expenses.

(4) Bone marrow transplantation will fall into one of three categories: syngeneic, allogeneic, or autologous. Expenses eligible for coverage include the charge to harvest bone marrow for Covered Persons diagnosed with any covered malignant condition or any conditions approved for coverage and determined to be medically necessary by the TPA. Coverage for harvesting, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow will be covered when re-infusion is scheduled within three months or less.

(K) Well-Child Checkups and Immunizations. Physician office visits for routine check-ups and immunizations are Covered Expenses. Annual checkups and immunizations as recommended by the Centers for Disease Control and Prevention (CDC) are covered for children ages 6-17.

(L) Prostate Screening. The Plan will cover PSA (prostate specific antigen) and transrectal ultrasound screenings annually (per Plan Year.

(M) Bariatric Surgery (weight reduction). The Plan will cover preauthorized surgical procedures for the treatment of morbid obesity as determined to be medically necessary by the TPA.

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

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

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

(3) Routine screenings for adults (annually per Plan Year) are considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

(O) Hearing Impairment Screening and Testing. The Plan will cover, as determined by the TPA, medically necessary hearing impairment screening (annually per Plan Year) and testing for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The TPA has determined eligibility of many of the tests/screenings to be specific to infants.

(P) Nutritional Treatment of Inborn Errors of Metabolism. The Plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup urine disease, homocystinuria, methylmalonic acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the TPA. Coverage includes licensed professional medical services under the supervision of a physician and those special dietary formulas that are medically necessary for therapeutic treatment.

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

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

12.04 Exclusions and Limitations.

No exclusion of benefits under this section shall apply to benefits required by applicable state or federal laws or regulations.

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

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

(2) Drugs and medicines which can be obtained without a written prescription except as covered pursuant to Section 12.02(O)(2) and 12.02(O)(4);

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

(4) Services and supplies (notwithstanding organ donations) provided by an Immediate Relative of the Covered Person;

(5) Services rendered prior to the Effective Date of coverage;

(6) Services incurred after the Covered Person's coverage under this Plan is terminated;

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

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

(9) Treatment of an Injury or Illness due to declared or undeclared war;

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

(11) Charges which the TPA determines to be more than the Maximum Allowable Charge for that procedure or supply and for charges made which are not medically necessary as determined by the TPA;

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

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

(14) Expenses incurred for contact lenses, eyeglasses, sunglasses or for examinations for prescription or fitting of eyeglasses or contact lenses, except as may be allowed pursuant to Section 12.02;

(15) Expenses incurred for hearing aids or for examinations for prescription or fitting of hearing aids and hearing aid accessories including batteries, cords, and other assistive listening devices (except as previously defined in Section 12.02 and/or12.03);

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

  (a) The Covered Person experienced a traumatic Injury or Illness, whichrequires the cosmetic surgery;

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

  (c) If elected by the Covered Person following a mastectomy pursuant to 12.02(O)(13);

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

(17) Arch supports, corn plaster (pads, etc.), foot padding (adhesive moleskin, etc.), orthotic or orthopedic shoes and other foot orthoses (including inner soles or inserts) unless specified in sections 12.02 and 12.03, foot orthoses primarily used for cosmetic reasons or for improved athletic performance or sports participation;

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

(19) Garter belts;

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

(21) Hotel charges or travel expense incurred while receiving treatment as an inpatient or outpatient, (other than defined in Section 12.03(J) or Attachment A);

(22) Unapproved sitters;

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

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

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

(26) Organ transplants involving artificial organs and non-human organs unless determined to be medically necessary by the TPA, as well as any services or supplies in connection with experimental or investigational treatment, drugs, or procedures;

(27) Services or supplies for which there is no charge to the Covered Person, or for which the Covered Person would not have been charged if not covered by this Plan;

(28) Surgery or treatment for, or related to, sex transformations or sexual dysfunctions or inadequacies, including penile prosthesis due to psychogenic impotence other than psychological treatment or counseling;

(29) Services or supplies intended to create a pregnancy, including medications that trigger or regulate ovulation, reversal of sterilization, assisted reproductive services and associated laboratory, x-ray and other testing for procedures such as invitro fertilization (IVF), gamete intrafallopian tube placement (GIFT) and zygote intrafallopian transfer (ZIFT), ovulation predictor kits and sperm testing kits, donor eggs and sperm, and cryopreservation of donor eggs, sperm or embryos.

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

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

(32) Durable Medical Equipment not specified in Sections 12.02, 12.03 or Attachment B;

(33) The purchase or rental of any device, mechanical aid or other contrivance which may be required for the transportation of an individual on a public conveyance; roadway or other

means of transportation, except for those items specifically included as an eligible medical expense;

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

(35) Custodial Care;

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

(37) Services of a private-duty nurse in an inpatient setting which would normally be provided by hospital nursing staff;

(38) Diapers (incontinent pads);

(39) Cranial prosthesis (wig);

(40) Nutritional supplements, vitamins, and oral nutritional formulas for infants and adults which can be obtained at retail or over-the-counter without a written prescription. Nutritional treatment of inborn errors of metabolism, Enteral Nutrition (EN), and Total Parenteral Nutrition (TPN) are not excluded under this clause as noted in Section 12.03(O);

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

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

(43) Court or Employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the TPA;

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

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

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

(47) Services given by a pastoral counselor;

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

(49) Any medical, mental health or substance use service, treatment or expense that is prohibited by applicable state or federal law.

(B) Excluded Dental Expenses.

(1) Any dental care and treatment and oral surgery relating to the teeth and gums except those specifically provided as Covered Expenses in Section 12.03(I), including but not limited to dental appliances; dental prostheses such as crowns, bridges or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; treatment of dental caries, gingivitis or periodontal disease.

(2) Any other expenses incurred relating to the teeth and gums except those specifically provided as Covered Expenses pursuant to Section 12.03(I);

(C) On the Job Injuries and Illnesses. Expenses for Injuries or Illnesses incurred on the job are not covered expenses.

