Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. Health Plan

Plan Document

Revised May 1, 2017

TICUA Benefit Consortium has drafted this Plan Document and Summary Plan Description in good faith to comply with the requirements of the Affordable Care Act ("ACA"). However, the regulations and other guidance under the ACA may be interim, or in some cases, not yet promulgated. TICUA Benefit Consortium reserves the right to amend this Plan Document and Summary Plan Description, retroactively if deemed necessary, to comply with the ACA and the regulations and other guidance promulgated thereunder.

Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc.

Health Plan Document

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Section One
Introduction

This Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. Health Plan (the "Plan") shall be effective May 1, 2017. The Plan may be amended at any time, in whole or in part, by the Board of Directors.

The Plan has been approved by the Board of Directors of the Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. ("TICUA Benefit Consortium"). The Plan is intended to meet the requirements of:

- The Employee Retirement Income Security Act of 1974 ("ERISA"); and
- Section 501(c)(9) of the Internal Revenue Code of 1986 ("Code") and the Regulations promulgated thereunder.

This document and any amendments constitute the governing document of the Plan. This Plan is a multiple employer plan, designed and administered exclusively for the Members of the TICUA Benefit Consortium. You are entitled to this coverage if the provisions in the Plan have been satisfied. This Plan is void if You have ceased to be entitled to coverage. No clerical error shall invalidate such coverage if otherwise validly in force.

The Board of Directors intends to maintain the Plan indefinitely. However, the Board of Directors may modify or terminate the Plan at any time, and for any reason, as to any part or its entirety, and shall provide notice to Covered Persons of any such modification or termination of the Plan If the Plan is amended or terminated, You may not receive benefits described in the Plan after the effective date of such amendment or termination. Any such amendment or termination shall not affect Your right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, You may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA benefits. This may happen at any time. If this Plan is terminated, You will not be entitled to any vested rights under the Plan.

Advice on Reading this Document

Some of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this Document or in other relevant Sections. Becoming familiar with the terms defined in the Glossary will give You a better understanding of the procedures and benefits described.

Summary Plan Description

This Plan Document constitutes the Summary Plan Description required by ERISA Section 102.

The following information is provided to comply with Tennessee law. These health benefits are provided through the TICUA Benefit Consortium Health Plan, a self-funded qualified multiple employer welfare arrangement. Coverage and benefits provided under the TICUA Benefit Consortium Health Plan are not protected by the Tennessee Life and Health Insurance Guaranty Association. If the TICUA Benefit Consortium Health Plan does not pay expenses that are eligible for payment under the Plan for any reason, the Employer or Employee covered by the plan may be responsible for the payment of those expenses.

Section Two
Plan Identifying Information

Name of the Plan	Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. Health Plan
Type of Plan	Health and Welfare Plan
Funding Medium and Type of Plan Administration	Meritain Health, Inc. ("Meritain") is the Claims Administrator and processes claims under the Plan. Meritain does not serve as an insurer, but merely as a claims processor. 300 Corporate Parkway Amherst, NY 14226 (800) 828-6922 TICUA Benefit Consortium receives contributions from Members and Participants, and holds those assets in trust for the exclusive benefit of Participants and Dependents. Claims are paid out of these assets.
Address of Plan	Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. 1031 17th Avenue South Nashville, TN 37212 (615) 292-3535
Plan Administrator and Agent for Service of Legal Process	C. Gregg Conroy
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. EIN – 62-1859075
Plan Effective Date	May 1, 2001
Restatement Effective Date	May 1, 2017
Plan Renewal Date	May 1 of each year
Plan Year End	April 30

Named Fiduciary	The Board of Directors of the TICUA Benefit Consortium
Claims Administrator	Meritain Health, Inc. 300 Corporate Parkway Amherst, NY 14226 (800) 828-6922
Prenotification Provider	Quantum Health, Inc., dba, Coordinated Care Programs LLC P. O. Box 229 1215 Polaris Parkway Columbus, OH 43240-9902 (877) 498-6689 (800) 973-2321 - FAX
Board of Directors	**Chair:** Gary Carter – Union University **Secretary:** Greg Eller – Christian Brothers University **Treasurer:** George Ninan – Memphis College of Art

The benefits and coverages described herein are provided through a trust established by the TICUA Benefit Consortium. Excess insurance is provided by a licensed insurance company to cover high dollar medical claims. The Trust is not subject to any insurance guaranty association. The Trust is monitored by the Tennessee Department of Commerce and Insurance. Other related financial information is available from the TICUA Benefit Consortium.

TICUA Benefit Consortium Members are responsible for funding all covered claims under the Trust.

Section Three
Schedule of Benefits
Effective May 1, 2017

All benefits below are subject to the Plan's terms and conditions, including Deductibles, Copercentages, In Network discounts and Allowable charges. Benefit percentages payable by the Plan may change depending upon whether Covered Services are obtained from an In Network Provider. The list of In Network Providers may change from time to time. You may request a list of In Network Providers at any time. Therefore, it is important to verify that the Provider who is treating You is currently an In Network Provider. See Section Four for more details.

Note: Prenotification is required for all non-emergency Hospital admissions and some diagnostic procedures, whether Inpatient or Outpatient. See Section Five for more details. The penalty for non-compliance with Prenotification requirements is $250 per occurrence.

Note: The Deductibles and Annual Maximums are combined for both In Network and Out of Network Providers. However, the Out of Pocket Limits are not combined for In Network and Out of Network Providers.

General Provisions

	$400 Deductible Benefit		**$1,000 Deductible Benefit**		**QHDHP Benefit****		**Office Visit Copay Benefit**	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Plan Year Deductibles								
Individual	$400	$800	$1,000	$2,000	$2,500	$5,000	$300	$600
Family	$1,200	$2,400	$3,000	$6,000	$5,000	$10,000	$900	$1,800
Benefit Percentage Payable After Satisfaction of the Deductible (unless specified otherwise)	80%	50%	80%	50%	80%	50%	80%	50%
Plan Year Out of Pocket Limits (including Deductible)								
Individual	$1,200	$12,000	$2,000	$12,000	$5,000	$12,000	$2,000	$12,000
Family	$3,600	$36,000	$6,000	$36,000	$10,000	$36,000	$6,000	$36,000

Note: Your Out of Pocket (OOP) Limits under the Plan are less than those allowed under the ACA and the IRS for a Qualified High Deductible Health Plan. The ACA/IRS OOP Limits are the lower of the Out of Pocket Limits as set by the IRS and the ACA, which in 2017 are $6,550 for an Individual and $13,100 for a Family. Expenses incurred for the following will not be applied toward the Plan's or the ACA/IRS OOP Limits: (1) Non-Covered Services, as set forth in the Limitations and Exclusions section of this Plan, (2) Premiums and (3) Balance Billing. Additionally, Prenotification penalties will not be applied towards the Plan's OOP Limits, but copayments and Prenotification penalties will be applied towards the ACA/IRS OOP Limits.

*Under § 1302(c)(1) of the ACA the Individual OOP limit applies to each Individual, regardless of whether the Individual is enrolled in Individual coverage or Family coverage.

** **Qualified High Deductible Health Plan** means a "high Deductible health plan" as defined in IRC § 223(c)(2), as may be amended from time to time. Individual Deductible limit does not apply to Employee plus One or Employee plus Family coverage.

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Allergy Testing and Treatments	80%	50%	80%	50%	80%	50%	80%	50%
Ambulance Service[1]	80%	50%	80%	50%	80%	50%	80%	50%
Convalescent, Extended Care, Rehabilitation and Skilled Nursing Facilities *Maximum Annual Benefit 120 days per Plan Year, unless Prenotified*	80%	50%	80%	50%	80%	50%	80%	50%
Home Health Care *Maximum Annual Benefit 50 days per Plan Year*	80%	50%	80%	50%	80%	50%	80%	50%
Hospice Care	80%	50%	80%	50%	80%	50%	80%	50%
Hospital Services	80%	50%	80%	50%	80%	50%	80%	50%
Covered Room & Board charge	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate
Special Care Unit	80%	50%	80%	50%	80%	50%	80%	50%
X-rays and Other Outpatient or Miscellaneous Services	80%	50%	80%	50%	80%	50%	80%	50%
Emergency Room (Out of Network will be paid as if the services were provided In Network when service is provided in connection with an Emergency Medical Condition)	80%	80%/50%	80%	80%/50%	80%	80%/50%	80%	80%/50%
Maternity Care *Limit 2 ultrasounds, sonograms, etc.*	80%	50%	80%	50%	80%	50%	80%	50%

[1] Ambulance Services provided Out of Network will be paid as if the services were provided In Network when the Ambulance Service is provided in connection with an Emergency Medical Condition and the Ambulance Service was provided outside of the Covered Person's control or election.

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Laboratory Charges(Non-hospital)[§] • Blood testing • Urine testing • Cytology and Pathology (e.g. Pap smears, biopsies) • Cultures (e.g., throat culture)	100%	50%	100%	50%	100% after Deductible	50%	100%	50%
Mental Health Condition								
Inpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Occupational/Physical/ Speech Pathology Therapy *Maximum Annual Benefit 60 visits per Plan Year (for each type of therapy) (Treatment plan must be Prenotified)*	80%	50%	80%	50%	80%	50%	80%	50%

[§] 100% coverage for Outpatient Laboratory Charges and any Deducible, other than the QHDHP Deductible, will be waived when performed at an In Network lab. This does not apply to lab work performed by a hospital on an inpatient or outpatient basis, which may be covered in accordance with other applicable Plan provisions. Note: Any related specimen collection charges are subject to the Plan's normal Deductibles and Co-payments.

To ensure Outpatient Laboratory Charges services are paid at 100%, You should do the following:

1. If Your doctor is collecting Your sample in the office, ask that it be sent to a participating In Network Lab;
2. If Your doctor is sending You to a lab for the testing, contact the Care Coordinators at the number on Your Plan ID Card, visit www.ticua.org/tbc for a list of In Network labs, or ask for a Lab requisition form to an In Network Lab.

80% coverage for Out of Network Outpatient Laboratory Charges when performed outside the Covered Person's control or election. Please see Section 9, Covered Services, for additional information relating to Diagnostic Charges and Pre-Admission Testing.

[**] For a Covered Person's designated In Network Primary Care Provider (PCP) (see Section Four for instructions on designating a PCP with the Plan) or for an In Network Specialist to whom **the Covered Person's PCP has notified the Plan of a referral**, Office Visit charges under the $400 and $1,000 Deductible Benefit Options are paid without application of any Deductible. For the QHDHP benefit option, Office Visit charges are paid at 90% once the Deductible has been met.

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Office Visits *(Includes office visits during which routine diagnostic procedures are performed)*[***]								
Designated Primary Care Provider (PCP) and Pre-notified Specialist Office Visits[**] *(This amount also applies to Minor Surgery performed by a PCP during an Office Visit. All other Minor Surgery procedures will be paid as shown elsewhere in the schedule of benefits.)*	85%	50%	85%	50%	90% after Deductible	50%	100% after $20 Copay[***]	50%
All Other Office Visits	80%	50%	80%	50%	80%	50%	100% after $30 Copay[***]	50%
Outpatient Surgical Services	80%	50%	80%	50%	80%	50%	80%	50%
Physician's Services *(not elsewhere identified in the schedule of benefits)*	80%	50%	80%	50%	80%	50%	80%	50%
Second Surgical Opinion	100%	50%	100%	50%	100%	50%	100%	50%
Non-Surgical Back Treatment *Maximum Annual Benefit 60 visits per Plan Year (Treatment plan must be Prenotified)*	80%	50%	80%	50%	80%	50%	80%	50%
Substance Use Disorder								
Inpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Care	80%	50%	80%	50%	80%	50%	80%	50%

[***] Office Visit Copayments do not apply to the Deductibles or Plan's Out of Pocket Maximums. Copayments do apply to the ACA/IRS OOP Limits; see Note, pg. 4, for further information concerning Out of Pocket Limits.

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Preventive Care Benefits								
Note: Preventive Care Benefits are Not Subject to Deductible. Benefit equals 100% of charge.								
Coverage for preventive services with a rating of A or B from the U.S. Preventive Task Force; found at http://www.uspreventiveservicesstaksforce.org								
Annual Physical Examination for Adults	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
Colonoscopy								
Age < 50	None	No Benefit	None	No Benefit	None	No Benefit	None	No Benefit
Age 50+	One test every five Plan Years	No Benefit	One test every five Plan Years	No Benefit	One test every five Plan Years	No Benefit	One test every five Plan Years	No Benefit
Hemocult	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit
Immunizations (All ages)	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
Mammography*								
Age < 30	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Age 30-39	100% of one baseline mammogram	No Benefit	100% of one baseline mammogram	No Benefit	100% of one baseline mammogram	No Benefit	100% of one baseline mammogram	No Benefit
Age 40-49	100% of one every other Plan Year	No Benefit	100% of one every other Plan Year	No Benefit	100% of one every other Plan Year	No Benefit	100% of one every other Plan Year	No Benefit
Age 50+	100% of one per Plan Year	No Benefit	100% of one per Plan Year	No Benefit	100% of one per Plan Year	No Benefit	100% of one per Plan Year	No Benefit
Pap Smear Cytology *One test per Plan Year*	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit

Note: Effective March 1, 2017, Mammography coverage now includes digital tomosynthesis (3D mammograms).

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
PSA Blood Test								
Age <50	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Age 50+	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit
Well Child Visits	100%	50%	100%	50%	100%	50%	100%	50%
Well Woman Visits	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit

Note: All percentages noted above are subject to Deductibles and Allowable fees, unless otherwise noted. Allowable charges for In Network Providers will conform to the pricing/fee arrangements contracted with them.

Note: Covered Services obtained from an Out of Network Provider will be covered at In Network percentages and rates if the Covered Person was referred to an Out of Network Provider by the treating In Network Provider, subject to receipt of a letter of Medical Necessity by the referring Physician. Covered Services will also be considered at In Network levels if an accident, Injury or Illness occurs and immediate services are required inside or outside the Network covered area.

Note*:* Out of Network Providers of ancillary services (assistant surgeons, lab, radiology, anesthesia, Durable Medical Equipment, and Emergency room Physicians) will be paid at the In Network level when rendered at a Network facility or the services were performed outside the Covered Person's control or election.

Prescription Drug Card

The Prescription Drug Card benefits under this Plan are provided through CVS/caremark Drug Card Network, which is separate and distinct from the medical PPO Network. For more specific details regarding covered and/or excluded Prescription Drugs, see Section Six.

This drug card allows the Covered Persons to receive discounts at In Network pharmacies. Prescription Drug Copayments are payable at the time a prescription is filled.

	$400 Deductible Benefit		**$1,000 Deductible Benefit**		**QHDHP Benefit**		**Office Visit Copay Benefit**	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Generic Drugs*	$20 Copayment, then 100%	No Benefit	$20 Copayment, then 100%	No Benefit	$20 Copayment after Deductible is met	No Benefit	$20 Copayment, then 100%	No Benefit
Brand-Name Drugs**								
Preferred	$35 Copayment, then 100%	No Benefit	$35 Copayment, then 100%	No Benefit	$35 Copayment after Deductible is met	No Benefit	$35 Copayment, then 100%	No Benefit
Non-Preferred	$50 Copayment, then 100%	No Benefit	$50 Copayment, then 100%	No Benefit	$50 Copayment after Deductible is met	No Benefit	$50 Copayment, then 100%	No Benefit
Mail Order* **	Twice the Copayment for a 90 day supply	No Benefit	Twice the Copayment for a 90 day supply	No Benefit	Twice the Copayment for a 90 day supply	No Benefit	Twice the Copayment for a 90 day supply	No Benefit

Except for covered drugs obtained under the QHDHP, covered drugs not obtained with the Prescription Drug Card will not be reimbursed by the Prescription Drug card or by the Plan. Prescription Drug benefits will be paid in accordance with the provisions of the Prescription Drug card contract.

*For a Covered Person engaged in the Plan's Chronic Conditions Program the copay for generic medications, when available, prescribed to treat the Participant's Chronic Conditions will be waived.

** For a Covered Person engaged in the Plan's Chronic Conditions Program the copay for brand medications prescribed to treat the Participant's Chronic Conditions will be reduced to 50% of the usual copay shown in the schedule.

See Section 6 for further information about the enhanced prescription benefit or call a Care Coordinator at 1-877-498-6689.

Note that required Copayments will be applied to the ACA/IRS Out of Pocket Limits.

Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card program elected by the TICUA Benefit Consortium and will not be subject to any limitations and exclusions under the major medical plan. The Prescription Drug Card Program is a separate benefit from the major medical plan.

Medicare Supplement Benefit

***Note*: The Plan requires that Medicare Eligible Covered Retirees and Retiree's Covered Dependents who enroll in Medicare Part B pay the premium for Part B.**

Services	*Medicare Pays*	*Plan Pays*	*You Pay*
Medicare Part A			
Hospitalization (Semi-private room, general nursing and miscellaneous services and supplies)			
First 60 days	All Medicare approved charges less Part A Deductible	The Part A Deductible	Any remaining charges
61-90th day	All Medicare approved charges less daily Copayment	The daily Copayment	Any remaining charges
91st day and after			
While using 60 lifetime reserve days	All Medicare approved charges less daily Copayment	The daily Copayment	Any remaining charges
Once lifetime reserve days are used: additional 365 days	$0	100% of Medicare eligible expenses	Any remaining charges

Services	*Medicare Pays*	*Plan Pays*	*You Pay*
Medicare Part A			
Skilled Nursing Facility Care (Medicare requires that You have been in a Hospital for at least 3 days and then enter a Medicare-approved Facility within 30 days after leaving the Hospital.)			
First 20 days	All Medicare-approved charges	$0	$0
21st - 100th day	All Medicare approved charges less daily Copayment	The daily Copayment	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as Your Physician certifies You are Terminally Ill and You elect to receive these services	All but very limited Copercentage for Outpatient drugs and Inpatient respite care	$0	Any remaining charges

Services	*Medicare Assumed to Pay*	*Plan Pays*	*You Pay*
Medicare Part B			
Medical Services Physician services Medical Supplies Ambulance Other Covered Services, including Outpatient Hospital	80% of Medicare approved charges less the Medicare Part B Deductible	The 20% Copayment plus the Medicare Part B Deductible.	Any remaining charges
Blood	All Medicare Approved charges less the Deductible (equal to costs for first 3 pints) each Calendar Year	Charges for the first 3 pints of blood	Any remaining charges
Clinical Laboratory Services Blood Tests For Diagnostic Services	100%	$0	$0

Medicare Part A and B			
Home Health Care			
Medicare approved services: Medically Necessary skilled care and supplies	100%	$0	$0
Durable Medical Equipment			
First $100 of Medicare approved amounts	0%	100% (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

Section Four
Cost Containment Procedures

Note: This Section and the following Section on Prenotification Procedures discuss Cost Containment Procedures and the Care Coordination Process based on a program called Coordinated Health/Care™, including the Prenotification requirement, when to Prenotify and the penalty for failure to Prenotify. Prenotification Claims Procedures are discussed in the Claims Procedures Section.

4.01 Preferred Provider Organization

The Plan Administrator has entered into an agreement with one or more networks of Hospitals and Physicians, called "PPO Networks." These PPO networks offer Covered Persons health care services at discounted rates. Using a PPO network provider will normally result in a lower cost to the Plan as well as to the Covered Person. In no event shall a PPO network provider or a non-PPO network provider be paid more by the Plan than the amount deemed by the Plan Administrator to be within the Applicable Plan Limit.

A PPO is a network of Hospitals, Physicians and other healthcare facilities that have agreed to accept set fees for providing medical services to Covered Persons if such Covered Person chooses to use them.

Contractual arrangements entered into by the Plan are intended to be for the exclusive benefit of the Plan and its Participants and Beneficiaries. If the Plan Administrator or Named Fiduciary, in its capacity as a fiduciary of the Plan and in accordance with ERISA, determines, in its discretionary authority, the contractual arrangements are not in the best interest of the Plan or violate applicable laws, the Plan Administrator or Named Fiduciary shall pay benefits in accordance with its Fiduciary duties regardless of any contractual arrangements to the contrary. Similarly, under ERISA §404(d), if any Plan documents, in the Plan Administrator's or Named Fiduciary's discretionary authority, contain provisions that are inconsistent with ERISA, including ERISA's Fiduciary duties, the Plan Administrator or Named Fiduciary is released from its obligation to administer the Plan in accordance with the conflicting provision.

Some PPO network provider Hospitals may have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the Plan will pay the PPO Network provider Hospitals' per diem or DRG rates; not to exceed the Allowable charges for such services, as determined by the Plan Administrator regardless of any contractual arrangement to the contrary.

A current list of PPO Network providers is available, without charge, through the website located at www.ticua.org/tbc. Covered Persons may also contact the PPO Network at the phone number on the Plan ID card.

4.02 Care Coordination Process

- **Introduction**

  The Plan incorporates a "Care Coordination" Process based on a program called Coordinated Health/Care™. This program includes a staff of Care Coordinators who receive a notification regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the Providers.

  Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and encourage early identification of complex medical conditions. The Care Coordinators are available to Covered Persons and their Providers for information, assistance, and guidance, and can be reached toll-free by calling:

Care Coordinators: 1-877-498-6689

- **Process of Care Requirements**

  The Care Coordination Process allows Covered Persons to receive the highest benefits available in the Plan. To take advantage of these increased benefits, Covered Persons must follow the "Care Coordination Process" outlined in this section. In some cases, failure to follow this process of care can result in benefit reductions and/or penalties for specific services. The Care Coordination Process generally includes:

  - Designating a coordinating Provider (Primary Care Provider, referred to as the PCP); and
  - Review and coordination process, including:
    - Referrals from a PCP for all visits to Specialist Physicians. (The PCP or Participant must notify the Care Coordinators of a proposed visit to a Specialist to get the highest benefit available under the Plan.)
    - Prenotification of certain procedures.
    - Utilization Review.
    - Concurrent Review of hospitalization and courses of care.
    - Case Management.

  As described below, referral and Prenotification authorizations are generally requested by the Providers on behalf of their Covered Persons.

  Overview

  Designated Coordinating Provider

  Upon enrollment, all Covered Persons are asked to designate a coordinating Primary Care Provider (PCP) for each member of their family. While such designation is not mandatory, it is strongly recommended. **For a Covered Person to obtain the highest benefit under this plan, and the most complete coordination of care, all Covered Persons are encouraged to designate an In Network PCP to be their Coordinating Provider.**

  The Care Coordination Process generally begins with the "coordinating Provider," who is a PCP who maintains a relationship with the Covered Person and provides general healthcare guidance, evaluation, and management. The following types of Providers can be selected by Covered Persons as their coordinating PCP:

  - Family Medicine Physician
  - Internal Medicine (general) Physician
  - Pediatrician (for children)
  - A Nurse Practitioner acting within the scope of their license and authority
  - An OB/GYN may serve as a PCP ONLY during the course of a woman's pregnancy
  - A Mental Health provider may serve as a PCP during the course of treatment for Mental Health Conditions and Substance Use Disorders as set forth in the Covered Services Section. Mental Health PCPs include Psychiatric Nurse Practitioners, Licensed Clinical Social Workers (LCSW), Licensed Master's Social Workers (LMSW) working under LCSW supervision, Licensed Professional Counselors with or without Mental Health Services Provider (HSP) Designation,

Licensed Psychological Examiners under supervision of Licensed Psychologist with HSP designation and Licensed Senior Psychological Examiners.

OB/GYN's are considered to be Specialists and not PCPs, as they typically do not provide general care regarding all body systems and family conditions, comprehensive preventive screening, and longitudinal tracking and care of non-OB/GYN-related symptoms and conditions. Most OB/GYN's state that they are a Specialist and NOT a PCP, and do not wish to be considered a PCP. For instance, You may ask Your OB/GYN if they want to treat sore ankles, chest pain, or chronic joint pain; generally, the OB/GYN will say no, and they are therefore not a PCP. However, if a Covered Person's OB/GYN wishes to serve as their PCP and agrees to provide comprehensive care for all body systems, longitudinal care and preventive screening, Coordinated Health/Care™ will list this Physician as the Covered Person's PCP and accept referral notifications from the OB/GYN to other Specialists.

Covered Persons are encouraged to begin all healthcare events or inquiries with a call or visit to a PCP, who will guide Covered Persons as appropriate. In addition to providing care coordination and submitting referral and Prenotification requests, the PCP will also receive notices regarding healthcare services that their designated Covered Persons receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If You have trouble obtaining access to a PCP, the Care Coordinators may be able to assist You by providing a list of available PCPs and even contacting PCP offices on Your behalf. Please contact the Care Coordinators at 1-877-498-6689.

Use of In Network Providers

As set forth in Section 4.01, the Plan offers a broad Network of Participating Providers and provides the highest level of benefits when Covered Persons utilize In Network Providers. The Network applicable to a Covered Person is indicated on his/her Plan identification card. **Services provided by Out of Network providers will not be eligible for the highest benefits**. Specific benefit levels are shown in the Schedule of Benefits.

Review and Coordination Process

The Care Coordination Process includes the following components:

- **Referrals for Specialty Care**

  It is recommended that the Covered Person begin every healthcare event with a call or visit to a PCP. If and when a PCP refers the patient to a sub-Specialist, he/she will submit a notification of this referral to Coordinated Health/Care™. The Covered Person's ID card alerts the PCP that "the patient receives the best benefits and/or coordination when You submit a notification that You are referring the patient to a Specialist." Referral notices can be submitted by any PCP, including Out of Network providers. (Please note: An office visit to an Out of Network provider would be covered at the Out of Network benefit level.) The referral will be authorized for a certain time period, number of visits, or number of units, as requested by the PCP. During the authorized period, further referrals are not required for additional visits or treatments associated with the initial referral.

  The Schedule of Benefits included in Section Three specifies the benefit difference which applies for specialty services that are received without an authorized specialty referral in place.

The PCP is responsible for submitting the referral notice with all required information to the Care Coordinators, who will process the referral and notify the PCP's office upon authorization. (PCP offices have been provided with materials and education regarding this referral process.) While the referral process is initiated by the PCP, the Covered Person is ultimately responsible for ensuring that the referral authorization is in place before the specialty visit. Whenever possible, notice of this referral is sent to the Covered Person; however, **Covered Persons can verify that the referral is in place by calling the Care Coordinators at 1-877-498-6689** or visiting the website on Your ID card. Referral submissions will not be accepted after the specialty service has been received except for Emergency Services. Please refer to the Emergency Services section below for additional information regarding those circumstances.

OB/GYN Office Visits: As noted above, OB/GYN Specialists are generally not considered to be PCPs. However, to ensure open and unhindered access to OB/GYN care, all office visits to OB/GYN Specialists receive the same benefit level as a PCP Office Visit. Covered Persons do not have to obtain a referral from a PCP to see their OB/GYN Specialist or receive the highest level of benefits for an Office Visit to an OB/GYN.

Mental Health provider Office Visits: As noted above, certain Mental Health providers may serve as a PCP during the course of treatment for Mental Health Conditions and Substance Use Disorders as set forth in the Covered Services Section. The referrals for Specialty Care procedures also apply to Mental Health Specialists. Mental Health Specialists include Psychologists and Psychiatrists.

4.03 General Provisions for Care Coordination

Providers May Make Referrals

The Covered Person is ultimately responsible for ensuring that all referrals and Prenotifications are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual referral and Prenotification process will be executed by the Covered Person's Physician(s) or other Provider(s). By enrolling in this Plan, the Covered Person authorizes the Plan and its designated service providers (including Coordinated Health/Care™, the Claims Administrator, and others) to accept Providers making referral and Prenotification submissions, or who otherwise have knowledge of the Covered Person's medical condition, to act on behalf of the Covered Person in matters of Care Coordination. Communications with and notifications to such healthcare providers shall be considered notification to the Covered Person.

Time of Notice

The referral and Prenotification notifications must be made to Coordinated Health/Care™ within the following timeframe:

- At least three business days before a scheduled (elective) Inpatient Hospital admission
- By the next business day after an Emergency Hospital Service
- Upon being identified as a potential organ or tissue transplant recipient
- At least three business days before receiving any other services requiring Prenotification

"Emergency" Services

Any Hospital admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the Covered Person's health is considered an Emergency for purposes of the Utilization Review notification.

Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination Process complies with all state and federal regulations regarding Utilization Review for maternity admissions. Covered Services for any Hospital stay in connection with childbirth for the mother is more fully described in the Covered Services Section and in the Notice of Newborn's Act Disclosure found at the end of this Plan.

Care Coordination is not a guarantee of payment of benefits

The Care Coordination Process does not provide a guarantee of payment of benefits. Approvals of referral and Prenotification notices for specialty visits, procedures, hospitalizations and other services, indicate that the medical condition, services, and care settings meet the Utilization Criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a Covered Service, that the Covered Person is eligible for such benefits, or that other benefit conditions such as Copayment, Deductible, Copercentage, or Maximums have been satisfied. Actual payment of benefits is governed by all terms, conditions, limitations and exclusions of the Plan. The Plan Administrator has the final authority to determine, in its discretionary authority, whether the admission or treatment is covered under the Plan.

Result of not following the Care Coordination Process

Failure to comply with the Care Coordination Process of care may result in benefit reductions and/or penalties. The Schedule of Benefits included in this Plan specifies the reduction in benefits and penalty. The "Penalties for not obtaining Prenotification" in Section Five specifies applicable penalties. Charges You must pay due to any penalty for failure to follow the Care Coordination Process do not count toward satisfying any Deductible, Copercentage or the Plan's OOP Limits. The Prenotification Penalty, however, will apply towards the ACA/IRS OOP Limits.

Section Five
Prenotification Procedures

5.01 Prenotification of Certain Procedures

To be covered at the highest level of benefit and to ensure complete care coordination, the Plan requires that certain care, services and procedures be Prenotified **before** they are provided. Prenotification requests are submitted to the Care Coordinators by a Specialty Physician, designated PCP, other PCP, or other healthcare provider. Provider offices have been provided with materials and education regarding this referral process and Your Plan identification card includes instructions. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the Prenotification request and to ensure that the care, service and/or procedure meet Plan criteria. If a Prenotification request does not meet Plan criteria, the Care Coordinators will contact the Covered Person and healthcare provider and assist in redirecting care if appropriate.

The following services require Prenotification:

- Hospital Admissions
- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy and radiation therapy)
- Home Health Care
- Hospice Care
- Durable Medical Equipment (DME) – all rentals and any purchase over $500
- Organ, Tissue and Bone Marrow Transplants
- Dialysis
- Occupational, Physical and Speech Therapy

PENALTIES FOR NOT OBTAINING REQUIRED PRENOTIFICATION:

The penalty for a failure to obtain a required Prenotification is the amount You must pay if Prenotification of the service is not provided prior to receiving a service. Benefits payable for Covered Services will be reduced by $250 per occurrence if a Covered Person receives services but did not obtain the required Prenotification for the services listed immediately above.

Utilization Review

The Care Coordinators will review each Prenotification request to evaluate whether the care, requested procedures, and requested care setting all meet Utilization Criteria established by the Plan. The Plan has adopted the Utilization Criteria in use by the Coordinated Health/Care™ program. If a Prenotification request does not meet these criteria, the request will be reviewed by one of the medical directors for Coordinated Health/Care™, who will review all available information and if needed consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field. The medical director will then provide, through the Care Coordinators, a recommendation to the Plan Administrator whether the request should be approved, denied, or allowed as an

exception. In this manner, the Plan ensures that Prenotification requests are reviewed according to nationally accepted standards of Medical Care, based on community healthcare resources and practices.

If the proposed Medical Care and treatment for the Participant or Dependent is determined medically inappropriate or not Medically Necessary the Covered Person will be notified of the determination. Such Covered Person will then have the right to appeal the decision and request a reconsideration of the determination. See Section Thirteen for details in appealing an Adverse Benefit Decision.

Concurrent Review

The Coordinated Health/Care™ Program will regularly monitor a Hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and examine the possible use of alternate facilities or forms of care. The Care Coordinators will communicate regularly with attending Physicians, the Utilization Management staff of such facilities, and the Covered Person and/or family, to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review, and authorization for Plan coverage of Hospital days, is conducted in accordance with the Utilization Criteria adopted by the Plan and Coordinated Health/Care™.

Case Management

Case Management is an ongoing, proactive coordination of a Covered Person's care in cases where the medical condition is, or is expected to become catastrophic, chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt Case Management intervention include but are not limited to, cancer, chronic obstructive pulmonary disease, multiple trauma, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high risk pregnancy, and premature birth.

Case Management is a collaborative process designed to meet a Covered Person's health care needs, maximize their health potential, while effectively managing the costs of care needed to achieve this objective. The case manager will consult with the Covered Person, the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provides the most appropriate health care and services in a timely, efficient and cost-effective manner.

If the case manager, Covered Person, and the Plan Administrator all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, the Plan Administrator may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined by the Plan Administrator.

In developing an alternative plan of treatment, the case manager will consider:

- The Covered Person's current medical status;
- The current treatment plan;
- The potential impact of the alternative plan of treatment;
- The effectiveness of such care; and
- The short-term and long-term implications this treatment plan could have.

If an alternative plan of treatment is warranted, the Care Coordinators will submit this plan to the Plan Administrator for prior review and approval.

The Plan Administrator retains the right to review the Covered Person's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies which are not Covered Services under the Plan if:

- The attending Physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment;
- The goal of the alternative care of treatment has been met; or
- The alternative plan of care is not achieving the desired results or is no longer beneficial to the Covered Person.

If the Plan elects to provide alternative benefits for a Covered Person in a certain instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons in any other instance, nor shall it be construed as a waiver of the Plan Administrator's right to administer this Plan in strict accordance with its terms.

Outpatient Review

As a part of Case Management, the Plan provides a comprehensive program designed to assure that long-term Outpatient Care is appropriate for the Covered Person, while protecting the Covered Person from excessive or unnecessary use of therapies, including medications. Outpatient Review shall apply to any patient with the following indications:

- A pattern of multiple medication refills;
- A pattern of three or more office visits monthly;
- A pattern of treatment of more than four diagnoses; or
- Planned elective surgery.

When a Covered Person qualifies for Outpatient Review, notification will be sent to the Covered Person, the attending Physician, and to the Plan Administrator. In some instances, Case Management may suggest alternative modes of treatment or recommend obtaining a second opinion.

Appeal of Care Coordination Determinations

Covered Persons have certain appeal rights regarding Adverse Benefits Decisions in the Care Coordination Process, including reduction of benefits and penalties. The appeal process is detailed in Section Thirteen, the Claims Procedures section within this document.

CAUTION:

Please remember that Prenotification does not verify eligibility for benefits nor does it guarantee benefit payments under the Plan.

A Prenotification recommendation also does not constitute a guarantee or warranty of the quality of the medical treatment received by the Covered Person. Actual payment of benefits is governed by all terms, conditions, limitations and exclusions of the Plan.

The Plan Administrator has the final authority to determine, in its discretionary authority, whether the admission or treatment is covered under the Plan.

Please note that a Prenotification claim may be an Urgent Care Claim and will be handled as set forth in Section Thirteen.

Section Six
Prescription Drug Care

6.01 Preventive Care Medications

The ACA requires the Plan to provide coverage for certain recommended preventive services and preventive care medications without the application of any Copayment, Deductible or coinsurance. These preventive care services and medications will be covered by the Plan at 100%. All preventive care medications require a prescription from a licensed health care provider and must be obtained through the Plan's Prescription Drug Card program to be covered at 100%.

Covered Persons may call the number on the back of the Plan ID card for additional information about these preventive services and medications. Covered Persons may also visit the federal government website for a complete list of preventive services and medications at: https://www.healthcare.gov/preventive-care-benefits/

6.02 Retail Prescription Program

To receive drug benefits under the Plan, a Covered Person can purchase Prescription Drugs from an In Network pharmacy in amounts up to a 30 day supply as further described in the Schedule of Benefits.

6.03 Mail Service Prescription Program

A Covered Person can order long-term maintenance Prescription Drugs by mail order in amounts up to a 90 day supply or 300 units, whichever is less, as further described in the Schedule of Benefits.

6.04 Enhanced Prescription Benefits

If a Covered Person with certain chronic conditions becomes "Engaged" with the chronic conditions program administered by Coordinated Health/Care, the Covered Person will receive enhanced prescription benefits. The chronic conditions and benefit enhancement for each are as follows:

<u>Asthma</u>

- $0 Copayment on generic metered dose inhalers and 50% off Copayments on Brand/formulary

<u>Chronic Obstructive Pulmonary Disease (COPD)</u>

- $0 Copayment on generic metered dose inhalers and 50% off Copayments on Brand/formulary

<u>Congestive Heart Failure (CHF)</u>

- $0 Copayment on generic medications to treat cholesterol and/or high blood pressure and 50% off Copayments on Brand/formulary
- $0 Copayments on generic medications to treat heart conditions and 50% off Copayments on Brand/formulary

<u>Coronary Artery Disease (CAD)</u>

- $0 Copayment on generic medications to treat cholesterol and/or high blood pressure and 50% off Copayments on Brand/formulary
- $0 Copayment on generic medications to treat heart conditions and 50% off Copayments on Brand/formulary

Diabetes

- $0 Copayment on generic Diabetes Medication and 50% off Copayments on Brand/formulary
- $0 Copayment on Diabetic Testing Supplies (In Network & on formulary)

Becoming or being "Engaged" means that Covered Persons with Asthma, COPD, CHF, CAD and Diabetes complete at least 50% of the care pathway activities related to the Covered Person's condition(s) as outlined in the Coordinated Health/Care materials. To learn more about these enhanced prescription benefits and care pathway activities, please call a Care Coordinator at 1-877-498-6689 or visit the TICUA website at: http://www.ticua.org/tbc and go to "Your Plan Document" on the "Participant Resources" tab.

6.05 Prescription Drugs Excluded From the Prescription Drug Card Program

- Anabolic steroids.
- Anorexiants (any drug used for the purpose of weight loss) unless diagnosed with Morbid Obesity (See Glossary for more information on Morbid Obesity).
- Charges for administration or injection of any drug.
- Cosmetic indications and anti-wrinkle agents (e.g. Botox, Renova) for individuals 26 years or older.
- Dermatologicals, hair growth stimulants (e.g. Rogaine).
- Drugs covered under Workers Compensation or Medicare.
- Drugs intended for use in a Physician's office or settings other than home use, unless such drugs are covered under the Specialty Drug Program or covered under the preventive care medications, as further described in the Covered Services and Prescription Drug Care sections of this Plan.
- Drugs labeled, "Caution-limited by federal law to investigational use," or Experimental Procedures, even though a charge is made to the individual.
- Fertility/infertility medications.
- Fluoride products.
- Immunization agents, biological sera, blood or blood plasma, unless such immunizations are covered under the Specialty Drug Program or covered under the preventive care services and medications, as further described in the Covered Services and Prescription Drug Care sections of this Plan.
- Injectables, **except** insulin and other injectables provided through a voluntary specialty injectables program, unless such injectable is covered under the Specialty Drug Program or covered under the covered preventive care services and medications, as further described in the Covered Services and Prescription Drug Care sections of this Plan. For a complete list of covered injectables contact the Plan Administrator.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, Ambulatory Care Facility, Extended Care Facility, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Other Facility Provider, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

- Non-legend drugs other than those specifically listed above.
- Over-the-counter drugs.
- Prescription Drugs or medications used for the treatment of sexual dysfunction, including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia, and decreased libido (e.g. Viagra), except where such sexual dysfunction is caused by surgery (e.g., prostate surgery).
- Therapeutic devices or appliances, including support garments, respiratory chambers (e.g. Aerochamber), and other non-medicinal substances.
- Tretinoin topical (e.g. Retin-A) for individuals 26 years or older.
- Vitamins or minerals, singly or in combination, **except** legend vitamins.

Cancer Prescription: Coverage may not be excluded for any Prescription Drug approved by the Food and Drug Administration that has been proven effective and is acceptable to treat the specific type of cancer for which the Prescription Drug has been prescribed by either: (1) The American Medical Association Drug Evaluations; (2) The American Hospital Formulary Service Drug Information; or (3) The United States Pharmacopoeia Drug Information.

Any drug listed by brand name in this Section shall include its generic equivalent when available. Charges for the administration or injection of any drug are not covered under the Prescription Drug Plan.

If You have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives You more choices about Your Prescription Drug coverage. The Plan will provide You with a Medicare Part D notice annually that discusses the details and options relating to Your Prescription Drug coverage**.**

Section Seven
Enrollment and Contributions

7.01 Participant Enrollment

The "Effective Date" for the Employees of a Member shall be the first day of the month following or coinciding with the Employee's date of hire, provided that:

- **Enrollment.** The Employee meets the requirements for eligibility and properly enrolls in the Plan. An Employee may opt out of the Plan only upon demonstration of other group health coverage; and
- **Contributions.** The Member, Employee or Part Time Employee makes any required Contributions toward the cost of the Participant and any Covered Dependent(s). The formula used for allocating the Contributions between the Member and Employees must be approved by the Board of Directors. The amount of the respective Contributions shall be set forth in notices from the Plan Administrator and may be changed from time to time by the Board of Directors.

7.02 Dependent Enrollment

- **Initial Enrollment.** If a Participant enrolls a Dependent within 31 days of the date of hire, the Dependent's Effective Date shall be the same day as the Participant's Effective Date.
- **Later-Acquired Dependent.** If a Participant acquires an eligible Dependent(s), after initial enrollment, the Participant may complete, sign and return an application to the Plan Administrator within the time period set forth below after acquiring the new Dependent(s). If the newly acquired Dependent(s) are enrolled within this period, the effective date of that Dependent's coverage is the first date in which the Dependent met the definition of Dependent.
  - **Newborns (Special Enrollees)**. Newborn children shall be covered from the moment of birth for a period of 31 days following birth. Covered Services during the first 31 days include, but are not limited to, the necessary care or treatment of medically diagnosed Congenital Defects, birth abnormalities or prematurity. In order to continue coverage beyond 31 days, the child must be properly enrolled as a Dependent within 60 days of the child's date of birth. This provision shall not apply to or in any way affect the maternity coverage applicable to the mother.