(D) Excluded Mental Health/Substance Use Expenses. In addition to relevant exclusions noted in Section 12.04(A), the following are specifically excluded under the mental health/substance use benefit:

(1) Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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

ATTACHMENT A
SCHEDULE OF BENEFITS

ATTACHMENT A.1
SCHEDULE OF PPO BENEFITS

Table 1 Member Costs PPO Plans: Services in this table ARE NOT subject to a deductible.

PPO HEALTHCARE OPTION	PREMIER		STANDARD	
COVERED SERVICES	**In-Network [1]**	**Out-of-Network [1]**	**In-Network [1]**	**Out-of-Network [1]**
PREVENTIVE CARE — OFFICE VISITS				
• Well-baby, well-child visits as recommended • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended • Annual hearing and non-refractive vision screening • Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	$45	No charge	$50
OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA				
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Provider based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Inc surgery in office setting & initial maternity visit	$25	$45	$30	$50
Specialist Office Visit • Including surgery in office setting • Provider based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	$45	$70	$50	$75
Behavioral Health and Substance Use [2] • Including virtual visits	$25	$45	$30	$50
Telehealth Carrier Programs (MDLive/Teladoc)	$15	N/A	$15	N/A
Allergy Injection Without an Office Visit • Allergy Serum has additional member cost	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Chiropractic and Acupuncture • Limit of 50 visits of each per year	Visits 1-20: $25 Visits 21-50: $45	Visits 1-20: $45 Visits 21-50: $70	Visits 1-20: $30 Visits 21-50: $50	Visits 1-20: $50 Visits 21-50: $75
Convenience Clinic	$25	$45	$30	$50
Urgent Care Facility	$45	$70	$50	$75
PHARMACY				
30-Day Supply generic | preferred brand | non-preferred	$7 | $40 | $90	copay plus amount exceeding MAC	$14 | $50 | $100	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order) generic | preferred brand | non-preferred	$14 | $80 | $180	N/A - no network	$28 | $100 | $200	N/A - no network
Maintenance Medications (90-day supply of certain maintenance medications from 90-day network pharmacy or mail order) [3] generic | preferred brand | non-preferred	$7 | $40 | $160	N/A - no network	$14 | $50 | $180	N/A - no network
Specialty Medication Tier 1 (generics;30-day supply from a specialty network pharmacy)	In-Network = 20%; minimum $100; maximum $200 Out-of-Network = NA – no network			
Specialty Medication Tier 2 (all brands; 30-day supply from a specialty network pharmacy)	In-Network = 30%; minimum $200; maximum $400 Out-of-Network = NA – no network			

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

Table 2 Member Costs PPO Plans: Services ARE subject to a deductible unless noted with a [5].

PPO HEALTHCARE OPTION	PREMIER		STANDARD	
COVERED SERVICES	**In-Network [1]**	**Out-of-Network [1]**	**In-Network [1]**	**Out-of-Network [1]**
PREVENTIVE CARE — OUTPATIENT FACILITIES				
• Recommended screenings such as colonoscopy, mammogram, colorectal, and bone density scans	No charge [5]	40%	No charge [5]	40%
OTHER SERVICES				
Hospital/Facility Services [4] • Inpatient care [7]; outpatient surgery [7] • Inpatient behavioral health/ substance use [2] [6]	15%	40%	20%	40%
Emergency room services [7]	15%		20%	
Maternity - Global billing for labor and delivery and routine services beyond initial office visit	15%	40%	20%	40%
Home Care [4] • Home health; home infusion therapy	15%	40%	20%	40%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4] • Outpatient PT/ST/OT/ABA [5]; Other therapy	15%	40%	20%	40%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) [5]	15%		20%	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	15%	40%	20%	40%
Pathology and Radiology Reading, Interpretation and Results [5]	15%		20%	
Ambulance (medically necessary air and ground)	15%		20%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	15%	40%	20%	40%
Allergy Serum	15%	40%	20%	40%
Also Covered – see Member Handbook for details	Certain limited Dental benefits, Hospice Care and Out-of-Country charges			
DEDUCTIBLE – ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE				
Employee Only	$750	$1,500	$1,300	$2,600
Employee + Child(ren)	$1,125	$2,250	$1,950	$3,900
Employee + Spouse	$1,500	$3,000	$2,600	$5,200
Employee + Spouse + Child(ren)	$1,875	$3,750	$3,250	$6,500
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE, COUNT				
Employee Only	$3,600	$7,200	$4,400	$8,800
Employee + Child(ren)	$5,400	$10,800	$6,600	$13,200
Employee + Spouse	$7,200	$14,400	$8,800	$17,600
Employee + Spouse + Child(ren)	$9,000	$18,000	$11,000	$22,000

For PPO plans, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members

[1] Subject to maximum allowable charge. The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, member pays the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise specified by state or federal law.
[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient", prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.
[3] List of eligible medication classes and a list of participating Retail-90 pharmacies can be found at https://www.tn.gov/partnersforhealth/health-options/pharmacy.html.
[4] Prior authorization (PA) required for non-emergent services. When using out-of-network providers, benefits for non-emergent medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.
[5] Deductible DOES NOT apply.
[6] Select Substance Use Treatment Facilities are preferred with an enhanced benefit. PPO members won't have to pay a deductible or coinsurance for facility-based substance use treatment; Copays will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.
[7] In-network benefits apply to out-of-network professional services at certain in-network facilities.

ATTACHMENT A.2
SCHEDULE OF CDHP/HSA BENEFITS

Table 1 Member Costs CDHP/HSA Plan: Services in this table ARE subject to a deductible with the exception of in-network preventive care and maintenance medications.

CDHP/HSA HEALTHCARE OPTION	CDHP/HSA	
COVERED SERVICES	**In-Network [1]**	**Out-of-Network [1]**
• Well-baby, well-child visits as recommended • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended • Annual hearing and non-refractive vision screening • Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	40%
OUTPATIENT SERVICES		
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Provider based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Inc surgery in office setting and initial maternity visit	20%	40%
Specialist Office Visit • Including surgery in office setting • Provider based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	20%	40%
Behavioral Health and Substance Use [2] • Including virtual visits	20%	40%
Telehealth Carrier Programs (MDLive/Teladoc)	20%	N/A
Allergy Injection Without Office Visit • Allergy Serum has additional member cost	20%	40%
Chiropractic and Acupuncture • Limit of 50 visits of each per year	20%	40%
Convenience Clinic	20%	40%
Urgent Care Facility	20%	40%
PHARMACY		
30-Day Supply generic | preferred brand | non-preferred	20%	40% plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order) generic | preferred brand | non-preferred	20%	NA – no network
Maintenance Medications (90-day supply of certain maintenance medications from 90-day network pharmacy or mail order) [3] generic | preferred brand | non-preferred	10% without first having to meet deductible	NA – no network
Specialty Medication Tier 1 (generics; 30-day supply from a specialty network pharmacy)	20%	NA – no network
Specialty Medication Tier 2 (all brands; 30-day supply from a specialty network pharmacy)	20%	NA – no network

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

Table 2 Member Costs CDHP/HSA PLAN: Services ARE subject to a deductible with the exception of in-network preventive care.

CDHP HEALTHCARE OPTION	CDHP/HSA	
COVERED SERVICES	**In-Network [1]**	**Out-of-Network [1]**
PREVENTIVE CARE — OUTPATIENT FACILITIES		
• Recommended screenings such as colonoscopy, mammogram, colorectal, and bone density scans	No charge	40%
OTHER SERVICES		
Hospital/Facility Services [4] • Inpatient care [6]; outpatient surgery [6] • Inpatient behavioral health and substance use [2] [5]	20%	40%
• Emergency room services [7]	20%	
Maternity - Global billing for labor and delivery and routine services beyond initial office visit	20%	40%
Home Care [4] • Home health; home infusion therapy	20%	40%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4]; • Outpatient PT/ST/OT/ABA [5]; Other therapy	20%	40%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	20%	40%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	20%	40%
Pathology and Radiology Reading, Interpretation and Results	20%	
Ambulance (medically necessary air and ground)	20%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	20%	40%
Allergy Serum	20%	40%
Also Covered – see Member Handbook for details	Certain limited Dental benefits, Hospice Care and Out-of-Country charges	
DEDUCTIBLE – ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE		
Employee Only	$1,700	$3,400
Employee + Child(ren)	$3,400	$6,800
Employee + Spouse	$3,400	$6,800
Employee + Spouse + Child(ren)	$3,400	$6,800
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE, COUNT		
Employee Only	$2,800	$5,600
Employee + Child(ren)	$5,600	$11,200
Employee + Spouse	$5,600	$11,200
Employee + Spouse + Child(ren)	$5,600	$11,200
CDHP HEATH SAVING ACCOUNT (HSA) CONTRIBUTION		
For individuals who enroll in the CDHP/HSA	$500 for employee only; $1,000 for all other coverage levels	

For the CDHP plan, the deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied.

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

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

[3] CDHP list of eligible medications and a list of participating Retail-90 pharmacies can be found at https://www.tn.gov/partnersforhealth/health-options/pharmacy.html.

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

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

[6] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.

ATTACHMENT B
LIST OF DURABLE MEDICAL EQUIPMENT

ATTACHMENT B

LIST OF DURABLE MEDICAL EQUIPMENT

Item of Equipment	Approve Purchase	Approve Rental	Deny	Refer to Benefits Review
Air conditioner			X	
Air purifier, cleaner or filter			X	
Bathroom Chairs and Stools			X	
Bathtub Handrails			X	
Bedboards				X
Bedside Commode	X			
Blood Glucose Monitor	X			
Cane	X			
Compressor, Concentrator – oxygen				X
Continuous Positive Airway Pressure				X
Crutch	X			
Dehumidifier (room or central unit)			X	
Electric chair lift			X	
Electrical stimulator for bone growth (Bi-Osteogen, etc.)				X
Electrical stimulator (TENS)				X
Exercise Equipment			X	
Heater			X	
Heating Pad			X	
Heat Lamp				X
Hospital bed, twin size, standard, Siderails Trapeze				X X X
Hospital bed, twin size, electrical or deluxe				X
Hospital bed, Kinetic, Trauma bed, Roto Rest				X
Hospital bed with siderails				X
Hot Tub			X	
Hot water bottle			X	
Humidifier (room or central unit)			X	
Hydrocollator unit				X
Hydrocollator steam packs				X
Infusion Pump (insulin, chemotherapy)				X
Infusion regulating device (IVAC, etc.)				X
Iron Lung				X
IPPB Machine				X
Massage Device			X	
Massage (as part of hospital bed)				X
Mattress (air, gel or water for alternating pressure)				X
Mattress (any other)			X	
Monitor, SIDS (apnea)				X

Item of Equipment	Approve Purchase	Approve Rental	Deny	Refer to Benefits Review
Overbed table				X
Oxygen-tanks, tents, regulators, flow meters, etc.	X	X		
Paraffin bath unit, portable or standard				X
Patient lift				X
Pulse tachometer			X	
Sauna bath			X	
Sphygmomanometer with cuff			X	
Stethoscope			X	
Suction machine (gomeo)				X
Sun lamp				X
Traction		X		
Ultraviolet cabinet, stand or bulbs				X
Walker	X			
Waterbed			X	
Wheelchair, standard				X
Wheelchair, electric				X
Wheelchair, custom made				X
Whirlpool			X	

Listed items are examples only, meeting the definition of equipment which may be prescribed by a physician, and may be provided consistent with a patient's diagnosis, when medically necessary as determined by the TPA and recognized as therapeutically effective and not meant to serve as a comfort or convenience item.

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

PART II
FLEXIBLE BENEFITS AND PARKING/TRANSPORTATION EXPENSE PLAN

INTRODUCTION

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

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

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

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

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

Who is the Claims Administrator?

All FSA benefits described in this document (except parking & transportation, which are only applicable to state employees) are administered by the state's contracted claims administrator. Contact information for the claims administrator can be found on the Benefits Administration website at https://www.tn.gov/partnersforhealth.html.For parking & transportation expense questions, contact the Plan Administrator. 1-800-253-9981 Mon-Fri 8:00 am-4:30 pm CT or email Benefits.Info@tn.gov.

Who is the Plan Administrator?