    Actual Enrollment Necessary Upon Birth of Newborn. It is necessary for the Participant to obtain, complete, sign, and return a **new enrollment form** to extend the coverage of a newborn beyond the first 31 days of life. If the Participant fails to complete, sign and return an enrollment form within 60 days after the birth of a newborn, the Dependent **will not have coverage beyond the 31 days referred to above**, and will not be able to enroll until the next Open Enrollment period. A Participant will not pay a contribution for the first 31 days following birth unless the Participant enrolls the child as described above.

    Claims for maternity expenses or maternity leave **do not** constitute notification or enrollment of a new Dependent for coverage beyond the 31 day period referred to above.

  - **Adopted Children or Foster Children (Special Enrollees).** Newly adopted children and newly acquired Foster Children shall be covered for Injury or Illness from the moment of adoption, placement for adoption or placement of the foster child, provided the child is properly enrolled as a Dependent within 60 days of the date of adoption, placement for adoption or

placement of a foster child. If the adopted child or foster child is a newborn, the coverage relating to newborns as described in the subsection directly above shall apply.

> **Actual Enrollment Necessary Upon Placement for Adoption or Placement of a Foster Child.** It is necessary for the Participant to obtain, complete, sign, and return a **new enrollment form** to add an adopted child or foster child to the Plan. If the Participant fails to complete, sign and return an enrollment form within 60 days after placement for adoption or placement of a foster child, the Dependent **will not have coverage** or be able to enroll until the next Open Enrollment period.

- **Siblings and Other Dependents Upon Birth or Adoption (Special Enrollee).** If a Participant's other Dependents are not Covered Persons, the Participant may enroll these other Dependents along with a newborn, adopted child, placement for adoption, or the placement of a foster child as described in the subsection above. If the Participant enrolls the other Dependents within 60 days, the Special Enrollment Date and coverage shall become effective on the child's date of birth, adoption, placement of an adopted child, or the placement of a foster child.
- **Spouse Upon Marriage (Special Enrollee).** A Spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent within 31 days of the date of marriage.
- **Court Order or Decree.** If a Dependent is acquired through a court order, decree or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled within 31 days of the court order, decree, or marriage.
- **Qualified Medical Child Support Order.** A child may become eligible for coverage as set forth in a Qualified Medical Child Support Order. The Plan Administrator will establish written procedures for determining (and have discretionary authority to determine) whether a medical child support order is qualified and for administering the provisions of benefits under the Plan pursuant to a Qualified Medical Child Support Order. The Plan Administrator, in its discretionary authority, may seek clarification and modification of the order, up to and including, the right to seek a hearing before the court or agency which issued the order.

- **Dependent Contributions.** A Participant or Dependent may be required to make periodic contributions toward the cost of the Dependent's coverage under the Plan in an amount determined by the Plan Administrator. The amount of the respective Contributions shall be set forth in notices from the Plan Administrator, and may be changed from time to time by the Board of Directors.

7.03 Loss of Alternate Health Coverage (Special Enrollees)

A Participant or a Dependent who was previously eligible for coverage, but did not enroll because of alternate health coverage, may complete, sign and return an application to the Plan Administrator within the 31 day Special Enrollment Period following the Participant or Dependent's loss of such other coverage including as a result of reasons such as any of the following:

- Exhaustion of COBRA Continuation Coverage;

- Loss of eligibility for such other coverage including, but not limited to, loss of eligibility due to divorce, legal separation, cessation of dependent status, death, Termination of Employment or reduction of hours of employment, or disenrollment from an institute of higher learning;
- Termination of Employer contributions; or
- Reaching the lifetime limit on all benefits under the Eligible Employee's or Dependent's prior plan.

Individuals who lose coverage due to nonpayment of premiums or for cause (e.g. filing fraudulent claims) shall not be Special Enrollees hereunder. Coverage for a Special Enrollee hereunder shall begin as of the first day of the calendar month following the enrollment request. However, in the event that the Special Enrollee loses coverage on other than the last day of the month, the Effective Date of the Special Enrollees coverage shall be the later of the first day after the other coverage ends, or the first day after the date the enrollment request is received by the Plan Administrator.

7.04 Special Enrollment Based on State Children's Health Insurance Program (SCHIP)

Employees and Dependents who are eligible but not enrolled for coverage when initially eligible may become a Special Enrollee in two additional circumstances:

- The Employee's or Dependent's Medicaid or SCHIP coverage is terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
- The Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or SCHIP, and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

7.05 Change in Status

The Plan allows election changes outside of Open Enrollment based on certain change in status events. The cafeteria plan of the Member governs whether a corresponding mid-year change is allowed to a Participant's pre-tax salary reduction election. Participants should refer to the Member's Plan document governing the cafeteria plan to determine whether pre-tax salary reduction elections can be changed for the following change in status events allowed under this Plan:

- When a change in contribution is significant, a Participant may either increase the contribution or change to a less costly coverage election.
- When a new benefit option is added, a Participant may change to elect the new benefit option.
- When a significant overall reduction is made to a benefit option, a Participant may elect another available benefit option.
- A Participant may make a coverage election change if the Spouse or Dependent becomes eligible for coverage under a student health plan, provided that the student health plan meets minimum essential coverage requirements.
- A Participant may make a coverage election change if the Spouse or Dependent is covered as an Employee or Dependent under another employer plan and that plan incurs a change such as adding or deleting a benefit option and:
    - Allows a permitted mid-year election change; or
    - Allows election changes due to that plan's annual Open Enrollment which does not coincide with this Plan's.

7.06 Disenrollment Due to Marketplace Coverage

The Plan will allow Covered Persons to disenroll from the Plan when:

- A Participant is eligible for Special Enrollment in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period, provided that the Participant certifies that the Participant and related Dependents whose coverage under the Plan is ending have enrolled or intend to enroll in a Qualified Health Plan through the Marketplace effective no later than the day immediately following the last day of coverage under the Plan.

7.07 Late Enrollees

Late Enrollees may enroll in the Plan during Open Enrollment as set forth in the Open Enrollment subsection below. The Effective Date of the Late Enrollee's coverage is the first day of the Plan Year following enrollment.

7.08 Participant's and Dependent's Termination of Participation

Subject to the rules regarding continuation coverage as set forth in Section 8, a Participant's and Dependent's participation under the Plan shall terminate on the earlier of the following occurrences:

- The end of the month in which the Participant Terminates Employment with a Member unless the Member is obligated to continue to make contributions on behalf of such Participant by terms of the employment agreement between the Member and the Participant including the Member's personnel manual;
- The end of the month in which the Participant loses his status as a Participant, or the Dependent loses his status as a Covered Dependent;
- The Plan terminates;
- While on an Approved Leave of Absence or Approved Sabbatical, the Participant becomes employed full time by another employer;
- The failure to pay required contributions. In such case, coverage shall terminate on the last date for which the required contributions were paid, as determined by the Plan Administrator;
- Upon a Participant's death, any Covered Dependent may remain a Dependent for the applicable period of Continuation Coverage set forth in the Continuation Coverage Section, provided that the Covered Dependent complies with the conditions therein; or
- For cause (e.g. filing fraudulent claims).

7.09 Rescission of Coverage

The Plan Administrator, in its discretionary authority, reserves the right to rescind coverage under the Plan if an Employee, spouse or child becomes covered under this Plan or receives Plan benefits as a result of an act, practice or omission that constitutes fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the Employee, spouse or child became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days advance notice to an Employee, spouse or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage only has a prospective effect;
- The cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay Premiums (including COBRA Premiums) toward the cost of coverage; or
- The cancellation or discontinuance of coverage is initiated by an individual (or the individual's personal representative).

A rescission is subject to the claims payment and appeal procedures described in Section Thirteen.

7.10 Open Enrollment

The Plan shall conduct Open Enrollment each Plan Year. During Open Enrollment, Participants may make any of the following changes regarding participation in the Plan, subject to the other governing provisions of this Plan document:

- Enroll as a Late Enrollee;
- Add Dependents not able to enroll during the Plan Year as Special Enrollees or remove existing Dependents from coverage; and
- Make such other changes as permitted by this Plan.

7.11 Retiree Eligibility; Spouse and Dependents of Eligible Retiree

An Eligible Retiree shall participate in the Plan as of the date of retirement from a Member, subject to the following:

- If a Participant becomes an Eligible Retiree, such Participant may continue as a Covered Person subject to any limitations contained herein;
- If a Participant's Dependent spouse is not a Covered Person at the time the Participant becomes an Eligible Retiree, such Dependent spouse may not thereafter become a Covered Person in the Plan unless the Participant and Dependent spouse acquired a new Dependent by adoption, placement for adoption, birth, or placement of a foster child (see Dependent Enrollment for further information);
- A Dependent spouse acquired after a Participant becomes an Eligible Retiree may not become a Covered Person in the Plan as a Special Enrollee (see Dependent Enrollment for further information);
- If an Eligible Retiree or an Eligible Retiree's Dependent spouse who was a Covered Person terminates participation in the Plan, such person may not become a Covered Person thereafter;
- When an Eligible Retiree becomes eligible for Medicare, participation in the Plan for the Eligible Retiree will terminate as of the date the Eligible Retiree became eligible for Medicare, unless the Eligible Retiree enrolls in the Medicare Supplemental Plan;
- Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered spouse and Covered Dependent may remain a Covered Person in the Plan until the earlier of the date of such Covered spouse's death or termination of participation due to Medicare eligibility;
- When an enrolled Dependent who was not eligible for Medicare coverage becomes eligible for Medicare, participation in the Plan will terminate as of the date the Dependent became eligible for Medicare, unless the Dependent enrolls in the Medicare Supplemental Plan;

- If a Covered spouse terminates participation due to death or eligibility for Medicare, or if no spouse is covered at the time of the Eligible Retiree's termination of participation, any Covered Dependent may remain a Dependent for the applicable period of Continuation of Coverage as set forth under COBRA provided that the Dependent complies with the conditions therein;
- Upon the death or retirement of a Participant who is Medicare eligible and who, except for such eligibility for Medicare, would qualify as an Eligible Retiree, any Covered Dependents may remain a Covered Dependent on the same basis as the Covered Dependents of an Early Retiree who is terminating due to death or eligibility for Medicare; and
- If an Eligible Retiree terminates participation in the Plan for any reason other than for death or eligibility for Medicare, the eligible Dependents of such Eligible Retiree shall terminate participation in the Plan as of the Eligible Retiree's termination of participation.

Section Eight
Continuation of Coverage

Federal law, through passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), created the right to a temporary extension of group health coverage under the Plan in certain circumstances when coverage would otherwise end. COBRA Continuation Coverage can apply to Qualified Beneficiaries when such persons would otherwise lose group health coverage under the Plan. A "Qualified Beneficiary" is an individual who was covered by the Plan on the day before a Qualifying Event occurred that caused him or her to lose coverage. A Qualified Beneficiary must be a Participant or Dependent under the Plan. The following explains COBRA Continuation Coverage, when it may become available and how to protect the right to receive COBRA.

When You become eligible for COBRA, You may also become eligible for other coverage options through the Health Insurance Marketplace, Medicaid, or another group health plan (such as a spouse's plan) through a special enrollment period. Some of these options may cost less than COBRA coverage.

- **Health Insurance Marketplace.** The Marketplace offers the ability to find and compare private health insurance options. Through the Marketplace, You could be eligible for a tax credit that lowers Your monthly premiums and cost-sharing reductions that lower Your out of pocket costs for Deductibles, co-insurance, and co-payments. You have a 60-day special enrollment period following the date You lose coverage under this Plan in which to enroll in the Marketplace. After 60 days, Your special enrollment period will end, and You may not be able to enroll until the Marketplace's next annual open enrollment period. To find out more about enrolling in the Marketplace, visit www.HealthCare.gov.
- **Enrollment in another Group Health Plan.** You may be eligible to enroll in coverage under another group health plan (such as a spouse's plan) if You request enrollment within 30 days of the loss of coverage under this Plan. If You or Your Dependent chooses to elect COBRA coverage instead of enrolling in another group health plan for which You are eligible, You may have another opportunity to enroll in the other group health plan within 30 days of losing Your COBRA coverage.

For additional information about rights and obligations under the Plan and under Federal law, contact the Plan Administrator which administers COBRA for the Plan.

8.01 COBRA Continuation Coverage

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event".

- **COBRA Qualifying Events for Participants.** A Participant may elect COBRA Continuation Coverage, at the Participant's own expense, if participation under the Plan terminates as the result of a Qualifying Event. Qualifying Events for Participants include Termination of Employment, either voluntary or involuntary, or a reduction in hours of employment. COBRA Continuation Coverage will not be offered when the Termination of Employment was due to the Participant's gross misconduct.
- **COBRA Qualifying Events for Dependents**. A Dependent may elect COBRA Continuation Coverage, at the Dependent's own expense, if the Dependent's participation under the Plan terminates as the result of a Qualifying Event. Qualifying Events for Dependents include the following:
    - Death of the Participant;

- The Participant's loss of employment, either voluntary or involuntary, unless caused by the Participant's gross misconduct;
- A reduction in the Participant's hours of employment;
- A Participant becomes entitled to Medicare;
- Divorce or legal separation from the Participant (If a Participant cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that the Participant cancelled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation); or,
- A Dependent Child ceases to qualify as a Dependent under the Plan.

- Other individuals who may be Qualified Beneficiaries of COBRA include:
  - **Recipients under Qualified Medical Child Support Orders.** A child of the Participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Participant's period of employment is entitled to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.
  - **Children born to or placed for adoption during COBRA period.** A child born to, adopted by, or placed for adoption with a Participant during a period of Continuation Coverage is considered to be a Qualified Beneficiary provided that the Participant has elected Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and it lasts for as long as COBRA coverage lasts for other Family members of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.
  - **Participants and Dependents after FMLA.** If a Participant takes FMLA leave and does not return to work at the end of the leave, the Participant and any Dependents will be entitled to elect COBRA if:
    - They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
    - They will lose Plan Coverage within 18 months because of the Participant's failure to return to work at the end of the leave.

  COBRA Continuation Coverage elected in these circumstances will begin on the last day of the FMLA leave.

  COBRA Continuation Coverage is the same coverage that the Plan gives to other Participants and their Dependents under the Plan that are not receiving COBRA Continuation Coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Participants or Dependents covered under the Plan, including open enrollment and special enrollment rights.

- Duty to Notify Plan Administrator of Qualifying Events.

- The Employer must notify the Plan Administrator within 30 days of one of the following Qualifying Events:
  - The Participant's loss of employment, either voluntary or involuntary;
  - A reduction in the Participant's hours of employment;
  - Death of the Participant;
  - Participant becoming entitled to Medicare; or
  - Bankruptcy of the Employer.
- In order to be eligible for COBRA Continuation Coverage, the **Participant or Dependent must notify the Plan Administrator**, in writing, within 60 days of one of the following Qualifying Events:
  - Divorce;
  - Legal Separation; or
  - A Dependent Child ceases to qualify as a Dependent under the Plan.
- If the Participant or Dependent provides a written notice that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely **if all of the following conditions are met**:
  - Notice is mailed or hand delivered by the deadline;
  - From the Notice, the Plan Administrator is able to determine the identity of the Employer, Participant and Qualified Beneficiaries, and the Qualifying Event; and
  - The Notice is supplemented with the additional information and documentation to meet the Plan's requirements within 15 business days after a written or oral request from Plan Administrator requesting more information.

  If any of these conditions is not met, the incomplete Notice will be rejected and COBRA WILL NOT BE OFFERED.

Caution: If these procedures are not followed or if written notice is not provided to the Plan Administrator within the specified time period, any Participant or Dependent who loses coverage will **not be offered the option to elect Continuation Coverage.**

Notice Procedures: Any notice provided must be in writing. Oral notice, including notice by telephone or e-mail, is not accepted. The notice must be mailed or hand-delivered to the Plan Administrator at this address:

Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc.
Attn: C. Gregg Conroy
1031 17th Avenue South
Nashville, TN 37212

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name of the Plan (Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. Health Plan), the name and address of the Participant covered under the Plan, and the name(s) and address(es) of the Dependent(s) who lost coverage. The notice must also name the Qualifying Event and the date it happened.

The Plan's Notice of Qualifying Event Form should be used to notify the Plan Administrator of a Qualifying Event. (A copy of this form can be obtained from the Plan Administrator). If the Qualifying Event is a divorce, the notice must include a copy of the divorce decree.

Notice of a Second Qualifying Event (a copy can be obtained from the Plan Administrator) also must name the event and the date it happened. If the Qualifying Event is a divorce, the notice must include a copy of the divorce decree.

Notice of Disability must also include the name of the disabled qualified Dependent, the date when the Dependent became disabled, the date the Social Security Administration made its determination, and a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled. The Notice of Disability must include a copy of the Social Security Administration's determination. (A copy of this form can be obtained from the Plan Administrator).

- **Electing COBRA Continuation Coverage**. The following rules apply to COBRA election:
  - COBRA Continuation Coverage will begin on the date of the Qualifying Event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage;
  - Each Qualified Beneficiary has an independent right to elect Continuation Coverage;
  - A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA Election Notice, using the Plan's Election Form and following the procedures specified on the Election Form;
  - Written notice of election must be provided to the Plan Administrator at the address provided on the Plan's Election Form. If mailed, the Election Form must be postmarked no later than the last day of the 60 day election period;
  - An affirmative election of COBRA Continuation Coverage by a Participant shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan;
  - A Participant or Dependent may change a prior rejection of Continuation Coverage at any time during the 60 day period by providing the written notice of election above; and
  - Failure to elect Continuation Coverage within the 60 day election period will terminate all rights to COBRA Continuation Coverage.
  - The Participant (i.e. the Employee or Former Employee who is or was covered under the Plan), Dependent, or a representative acting on behalf of either may provide the Notice. A Notice provided by any of these individuals will satisfy the responsibility to provide Notice on behalf of all Qualified Beneficiaries who lost coverage due to the Qualifying Event described in the Notice.
- Finally, You should take into account that You have Special Enrollment rights under federal law. You have the right to request Special Enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within 30 days after Your group health coverage ends because of the Qualifying Event listed above. You will also have the same Special Enrollment right at the end of Continuation Coverage if You get Continuation Coverage for the maximum time available to You.

- **Length of Continuation Coverage.** COBRA Continuation Coverage is a temporary continuation of coverage. The COBRA Continuation Coverage periods described below are maximum coverage periods.
  - **Period of Continuation Coverage for Participants.** A Participant, who qualifies for COBRA Continuation Coverage as a result of Termination of Employment or reduction in hours of employment described above, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the Qualifying Event.

    Coverage under this Section may not continue beyond:

    - The date on which the Employer ceases to maintain a group health plan;
    - The last day of the month for which the required contributions have been made, in accordance with the Cost of COBRA Continuation Coverage subsection below;
    - The date the Participant becomes entitled to Medicare; or
    - The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by the TICUA Benefit Consortium.

    COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate Coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (such as fraud).
  - **Period of COBRA Continuation Coverage for Dependents.** If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the Participant's Termination of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the Qualifying Event. COBRA Continuation Coverage for all other Qualifying Events may continue for up to 36 months.

    In addition to maximum periods discussed immediately above, Continuation Coverage under this Subsection may not continue beyond:

    - The last day of the month for which required contributions have been made, in accordance with the Cost of COBRA Continuation Coverage Section below;
    - The date the Dependent becomes entitled to Medicare;
    - The date on which the Employer ceases to maintain a group health plan; or
    - The first day after the COBRA Continuation Coverage election, when the Dependent is covered under any other group health plan that is not maintained by TICUA Benefit Consortium.

    COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (such as fraud).
  - **Second Qualifying Events.** If during an 18 month maximum period of Continuation Coverage, a Qualified Beneficiary experiences a second Qualifying Event that is the death of a Participant, the divorce or legal separation from a Participant, a Participant becoming enrolled in Medicare, or a Dependent child ceasing to be eligible for coverage as a Dependent under the Plan, coverage may be continued for a maximum of 36 months from the date of the first

Qualifying Event. The Qualified Beneficiary must notify the Plan Administrator within 60 days after the second Qualifying Event using the Notice Procedures in the box above. (This extension is not available under the Plan when a Covered Participant becomes entitled to Medicare). **Failure to provide timely notice of a second Qualifying Event will result in non-extension of COBRA Continuation Coverage.**

- **Medicare or Other Group Health Coverage**

  Note: You must notify the Plan Administrator if any Qualified Beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement.

  Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA Continuation Coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

  The rules set forth in Section Twelve concerning coordination of benefits with Medicare apply for the period of Continuation Coverage only when a Qualified Beneficiary was also entitled to Medicare benefits on or before the date on which the Qualified Beneficiary elected COBRA.

- **Extension of COBRA Continuation Period for Disabled Participants**. The period of continuation shall be extended to 29 months (measured from the date of the initial Qualifying Event) in the event:

  - The Participant is disabled (as determined by the Social Security laws) within 60 days after the date of the Qualifying Event, and
  - The individual provides evidence to the Plan Administrator or its authorized representative of such Social Security Administration determination prior to the earlier of 60 days after the date of the Social Security Administration determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.

    In such event, the Plan may charge the individual up to 150% of the COBRA cost of the coverage for all months after the 18th month of COBRA coverage, so long as the disabled Participant is in the covered group. The Participant must notify the Plan Administrator if Participant is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the month that is more than 30 days after the Social Security Administration determination.