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

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

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

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

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

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

The following fringe benefits authorized under IRC Section 132 are offered to state employees only:
• The parking & transportation/transportation expense plan (P&T) is available for state employees who wish to set aside up to $280 per month in a pre-tax funded account in order to pay for qualified parking and transportation expenses while at work or commuting to/from their place of employment. University of Tennessee and Tennessee Board of Regents employees or TBR college and university employees are not participating employers in the parking and transportation expense plan; this benefit applies only to state employees.

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

Who is eligible for the plan?

Insurance-eligible employees of the State of Tennessee, the University of Tennessee campuses, or the various colleges, schools, and universities under the purview of the Tennessee Board of Regents are eligible to participate in the medical FSA, the DC-FSA, and the L-FSA. Only state employees may participate in the parking & transportation expense plan.
New employees who are insurance eligible must enroll in the medical FSA, L-FSA and/or DC-FSA within 31 days of their employment, re-hire, or reinstatement. Coverage is effective on the first day of the month following one full calendar month of work, (i.e., the effective date) except for the University of Tennessee, which allows coverage to begin on the hire date. The IRS generally prohibits retroactive enrollments.
If you fail to enroll for medical FSA, DC-FSA, or L-FSA during the applicable new employee enrollment period, you cannot enroll until the following Benefits Administration annual enrollment period (usually a designated time period during the month of October), unless you have an event which constitutes a "status change." If you enroll mid-year based on a status change, see Article I, Section 1.06 for more information. If you enroll for a plan during annual enrollment AND you are on payroll on the following January 1, your plan coverage will begin on January 1 (i.e., the effective date).
State employees may enroll in the parking & transportation expense plan at any time during the year and may cancel enrollment in the parking & transportation expense plan at any time during the year. For parking & transportation (state employees only), the effective date will be the first day of the month following the date that your parking & transportation enrollment form is received by the Division of Benefits Administration.

What if I work less than a full calendar year?

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

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

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

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

What is the purpose of the flexible benefits and parking/transportation expense plan?

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

Are there any risks involved in participating in this plan?

YES! UNDER CERTAIN CIRCUMSTANCES, YOU RISK FORFEITING PART OR ALL OF THE MONEY YOU HAVE CONTRIBUTED. In general, you will forfeit money if you do not incur enough eligible expenses to cover your contributions or if you fail to file a complete reimbursement request by the final deadline of the plan year. This risk of forfeiture is required by federal regulations. For more information on the forfeiture risk, see the applicable sections for the medical FSA, L-FSA, and DC-FSA. Generally, participants may carry over to the next plan year any unused balance in their medical FSA and limited purpose FSA (L-FSA) of $570 or less. Please see the section titled "*If I have money left in my account at the end of the year, can it carry forward into the next year?*"

What time period does the plan cover?

This document describes the plan as of January 1, 2023. The plan year runs January 1 through December 31. Generally, employees enroll during annual enrollment prior to the beginning of the plan year. Employees who enroll or end their participation during the plan year due to a status change have a shorter period of coverage. For further information, see the applicable sections for the medical FSA, DC-FSA, L-FSA, and parking/transportation (state employees only).

Does this plan affect my benefits from other employer benefit programs that are based on my pay (e.g. Life Insurance)?

No. All benefits from your pay-related benefit plans are based on your gross pay without regard to any salary deduction amounts under this plan.

Which plans does this booklet describe?

This booklet is a description of plan features for the Flexible Benefit Plans and the Parking/Transportation Expense Plan.

What if I have questions about the plan?

The state's contracted claims administrator for the medical FSA, L-FSA, and the DC-FSA, or your ABC can help you if you have specific questions about those plans. Their contact information is available on the Division of Benefits

Administration website. You may also wish to consult with your tax advisor. Benefits Administration, the administrator of the parking/transportation plan for state employees, can answer questions about that program for state employees.

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

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

NOTICE:

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

Contributions to Flexible Benefit Plan accounts may be modified, reduced, or recharacterized at any time to comply with applicable Internal Revenue Code provisions.

ARTICLE I
ACRONYMS AND DEFINITIONS

1.01 "ABC"

Agency Benefits Coordinator

1.02 "BA"

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

1.03 "CDHP"

Consumer Directed Health Plan

1.04 "COBRA"

Consolidated Omnibus Budget Reconciliation Act

1.05 "DC-FSA"

Dependent Care (daycare) Flexible Spending Account

1.06 "Effective Date"

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

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

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

(C) For employees who enroll during the Plan's annual enrollment period, the effective date is January 1 of the next plan year. For example, if you enroll during annual enrollment in October 2023, your benefits would begin on January 1, 2024.

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

1.07 "FMLA"

Family Medical Leave Act

1.08 "FSA"

Healthcare Flexible Spending Account

1.09 "HIPAA"

Health Insurance Portability and Accountability Act

1.10 "HSA"

Health Savings Account

1.11 "IRC"

Internal Revenue Code

1.12 "IRS"

Internal Revenue Service

1.13 "L-FSA"

Limited Purpose Flexible Spending Account

1.14 "OTC"

Over the counter

1.15 "Plan Year"

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

ARTICLE II
MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)

The Medical Flexible Spending Account (FSA) allows you to pay for certain unreimbursed medical, dental, vision, and over-the-counter expenses with up to $2,850 of pre-tax dollars. You participate in the program by enrolling during annual enrollment. New employees must enroll within 31 days of their employment, re-hire, or reinstatement. Employees who become insurance eligible mid-year must enroll within 31 days of becoming eligible for the benefits. You must enroll each year during annual enrollment for the following plan year in which you wish to participate. Enrollment is not automatic. You must take an active role in both re-enrolling each year and determining the contribution amount that is best for you. There is no minimum annual enrollment amount; however, the maximum enrollment amount is subject to change each year per the IRS. For 2023, the maximum contribution amount allowed by the State and Higher Education institutions is $2,850.

When you enroll in this account, you must decide how much of your wages for the year you wish to contribute to this account to pay for medical, dental, vision or certain qualified, prescribed-by-a-physician over–the-counter (OTC) expenses that would otherwise be paid out of your pocket. These expenses may be for your spouse and other tax -qualified dependents as well as for yourself. Plan your amount carefully since the amount elected is an irrevocable election for the plan year. IRS regulations do not authorize the State to refund or reimburse all or a portion of your contributions to the plan because you have overestimated your expenses or do not want to use the entire amount of contribution.