- **Extension of COBRA Continuation Period for Disabled Dependents.** The period of continuation shall be extended to 29 months (measured from the date of the qualifying event) in the event the Dependent is disabled as determined by Social Security Laws within 60 days after the date of the qualifying event and the individual provides written evidence to the Plan Administrator or its authorized representative of such Social Security Administration determination prior to the earlier of 60 days after the date of the Social Security Administration determination, or the expiration of the initial 18 months of COBRA Continuation Coverage. In such event, the Plan may charge the individual up to 150% of the COBRA cost of the coverage from all months after the 18 months of coverage, so long as the disabled Dependent is in the covered group.

- **Cost of COBRA Continuation Coverage**
  - **Amount**. Each Qualified Beneficiary may be required to pay the entire cost of Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both Employer and Participant contributions) for coverage of a similarly situated Plan Participant or Dependent who is not receiving Continuation Coverage (or in the case of an extension of Continuation Coverage due to a Disability, 150%).
  - **Timely Payment of Premiums**. Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the Qualifying Events specified above must make Continuation Coverage Payments.

    Participants and Dependents must make the Continuation Coverage Payment monthly prior to the first day of the month in which such coverage will take effect. However, a Participant or Dependent has 45 days from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a 31 day grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the 31 day grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required contributions were made. The 31 day grace period shall not apply to the 45 day period for payment of COBRA premiums as set out in this Subsection.
  - **Trade Act of 2002**. Two provisions under the Trade Act affect benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. Participants should consult the Plan Administrator if he or she believes the Trade Act applies to their situation.

8.02 USERRA Coverage

Participants and Dependents Have Rights Under Both COBRA and USERRA. Rights under COBRA and USERRA are similar but not identical. Any election made pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the Continuation Coverage elected. If COBRA or USERRA provides different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain Employees who are involved in the Uniformed Services. A

Participant involved in the Uniformed Services has rights pursuant to COBRA and USERRA. USERRA permits a Participant to continue health coverage under the TICUA Benefit Consortium Health Plan for both himself or herself and any covered Dependents.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of War or national emergency.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

- **Duration of USERRA Coverage.**
  - **General rule 24 months maximum**. When a Participant takes a leave for service in the Uniformed Services, USERRA coverage for the Participant (and Covered Dependents for whom coverage is elected) begins the day after the Participant (and Covered Dependents) lose coverage under the Plan, and it may continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place:
    - Failure to make a premium payment within the required time;
    - Failure to return to work within the timeframe required under USERRA (see below) following the completion of service in the Uniformed Services; or
    - Rights under USERRA are lost as a result of a dishonorable discharge or other conduct specified in USERRA.
  - **Returning to Work**. A Participant's right to continue coverage under USERRA will end if he or she does not notify the Employer of the intent to return to work within the timeframe required under USERRA following the completion of service in the Uniformed Services by either reporting to work (when absence was for less than 31 days) or applying for reemployment (if absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

Period of Absence	Return to Work Requirement
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 30 days but less than 181 days	Submit an application for employment no later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.

More than 180 days	Submit an application for employment no later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly-scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Any period of hospitalization, resulting from an Injury or Illness incurred or aggravated as a result of service	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to 2 years. The 2 year period is extended by any minimum time required to accommodate circumstances beyond the Employee's control that make compliance with these deadlines unreasonable or impossible.

- **Concurrent.** COBRA coverage and USERRA coverage begin at the same time and run concurrently. However, COBRA coverage can continue longer, depending on the qualifying event, and is subject to different early termination provisions. In contrast, USERRA coverage can continue for up to 24 months, as described earlier in this Section.
- **Premium Payments for USERRA Continuation Coverage.** If continuation health coverage is elected pursuant to USERRA, the premium for such elected coverage is 102% of the full premium for the coverage elected (the same rate as COBRA). However, if the Uniformed Services leave of absence is less than 31 days, the premium for the continuation health coverage is not more than the amount paid if the Participant had stayed an active Employee.

8.03 Family and Medical Leave Act

If a Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act of 1993 ("FMLA"). The Plan will continue coverage as if the Participant was Actively at Work as long as the following conditions are met:

- The required Contribution is paid; and
- The Participant has written approval of leave from the Member.

Coverage will be continued for up to the greater of:

- The leave period required by FMLA and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a Family or Medical Leave of Absence, when the former Participant returns to Actively at Work status and re-enrolls in the Plan, no new Waiting Period will apply.

Section Nine
Covered Services

The Plan shall not pay for any service, procedure or supply incurred by the Covered Person, unless it is specifically listed as a Covered Service below.

9.01 Comprehensive Major Medical Expense Benefit

The Comprehensive Major Medical Expense Benefit provides coverage for a wide range of services called Covered Services. The services associated with this benefit are covered to the extent that they are:

- Medically Necessary;
- Prescribed by or given by a Physician;
- Allowable charges; and
- Provided for care and treatment of a covered Illness or Injury.

Benefits are payable in accordance with the applicable Deductible amounts and benefit Copercentages listed in the Schedule of Benefits, unless otherwise listed as a Covered Service.

9.02 Covered Services

Covered Services are the services listed below, subject to the Limitations and Exclusions, and all other provisions of this Plan:

- **Allergy Services.** Allergy testing, treatment, serum and injections will be payable as shown in the Schedule of Benefits.
- **Ambulance Service.** Hospital or licensed ambulance or air ambulance service when Medically Necessary for transportation to and from a local Hospital or to the nearest Hospital. Also included is a transfer to the nearest facility equipped to treat the emergency, as shown in the Schedule of Benefits.
- **Ambulatory Surgical Facility.** Services and supplies furnished by an Ambulatory Surgical Facility.
- **Anesthetics.** Coverage for general, spinal block, or monitored regional anesthesia ordered by the attending Physician and administered by or under the supervision of a Physician other than the attending surgeon or assistant at surgery.
- **Attention Deficit Disorder.** Treatment and prescription medication as deemed Medically Necessary for attention deficit disorders.
- **Blood Plasma.** Services and supplies required for the administration of blood transfusions, including blood, blood plasma, and plasma expanders, when not available to the Covered Person without charge.
- **Bone Mass Measurement.** Coverage for scientifically proven and approved bone mass (bone density) measurement in the diagnosis and evaluation of osteoporosis or low bone mass. Coverage will be provided if:
    - At least 23 months have elapsed since the previous bone mass measurement was performed; or

- If Medically Necessary, more frequent bone mass measurements are covered and may include but are not limited to:
  - Monitoring Covered Person on long-term glucocorticoid therapy for more than 3 months; and
  - Allowing for a central bone mass measurement to determine the effectiveness of adding on additional treatment regimens for a Covered Person who is proven to have low bone mass, as long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

- **Breast Reduction Surgery.** Breast Reduction Surgery when Medically Necessary and not Cosmetic.
- **Cervical Cancer Screening.** Cervical cancer screening will be covered as listed in the Schedule of Benefits. Covered procedures include: Pap smear screening, liquid based cytology and Human Papilloma Virus ("HPV") detection methods for covered females with equivocal findings on cervical cytologic analysis that have been approved by the United States Food and Drug Administration.
- **Chiropractic Treatment**. See Non-Surgical Back Treatment.
- **Chlamydia.** Annual Chlamydia screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age and for older females who are at increased risk.
- **Clinical Trials.** Coverage for Clinical Trial Costs as defined in the Glossary.
- **Cleft Lip and Related Conditions.** Inpatient and Outpatient dental, oral surgical, and orthodontic services which are Medically Necessary for the treatment of cleft lip, cleft palate or ectodermal dysplasia.
- **Colorectal Cancer Screening.** Colorectal cancer screening will be covered as listed in the Schedule of Benefits. Covered procedures include: medically recognized screening, specialty screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging shall be provided in accordance with the most recently published recommendation established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendation.
- **Contact Lenses or Eyeglasses After Cataract Surgery.** The initial purchase of either one pair of contact lenses and/or eyeglasses if required as a result of cataract surgery and purchased within 6 months of such surgery.
- **Cosmetic or Reconstructive Surgery.** Cosmetic or reconstructive surgery, only if such surgery is to restore bodily function or correct deformity resulting from an Illness or Injury covered under this Plan.
- **Craniofacial Abnormalities.** For children younger than 18 years of age, reconstructive surgery for craniofacial abnormalities, meaning surgery to improve function of, or attempt to create a normal appearance of an abnormal structure caused by Congenital Defects, development deformities, trauma, infections or disorder.
- **Dieticians.** Services of a licensed dietician within the scope of licensure if related to Injury or Illness covered by the Plan and if recommended by a Physician in connection with an examination or treatment covered by the Plan.

- **Dental Care.** Medical expenses for oral surgery and dental care:
  - When necessitated as the direct result of an Injury to natural teeth or dental prosthesis if treatment begins within 6 months of the date of the Injury (chewing related expenses not covered);
  - For the surgical removal of impacted wisdom teeth;
  - Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with extractor or repair of teeth;
  - Care of fractures or complete dislocation of the jaw;
  - Surgical removal of tumors within the oral cavity; and
  - Anesthesia and Hospital expenses associated with any Inpatient or Outpatient Hospital dental procedure where the procedure being performed is on a Dependent under the age of 8 and such procedure cannot be safely performed in a dental office setting.

  For the purpose of the dental work or oral surgery covered by the terms of this benefit, Covered Services shall be deemed to include fees of a duly licensed dentist. No other expenses for dental work are included as a Covered Service. The Plan shall always pay secondary to any other dental coverage.

- **Diabetic Care.** Office visits and consultations with Physicians and practitioners as Medically Necessary for the diagnosis and treatment of diabetes. Covered Services also include insulin, test strips, needles, syringes and related supplies if not covered by the Prescription Drug Program. Alcohol swabs shall not be Covered Services.

  Outpatient self-management training and educational services, including medical nutrition counseling, when prescribed by a Physician for a patient with diabetes. Diabetes Outpatient self-management training and educational services, including medical nutrition counseling, shall be provided by licensed Physicians or, upon referral by a Physician, by registered nurses or properly licensed dietitians, or properly licensed pharmacists who have completed a diabetes patient management program offered by a provider recognized by the American Council on Pharmaceutical Education and the Tennessee board of pharmacy, or other health care professionals licensed in the state of Tennessee that have expertise in diabetes management as determined by the Plan. Coverage for such training and education is limited to visits which are certified by a Physician to be Medically Necessary:
  - Upon the diagnosis of diabetes in a patient;
  - Significant change in a patient's symptoms or condition; or
  - Re-education or refresher training.

- **Diagnostic Charges and Preadmission Testing.** X-ray, laboratory services, diagnostic charges and preadmission testing, subject to the Schedule of Benefits.

  Except under the Qualified High Deductible Plan ("QHDHP"), **out-patient laboratory services** provided by an In Network provider (excluding a Hospital) are covered by the Plan at 100% and are not subject to the Plan's Deductibles. Any related specimen collection charges are subject to the Plan's normal Deductibles and Copercentages.

Laboratory services include:

- Blood testing (e.g. cholesterol, CBC);
- Urine testing (urinalysis);
- Cytology and Pathology (e.g., Pap smears, biopsies); and
- Cultures (e.g., throat culture)

To ensure these services are covered at 100%, You should do the following:

- If Your doctor is collecting Your sample in the office, ask that it be sent to a participating In Network Lab; and
- If Your doctor is sending You to a lab for the testing, contact the Care Coordinators at the number on Your Plan ID Card, or visit www.ticua.org/tbc for a list of In Network labs, or ask Your doctor for a Lab requisition form to an In Network lab.
- **50% Coverage**. Out of Network Diagnostic Charges and Preadmission Testing are paid by the Plan at 50%, subject to the applicable Deductible.
- **80% Coverage**. Out of Network Diagnostic Charges and Preadmission Testing performed outside the Covered Person's control or election will be paid at 80%, subject to the applicable Deductible.
- **Other Charges and Testing**. The following tests will be covered in accordance with other applicable Plan provisions:
  - Lab work performed by a Hospital whether on an inpatient or outpatient basis;
  - Lab work needed on an Emergency basis and time-sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests;
  - Non-laboratory work such as mammography, x-ray, and imaging; and
  - Testing not approved and/or covered by the Plan.

- **Durable Medical Equipment.** The lesser of the rental or purchase price of Medically Necessary Durable Medical Equipment, at the percentage shown in the Schedule of Benefits.
- **Emergency Services.** Emergency Services to the extent necessary to screen and stabilize the Participant. Prenotification is not required if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:
  - Placing the person's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- **Foreign Travel**. Foreign travel immunizations.
- **Genetic Testing and Counseling**. Coverage for Genetic Testing and Counseling when Medically Necessary and there is adequate evidence to support its use. This benefit is covered by the Plan at 80% when performed by an In Network Provider and covered by the Plan at 50% when performed

by an Out of Network Provider. Some factors that show adequate evidence to support genetic testing include:

- The Covered Person has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes);
- Conventional diagnostic procedures are inconclusive;
- The Covered Person has risk factors or a particular family history that indicate a genetic cause;
- The Covered Person meets criteria defined by the Physician that places the Covered Person at high genetic risk for the condition;
- The genetic test is not considered an Experimental Procedure;
- The test is performed by a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory;
- The test result will directly influence the disease treatment management of the Covered Person.

Genetic Testing is not covered for:

- Non-medical purposes, such as forensic identification or establishing paternity or familial relationships;
- Population screening without a personal or family history, with the exception of newborn screening and preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease and other hemoglobinopathies;
- Informational purposes;
- Minors for adult-onset conditions; and
- A relative of a Covered Person who is not also a Covered Person unless (1) the genetic test results are necessary for the Medical Care of the Covered Person, and (2) the relative can provide evidence of coverage denial from his or her health insurance plan.

- **Growth Hormones**. Coverage for growth hormones when Medically Necessary for treatment of growth hormone deficiency in children and adults.
- **Hearing Aids For Children 18 and Under.** For children 18 years of age and under, coverage for one (1) hearing aid per ear every three (3) years. Coverage includes ear molds and services to select, fit, and adjust the hearing aid. Accessories such as batteries, cords, and other assistive listening devices such as FM systems are excluded.
- **Hemophilia and Other Congenital Bleeding Disorders**. Coverage for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Coverage includes purchase of blood products and blood infusion equipment required for home treatment when the home treatment program is under the supervision of a state-approved hemophilia treatment center.
- **HIV/AIDS**. Injuries or Illnesses as a result of HIV/AIDS.
- **Home Health Care**. Services of a Home Health Care Agency, at the percentage shown in the Schedule of Benefits, for services furnished to a Covered Person in the home in accordance with a Home Health Care plan. The Home Health Care plan must be established and approved by the

Physician and must certify that an Inpatient Hospital confinement would otherwise be required. Covered Services include:

- Part time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.), if Medically Necessary;
- Part time or intermittent home health aide performing services specifically ordered by a Physician;
- Occupational therapy, speech therapy, physical therapy and respiratory therapy provided by a Home Health Care Agency; and
- Medical supplies, medicines, and equipment prescribed by a Physician and provided by the Home Health Care Agency if such items would have been covered while Hospital confined.

For determining the limit of benefits with respect to services set forth above, each visit by a member of a Home Health Care Agency shall be considered as one Home Health Care visit and 4 hours of home health aide services shall be considered as one Home Health Care visit.

In addition to the Limitations and Exclusions below, benefits will NOT be provided for any of the following:

- Services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's Family or spouse's Family;
- Custodial Care, consisting of services and supplies which are provided to an individual primarily to assist in the Activities of Daily Living;
- Any period during which the Covered Person is not under the continuing care of a Physician;
- Homemaker or housekeeping services except by home health aides as ordered in the Home Health Care treatment plan;
- Supportive environmental materials such as handrails, ramps, air conditioners and telephones;
- Services performed by volunteer workers;
- Social services and dietary assistance;
- Separate charges for records, reports or transportation;
- Expenses for the normal necessities of living, such as food, clothing, and household supplies;
- Services rendered or supplies furnished to other than the Covered Person;
- Any services or supplies not included in the Home Health Care treatment plan or not specifically set forth as a Covered Service; and
- Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Hospice Care benefit.

- **Hospice Care.** Hospice Care on either an Inpatient or Outpatient basis as an alternative to hospitalization for a Terminally Ill person, as shown in the Schedule of Benefits.

  Covered Services must be rendered, furnished and billed by a Hospice and included in a written Hospice treatment plan established and periodically reviewed by a Physician. The Hospice treatment plan must:

  - Certify that the Covered Person is Terminally Ill and has less than a 6 month life expectancy;

- Certify that it is medically advisable for the Covered Person to live at home;
- Certify that Hospital confinement would be required in the absence of Hospice Care; and
- Describe the services and supplies for the palliative care and Medically Necessary treatment to be provided to the Covered Person by the Hospice.

Covered Services include:

- An assessment visit and initial testing;
- Room and board, services and supplies furnished by a Hospice while confined therein;
- Patient care provided by home health aides;
- Visits by speech therapists and psychotherapists;
- Intermittent care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
- Drugs and medicines for the Terminal Illness that are legally obtainable only upon a Physician's written prescription and insulin while receiving Hospice Care on an Inpatient basis only;
- Medical supplies normally used for Hospital Inpatients, such as oxygen, catheters, needles, syringes, dressing materials used in aseptic techniques, irrigation solutions, intravenous solutions and other medical supplies including splints, trusses, braces or crutches;
- Rental of Durable Medical Equipment;
- Family counseling of immediate Family members;
- Respite care;
- Professional medical, psychological, social and pastoral counseling services provided by salaried employees of the Hospice; and
- Supportive services to the bereaved immediate Family members for up to 3 months following the death of the Covered Person.

In addition to the Limitations and Exclusions below, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services except by home health aides as ordered in the Hospice treatment plan;
- Supportive environmental materials such as handrails, ramps, air conditioners and telephones;
- Services performed by family members or volunteer workers;
- "Meals on Wheels" or similar food services;
- Separate charges for records, reports or transportation;
- Expenses for the normal necessities of living, such as food, clothing and household supplies;
- Services rendered or supplies furnished to other than the Terminally Ill Covered Person except as listed above;
- Any services or supplies not included in the Hospice treatment plan or not specifically set forth as a Covered Service;
- Legal and financial counseling services; and

- Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Home Health Care benefit.

- **Hospital Services**.
  - **Inpatient.** Hospital room and board, general nursing care, and regular daily services to the extent of the room and board allowance shown in the Schedule of Benefits.

    > **Note:** If a private room is used, the most frequent semi-private room rate will be used unless confinement in a private room is specifically requested by the Physician due to the nature of the Illness and/or Injury. An explanation must be submitted to the Claims Administrator.

    Intensive Care Unit or other special care unit such as Coronary Care, up to the amount specified in the Schedule of Benefits (but not for the concurrent use of any other Hospital room).

    Medically Necessary services and supplies furnished by the Hospital while confined as an Inpatient.

    Coverage is not extended for a Hospital when the services could be rendered by another Facility Provider at a lesser expense.
  - **Outpatient.** Medically Necessary services and supplies furnished by a Hospital while being treated on an Outpatient basis such as:
    - Allergy testing;
    - Chemotherapy;
    - Dialysis;
    - Emergency Room Services (subject to the Schedule of Benefits);
    - Laboratory tests and x-rays;
    - Preadmission testing;
    - Radiation therapy;
    - Respiratory therapy; and
    - Surgical services.

- **Lymphedema.** Coverage for equipment, supplies, complex decongestive therapy, and Outpatient self-management training and education for the treatment of lymphedema if lawfully prescribed by a Physician.

- **Mammography.** Coverage includes digital tomosynthesis (3D mammograms).
  - A baseline mammogram for women 30 to 39 years of age;
  - A mammogram every 2 years or more frequently based on the recommendation of the woman's Physician for women 40 to 49 years of age;
  - A mammogram every year for women 50 years of age and over; and
  - Further mammograms may be covered if the Covered Person has a history of breast cancer and such additional mammogram is Prenotified.

- **Mastectomy, Related Procedures, and Reconstructive Surgery Following Mastectomy.** Expenses incurred with respect to a mastectomy or lymph node dissection in connection with breast cancer.

For a mastectomy, the Plan will cover a minimum 48 hour Hospital stay. For lymph node dissection, the Plan will cover a 24 hour Hospital stay.

The Plan will cover, as provided in the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), breast implants and reconstructive surgery as well as complication of implants and reconstructive surgery as follows:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the nondiseased breast to produce a symmetrical appearance;
- Prosthesis and treatment of physical complications including lymphedemas; and
- External breast prostheses and bras.

- **Maternity Services.** Hospital and professional services incurred by either Participant or Covered Dependent as shown in the Schedule of Benefits, for:
  - Pregnancy to include prenatal care, services provided by a Birthing Center, one amniocentesis test per pregnancy, and up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary); and
  - Complications of Pregnancy.