The funds you contribute to the FSA will be deducted before taxes from each paycheck you receive throughout the year. The amounts deducted may not always be equal. The full amount of your payroll deduction election will be available to you for use on January 1.

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

2.01 What dependents are covered under the FSA?

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

individual who is the employee's son, daughter, stepson, stepdaughter, individuals adopted or placed for adoption with the employee, and eligible foster child.

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

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

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

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

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

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

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

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

Refer to eligible healthcare expenses from IRS Publication 502 or on the claims administrator's website, which can be found on the Benefits Administration website at https://www.tn.gov/partnersforhealth.html. Some of these may be covered with a letter of medical need from your physician

2.03 When is an expense incurred?

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

2.04 What is my period of coverage?

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

2.05 Are insurance premiums eligible for pre-tax reimbursement under this account?

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

2.06 Can I change the amount I am contributing to the FSA during the year?

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

2.07 What status changes allow mid-year election changes?

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

(A) Change in employee's legal marital status

(1) Marriage

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

(B) Change in number of employee's dependents

- (1) Birth, adoption, or placement for adoption
- (2) Death of dependent

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

- (1) Termination or commencement of employment
- (2) strike or lockout
- (3) commencement of or return from an unpaid leave of absence
- (4) a change in worksite
- (5) switching from salaried to hourly, union to non-union or full-time to part-time (or vice versa)
- (6) incurring a reduction or increase in hours of employment
- (7) any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit

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

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

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

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

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

- (1) Attaining a specified age
- (2) Family Medical Leave Act (FMLA) leave
- (3) Judgments, decrees or orders
- (4) Entitlement to Medicare or Medicaid (not Medical Assistance)

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

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

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

2.08 What about mid-year enrollment for new employees?

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

2.09 How do I submit requests for reimbursement?

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

The first option is to enter your reimbursement request online. After entering the request online, the documentation to substantiate the request can then be uploaded to the claims administrator's website or faxed or mailed to them (see the section on acceptable documentation). All on-line claims entry must be completed, and documentation uploaded and/or received by the claims administrator by the plan year claim submission deadline of April 30th of the following year. Up to $570 (maximum) of unused funds in the medical FSA and L-FSA may be carried over into the next plan year.

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

If you prefer, the second option for receiving reimbursement for your eligible FSA expenses is to complete a Reimbursement Request Form. Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form either via fax or mail. Attach a statement from the provider indicating the date the service was provided, a description of the service, and the charge for the service (see the section on acceptable documentation). Reimbursement forms are available on the claims administrator's website.
If you submit requests for reimbursements either on-line or using the reimbursement form, expenses will be reimbursed to you weekly if you are a University of Tennessee employee; all other higher education and state employees are reimbursed daily. If you do not receive reimbursement within two

weeks of submitting your request and you have not been notified of the denial of your claim, contact the claims administrator.

The third way to access funds is to use your flexible spending account debit card. The debit card will reimburse up to the available FSA balance, including any carried over funds, if applicable. When the card is used, the merchant is paid the full amount of the charge (not to exceed the account balance) and your FSA is reduced by the same amount. When you use your debit card for reimbursement, you are certifying that the debit card is being used only for eligible medical expenses for yourself and/or your eligible dependents and that the expenses paid with the card have not been and will not be reimbursed by another health plan. You should not use the debit card to pay for expenses whose date of service is from a previous plan year, regardless of the billing date by the provider. If you do so in error, please contact the claims administrator for assistance.

2.10 Using the Flexible Spending Account debit card correctly

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

2.11 Providing debit card transaction substantiation

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

In addition, if your card is on hold for a debit card transaction and you submit a manual claim for reimbursement, your claim will automatically be used to offset the transaction for which the card is on hold (as long as the on hold transaction and the date of service on the manual claim occurred in the same plan year). Further, if the FSA claims administrator contacts you to request substantiating documentation for a claim and you do not provide

the requested information in a timely manner, your debit card may be placed on hold until such documentation is provided. This means that your debit card will not work when you attempt to use it at a pharmacy, physician's office or similar. If the substantiation, repayment, or offset is not provided, the amount may be included as wages on your W-2.

Acceptable documentation

Acceptable documentation is an itemized receipt or Explanation of Benefits (EOB) that reflects the actual date of service or product purchase, description of service or product, and patient portion of the charges. Please note that the following are not sufficient forms of documentation for most expenses: cancelled checks, copies of checks, cash register/credit card receipts, credit card
statements, predetermination or estimate of insurance benefits forms, balance forward statements, statements from your dentist or other provider that say, "estimated insurance amount," and balance due statements.

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

Over the Counter (OTC) Medicines

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

2.12 How are expenses paid through the FSA?

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

The plan will pay the lesser of:

• The amount of the expense you are submitting, or

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

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

2.13 Is there a minimum reimbursement request amount?

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

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

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

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

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

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

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

Yes, up to a certain amount. In accordance with IRS regulations and effective with the 2017 plan year, the FSA now includes a carryover feature. The IRS allows up to $570 to carry over from one plan year to the next. Therefore, if you are an active participant in the 2023 FSA plan on December 31, 2023 any funds in your account up to and including $570 of unreimbursed money will carry over from your 2023 FSA to be used in 2024. If your balance at the end of the plan year is greater than $570, any funds remaining in the account over the $570 carryover limit will be forfeited. These are IRS rules. However, if you carryover funds from one plan year to the next and participate in a CDHP in the next year, you will not be eligible to contribute to an HSA.

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

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

2.18 What happens to forfeited money?

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

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

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

Tips to Prevent Forfeiture If You Over-Estimate
By December 31st of each year (for you and your family):

- Get eye exams
- Buy a pair of glasses or prescription eyeglasses
- Stock up on contact lenses
- Get your teeth cleaned
- Fill prescriptions early, before the end of the year if able

Expenses incurred after your termination date will not be reimbursed.
Federal regulations (COBRA), allow you to continue participation in the FSA and L-FSA by electing to continue contributions to the plan through monthly payments, on an after-tax basis. You will receive notification of your right to continue and how to make the appropriate election upon termination of employment.

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

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

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

(A) You must be qualified. The following people qualify for continuation:
An employee (and any covered dependents) whose coverage would otherwise end due to: (1) termination of employment for a reason other than gross misconduct (2) reduced hours.
An employee's surviving spouse and/or children, whose coverage would otherwise end due to the employee's death, divorce or children who lose their dependent status.
Exception: Continuation is not available to any employee, spouse, or dependent who as of the date of the status change has "overspent" the FSA. An account is overspent when more dollars have been reimbursed than have been deducted from a participant's paycheck as of the status change.

(B) You must pay the monthly cost. A person who elects continuation will be required to pay the entire cost of the continued coverage plus any administrative fees that your employer (state or higher education

institution) has been paying to the claims administrator on your behalf. For instance, if you have a bi-weekly payroll deduction of $25.00 then the monthly COBRA
premium due to the claims administrator would be $50.00 plus any additional administrative fee charged by the claims administrator.

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

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

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

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

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

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

If during the leave of absence, you continue to receive regular pay, sick pay, or vacation pay from the State of Tennessee or a participating higher education institution, your contributions to and coverage under the FSA will continue. If you are in an active pay status, then you will stay enrolled until you terminate or at the end of the plan year.
When you return to work, you can change your election amount due to a qualified status change, if applicable. Otherwise, your remaining pledge balance will be recalculated based on the number of paychecks remaining in the year and payroll deductions will resume. The event of returning to work is not a qualifying reason to make a change in your election. The election change must be consistent with the status change. Your deductions will be adjusted to reflect the new amount. If you had a qualified status change and wish to change your FSA election upon returning to work, you must complete a Flexible Benefits Family Status Change Application to adjust your election. This form must be received by Benefits Administration within 31 days of your return-to-work date.

2.23 What will happen to my FSA when I retire?

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

If you want to extend your participation in the FSA when you retire
You can elect and pay COBRA continuation payments until you can submit expenses for the election amount. Extending your period of coverage will give you more time to incur eligible expenses, thus providing you with more opportunity to claim reimbursements from your account. If you elect to pay COBRA payments through the balance of the plan year in which you retire, you may be eligible to have up to $570 of the unused balance in your account carry over to the new plan year. In this situation, the funds may be used on dates of service up to 18 months following your retirement date, or until the funds are depleted - whichever occurs earliest.

If you choose to terminate your FSA

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

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

On your federal tax return, only your uninsured medical, behavioral health, dental and vision expenses in excess of 10 percent of your adjusted gross income are deductible. However, under the FSA, up to $2,850 of your uninsured medical, behavioral health, dental, vision and over-the-counter expenses can be paid with pre-tax dollars. In addition, under current law, you don't pay Social Security taxes on dollars directed to your FSA. Therefore, if you expect to incur uninsured medical and dental expenses, paying for them through the FSA is likely to be more advantageous than taking a deduction for those expenses on your tax return – particularly if your medical expenses paid out-of-pocket do not exceed 10 percent adjusted gross income (AGI).

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

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

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

In this situation you may only enroll in a limited-purpose FSA. IRS rules surrounding a HDHP stipulate that in order to be eligible to contribute to an HSA, the individual cannot have access to, or enroll in, a FSA. You can, however, elect to have a "limited purpose" FSA (L-FSA) that can be used to reimburse up to $2,850 in eligible dental or vision expenses. This L-FSA allows your spouse to still
maintain HSA eligibility. If you want to enroll in the L-FSA, you may do so each fall during the Annual Enrollment period or within 31 days of your hire date.

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

2.27 Formal COBRA Notice for FSA Participants

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

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

For the FSA and L-FSA, COBRA coverage will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for FSA or L-FSA COBRA coverage that will be charged for the remainder of the plan year.

2.28 What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

2.29 Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

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

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

then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

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

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

2.30 What is a Qualifying Event?

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

(A) The death of a covered Employee.

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

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

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

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

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

2.31 What is the Procedure for Obtaining COBRA Continuation Coverage?

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

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

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

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

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

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

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

(B) Death of the employee,

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

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

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

IMPORTANT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For FSA and L-FSA, participants with underspent accounts can receive FSA and L-FSA COBRA coverage only through the end of the plan year in which the COBRA qualifying event occurs. However, qualified beneficiaries who continue COBRA coverage through December 31 of that plan year may carry over up to $570 of unused FSA and L-FSA amounts remaining at the end of the plan year, in accordance with the carry-over provisions set forth in this document, until the end of the 18, 29, or 36-month maximum COBRA coverage period that applies under the other medical plan or until the amounts are used up, if earlier.

2.37 Does the Plan Require Payment for COBRA Continuation Coverage?

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

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

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

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

Timely Payment means a payment made no later than 45 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan,

covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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

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

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

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

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

2.41 KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

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

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

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

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

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

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

2.42 May I request a refund of my contributions to the plan if I do not use them?

No, IRS regulations do not allow for a refund of your contributions to the plan simply because you do not use them.

ARTICLE III
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DC-FSA)

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

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

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

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

As you incur eligible dependent care (daycare) expenses, fill out a Reimbursement Request Form (found on the claims administrator's website), itemize your expenses including the name and Tax ID# of your dependent care provider (or social security number for an in-home provider), and either enter the information online, scan and upload the documentation or fax or mail it to the claims administrator. A reimbursement check will be mailed to your home or deposited directly in your bank account if you have signed up for direct deposit. (See the section titled How do I submit requests for reimbursement?). IRS regulations do not authorize the State to refund or reimburse all or a portion of your contributions to the plan because you have overestimated your expenses or do not want to use the entire amount of contribution.

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

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

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

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

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

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. Contact the Claims Administrator for more information.

If the expenses are incurred for a Qualifying Individual who is not under age 13 who is your qualifying child, then the Qualifying Individual must spend at least 8 hours per day in your household.