    For an uncomplicated vaginal delivery, this Plan will cover a 48 hour Hospital stay. For an uncomplicated cesarean delivery, the Plan will cover a 96 hour Hospital stay. If a decision is made to discharge a mother or newborn before the expiration of the minimum hours, above, coverage is provided for timely post-delivery care by a Physician, midwife, Registered Nurse, or Other Professional Provider.
- **Medical and Surgical Supplies**. Casts, splints, trusses, braces, crutches, surgical dressings and other Medically Necessary supplies.
- **Mental Health Conditions**.
  - **Inpatient**. Hospital and professional services for treatment of Mental Health Conditions and/or complications thereof, during the course of a confinement, up to the maximum shown in the Schedule of Benefits, provided services are rendered by a Hospital, psychiatric Hospital, or a Physician, psychologist, or clinical social worker (upon referral by a Physician) holding license for such services and acting in accordance with that license.
  - **Outpatient**. Outpatient Care for treatment of Mental Health Conditions and/or complications thereof, up to the maximum shown in the Schedule of Benefits, provided services are rendered by:
    - A licensed Hospital;
    - Psychiatric Hospital;
    - Outpatient psychiatric center;
    - A community mental health center (coverage includes services rendered by a member of the clinical staff, so long as the community mental health center has in effect a plan for quality assurance approved by the Department of Mental Health and the treatment is supervised by a licensed Physician or a licensed psychologist designated as a health service provider);
    - A Physician;

- Psychologist;
- Licensed professional counselor; or
- Clinical social worker (upon referral by a Physician) holding a license for such services and acting in accordance with that license.

o **Partial day.** A partial day program must be licensed or approved by the state and must include day or evening treatment programs which lasts at least 6 or more continuous hours per day for Mental Health Conditions.

Covered Services are subject to the limits in Schedule of Benefits. Coverage for Mental Health Conditions shall be neither different nor separate from coverage for any other Illness for the purpose of determining Deductibles, annual discretional limits, Maximum Annual Benefits, episode or treatment limits, Copayments and Coinsurances.

- **Midwife Services.** Coverage for a Midwife when licensed in the state where services are rendered and when the Midwife acts within the scope of the license.
- **Morbid Obesity.** The Plan covers treatment for Morbid Obesity on a step therapy basis. First, the Plan covers counseling services of a dietician or nutritionist. Second, the Plan provides Prescription Drug coverage as set forth in Section Six. Thereafter, upon demonstration that other methods of correcting Morbid Obesity such as diet, exercise, and Prescription Drugs are unsuccessful, and upon approval by Case Management, the Plan will cover Medically Necessary treatment for diagnosed Morbid Obesity through gastric stapling and gastroplasty or other treatment methods as may be recognized by the National Institute of Health as effective for long-term reversal of Morbid Obesity. The specific clinical indications for gastric stapling and gastroplasty are as follows:
  - Morbid obesity has persisted for at least 5 years.
  - The Covered Person has completed growth (18 years of age or documentation of completion of bone growth).
  - Physician verification that the patent is at least 100 pounds overweight or has a Physician documented Body Mass Index (BMl) more than 40, or BMl more than 35 and one of the following:
    - Coronary heart disease;
    - Type 2 diabetes mellitus;
    - Obstructive sleep apnea as indicated by sleep apnea studies;
    - Hypertension with systolic BP of 140mmHg and diastolic BP more than 90mmHG; or
    - Any life threatening or serious medical condition that is weight induced.
  - Covered Person must have completed a structured diet program (either of the following) in the 2-year period that immediately precedes the request:
    - One structured diet program for 6 consecutive months; or
    - Two structured diet programs for 3 consecutive months.

      Commonly available diet programs, such as Weight Watchers or Jenny Craig, are considered to be structured diet programs.

Documentation of completion of a structured diet program shall include one or more of the following:

- Attending Physician notes [NOTE: A physiatrist summary letter is not sufficient documentation];
- Notes from other health care providers (other than Physicians):
- Receipts of payment for a structured diet program; or
- Diet or weight loss logs from a structured diet program.

o A psychological assessment has been completed that specifically addresses the patient's motivation regarding this procedure.

- **Newborn Expenses.** Newborn expenses for the following shall be paid under the newborn's own claim:

  o Hospital nursery expenses;

  o Pediatric care;

  o Circumcision; and

  o Hearing screening provided in accordance with current hearing screening standards established by a nationally recognized organization such as the Joint Committee on Infant Hearing Screening of the American Academy of Pediatrics.

  Note: Newborn coverage shall include coverage for Injury or Illness, including the necessary care or treatment of medically diagnosed Congenital Defects, birth abnormalities or prematurity.

  Note: From the moment of delivery, each newborn is subject to a separate Deductible and Copayments as set forth in the Schedule of Benefits.

- **Non-Surgical Back Treatment**. Treatment including procedures or palpation, examination of the spine and chiropractic clinical findings accepted by the Tennessee Board of Chiropractic Examiners as a basis for the adjustment of the spinal column and adjacent tissues for the correction of nerve interference and articular dysfunction. Patient care shall be conducted with due regard for nutrition, environment, hygiene, sanitation and rehabilitation designed to assist in the restoration and maintenance of neurological integrity and homeostatic balance. (See Schedule of Benefits for Non-Surgical Back Treatment).

- **Nursing Services.** Nursing care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) prescribed by a Physician.

- **Occupational Therapy.** Occupational therapy rendered by a licensed Occupational Therapist or Certified Occupational Therapist Assistant (C.O.T.A.). This care must be prescribed by a Physician. (See Schedule of Benefits for Outpatient Occupational/Physical/Speech Pathology Therapy).

- **Organ Transplant.** Medically Necessary organ or tissue transplant procedures for kidney, cornea, heart, heart/lung, liver, lung, pancreas, or bone marrow (including autologous bone marrow transplants) and all related Covered Services when incurred by a Covered Person who is the recipient of such transplant, provided such organ transplants are "human to human" and not

Experimental Procedures. In addition, organ and tissue procurement consisting of removing, preserving, and transporting the donated organ, are Covered Services subject to the maximums shown in the Schedule of Benefits and the following:

- When both the recipient and donor are covered by this Plan, services will be covered for each patient;
- When only the recipient is covered by this Plan, benefits are provided for services for both the recipient and donor, provided benefits to the donor are not furnished under some other form of surgical-medical coverage; and
- When the recipient is not covered by this Plan and the donor is covered, expenses will be eligible for the donor, to the extent that benefits are not provided under the recipient's program of coverage.

Prenotification is required for all transplant procedures. Please contact the Plan Administrator or Prenotification Provider for more information on any available transplant networks or centers of excellence.

- **Orthognathic Surgery or Appliance**. Coverage is available when service is Medically Necessary. Orthognathic surgery or appliance is considered Medically Necessary to treat a medical condition or Injury which prevents normal function of the joint or bone when the procedure can be reasonably expected to attain functional capacity of the affected part. A medical condition or Injury which prevents normal function of the joint or bone includes any of the following:
  - Choking, difficulty swallowing or ability to chew only soft or liquid food;
  - Symptoms must be documented in the medical record, must be significant and must persist for at least 4 months;
  - Other causes of swallowing/choking problems have been ruled out by history, physical exam or appropriate diagnostic studies including but not limited to, allergies, neurologic or metabolic disease or hypothyroidism;
  - Speech abnormalities determined by a speech pathologist or therapist to be due to a malocclusion and not helped by orthodontia or at least six months of speech therapy;
  - Intra-oral trauma while chewing related to malocclusion (e.g. loss of food through the lips during mastication, causing recurrent damage to the soft tissues of the mouth during mastication); or
  - Masticatory Dysfunction/Malocclusion as defined in the Glossary.

  Reconstructive. Orthognathic surgery is considered reconstructive when a significant physical functional impairment is not present, but when there is a significant variation in the normal anatomy of the maxilla and mandible.

  Cosmetic and Not Medically Necessary. Procedures intended to change a physical appearance that would be considered within normal human anatomic variation are considered cosmetic and not Medically Necessary.

  A genioplasty (or anterior mandibular osteotomy) not associated with masticatory malocclusion is considered cosmetic and not Medically Necessary.

  This Plan does not cover orthodontia (braces) services.

- **Ostomy Supplies.** Ostomy Supplies are a Covered Service.

- **Ovarian Cancer Screening.** Transvaginal ultrasound and rectovaginal pelvic examination are covered for females age 25 and older who are at risk of ovarian cancer.
- **Oxygen.** Oxygen and rental of equipment for its administration.
- **Pain Management.** Access to a pain management Specialist and coverage for treatment of pain, as recommended by a pain management Specialist for all Medically Necessary medications and procedures required to diagnose and develop a pain treatment plan.
- **Pap Smear.** Expenses incurred for laboratory charges for Pap smears, as shown in the Schedule of Benefits under Preventive Care benefits.
- **Phenylketonuria (PKU).** Treatment for phenylketonuria which includes licensed professional medical services under the supervision of a Physician and those special dietary formulas which are Medically Necessary for the therapeutic treatment of phenylketonuria.
- **Physical Therapy.** Physical Therapy rendered by a licensed Physical Therapist or Physical Therapist Assistant (P.T.A.). This care must be prescribed by a Physician. (See Schedule of Benefits for Outpatient Occupational/Physical/Speech Pathology Therapy).
- **Physician's Services.** Physician's fees for medical and surgical services as well as services of an assistant surgeon when required and in conjunction with other Medically Necessary services.

  Services performed in a Physician's office on the same or following business day after an office visit with that Physician for the same or related diagnosis, whether a Physician is seen or not, will be payable as shown in the Schedule of Benefits. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, allergy shots, cast application and minor surgery.
- **Podiatry.** Treatment by a Physician of Podiatry (D.P.M.) for the following foot conditions:
  - Weak, unstable or flat feet;
  - Bunions, when an open cutting operation is performed;
  - Non-routine treatment of corns or calluses;
  - Toenails when at least part of the nail root is removed;
  - Any Medically Necessary surgical procedures required for a foot condition; and
  - Orthotics, including orthopedic shoes when an integral part of a leg brace.
- **Postpartum Services.** Postpartum services including, Inpatient and Home Health Care visit or visits in accordance with guidelines for prenatal care prepared by The American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists including any changes to such guidelines or standards within 6 months of publication or any official amendment thereof.
- **Prescription Drugs.** FDA approved Prescription Drugs and medicines for the treatment of an Illness or Injury, required by law to be prescribed in writing by a Physician and dispensed by a licensed pharmacist are covered by the Prescription Drug Card Program. Only Physician-dispensed Prescription Drugs which were not filled through the Prescription Card Program are a Covered Service under the health Plan.

- **Preventive Care/ Wellness Services.** The Plan covers Preventive Care services for children, adolescents and adults at no cost.

  Preventive Care services generally include check-up visits, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance.

  Services are covered as preventive care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, but instead benefits will be considered in accordance with other applicable Plan provisions.

  Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and the provider performs additional necessary Covered Services, these services will not be considered as preventive care services and, instead, will be covered in accordance with other applicable Plan provisions. Deductibles, Copayments and Coinsurance amounts applicable to diagnostic and/or surgical services may be different from those applicable to preventive care services; for more information, please see the Schedule of Benefits which provides a summary of the Covered Expenses, Limitations and Exclusions that apply to the Plan.

  The Preventive Care services set forth in this section meet the requirements outlined under federal and state law. These services fall under four broad categories as shown below:

  - Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;
    - Type 2 diabetes mellitus;
    - Cholesterol; and
    - Child and adult obesity.
  - Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
  - Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
  - Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Women's contraceptives including all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, patient education, and counseling. Contraceptive coverage includes generic and single-source brand drugs as well as

injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Standard multi-source brand drugs will be covered under the Prescription Drug benefit.

- Breastfeeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy. Visits to a Lactation Consultant are covered. Your In Network OB/GYN or Pediatrician may offer Lactation Consultants through their office. You can also call the Plan Administrator or the Care Coordinators at the number listed on the back of Your I.D. card for additional information about these services.
- Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
- Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of Pap smear results.
- Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.
- Screening and counseling for interpersonal and domestic violence.
- Well woman visits.

If Your Plan limits any of these women's preventive care benefits, a Rider is attached to this Plan document. Participants may call the Plan Administrator or the Care Coordinators at the number listed on the back of their I.D. card for additional information about these services.

Participants may also visit the federal government websites:

- http://www.healthcare.gov/center/regulations/prevention.html;
- http://www.ahrq.gov/clinic/uspstfix.htm; or
- http://www.cdc.gov/vaccines/recs/acip/

- **Private Duty Nursing. Medically Necessary Private Duty Nursing s**ervices of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) prescribed by a Physician for a Covered Person who is receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided by a skilled nursing visit through a home health agency. Services provided by a close relative or a member of Your household are specifically excluded.
- **Prostate Cancer.** Annual medically recognized diagnostic examination for the detection of prostate cancer, including a prostate-specific antigen test for each male Participant and Dependent enrolled in the Plan who is:
  - At least 50 years of age; or
  - Under age 50 if a Physician determines that early detection for prostate cancer is Medically Necessary.
- **Prosthetics.** Artificial limbs and eyes when Medically Necessary for Activities of Daily Living as the result of an Illness or Injury, including the repair, maintenance and replacement when Medically Necessary.
- **Radiation Therapy and Chemotherapy.** X-ray, radium, radioactive isotope therapy, and chemotherapy are a Covered Service.

- **Respiratory Therapy.** Medically Necessary Respiratory Therapy when prescribed by a Physician.
- **Scalp Hair Prosthesis.** Purchase of an initial scalp hair prosthesis (wig) when necessitated by hair loss due to a medical condition covered under the Plan, subject to a lifetime maximum of $250.
- **Self-Inflicted Injury.** Costs arising from a self-inflicted Injury are a Covered Service.
- **Skilled Nursing Facility/Extended Care Facility Rehabilitation Facility.** Confinement in a Skilled Nursing Facility, provided:
    - Such confinement begins within 5 days following an eligible Hospital confinement;
    - Such confinement is under the supervision of a Physician;
    - The attending Physician certifies 24 hour nursing care is necessary for recuperation from the Injury or Illness which required Hospital confinement; and
    - Such confinement is for necessary recuperative care of the same condition requiring the prior hospitalization.

  The total of all Medically Necessary services and supplies (including room and board) furnished by the facility cannot exceed the maximum shown in the Schedule of Benefits.
- **Speech Therapy.** Speech therapy provided by a speech therapist when:
    - The services of a speech therapist are prescribed by a Physician who continues to control and direct the overall treatment of the case, as Medically Necessary to improve the specific defect, and
        - The Covered Person is under age 16 and speech therapy is for developmental delay, or
        - The service of a speech therapist is required to restore a speech Disability that the patient lost as a direct result of an Illness or Injury.

  (See Schedule of Benefits for Outpatient Occupational/Physical/Speech Pathology Therapy.)
- **Spinal Manipulation Treatment**. See Non-Surgical Back Treatment.
- **Sterilization**. Elective Sterilization regardless of Medical Necessity.
- **Substance Use Disorder Treatment**.
    - **Inpatient.** Treatment of Substance Use Disorder and/or complications thereof, up to the maximum specified in the Schedule of Benefits, provided services are rendered by a Hospital, psychiatric Hospital, a Physician, or a Substance Use Disorder Treatment Facility.
    - **Outpatient.** Care and treatment of Substance Use Disorder and/or complications thereof, up to the maximum specified in the Schedule of Benefits, provided services are rendered by a licensed Hospital, psychiatric Hospital, Outpatient psychiatric center or a community mental health center, a Physician or a Substance Use Disorder Treatment Facility.
    - **Partial day.** A partial day program must be licensed or approved by the state and must include day or evening treatment programs which lasts at least 6 or more continuous hours per day for Substance Use Disorders, or an intensive Outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.

Coverage for Substance Use Disorders shall be neither different nor separate from coverage for any other Illness for the purpose of determining Deductibles, annual discretional limits, Maximum Annual Benefits, episode or treatment limits, Copayments, and Coinsurances.

- **Surgery.** When 2 or more surgical procedures occur during the same operation, the Covered Services for all charges are as follows:
  - When multiple or bilateral surgical procedures that increase the time and amount of patient care are performed, the Covered Service is the Allowable charge for the major procedure and 50% of the Allowable charge for each of the lesser ones; and
  - When an incidental procedure is performed through the same incision, the Covered Service is the Allowable charge for the major surgical procedure only. Examples of incidental procedures are excision of a scar, appendectomy, lysis of adhesions, etc.
- **Transportation by Commercial Carrier.** Transportation by railroad or scheduled commercial airline to, but not from, a Hospital equipped to furnish special treatment approved and recognized by the American Medical Association for the Injury or Illness (excluding any transportation from or to points outside the continental limits of the United States or Canada), if approved by Case Management and the Prenotification Provider.

Section Ten
Limitations and Exclusions on Covered Services

10.01 Limitations and Exclusions

The Plan shall not pay for any service, procedure or supplies incurred by the Covered Person, which is not specifically listed as a Covered Service under Section Nine. By way of illustration, the Plan excludes the following specific items:

- **Abortion.** Services or supplies for abortion except to the extent otherwise covered under the Plan as a Complication of Pregnancy as defined in the Glossary.
- **Acupuncture or Acupressure.** Services or supplies for acupuncture or acupressure.
- **Administrative Charges.** Administrative charges billed by a provider, including charges for failure to keep an appointment, completion of a claim form or similar paperwork, obtaining medical records and late payments.
- **After Termination.** Services or supplies rendered after the termination of coverage, except under an extension of benefits.
- **Alternative Medicine.** Alternative medicine including but not limited to hydrotherapy, aromatherapy, naturopathy and homeopathic and holistic treatment.
- **Blood Donor Expenses.** Blood or blood plasma or blood donor expenses, except as specifically covered under Covered Services or as may be deemed Medically Necessary by the Plan Administrator.
- **Charges.** Charges in excess of Allowable limitations.
- **Complications of Non-Covered Services.** To the extent permitted by law, treatment, service or care required as a result of complications from a treatment or service not covered by the Plan.
- **Cosmetic or Reconstructive Surgery.** Services or supplies for cosmetic or reconstructive surgeries and related treatments, including but not limited to:
    - Surgical removal or reformation of sagging skin on any part of the body;
    - Enlargement, reduction or other changes in appearance of any part of the body, unless specifically covered under the Covered Services Section;
    - Hair transplant or removal of hair by electrolysis;
    - Chemical face peels or skin abrasions;
    - Removal of tattoos or birthmarks; and
    - Surgical treatments of scaring secondary to acne or chicken pox to include, but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.

  This exclusion shall not apply to cosmetic or reconstructive surgery specifically listed as a Covered Service, or as deemed Medically Necessary in connection with an Illness or Injury.
- **Counseling.** Marriage, job, industrial or sex counseling and therapy.
- **Custodial Care.** Custodial Care provided in the home that only assists with the Activities of Daily Living.

- **Dental.** Dental services or supplies, unless required as the result of an Injury to the Participant's natural teeth, and unless specifically listed as a Covered Service, and in any event limited to the benefits specified in the Plan. However, hospitalization and anesthesia are covered for a dental procedure for a child age 8 or younger where the procedure cannot safely be performed in a dental office setting.
- **Dentures.** Charges in connection with the fitting or wearing of dentures or implants.
- **Drugs.** Any drugs covered under the Prescription Drug Card Program will be paid under the Prescription Drug Card Program and not as a Covered Service under the Plan.
- **Durable Medical Equipment.** Durable Medical Equipment which is not primarily or customarily used to serve a medical purpose, disposable sheaths and supplies, exercise or hygienic equipment, correction appliances (except casts, splints and dressings), support appliances and supplies such as stockings, arch support, orthotic items, correction shoes, air conditioners, humidifiers, heating pads, hot water bottles, personal care items, wigs and cases (except for coverage for the initial purchase of a wig for hair loss resulting from a medical treatment covered under the Plan, subject to a Life Time Maximum of $250), whirlpools, jacuzzis and comfort items.
- **Erectile Dysfunction.** Treatment for Erectile Dysfunction is excluded, except where such sexual dysfunction is caused by surgery (e.g., Prostate surgery), or unless otherwise provided for in the Plan.
- **Examinations.** Examinations for:
    - Employment, insurance, licensing or litigation purposes;
    - Eye refractions;
    - Care and treatment of the teeth, gums or alveolar process; and
    - Sports or recreational activity.
- **Excess Expenses.** Covered Services in excess of the Maximum Benefit.
- **Exercise Programs and Equipment.** Any costs related to exercise programs and equipment such as, but not limited to, bicycles and treadmills.
- **Experimental Procedures.** Experimental Procedures as defined in the Glossary.
- **Eye Glasses.** Services and/or supplies for the purchase or fitting of eye glasses or lenses (except for the first pair of eye glasses and/or contact lenses provided within six (6) months of cataract surgery).
- **Governmental Benefits.**
    - Hospital services (including room and board), supplies or equipment obtained at government expense at any Veteran's Administration Hospital or any other Hospital owned or leased by the federal government. This exclusion applies only for charges for the treatment of a service-related Disability;
    - Any fee, service or supply received from any governmental body or subdivision thereof and any public or private educational institution;
    - Services or supplies for conditions caused by or arising out of an act of war, armed action, aggression or terrorism; or

- Care of an Injury or Illness incurred while on active or reserve military duty.

- **Hearing Exams and Hearing Aid.** All cost associated with Hearing Exams and Hearing Aids with the exception of newborn screening for hearing problems and Covered Services for hearing aid coverage for children 18 years old and under. For Children 18 years old and under, coverage for hearing aids is limited to one (1) hearing aid per ear every three (3) years and does not include accessories such as batteries, cords, and other assistive listening devices such as FM systems which are excluded.
- **Hypnotism.** Hypnotism, hypnotic anesthesia and biofeedback.
- **Infertility Treatment.** Charges for all forms of infertility treatment, including but not limited to artificial insemination, other artificial methods of conception, in vitro fertilization, in vivo fertilization, services for a surrogate mother, or treatment of sexual dysfunctions not related to organic disease.
- **Late Submittal Claims.** Services or supplies for which a claim is submitted more than one year and 90 days after the date on which charges for such services were incurred, except when the Covered Person lacks legal capacity and does not have a legal guardian to submit such claims. See Claims Procedures, Section Thirteen, for more information.
- **Music Therapy.** Music Therapy, remedial reading, recreational therapy and other forms of special education.
- **No Legal Obligation.** Services or supplies for which the Participant or Dependent is not legally obligated to pay or which no charge would be made in absence of the Plan. This exclusion shall not apply to services rendered by a non-governmental charitable research hospital which bills for services rendered, but does not enforce by judicial proceedings collection from patients in the absence of coverage under the Plan.
- **Non-Licensed Provider.** Services or supplies provided by a Provider, practitioner or institution who or which is not legally licensed to provide those services or supplies in the jurisdiction where such services or supplies were provided.
- **Non-Prescription Drugs.** Drugs, medications and supplies, which do not require a Physician's prescription and are not otherwise specifically listed as a Covered Service.
- **Non-Professional Care.** Medical or surgical care that is not performed according to generally accepted professional standards.
- **Not Medically Necessary.** Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.
- **Personal Comfort.** Services or supplies for Personal Comfort or convenience, (*i.e*. private room, television, telephone, guest trays, etc.).
- **Prior to Effective Date.** Services or supplies rendered prior to the Effective Date of coverage.
- **Radial Keratotomy or Refractive Keratoplasty.** Radial Keratotomy, Refractive Keratoplasty, lasik and other procedures performed solely for the correction of vision, except for surgical correction of an eye Injury.
- **Related Provider.** Services or supplies provided by persons who ordinarily reside at the same household, or who are related by blood, marriage or legal adoption to the Covered Person.

- **Reversal of Sterilization.** Procedures or treatments to reverse prior voluntary sterilization.
- **Rest Home.** Services provided by a rest home, convalescent facility, or nursing home that only assists with Activities of Daily Living such as bathing, dressing, walking, eating, preparing special diets, or supervising the taking of medications.
- **Self-Administered Service.** Services administered by the Covered Person.
- **Sex Change.** Any expenses, treatment or procedure related to sex change or designed to alter physical characteristics to those of the opposite sex, or any treatment, studies or expenses related to a transsexual operation sex transformation.
- **Taxes.** Charges for federal, state and local taxes.
- **Vocational and Educational Testing, Evaluation and Counseling**. Vocational and educational services rendered primarily for training or education purposes.
- **Warning Devices.** Warning devices, stethoscopes, blood pressure cuffs or other types of apparatus used for self-diagnosis or monitoring.
- **Workers Compensation or Similar Law.** Services or supplies for any Illness or Injury covered by the Plan for which benefits of any nature are recovered, recoverable or found to be recoverable under Workers' Compensation, any occupational disease law, or any other similar law.

10.02 Covered Person's Right to Choose

This Plan does not limit a Covered Person's right to choose his or her own Medical Care. If a medical expense is not a Covered Service, or is subject to a Limitation or Exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is Out of Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Copercentage level with the Covered Person being responsible for a larger percentage of the total medical expense.

Section Eleven
Coordination of Benefits

If a Covered Person is covered under more than one group plan, benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either the regular benefits or reduced benefits which, when added to the benefits of the other Plan, will not exceed 100% of the Allowable Expense.

11.01 Definitions

The following terms have special meaning in the Coordination of Benefits section:

- **Allowable Expenses.** Any Medically Necessary, Allowable expense incurred by a Covered Person which is covered at least in part under this Plan.
- **Claim Determination Period.** A Calendar Year or Plan Year or a portion of a Calendar Year or Plan Year during which the Covered Person for whom a claim is made has been covered under the Plan.
- **Plan.** Any plan under which medical or dental benefits or services are provided by:
  - Group, blanket or franchise insurance coverage;
  - Any group Hospital service pre-payment, group medical service pre-payment, group practice or other group pre-payment coverage;
  - Group coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefits plans; or
  - Coverage under governmental programs or coverage required or provided by any statute (including no-fault auto insurance), except Medicare. (Refer to the Coordination of Benefits with Medicare provision for treatment of this coverage under this Plan.)

11.02 Effect of Health Maintenance Organization (HMO) Coverage

This Plan will not consider as a Covered Service any charge which would have been covered by an HMO which is the primary payer. This Plan will not consider any charge in excess of what an HMO provider has agreed to accept as a Covered Service, subject to the Participant's Right to Appeal as described in Section 13 and following.

11.03 Order of Benefit Determination

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expenses. No plan pays more than it would without the Coordination of Benefits provision. A plan without a Coordination of Benefits provision is always the primary plan. If all plans have such a provision:

- The benefits of the plan which covers the person, on whose behalf a claim is based, as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
- For claims of a Dependent Child of parents not separated or divorced, the plan covering the parent whose birthday occurs earlier in the year pays first. The plan covering the parent whose birthday occurs later in the year pays second.

  If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have this birthday rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits;

- For claims of dependent children of parents separated or divorced, the male/female rule and the birthday rule do not apply. Instead:
  - The plan of the parent with primary custody pays first;
  - The plan of the spouse of the parent with primary custody (the step-parent) pays next; and
  - The plan of the parent without custody pays last.

  However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obligated to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual knowledge, this "court decree" rule is not applicable;
- The plan covering a person, on whose behalf a claim is based, as an employee who is neither laid off nor retired (or as that employee's Dependent) pays benefits first. The plan covering a person, on whose behalf a claim is based, as a laid off or retired employee (or as that laid off or retired person's Dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored; or
- If none of the above rules determines the order of benefits, the plan covering a person, on whose behalf a claim is based, longer pays first. The plan covering that person for the shorter time pays second.

The Coordination of Benefits provision may operate to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowance Expense and a benefit paid.

11.04 Recovery

If the amount of the payment made by this Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

Any person this Plan has paid or for whom it has paid;
Insurance companies; and
Other organizations.

11.05 Payment to Other Carriers

Whenever payments which should have been made under this Plan in accordance with the above provisions, have been made under any other plan, this Plan will have the right exercisable alone and in its discretionary authority to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

11.06 Subrogation

As a condition to receiving benefits under this Plan, a Covered Person agrees:

- To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for an Injury or Illness without obtaining the Plan's written approval; and
- Without limiting the preceding, that the Plan shall be subrogated to any and all claims, causes of action for rights that the Covered Person has or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies or funds for which the Covered Person claims an entitlement to benefits under this Plan.

The Plan Administrator, in its discretionary authority, may require the Covered Person (and/or the Covered Person's attorney) to execute and return a Subrogation Agreement to the Plan Administrator as a condition to the payment of benefits, including the payment of any future benefits. The Covered Person shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If a requested Subrogation Agreement is not executed and returned, or if information and assistance is not provided to the Plan Administrator upon request, the Plan Administrator, in its discretionary authority, may deny claims for benefits with respect to costs incurred in connection with said Illness or Injury.

If the Covered Person retains an attorney, that attorney must sign the Subrogation Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. If a requested Subrogation Agreement is not executed and returned, the Plan Administrator, in its discretionary authority, may deny claims for benefits with respect to costs incurred in connection with said illness or injury.

If the Covered Person (or legal representative of the Covered Person, including the guardian or estate) decides to pursue a claim against a first or third party for any coverage available to them as a result of the Injury or Illness, the Covered Person agrees to include the Plan's subrogation claim in that action. If there is failure to do so, the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue any and all claims against a first or third parties for coverage or damages, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claim in his or her name, to execute any and all documents necessary to pursue said claims in his or her name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person (or other legal representative of the Covered Person, including the guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgement and other legal instruments documenting the Plan's subrogation rights. The Plan is only responsible for legal costs that are related to the Plan's decision to enforce its subrogation rights.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against a first or third party for any coverage or damages available to them. This right of subrogation shall bind the Covered Person, the Covered Person's guardian(s), estate, executor, personal representatives, heirs, COBRA beneficiaries, and any other person who may recover on behalf of a Covered Person.

11.07 Reimbursement

As a condition to receiving benefits under this Plan, a Covered Person agrees:

- To notify the Plan Administrator immediately in writing if any recovery is received by or on behalf of a Covered Person from any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for an Injury or Illness (without regard to admission of fault);
- To serve as a constructive trustee and to hold in constructive trust such money or property resulting from any payments for medical expenses or settlement proceeds for medical expenses equal to the reasonable value of benefits paid or that will be paid by the Plan. The Covered Person agrees not to dissipate any such money or property resulting from any payments for medical expenses or settlement proceeds for medical expenses without prior written consent of the Plan, regardless of how such money or property is classified or characterized or regardless of any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies or funds from which such money or property was received;
- To restore to the Plan the reasonable value of any such benefit paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, or other insurance policies or funds; and
- To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for an Injury or Illness without obtaining the Plan's written approval.

The Plan Administrator, in its discretionary authority, may require the Covered Person (and/or the Covered Person's attorney) to execute and return a Reimbursement Agreement to the Plan Administrator as a condition to the payment of benefits, including the payment of any future benefits. The Covered Person shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If a requested Reimbursement Agreement is not executed and returned, or if information and assistance is not provided to the Plan Administrator upon request, the Plan Administrator, in its discretionary authority, may deny claims for benefits with respect to costs incurred in connection with said Illness or Injury.

In the event a Covered Person settles, or is reimbursed by any first or third party for any coverage or damages available to them, the Covered Person agrees that he or she is a constructive trustee, and shall hold any such funds received for medical expenses in constructive trust for the benefit of the Plan, and to transfer title to the Plan all benefits paid or that will be paid as a result of said Injury or Illness. The Covered Person acknowledges that the Plan has a property interest in the Covered Person's settlement, recovery, or reimbursement, and that the Plan's reimbursement rights shall be considered a first priority claim if the Plan pays primary and shall be paid before any other claims for the Covered Person as the result of the Injury or Illness, but only after the Covered Person is made whole. Once the Covered Person is made whole, if the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or Illness, the Covered Person is liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Plan will not pay the Covered Person's attorney's fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the Covered Person's attorney's fees and costs.

Attorneys' fees will be payable from the recovery only after the Plan has received full reimbursement. Notwithstanding the foregoing, if the Covered Person's attorney notifies the Plan before filing any suit or settling any claim so as to allow the Plan to enforce the Plan's rights and to recover the amount of the Plan benefit payments to you, the Plan may, in its discretion, share proportionately with you in any reasonable attorney's fees charged you by your attorney for obtaining the recovery.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A Covered Person's attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person or his/her legal representative pursuing a claim against first or third party for any coverage or damages available to them. This right of reimbursement shall bind the Covered Person, Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

11.08 Constructive Trust

The Covered Person, by accepting benefits under this Plan, agrees to hold in constructive trust for the Plan's benefit any money or property resulting from any recovery, insurance payments or settlement proceeds, first or third party payments, settlement proceeds or judgment for medical expenses, without regard to admission of fault, and that the Plan has an equitable lien by agreement over any such recovery in an amount equal to the reasonable value of benefits paid or that will be paid by the Plan to the Covered Person under this provision. The Covered Person further agrees to hold such amounts separately and without commingling with the Covered Person's (or the Covered Person's designee's) general assets.

The Covered Person acknowledges that the Plan has a property interest in the Covered Person's settlement, recovery, or reimbursement for medical expenses equal to the reasonable value of benefits paid or that will be paid by the Plan to the Covered Person, and that the Plan's reimbursement rights shall be considered a first priority claim if the Plan pays primary and shall be paid before any other claims for the Covered Person as the result of the Injury or Illness. If a Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any recovery or reimbursement received for medical expenses, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. This right of reimbursement shall bind the Covered Person, Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

Any amounts subject to a constructive trust under this section shall be limited to amounts received by the Covered Person or their legal representative for said Injury or Illness. Any recovery made by the Plan under this section shall be limited to the reasonable value of medical expenses and other fees and costs, including attorney's fees, paid by or payable by the Plan for said Injury or Illness.

11.09 Rights of Recovery

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other provider of health care, and the payment is found to be an overpayment within 18 months of such payment, the Plan will request a refund of the overpayment from the provider. If the refund is not received from the provider, or from the Covered Person, the amount of the

overpayment will be deducted from future benefits of the Covered Person, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

11.10 Right to Receive and Release Necessary Information

For the purpose of implementing the terms of this Plan, the Plan Administrator retains the right to request any medical information from any insurance company or other provider of service it deems necessary to properly process a claim in its discretionary authority. The Plan Administrator may, in its discretionary authority and without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Section Twelve
Coordination of Benefits With Medicare

12.01 Eligibility for Medicare

A Participant may have coverage under the Plan and under Medicare concurrently. Medicare means those benefits offered under Title XVIII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. When a Participant has coverage under the Plan and Medicare, the Plan will pay primary benefits for:

- An active employee who is age 65 and over;
- An active employee's covered spouse age 65 and over;
- An active employee or covered Dependent of an active employee under age 65 entitled to Medicare because of a Disability; or
- The first 30 months of treatment for End Stage Renal Disease received by any Participant, as set forth under the Medicare Secondary Payer Act, unless Medicare was already the primary payer for the Participant based on age or Disability prior to the ESRD diagnosis.

If a Participant does not fall into one or more of the categories above, the Plan will pay benefits secondary to Medicare. When the Plan is secondary, the Participant must first submit the claim to Medicare. After Medicare makes their payment, the Participant may then submit the claim to the Plan for payment.

When a Participant files for Social Security benefits, the Participant automatically becomes eligible for Medicare Part A hospital coverage, which has no premium expense. A Participant must voluntarily enroll in Medicare Part B medical coverage and pay premiums.

> ***Note:*** The definition of active employee for purposes of Medicare is different from the definition of Actively at Work or Employee for purposes of this Plan.

12.02 Election by Participant

A Participant who is covered under Medicare and the Plan, and who falls into the categories above, may elect to waive coverage under the Plan. If coverage is waived under the Plan, the Plan will no longer provide coverage for that person. If a Participant waives coverage under the Plan, the Participant may later reapply for coverage under the Plan as a Late Enrollee. The rules governing Late Enrollees will apply. If a Participant elects Medicare as the primary coverage, the Participant will have no further coverage under this Plan.

12.03 HCFA Regulation

This Section is based on regulations issued by the Health Care Financing Administration ("HCFA"), now known as Centers for Medicare and Medicaid Services ("CMS"), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer Rules. The Plan will coordinate with Medicare to the fullest extent permitted by applicable law. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay benefits in accordance with CMS regulations and other applicable federal law.

Section Thirteen
Claims Procedures

13.01 Introduction

Claimants are entitled to full and fair review of any Claims made under the Plan. The procedures described below are intended to comply with DOL regulations by providing reasonable procedures governing Claims and Appeals.

13.02 Definitions

- **Claim.** A Claim is any request for a Plan benefit or benefits made in accordance with these Claims Procedures. Communication regarding benefits that are not made in accordance with these procedures will not be treated as a Claim under these procedures.
- **Claimant.** A Claimant is an individual who makes a request for a Plan benefit or benefits in accordance with these Claims Procedures.
- **Incorrectly-Filed Claim.** Any request for benefits that is not made in accordance with these Claims Procedures is called an Incorrectly-Filed Claim.
- **Day.** When used in these Claims Procedures, the term Day means calendar day.
- **Authorized Representative.** An Authorized Representative may act on behalf of a Claimant with respect to a Claim or Appeal under these procedures. However, no person (including a treating health care professional) will be recognized as an Authorized Representative until the Plan receives an Appointment of Authorized Representative Form signed by the Claimant, except in the case of Urgent Care Claims. The Plan shall, even in the absence of a signed Appointment of Authorized Representative Form, recognize a health care professional with knowledge of the Claimant's medical condition (*e.g.*, the treating Physician) as the Claimant's Authorized Representative unless the Claimant provides specific written direction otherwise. An Appointment of Authorized Representative Form may be obtained from and shall be completed and returned to the Plan Administrator.

  An assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an Authorized Representative under these Claims Procedures.

  Once an Authorized Representative is appointed, the Plan shall direct all information, notification, etc. regarding the Claim to the Authorized Representative. The Claimant shall be copied on all notifications regarding decisions, unless the Claimant provides specific written direction otherwise.

  Any reference in these Claims Procedures to "Claimant" is intended to include the Authorized Representative of such Claimant appointed in compliance with the above procedures.

13.03 Four Types of Claims

- **Different Rules Apply.** There are four categories of Claims, each with somewhat different Claim and Appeal rules. The DOL regulations set different requirements based on the type of Claim involved. The primary difference is the timeframe within which Claims and Appeals must be determined.
- **Pre-Service Claim.** A Claim is a Pre-Service Claim if the Plan document specifically warrants Prenotification in whole or in part prior to receiving approval of the Medical Care unless the Claim

involves Urgent Care, as defined below. Benefits under the Plan that require approval in advance are specifically noted in this Plan document as being subject to Prenotification.

- **Urgent Care Claim.** An Urgent Care Claim is a special type of Pre-Service Claim. A Claim involving Urgent Care is any Pre-Service Claim for Medical Care or treatment that could seriously jeopardize the Claimant's life or health or ability to regain maximum function or would, in the opinion of a Physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without immediate care or treatment that is the subject of the Claim.

  On receipt of a Pre-Service Claim, the Plan will make a determination of whether it involves Urgent Care, provided that, if a Physician with knowledge of the Claimant's medical condition determines that a Claim involves Urgent Care, the Claim shall be treated as an Urgent Care Claim.

- **Post-Service Claim.** A Post-Service Claim is any Claim for a benefit under this Plan that is not a Pre-Service Claim or an Urgent Care Claim.

- **Concurrent Care Claims.** A Concurrent Care Claim occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of Concurrent Care Claims:

  - Reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and
  - An extension is requested beyond the initially-approved period of time or number of treatments.

- **Change in Claim Type.** The Claim type is determined initially when the Claim is filed. However, if the nature of the Claim changes as it proceeds through these Claims Procedures, the Claim may be recharacterized. For example, a Claim may initially be an Urgent Care Claim; however, if the urgency subsides, it may be recharacterized as a Pre-Service Claim.

Questions about Claim Type. It is very important to follow the requirements that apply to the particular type of Claim. Any questions regarding what type of Claim and/or what Claims Procedure to follow should be addressed to the Plan Administrator.

13.04 How to File a Claim For Benefits

- **General Filing Rules.** Except for Urgent Care Claims, discussed below, a Claim for benefits is made when a Claimant (or Authorized Representative) submits a written Claim for Benefits Form to the Claims Administrator. Claim forms may be obtained by contacting the Claims Administrator. A Claim for Benefits Form will be treated as received by the Plan:

  - On the date it is hand-delivered to the Claims Administrator; or
  - On the date that it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the Claims Administrator's name and address listed in the Plan Identifying Information Section. The postmark on any such envelope will be proof of date of mailing.

- **Post-Service Claims.** A Post-Service Claim shall be filed within 90 days following receipt of the medical service, treatment or product to which the Claim relates unless:

  - It was not reasonably possible to file the Claim within such time; and

- The Claim is filed as soon as possible and in no event later than 12 months after the date of receipt of the service, treatment or product to which the Claim relates, except when the Covered Person lacks legal capacity and does not have a legal guardian or Authorized Representative.

- **Urgent Care Claims.** In light of the expedited timeframes for decision of Urgent Care Claims, an Urgent Care Claim for benefits may be submitted to Coordinated Health/Care™ by telephone (877) 498-6689 or by fax (800) 973-2321. The Claim should include at least the following information:
  - The identity of the Claimant;
  - A specific medical condition or symptom; and
  - A specific treatment, service or product for which approval or payment is requested.
- **How Incorrectly-Filed Claims Are Treated.** These Claims Procedures do not apply to any request for benefits that is not made in accordance with these Claims Procedures, except that:
  - In the case of an Incorrectly-Filed Pre-Service Claim, the Claimant shall be notified as soon as possible, but no later than 5 days following receipt by the Plan of the Incorrectly-Filed Claim; and
  - In the case of an Incorrectly-Filed Urgent Care Claim, the Claimant shall be notified as soon as possible, but no later than 24 hours following receipt by the Plan of the Incorrectly-Filed Claim.

  The notice shall explain that the request is an incorrectly filed claim and describe the proper procedures for filing a Claim. The notice may be oral unless written notice is specifically requested by the Claimant.

13.05 Timeframe for Deciding Initial Benefit Claims

- **Pre-Service Claims.** The Plan shall decide an initial Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the Claim.
- **Urgent Care Claims.** The Plan shall decide an initial Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the Claim.
- **Concurrent Care Extension Request.** If a Claim is a request to extend a Concurrent Care Claim involving Urgent Care and if the Claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the Claim shall be decided within no more than 24 hours after receipt of the Claim. Any other request to extend a Concurrent Care Claim shall be decided in the otherwise applicable timeframes for Pre-Service, Urgent Care, or Post-Service Claims.
- **Concurrent Care Early Termination.** A decision by the Plan to reduce or terminate an initially approved course of treatment is an Adverse Benefit Decision that may be appealed by the Claimant under these procedures, as explained below. Notification to the Claimant of a decision by the Plan to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the Claimant to appeal the Adverse Benefit Decision and receive a decision on review under these procedures prior to the reduction or termination.
- **Post-Service Claim.** The Plan shall decide an initial Post-Service Claim within a reasonable time but no later than 30 days after receipt of the Claim.