In addition, a qualified dependent must meet both of the following conditions:

1. Your home is the dependent's "principal abode" for more than one half of the year. Special rule for child of divorced or separated custodial parent. The child of a divorced or separated employee who has custody (more than 50% of the time) of the child is treated as a qualifying child of the employee.
2. He or she must be a citizen or resident of the United States or a resident of Canada or Mexico.

The qualified dependent cannot be the qualified dependent of any other taxpayer in the taxable year.

3.02 How much would the plan's tax savings increase my take-home pay?

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

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

Sample Annual Tax Savings Comparison

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

Dependent care expenses paid after tax	(5,000)	-
Spendable income after taxes and dependent care expenses	**58,110**	**59,595**

3.03 What dependent care (daycare) expenses qualify?

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

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

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

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

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

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

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

Often times, parents find that their needs and plans change in unanticipated ways after the birth of a baby or adoption. For example, the mother may not return to work as soon as expected. If this happens to you, and deductions are already coming out of your check, you may not be able to change your election and may end up forfeiting money.

3.05 When is an expense incurred?

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

3.06 What is my period of coverage?

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

3.07 What is the maximum amount of dependent care expenses that may be reimbursed through the DC-FSA?

The calendar year maximum for this plan is $5,000 in dependent care (daycare) expenses for one or more dependents. This is a family maximum set by the IRS, so if your spouse also participates in a dependent care expense account, your $5,000 maximum must be reduced by your spouse's dependent care contribution for the year.

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

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

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

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

your spouse has worked for part of the year, the maximum income exclusion may be reduced as a result of your spouse's lack of earnings.

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

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

3.08 What qualifies as a dependent care eligible expense?

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

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

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

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

Generally, no—you may not begin, stop, or change your contribution amount during the year. You must decide during annual enrollment how much you wish to direct to your DC-FSA during the coming year. However, there

are some specified status changes in the federal regulations that allow changes or mid-year enrollment status changes. Otherwise, flexible benefit enrollments are irrevocable during the plan year.

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

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

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

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

(C) Change in employment status of employee, spouse, or dependent that affects eligibility
- (1) Termination or commencement of employment
- (2) strike or lockout
- (3) commencement of or return from an unpaid leave of absence
- (4) a change in worksite
- (5) switching from salaried to hourly, union to non-union or full-time to part-time (or vice versa)
- (6) incurring a reduction or increase in hours of employment
- (7) any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit
- (8) Unpaid leave
- (9) Termination and rehire within 30 days (amount of election at the time of termination must be reinstated unless another event has occurred that allows a change)
- (10) Termination and rehire after 30 days – employee may make new elections (the new election cannot be less than the amount the employee had contributed through payroll contributions nor less than the amount the employee had been reimbursed for eligible expenses)
- (11) Commencement or termination of employment by employee, spouse, or dependent that triggers eligibility

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

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

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

3.11 What about mid-year enrollment for new employees?

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

3.12 How do I submit requests for reimbursement?

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

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

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

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

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

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

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

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

Your final reimbursement request for expenses incurred during the plan year must be received by the claims administrator by the plan year claim submission deadline of April 30th of the following year. There is no carryover provision for the DC-FSA, so any funds remaining in your account after April 30th will be forfeited per IRS rules. Requests for reimbursement or faxes received after the deadline will not be processed and any money remaining in your account will be forfeited as required by federal law.

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

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

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

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

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

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

3.16 Is there a minimum reimbursement request amount?

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

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

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

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

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

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

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

3.20 What happens to forfeited money?

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

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

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

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

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

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

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

3.24 What happens if I take a leave of absence?

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

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

Due to the increasing complexity of the Federal and state tax codes, deciding which of these two options is most advantageous is a very complex issue. Generally, the more taxable income a person has, the greater the likelihood that the DC-FSA will result in the greatest tax advantage. However, there are other factors to consider, such as

the number of eligible dependents you have, or the amount of qualifying dependent care expenses you incur. If you have one eligible dependent, up to $3,000 of qualifying expenses may be used to calculate the credit, alternatively, you could set aside up to $5,000 in the DC-FSA. If you have two or more eligible dependents, up to $6,000 of qualifying expenses may be used to calculate the credit, while you can still only set aside up to $5,000 in the DC-FSA. For more information, consult with a qualified tax advisor or professional.

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

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

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

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

3.27 What about earned income tax credits (EIC)?

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

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

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

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

3.29 May I request a refund of my contributions to the plan if I do not use them?

No, IRS regulations do not allow for a refund of your contributions to the plan simply because you do not use them.

ARTICLE IV

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (L-FSA)

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

The limited purpose flexible spending account (L-FSA) is provided for state and higher education employees who are enrolled in the consumer directed health plan (CDHP). Eligible employees may contribute up to $2850 in pre-tax funds in order to save on certain IRS approved vision and dental expenses. For instance, if you are enrolled in a CDHP you must pay all plan expenses up to your plan's applicable deductible and then you are responsible for coinsurance. When you enroll in a CDHP, a health savings account (HSA) is opened for you with the state group insurance program's contracted partner for HSA services. Because you and/or your employer may fund your HSA with pre-tax dollars, you are not allowed to open a regular healthcare FSA. This is called "double dipping" and it is not allowed per IRS rules. However, for plan members or those with families who anticipate large dental (e.g. orthodontia) or vision expenses during the year or possible certain vision or dental expenses not covered by insurance (e.g. LASIK), you may fund up to $2,850 in your L-FSA to pay for those expenses. The full amount of your payroll deduction election will be available to you for use on January 1. IRS regulations do not authorize the State to refund or reimburse all or a portion of your contributions to the plan because you have overestimated your expenses or do not want to use the entire amount of contribution.
Expenses may be paid at many dental and vision providers using your L-FSA debit card or you may go online and pay your provider by utilizing the claims administrator's online feature to pay your provider directly from your account. Or you may pay for eligible expenses with cash, check or your personal credit card, then submit a claim to pay yourself back. It is best, however, not to use your debit card to pay for vision or dental expenses at the time of service. Rather, let your provider file the claim through your insurance, then after you get an explanation of benefits (EOB) from your insurance, you can either call your provider and pay over the phone using your debit card or file a claim to pay your provider. It is best to have an EOB in case your debit card is used, in order to provide substantiating documentation to the claims administrator. You can even have your claim payment deposited directly into your checking or savings account. The claims administrator even offers a mobile app that allows you to manage your account, view alerts, and snap a photo of your receipts and upload them to submit claims.