- **When Extensions of Time Are Permitted.** Despite the specified timeframes, nothing prevents the Claimant from voluntarily agreeing to extend the above timeframes. In addition, if the Plan is not able to decide a Pre-Service or Post-Service Claim within the above timeframes, due to matters beyond its control, one 15 day extension of the applicable timeframe is permitted, provided that the Claimant is notified in writing prior to the expiration of the initial timeframe applicable to the Claim. The extension notice shall include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for Urgent Care Claims.
- **Incomplete Claims.** If any information needed to process a Claim is missing, the Claim shall be treated as an Incomplete Claim.
- **How Incomplete Urgent Care Claims Are Treated.** If an Urgent Care Claim is Incomplete, the Plan shall notify the Claimant as soon as possible, but no later than 24 hours following receipt of the Incomplete Claim. The notification may be made orally to the Claimant, unless the Claimant requests written notice, and it shall describe the information necessary to complete the Claim and shall specify a reasonable time, no less than 48 hours, within which the Claim must be completed. The Plan shall decide the Claim as soon as possible but no later than 48 hours after the earlier of:
    - Receipt of the specified information; or
    - The end of the period of time provided to submit the specified information.
- **How Other Incomplete Claims Are Treated.** If a Pre-Service or Post-Service Claim is Incomplete, the Plan may deny the Claim or may take an extension of time. If the Plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the Claim shall be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the Claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the Claim may be decided without the requested information.

13.06 Notification of Initial Benefit Decision by Plan

- **Pre-Service and Urgent Care.** Written notification of the Plan's decision on a Pre-Service or Urgent Care Claim shall be provided to the Claimant whether or not the decision is Adverse.
- **Definition of Adverse.** A decision on a Claim is "Adverse" if it is:
    - A denial, reduction, or termination of benefits;
    - A failure to provide or make payment (in whole or in part) for a benefit; or
    - A rescission of coverage.
- **Notification of Adverse Benefit Decision.** Written notification shall be provided to the Claimant of the Plan's Adverse Benefit Decision on a Claim and shall include the following, in a culturally and linguistically appropriate format that is calculated to be understood by the Claimant:
    - Information sufficient to allow the Participant to identify the claim involved (including the date of service, the healthcare provider, the claim amount, and, if applicable, the treatment and diagnosis codes and their corresponding meanings;

- A statement of the specific reason(s) for the decision, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- A description of any additional material or information necessary to perfect the Claim and why such information is necessary;
- A description of the Plan's internal and external appeal procedures. This description will include information on how to initiate the appeal and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following a Final Adverse Benefit Decision;
- A statement disclosing any internal rules, guidelines, protocol or similar criterion relied on in making the Adverse Benefit Decision (or a statement that such information will be provided free of charge upon request); and
- If the decision involves scientific or clinical judgment, disclose either:
  - An explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances;
  - A statement that such explanation will be provided at no charge upon request; or
  - In the case of an Urgent Care Claim, an explanation of the expedited review methods available for such Claims.

  Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

  Notification of the Plan's Adverse Benefit Decision on an Urgent Care Claim may be provided orally, but written notification shall be furnished not later than 3 days after the oral notice.

13.07 Right to Appeal

A Claimant has a right to Appeal an Adverse Benefit Decision under these Claims procedures.

13.08 How to Appeal an Adverse Benefit Decision- First Level of Appeal

- **How to File an Appeal.** Except for Urgent Care Claims, discussed below, an Appeal of an Adverse Benefit Decision is filed when a Claimant (or Authorized Representative) submits a written Request for Review Form to the Named Fiduciary and/or the Plan Administrator.

  Request for Review Forms may be obtained by contacting the Named Fiduciary or the Plan Administrator at the following address:

  C. Gregg Conroy, Plan Administrator
  1031 17th Avenue South
  Nashville, TN 37212
  Telephone: (615) 292-3535, ext. 206
  Facsimile: (615) 292-3933

  A Request for Review Form will be treated as received by the Plan:

  - On the date it is hand-delivered to the Named Fiduciary or Plan Administrator; or

- On the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the name and address of the Named Fiduciary or the Plan Administrator. The postmark on any such envelope will be proof of the date of mailing.

- **Submission of Comments.** A Claimant has the right to submit documents, written comments, or other information in support of an Appeal.

- **Important Appeal Deadline.** The Appeal of an Adverse Benefit Decision must be filed within 180 days following the Claimant's receipt of the notification of Adverse Benefit Decision, except that the Appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment (see the definition of Concurrent Care Claim) must be filed within 30 days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate benefits. Failure to comply with these important deadlines may cause the Claimant to forfeit any right to any further review of an Adverse Benefit Decision under these Procedures.

- **Urgent Care Appeals.** In light of the expedited timeframes for decision of Urgent Care Claims, an Urgent Care appeal may be submitted to C. Gregg Conroy, Plan Administrator, by telephone ((615) 292-3535, ext. 206) or by fax ((615) 292-3933) or by e-mail (tbcappeal@ticua.org). The Claim should include at least the following information:

  - The identity of the Claimant;
  - A specific medical condition or symptom;
  - A specific treatment, service or product for which approval or payment is requested; and
  - Any reasons why the Appeal should be processed on a more expedited basis.

13.09 How the Appeal Will Be Decided

The Appeal of an Adverse Benefit Decision will be reviewed and decided by the Named Fiduciary. The person or people who review and decide an Appeal will be different than the person or people who made the initial Benefit Decision and will not be a subordinate of the person or people who made the initial Benefit Decision. The Plan will not make decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to claims adjudicators or medical experts based upon the likelihood that such individuals will support or tend to support a denial of benefits. The Named Fiduciary will follow these procedures when deciding any Appeal:

- **Consideration of Comments.** The review will take into account all information submitted by the Claimant, whether or not presented or available at the initial Benefit Decision. The Named Fiduciary will give no deference to the initial Benefit Decision.

- **Consultation with Expert.** In the case of a Claim denied on the grounds of a Medical Necessity, the Named Fiduciary will consult with a health professional with appropriate training and experience. The health care professional who is consulted on Appeal will not be the same individual who was consulted, if any, regarding the initial Benefit Decision or a subordinate of that individual.

- **Access to Relevant Information.** A Claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. If the advice of a medical or vocational expert was obtained in connection with the initial Benefit Decision, the names of each such expert shall be provided on request by the Claimant, regardless of whether the advice was relied on by the Plan.

- **Expedited Methods for Urgent Care.** All necessary information in connection with an Urgent Care Appeal shall be transmitted between the Plan and the Claimant by telephone, fax, or e-mail.
- **Additional Evidence.** The Plan will also provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim. In addition, before the Claimant receives an Adverse Benefits Decision based on new or additional rationale, the Plan will provide the Claimant, free of charge, with the rationale to give the Claimant a reasonable opportunity to respond.

13.10 Timeframes for Deciding Benefits Appeals

- **Pre-Service Claims.** The Named Fiduciary shall decide the Appeal of a Pre-Service Claim within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt by the Plan of the Request for Review Form.
- **Urgent Care Claims.** The Named Fiduciary shall decide the Appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Plan of the Request for Review.
- **Post-Service Claims.** The Named Fiduciary shall decide the Appeal of a Post-Service Claim within a reasonable period but no later than 60 days after receipt by the Plan of the Request for Review Form.
- **Concurrent Care Claims.** The Named Fiduciary shall decide the Appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment (see the definition of Concurrent Care Claim) before the proposed reduction or termination takes place. The Named Fiduciary shall decide the Appeal of a denied request to extend a Concurrent Care Claim in the Appeal timeframe for Pre-Service, Urgent Care, or Post-Service Claims described above, and as appropriate to the request.

13.11 Notification of Decision on Appeal

Written notification of the decision on appeal shall be provided to the Claimant whether or not the decision is Adverse.

- **Definition of Adverse.** A decision on Appeal is "Adverse" if it is
  - A denial, reduction, or termination of benefits;
  - A failure to provide or make payment (in whole or in part) for a benefit; or
  - A rescission of coverage.
- **Notification of Final Adverse Benefit Decision.** Written notification shall be provided to the Claimant of an Adverse Decision on Appeal; this written notification is the Final Adverse Benefit Decision. The written notification shall include the following, written in a culturally and linguistically appropriate format that is calculated to be understood by the Claimant:
  - Information sufficient to allow the Claimant to identify the claim involved (including the date of service, the healthcare provider the claim amount, and, if applicable, the treatment and diagnostic codes and their corresponding meanings;
  - The specific reason(s) for the appeal decision, including the denial code and its corresponding meaning, a description of the Plan's standard, if any, that was used in denying the claim;

- A reference to the specific Plan provision(s) on which the decision is based;
- A statement disclosing any internal rules, guidelines, protocol or similar criterion relied on in making the Final Adverse Benefit Decision (or a statement that such information will be provided free of charge upon request);
- A description of the Plan's internal and external appeal procedures. This description will include information on how to initiate the appeal and the time limits applicable to such procedures. This will also include a statement of the Claimant's right to bring a civil action following a Final Adverse Benefit Decision;
- Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process;
- A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- Disclose either:
  - An explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances; or
  - A statement that such explanation will be provided at no charge on request.

Notification of an Adverse Benefit Decision on Appeal of an Urgent Care Claim may be provided orally, but written notification shall be furnished no later than 3 days after the oral notice.

13.12 Second and Final Level of Appeal- External Review

If the outcome of the appeal is adverse to the Claimant, the Claimant may be eligible for an independent external review pursuant to federal law. The Claimant must submit a request for external review to the Plan within 4 months of the notice of the Final Adverse Benefit Decision. A request for external review must be in writing unless the Plan determines that it is not reasonable to require a written statement. The Claimant does not have to re-send the information that was submitted as part of the internal appeal. However, the Claimant is encouraged to submit any additional information that might be important for review. The request for external review may be delivered to the following address:

C. Gregg Conroy, Plan Administrator
1031 17th Avenue South
Nashville, TN 37212
Telephone: (615) 292-3535, ext. 206
Facsimile: (615) 292-3933

- **Expedited external review requests are to be initiated by telephone**

  For Urgent Care Claims or Concurrent Care/ Ongoing Course of Treatment claims, the Claimant may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. The Claimant or the Claimant's authorized representative may formally request it orally or in writing, but in order to support the fastest review the Claimant must call the Plan Administrator, C. Gregg Conroy, by telephone ((615) 292-3535, ext. 206). All necessary information, including the Plan's decision, can be sent between the Plan and the Claimant by telephone, facsimile or other similar method. To start an expedited external review, the Claimant or the Claimant's authorized representative must contact the Plan Administrator, C. Gregg Conroy, by telephone ((615) 292-3535, ext. 206) and provide at least the following information:

  - The identity of the claimant;
  - The date(s) of the medical service;
  - The specific medical condition or symptom;
  - The provider's name;
  - The service or supply for which approval of benefits was sought; and
  - Any reasons why the appeal should be processed on a more expedited basis.

- **Other external review requests**

  All other requests for external review should be submitted in writing unless the Plan determines that it is not reasonable to require a written statement. Such requests should be submitted by the Claimant or the Claimant's authorized representative to the following address:

  C. Gregg Conroy, Plan Administrator
  1031 17th Avenue South
  Nashville, TN 37212
  Telephone: (615) 292-3535, ext. 206
  Facsimile: (615) 292-3933

  The Claimant's decision to seek external review will not affect the Claimant's rights to any other benefits under this health care Plan. There is no charge for the Claimant to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

13.13 Decision by the Named Fiduciary

Subject to the Participant's right to appeal as described in Section 13, right to file suit under ERISA as described in Section Thirteen, and other state and federal law, the decision of the Named Fiduciary will be final and binding and will only be subject to review if such decision was arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Named Fiduciary shall be based only on such evidence present to or considered by the Named Fiduciary at the time it made the decision that is now subject to review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decision that the Named Fiduciary makes, in its discretionary authority, and further, subject to the Participant's right to appeal as described in Section 13.07, right to file suit under ERISA as

described in Section Thirteen, and other state and federal law, constitutes agreement to the limited scope of review described in this Section.

13.14 Failure to File a Request

If a Claimant fails to file a request for review in accordance with the procedures outlined herein, such Claimant shall have no rights of review and shall have no right to bring an action in any court. The denial of the claim shall become final and binding on all persons and for all purposes. The Plan's internal appeals procedure (but not an external review) must be exhausted before filing a lawsuit or taking other legal action of any kind against the Plan. The Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). If an appeal, as described above, results in an Adverse Benefit Decision, the claimant has a right to bring a civil action under Section 502(a) of ERISA. The Plan reserves the right to modify the policies, procedures and time frames in this section upon further clarification from Department of Health and Human Services and Department of Labor.

13.15 Administrative Exhaustion Requirement

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty. The Plan's internal appeals procedures can be deemed exhausted, however, and the claimant will be permitted to proceed to external review or judicial review, if the Plan fails to strictly adhere to the internal claims and appeals processes set forth in this Section.

The internal claims and appeals processes, however, will not be deemed exhausted if the Plan's noncompliance was (1) de minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the Plan's control; (4) in the context of an ongoing good-faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, the Plan will, within 10 days, include a specific description of the bases for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If the external reviewer or the court rejects the claimant's request for immediate review (based on a finding that the Plan met this standard) the Plan will provide the claimant notice of the opportunity to resubmit and pursue the internal appeals of the claims. The notice will be sent within a reasonable time after the external reviewer rejects the claims for immediate review, but not later than 10 days.

13.16 Action for Recovery

Any legal action for the recovery of benefits or breach of fiduciary duty must be commenced within three years after the Plan's claim review procedures have been exhausted.

13.17 Administrative Record

In any action for the recovery of benefits, the evidence which may be submitted for review shall be limited to the administrative record on the claim or appeal. Participants may not submit new arguments or theories of recovery in litigation.

Section Fourteen
Statement of ERISA Rights

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Participants shall be entitled to the following:

14.01 Receive Information About the Participant's Plan and Benefits

The Participant may examine, without charge, at the Plan's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

The Participant may obtain, upon written request to the Executive Director of the TICUA Benefit Consortium, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The TICUA Benefit Consortium may make a reasonable charge for the copies.

The Participant may receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the TICUA Benefit Consortium is required by law to furnish each Participant with a copy of this summary annual report.

14.02 Enforce the Participant Rights.

If the Participant's claim is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of document relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Participant or Dependent can take to enforce his or her rights. For instance, if a request for Plan documents is made to the Plan Administrator and such requested information is not received within 30 days, the Participant may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until such requested information is received by the requesting Participant or Dependent, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. Additionally, if a claim for benefits is denied or ignored, in whole or in part, and if the Participant has exhausted the claims procedures available to him/her under the Plan as described in Section Thirteen, the Participant may file suit in federal court.

14.03 Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Participant's Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and beneficiaries. No one, including the Participant's Employer or any other person, may fire the Participant or otherwise discriminate against the Participant in any way to prevent the Participant from obtaining a Plan benefit or exercising the Participant's rights under ERISA.

If it should happen that Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, then such Participant may seek assistance from the U.S. Department of Labor, or file suit in federal court. The court will decide who should pay court costs and legal fees. If a Participant or Dependent is successful, the court may order the person sued to pay these costs and fees. If the Participant or Dependent loses, the court may order such Participant or Dependent to pay these costs and fees, for example, if the court finds the claim is frivolous.

14.04 Questions

If the Participant has any questions about his or her Plan, the Participant should contact the TICUA Benefit Consortium at (615) 292-3535. If the Participant has any questions about this statement, or about his or her ERISA rights, or if the Participant needs assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section Fifteen
General Provisions

15.01 Verification

The Plan Administrator, in its discretionary authority, shall be entitled to require reasonable information to verify any claim or the status of any person as a Covered Person. If the Covered Person does not supply the requested information within the applicable time limits or provide a release for such information, such Covered Person shall not be entitled to benefits under the Plan.

15.02 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against a Member, the Board of Directors, TICUA Benefit Consortium, any of their employees, or any person connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related Trust, except as expressly provided herein or as provided by law.

15.03 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

15.04 Captions

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

15.05 Entire Plan

This document constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing. Any words herein used in the masculine shall also include the feminine and neutral where they would so apply. Words in the singular shall also include the plural and vice versa where they would so apply.

15.06 No Guarantee of Employment

Nothing contained in the Plan shall be construed as a contract of employment between a Member and any Participant, or as a right of any Participant to be continued in the employment of a Member, or as a limitation of the right of a Member to discharge any of the Participants, with or without cause.

15.07 Governing Law

This Plan document shall be governed by and construed and enforced with the laws of the State of Tennessee, to the extent not preempted by ERISA or other federal law.

15.08 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the IRS, we inform You that to the extent this communication (including any attachments) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (i) avoiding any penalties that may be imposed on You or any other person or entity under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein. If You are not the original addressee of this communication, You should seek advice from an independent advisor based on Your particular circumstances.

Section Sixteen
Plan Administrator Duties and Powers

16.01 Appointment of Plan Administrator

The TICUA Benefit Consortium shall appoint a Plan Administrator to administer the Plan and keep records of proceedings and Claims. The Plan Administrator will serve until resignation or dismissal by the TICUA Benefit Consortium. Any vacancy or vacancies shall be filled in the same manner as the original appointments. The TICUA Benefit Consortium may dismiss any person or persons serving as Plan Administrator at any time with or without cause. In the event the TICUA Benefit Consortium chooses to appoint more than one (1) person to act as Plan Administrator, a majority vote of such persons shall be necessary for the transaction of business. In the event only 2 persons are named as Plan Administrator, the transaction of business shall require the unanimous vote of both parties.

16.02 Powers of Plan Administrator

Subject to the limitations of the Plan, the Plan Administrator will from time to time establish rules for the administration of the Plan and transaction of its business. The Plan Administrator will rely on the records of the Members with respect to any and all factual matters dealing with the employment and eligibility of an Employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including, but not limited to, the discretion to:

- Construe and interpret the Plan;
- Decide the question of eligibility to participate in the Plan; and
- Determine the amount, manner and time of payment of any benefits to any Covered Person.

Subject to the Participant's right to appeal as described in Section 13, right to file suit under ERISA as described in Section Thirteen, and other applicable state and federal law and regulations, the Plan Administrator will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding.

16.03 Outside Assistance

The Plan Administrator, in its discretionary authority, may employ such counsel, accountants, Claims Administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The TICUA Benefit Consortium shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

16.04 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Plan Administrator to properly carry out such duties. The Plan Administrator shall have no power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Section.

Section Seventeen
Amendments, Terminations and Mergers

17.01 Right to Amend, Merge or Consolidate

The TICUA Benefit Consortium reserves the right to merge or consolidate the Plan, and to make any amendment or restatement to the Plan from time to time, including those which are retroactive in effect. Such amendments may be applicable to any Covered Person.

Any amendment or restatement shall be deemed to be duly executed by the TICUA Benefit Consortium when approved by the Board of Directors. This approval shall be drafted in a Board Resolution that is to be signed by either the President or Vice-President, and attested by the Secretary or Treasurer.

17.02 Right to Terminate

The Plan is intended to be permanent, but the TICUA Benefit Consortium may at any time terminate the Plan in whole or in part.

17.03 Effect on Benefits

Except as may otherwise be provided by applicable law or this Plan document, if the Plan is amended or terminated, Covered Persons may not receive benefits described in the Plan after the effective date of such amendment or termination. Any such amendment or termination shall not affect a Covered Person's right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, Covered Persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen from time to time. If the Plan is terminated, Covered Persons will not be entitled to any vested rights under the Plan.

Glossary
Definitions

The following terms, as used in the Plan, shall have the meaning specified in this Glossary, unless a different meaning is clearly required by the context in which it is used:

ACA/IRS OOP Limits shall mean the lower of the Out of Pocket Limits as set by the IRS and the ACA, which in 2017 are $6,550 for an Individual and $13,100 for a Family.

Actively at Work shall mean performing the Employee's job at the location where the Employee generally reports to work. If such Employee is on vacation, Approved Leave of Absence (other than Disability), Approved Sabbatical, or is off due to a holiday or other reason approved by the Employer, the Employee will be deemed Actively at Work if the Employee was Actively at Work on the day immediately prior to the vacation, Approved Leave of Absence, Approved Sabbatical, day off or holiday.

Activities of Daily Living shall refer to the following, with or without assistance:

- Bathing, which is the cleansing of the body in either a tub or shower, or by sponge bath;
- Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting, which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
- Transferring, which is to move in and out of a bed, chair, wheelchair, tub or shower;
- Mobility, which is to move from one place to another, with or without the assistance of equipment;
- Eating, which is getting nourishment into the body by any means other than intravenous; and
- Continence, which is voluntarily maintaining control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Affordable Care Act or ACA shall mean the Patient Protection and Affordable Care Act of 2010.

Allowable shall mean those charges made for medical services and/or supplies essential to the care of a Covered Person which will be considered Allowable if they are the amount normally charged by the Provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers for comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are Allowable, due consideration will be given to the nature or severity of the Illness or Injury being treated and any medical complications, degree of professional skill or unusual circumstances which require additional time, skill or experience.