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

Yes, up to a certain amount. In accordance with IRS regulations and effective with the 2017 plan year, the L-FSA now includes a carryover feature. The IRS allows up to $570 to carry over from one plan year to the next. For example, if you are an active participant in the 2023 FSA plan on December 31, 2023 and contributed your full election amount, up to $570 of unreimbursed money will carry over from your 2023 L-FSA to be used in 2024. If your balance at the end of the plan year is greater than $570, any funds remaining in the account over the $570 carryover limit will be forfeited. These are IRS rules.

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

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

4.03 What is my period of coverage?

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

4.04 What happens to forfeited money?

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

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

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

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

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

4.07 May I request a refund of my contributions to the plan if I do not use them?

No, IRS regulations do not allow for a refund of your contributions to the plan simply because you do not use them.

ARTICLE V

PARKING AND TRANSPORTATION REIMBURSEMENT PLAN (STATE EMPLOYEES ONLY)

The Parking & Transportation (P&T) Reimbursement Plan (for state employees only) is another way to get the most money from your paycheck. The plan allows you to pay for qualified work-related transportation expenses with money that is sheltered from taxes by deducting the funds from your pay before it is taxed. Since less of your pay is taxed, you should come out ahead at the end of the year. This plan is governed under Section 132 of the Internal Revenue code and therefore, certain rules and guidelines apply, so be sure you fully understand the program before you choose to participate. IRS regulations do not authorize the State to refund or reimburse all or a portion of your contributions to the plan because you have overestimated your expenses or do not want to use the entire amount of contribution.

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

5.01 Who is eligible for the plan?

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

5.02 What is my period of coverage?

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

5.03 How it works

Unlike Medical and Dependent Care Flexible Benefits Accounts, there is no requirement for new employees to enroll within 31 days of being hired and there is no annual enrollment period for employees. A state employee may enroll in a Transportation Account and/or a Parking Account at any time during employment.
An employee may enroll by completing the appropriate form and faxing to 615-741-8196. The form can be accessed at https://www.tn.gov/partnersforhealth/other-benefits/flexible-benefits.html.

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

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

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

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

The maximum contribution amount is:

- $280 f or the parking account, and
- $280 for the transportation account

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

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

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

- you can't spend more than $280 of your parking account funds in a month, even if you have a balance greater than $280; and
- you can't spend more than $280 of your transportation account funds in a month, even if you have a balance greater than $280

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

5.07 Can I combine my parking and transportation contributions?

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

5.08 Filing Claims and Getting Reimbursed

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

Sample Paycheck Comparison

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

Compensation after tax	$22,679	$22,463
Bus pass expenses paid after tax	(300)	0
Spendable income after taxes and bus pass expenses	$22,379	$22,463

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

5.09 May I request a refund of my contributions to the plan if I do not use them?

No, IRS regulations do not allow for a refund of your contributions to the plan simply because you do not use them.

5.10 What are some of the expenses for which I may request reimbursement?

The Transportation FSA and Parking FSA are used to pay for certain work-related commuting and/or parking expenses, such as mass transit vehicles and passes (e.g., bus, commuter vanpool) used to commute to and from your workplace and for vendor parking lots and garages while at work. These accounts may not be used for parking or transportation expenses incurred while on personal time, nor may they be used for fuel, oil changes, car repairs or similar vehicle servicing and upkeep. Payroll contributions will not be refunded. You must have eligible expenses to be reimbursed your contributions.

ARTICLE VI
PAYROLL DEDUCTION ACCOUNT (PDA)

6.01 Is there a limitation on the amounts of transportation expenses that may be deducted on a pre-tax basis?

Yes, and these limits are subject to change by the IRS each year. For 2023, the limits are $280 per month for qualified parking expenses and $280 per month for qualified transportation expenses. Participants' elections will not be monitored by Benefits Administration or the State; it is your responsibility to ensure that you do not exceed the maximums allowed by law.

6.02 How are payments for payroll deducted transportation expenses handled?

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

6.03 Can I change my PDA?

Yes, you can cancel or change your participation in the PDA at any time.

6.04 How long do I have to file claims?

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

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

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

ARTICLE VII
NOTICE OF PRIVACY PRACTICES

7.01 Privacy of Protected Health Information and HIPAA Compliance

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

7.02 State of Tennessee Insurance Committee Certification of Compliance

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

7.03 Purpose of Disclosure to State of Tennessee Insurance Committee.

(A) The plan and any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the State of Tennessee Insurance Committee only to permit the State of Tennessee Insurance Committee to carry out plan administration functions for the plan not inconsistent with the requirements of HIPAA and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the State of Tennessee Insurance Committee of plan participants' protected health information will be subject to and consistent with the provisions of Sections 7.04 and 7.05 of this article.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) The following employees or classes of employees or other workforce members under the control of the State of Tennessee Insurance Committee may be given access to plan participants' protected health information received from the plan or a health insurance issuer or business associate servicing the plan:

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

(2) Other employees or subcontractors designated by the State of Tennessee Insurance Committee. This list includes the class of employees or other workforce members under the control of the State of Tennessee Insurance Committee who may receive plan participants' protected health information relating to payment under, health care operations of, or other matters pertaining to the plan in the ordinary course of business.

(B) The classes of employees or other workforce members identified in Section 7.05 (A) of this article will have access to plan participants' protected health information provided to the State of Tennessee Insurance Committee by the plan only to perform the plan administration functions that the State of Tennessee Insurance Committee provides for the plan.

(C) The classes of employees or other workforce members identified in Section 7.05 (A) of this article will be subject to the appropriate personnel policies of the State of Tennessee regarding disciplinary action for any use or disclosure of plan participants' protected health information provided to those employees by the State of Tennessee Insurance Committee in its capacity as plan sponsor in breach or violation of or noncompliance with the provisions of this article. The State of Tennessee Insurance Committee will promptly report such breach, violation or noncompliance to the plan, as required by Section 7.04 (D), (J) and (K) of this article and will cooperate with the plan to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.

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