Ambulatory Care shall mean services provided in an Ambulatory Care Facility.

Ambulatory Care Facility shall mean a facility that provides Outpatient Care.

Ambulatory Surgical Facility shall mean an ambulatory surgical center, free-standing surgical center, or Outpatient surgical center, which is not part of a Hospital and which:

- Has an organized medical staff of Physicians;
- Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

- Has continuous Physician's services and registered nursing (R.N.) services whenever a patient is in the facility;
- Is licensed by the jurisdiction in which it is located; and
- Does not provide for overnight accommodations.

Approved Disability Leave shall mean an approved leave for purposes of Disability.

Approved Leave of Absence shall mean an Approved Leave of Absence for a period not to exceed the number of consecutive months defined in the Member's policy manual or handbook, with the stated intention of returning to full time employment with the Member. For purposes of this Plan the term Approved Leave of Absence shall not refer to leave under the Family and Medical Leave Act.

Approved Sabbatical shall mean an approved paid sabbatical or fellowship for a period not to exceed 12 consecutive months. A Participant must be covered prior to Effective Date of Leave.

Benefit Year shall mean the Plan Year.

Birthing Center shall mean a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. The birthing center must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Bone Mass Measurement shall mean a scientifically proven radiologic, radioisotopic, or other procedure performed to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

Calendar Year shall mean January 1 through December 31 of each year.

Care Coordination Process/Coordinated Health Care Program shall have the definition as set forth in the Cost Containment Procedures Section.

Care Coordinator shall have the definition as set forth in the Cost Containment Procedures Section.

Case Management shall have the definition as set forth in the Cost Containment Procedures Section.

Claims Administrator shall mean the person or persons appointed by the Plan Administrator to determine benefit eligibility and to adjudicate claims under the Plan.

Clinical Trial Costs shall mean routine patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer or life-threatening condition where all of the following circumstances exist:

- The treatment is being conducted in a Phase I, II, Phase III, or Phase IV clinical trial;
    - Treatment provided by a clinical trial is approved or funded by one of the following:
        - The National Institutes of Health;
        - The U.S. Food and Drug Administration in the form of an investigational new drug application;
        - The Centers for Disease Control and Prevention;
        - The Agency for Health Care Research and Quality; or
        - The Federal Department of Veterans Affairs.

- With respect to the treatment provided by a clinical trial:
    - There is no clearly superior, non-investigational treatment alternative;
    - The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative;
    - The Covered Person's treating Physician, who is providing covered health care services to the Covered Person under the Plan, recommends participation in the Clinical Trial after determining that it has a meaningful potential benefits to the Covered Person; and
    - The Clinical Trial must involve determinations by treating Physicians, relevant scientific data, and opinions of experts in relevant medical specialties
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise, and volumes of patients.

"Routine patient cost" means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Covered Person for purposes of a clinical trial.

Routine patient cost does not include, (1) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, such as travel, housing, companion expenses, and other nonclinical expenses, (2) costs associated with items and services that are provided solely to satisfy date collection and analysis needs, and that are not used in the direct clinical management of the patient, (3) the cost of the investigational, item, drug, device or service, itself, or (4) health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

"Life-threatening disease or condition" as used in the Clinical Trials description means a disease or condition likely to result in death unless the disease or condition is interrupted.

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

COBRA Continuation Coverage or Continuation Coverage shall mean the continuation of health care benefits for Participants and Dependents on the occurrence of a qualifying event as defined by COBRA, and as further set forth in the Continuation of Coverage Section.

Code shall mean the Internal Revenue Code of 1986, as amended.

Complications of Pregnancy shall mean:

- Conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, abortion where the life of the mother is endangered or the fetus is non-viable and complications of abortion and similar medical and surgical conditions of comparable severity; and
- Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Congenital Defects shall mean newborn coverage including coverage for Injury or Illness, and the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, anomalies, including cleft lip or cleft palate or prematurity.

Continuation Coverage Payments shall mean the payments required for COBRA Continuation Coverage.

Copayment shall mean the Covered Person's portion of the payment for benefits indicated in the Schedule of Benefits. This payment may be requested at the time of service. Copayments do not count toward the satisfaction of Deductibles or Out of Pocket Maximums, but they do count toward the satisfaction of the ACA/IRS OOP Limits.

Copercentage shall mean the percentage of a Covered Service that a Covered Person pays after the satisfaction of any applicable Deductible.

Cosmetic Procedure shall mean medical or surgical procedures to alter normal structures of the body in order to improve appearance, treat a Mental Health Condition or improve self-esteem.

Covered Person shall mean a Participant or Dependent covered under the Plan.

Covered Services shall mean those services listed as covered in the Covered Services Section.

Custodial Care shall mean non-medical aid consisting of services and supplies, provided to an individual in or out of an institution, primarily to assist such person in daily living activities, whether or not disabled.

Day Treatment or Partial Hospitalization shall mean an Outpatient treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting, 20 or more daytime hours or 12 or more evening hours per week. The program is designed to treat patients with serious mental, nervous and chemical dependency disorders and offers major diagnostic, psycho-social and prevocational modalities. Such programs must be in a less restrictive, less expensive alternative to Inpatient treatment.

Deductible shall mean Covered Services which are paid by the Covered Person each Plan Year prior to a benefit being payable by the Plan. The Family Deductible for the Plan can be satisfied by combining Covered Services from each covered Family member. With respect to the $400 Deductible Benefit, $1,000 Deductible Benefit and Office Visit Copay Benefit plans, each Covered Person cannot contribute more than one Individual Deductible amount to the Family Deductible. With respect to the QHDHP benefit plan, a Covered Person with Employee plus one or family coverage may accumulate amounts in excess of the Individual Deductible up to the total amount of the Family Deductible.

Dental Practitioner shall mean an individual licensed as a dental practitioner in the jurisdiction where services are provided.

Dependent shall mean any person described below.

(1) **Spouse**. The legally recognized spouse of a Participant. A spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for the purpose of COBRA Continuation Coverage.

(2) **Child**. A child up to age 26 who is:

- A natural child;
- A legally adopted child, or child lawfully placed for adoption, or a foster child placed by an authorized placement agency;
- A stepchild;
- A child of a Participant required to be covered in accordance with the applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609;
- A child with proof of legal guardianship by the Participant;
- A child, as defined above, who has a Disability; or

- A child, as defined above, with a Disability, age 26 or over. Coverage will be extended for a disabled child age 26 and older who meets the eligibility requirements, is mentally or physically incapable of earning a living and who is chiefly dependent upon the Participant or the Participant's spouse for Support and maintenance, provided that the onset of such incapacity occurred before age 26. Proof of such incapacity must be furnished to the Plan by the Participant upon enrollment of the Dependent or at the onset of the Dependent child's incapacity prior to reaching age 26 and from time to time as requested by the Plan. The Participant shall also provide proof of such Disability within the 31 day period after the date the child would otherwise lose Dependent status.
    - Definition of Support. For purposes of coverage for a disabled child age 26 and older under this Plan, a Participant is considered to Support such child when the Participant provides over 50% of the child's living expenses.
    - The extension of coverage for a disabled child will continue until the earliest of:
        - The date he or she ceases to be incapacitated;
        - The date he or she is no longer continuously incapable of self-support because of a Disability;
        - The date he or she is no longer dependent on the Participant for Support and maintenance;
        - The date he or she ceases to meet the eligibility requirements of the Plan for reasons other than age;
        - The 30th day after failure to provide additional proof of his or her incapacity following a request from the Plan for such proof; or
        - The date the Plan is terminated or discontinued for any or no reason, with or without notice.

(3) **Dependent does not include:**

- The spouse if already covered under the Plan as an Employee; and
- A grandchild of the Participant or the Participant's Spouse, unless either is named the legal guardian of the child.

For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

Disability shall mean any congenital or acquired physical or mental Illness, defect or characteristic preventing or restricting an individual from participating in normal life, or limiting the individual's capacity to work. Such Disability must be certified by a Physician.

Durable Medical Equipment shall mean equipment prescribed by a Physician, which meets all of the following requirements:

- Is Medically Necessary;
- Is primarily and customarily used to serve a medical purpose;
- Is designed for prolonged and repeated use;
- Is for a specific therapeutic purpose in the treatment of an Illness or Injury;
- Would have been covered if provided in a Hospital; and

- Is appropriate for use in the home.

Effective Date shall mean the first day of coverage under this Plan as set forth in the Enrollment and Contributions for Participants and Dependents Section.

Eligible Retiree shall mean each Employee who is a Participant in the Plan during the 3 month period immediately prior to retirement from a Member, was Actively at Work on the day prior to retirement, and

- Is at least 55 years of age and has 10 years of continuous service with the Member; or
- Is at least 60 years of age and has at least 5 years of continuous service with the Member.

Emergency Care Facility shall mean a facility which is engaged primarily in providing minor emergency and episodic Medical Care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

Emergency Medical Condition shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to, severe pain, or acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ part.

Emergency Services shall mean health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

Employee shall mean:

- An employee regularly scheduled to work at a position for minimum of 1,560 hours per year or equivalent;
- A faculty member teaching for a minimum 18 undergraduate semester credit hours or equivalent during the academic year with a Member;

  (For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers, and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)
- An Employee on an Approved Leave of Absence;
- An Employee on an Approved Disability Leave; or
- An Employee on an Approved Sabbatical.

The term *Employee* shall not include leased employees or collectively bargained employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals.

Engaged shall mean that a Covered Person with certain chronic conditions completes at least 50% of the care pathway activities related to the Covered Person's condition(s) as outlined in the Enhanced Prescription Benefits materials. A Covered Person must become or be Engaged to receive the enhanced prescription benefit, as more fully described in Section 6, Prescription Drug Care.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental Procedure and/or Investigational (Experimental) shall mean services, supplies, care, and treatment initially determined by the Claims Administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency. Drugs are considered Experimental if they are not commercially available for purchase and/or are not approved by the U.S. Food and Drug Administration for a Covered Person's specific condition or for general use or if they are used for a purpose other than that for which approved including off-label usage of drugs. Experimental Procedures are not widely accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatment; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments of course of treatment which:

- Do not constitute accepted medical practice under the facts, circumstances, and standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
- Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of Clinical Trials shall be considered Experimental, except that expenses for Clinical Trial Costs (as defined herein) Incurred by a Covered Person participating in a Clinical Trial will be covered to the extent legally required and as provided by the Plan.

In addition to the above, the Claims Administrator and Named Fiduciary will be guided the following principles to determine whether a proposed service or treatment is deemed to be Experimental. A drug, device, or medical treatment or procedure is Experimental if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The drug, device, treatment or procedure or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed by the treating facility's Institutional Review Board or other body serving a similar function or if federal law request such review or approval;
- Reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    - maximum tolerated dose;
    - toxicity;
    - safety;

- efficacy; and
- efficacy as compared with the standard means of treatment or diagnosis; or

- Reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

  "Reliable evidence" shall mean:

  - Only published reports and articles in the authoritative medical and scientific literature;
  - The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
  - The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Expenses for drugs, devices, services, treatments, or procedures related to an Experimental and/or Investigational treatment ("Related Services") and complications from an Experimental and/or Investigational treatment and their Related Services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

The Named Fiduciary retains maximum legal authority and discretion to determine what is Experimental, Medically Necessary, and/or whether a proposed drug, device, treatment or procedure is covered under the Plan. The Named Fiduciary's decision will be final and binding on the Plan.

Extended Care Facility shall mean an institution which:

- Is duly licensed as an Extended Care Facility, convalescent facility, or Skilled Nursing Facility and operates in accordance with governing laws and regulations;
- Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;
- Is staffed with a Physician or Registered Nurse on duty 24 hours a day;
- Operates in accordance with medical policies, whereby such policies are supervised and established by a Physician other than the patient's own Physician;
- Regularly maintains a daily medical record for each patient;
- Is not, other than incidentally, a place for the aged, a place for individuals addicted to drugs or alcohol, or a place for Custodial Care; and
- Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

Family shall mean a Participant and Dependents.

Genetic Information shall mean, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individuals, and the manifestation of a disease or disorder in family members of such individual.

Home Health Care Agency shall mean any of the following:

- A Home Health Care agency licensed by the jurisdiction in which it is located;
- A home health agency as defined by the Social Security Administration; or
- An organization licensed in the jurisdiction in which it is located and is an appropriate provider of home health services that meet the following requirements:
    - Has a full time administrator;
    - Keeps written medical records; and
    - Has at least one Registered Nurse (R.N.) on staff, or the services of an R.N. available.

Home Health Care or Home Health Care Services shall mean the following care provided to the Covered Person at the Covered Person's home or a Home Health Care Agency on recommendation of a Physician:

- Intermittent care by a:
    - Registered Nurse (R.N.);
    - Licensed Practical Nurse (L.P.N.);
    - Home Health Aide;
    - Occupational and Physical Therapist;
    - Licensed Vocational Nurse (L.V.N.);
    - Physical Therapist Assistant (P.T.A.); or
    - Certified Occupational Therapist Assistant (C.O.T.A.).
- Private duty nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
- Social work; and
- Nutrition services, including special meals.

Hospice shall mean a public agency or a private organization which provides care and services for covered Terminally Ill persons and their families. Such agency or organization must be qualified to receive Medicare payments, or satisfy the following requirements:

- Provides and has service available 24 hours per day:
    - Palliative and supportive care for Terminally Ill persons,
    - Services which encompass the physical, psychological and spiritual needs of Terminally Ill persons and their families, and
    - Acute Inpatient Care, Outpatient Care, and Home Health Care. Care and counseling must be furnished directly by, or under the arrangement of such agency or organization;
- Has a medical director who is a Physician;
- Has an interdisciplinary team to coordinate care and services, which includes at least one Physician, one R.N. and one social worker; and
- Is licensed or accredited as a Hospice, if the laws of the jurisdiction in which it is located allow for the licensing or accreditation of Hospices.

Hospice Care shall mean care rendered by a Hospice in response to the special physical, psychological and spiritual needs of Terminally Ill Covered Persons and/or their Family members.

Hospital shall mean an institution engaged primarily in providing Medical Care to sick and injured persons on an Inpatient basis at the patient's expense which fully meet all the requirements set forth below:

- It is an institution operating in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as Hospitals. It is primarily Engaged in providing Medical Care of injured and sick persons by or under the supervision of a staff of Physicians or surgeons for compensation from its patients on an Inpatient basis. It continuously provides 24 hour nursing services by Registered Nurses. It maintains facilities on the premises for major operative surgery. It is not, other than incidentally, a nursing home, a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of Substance Use Disorder.
- It is accredited by the Joint Commission of Accreditation of Hospitals ("JCAH") or is recognized by the American Hospital Association (AHA) and is qualified to receive payments under the Medicare program.
- It is a psychiatric hospital, as defined by Medicare, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

Illness shall include disease, mental, or nervous disorders, pregnancy and Substance Use Disorder.

Incurred Expense shall mean an expense for services or supplies that are actually received. An expense shall be considered an Incurred Expense on the date the supplies or services are actually received.

Injury shall mean bodily Injury.

In Network shall mean the services or supplies provided by a Participating Provider, or authorized by any of the TICUA Benefit Consortium's contracted Managed Care Networks.

Inpatient shall mean a registered bed patient in a Hospital or Other Facility Provider and for whom a room and board charge is made. A person is not an Inpatient on any day on which he or she is on leave or is otherwise gone from the Hospital, whether or not a room and board charge is made.

Inpatient Care shall mean Medical Care provided to an Inpatient.

Late Enrollee shall mean a Participant or Dependent that fails to be properly enrolled during the periods set forth in the Enrollment and Contributions Section. A Special Enrollee shall not be considered a Late Enrollee.

Masticatory Dysfunction/Malocclusion means:

- Anteroposterior discrepancies of greater than 2 standard deviations of published norms defined as either of the following:
  - Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a value less than or equal to zero (norm 2mm). (Note: Overjet up to 5mm may be treatable with routine orthodontic therapy); or
  - Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm);
- Vertical discrepancies:
  - Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks;

- Open bite:
  - No vertical overlap of anterior teeth;
  - Unilateral or bilateral posterior open bite greater than 2mm;
- Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch;
- Supra-eruption of a dentoalveolar segment due to lack of occlusion;

- Transverse Discrepancies:
  - Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms;
  - Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth;

- Asymmetries:
  - Anteroposterior, transverse or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry.

    When the condition involves treatment of malocclusion, both of the following must be present:
    - Completion of skeletal growth with long bone x-ray or serial cephalometrics showing no change in facial bone relationships over the last three to six month period (Class II malocclusions do not require this documentation); and
    - Documentation of malocclusion with either intra-oral casts (if applicable) bilateral, lateral x-rays, cephalometric radiograph with measurements, panoramic radiograph or tomograms.

      When the condition involves treatment of skeletal deformity, the deformity must be documented either by CT, MRI or x-ray.

Maximum Annual Benefit shall mean the maximum amount to be paid by the Plan on behalf of a Covered Person for Covered Services which are incurred within a specific Benefit Year which shall be paid by the Plan during that Benefit Year.

Maximum Benefit shall mean the maximum amount to be paid by the Plan on behalf of a Covered Person for Covered Services which are incurred while such Covered Person is covered under the Plan.

Medical Care shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness or Injury.

Medically Necessary or Medical Necessity shall mean the drug, device, procedure, service, treatment or supplies which are required to identify or treat a Covered Person's Illness or Injury and which are:

- Provided for the diagnosis, treatment, care or relief of a health condition, or Injury or Illness or disease and is not for experimental, investigational, or cosmetic purposes;
- Necessary for and appropriate to the diagnosis, treatment, care or relief of a health condition, Illness, Injury, disease or its symptoms;
- Within generally accepted standards of Medical Care in the community; or

- Not solely for the convenience of a Participant, the Participant's Family or the Provider.

Note: Although a Physician or Other Professional Provider may have prescribed treatment, such treatment may not be considered Medically Necessary within this definition.

Right to Choose. The Plan does not limit a Covered Person's right to choose his or her own Medical Care. If a medical expense is not a Covered Service, or is subject to a Limitation or Exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if applicable, if the provider is Out of Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Copercentage level with the Covered Person being responsible for a larger percentage of the total medical expense.

Medicare shall mean Title XVIII of the United States Social Security Act, as amended, and the Regulations promulgated thereunder.

Member or Employer shall mean the independently governed and operated institutions of higher education in the State of Tennessee, who are Members of the Tennessee Independent Colleges and Universities Association, and who have been approved for membership as set forth in the Articles of Incorporation and Bylaws. The term Member shall also mean any affiliated foundation or other entity associated with such institutions, and any other entity adopting the Plan with the approval of its governing body and the Consortium as set forth in the Articles of Incorporation. If a Member merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Members covered by the Plan immediately before such merger or consolidation, be a Member as defined hereunder, unless the Consortium specifies to the contrary. In the case of any other merger or consolidation, the successor shall not be a Member except to the extent that it acts, with the approval of the Consortium, to adopt the Plan.

Mental Health Condition shall mean a neurosis, psychoneurosis, psychopathy, psychosis or psychiatric related disease or disorder of any kind, including personality disorders, such as autism, so long as such condition has as its standard and accepted course of treatment the taking of Prescription Drugs. Dementias (presenile and arteriosclerotic) are not classed as Mental Health Conditions but are considered as other Illnesses. Learning Disability, behavioral problems and attention deficit disorders are not classed as Mental Health Conditions but are considered as other Illnesses. Psychiatric disorders resulting from specific external factors, such as grief, are classed as Mental Health Conditions.

Minor Surgery shall mean any surgical procedure that involves little hazard to the life of the patient and that does not involve general anesthesia or respiratory assistance during the surgical procedure.

Morbid Obesity shall mean any of the following:

- A weight that is a least 100 pounds over or twice the ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
- A bone mass index ("BMI") equal or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea or diabetes; or
- A BMI of 40 kilograms per meter squared without such comorbidity.

As used herein, BMI equals weight in kilograms divided by height in meters squared.

Network shall mean any preferred provider or managed care network under contract with the TICUA Benefit Consortium to provide or arrange to provide services or supplies to Covered Persons.

Non-Surgical Back Treatment shall mean treatment including procedures or palpation, examination of the spine and chiropractic clinical findings accepted by the Tennessee Board of Chiropractic Examiners as a basis for the adjustment of the spinal column and adjacent tissues for the correction of nerve interference and articular dysfunction. Patient care shall be conducted with due regard for nutrition, environment, hygiene, sanitation and rehabilitation designed to assist in the restoration and maintenance of neurological integrity and homeostatic balance.

Other Facility Provider shall mean any of the following: Ambulatory Care Facility, Substance Use Disorder Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric Hospital, psychiatric Day Treatment facility, Hospice, Extended Care Facility, or rehabilitation Hospital, which is licensed as such in the jurisdiction in which it is located.

Other Professional Provider or Professional Provider shall mean the following persons or practitioners, including Physicians, acting within the scope of such provider's license which is certified and licensed in the jurisdiction in which the services are provided:

- Anesthesiologist
- Certified Nurse Practitioner
- Clinical Social Worker
- Dental Practitioner
- Emergency medical technician
- Independent laboratory technician
- Licensed Practical Nurse
- Occupational Nurse
- Pharmacist
- Physical Therapist
- Physician Assistants
- Registered Nurse
- Respiratory Therapist
- Speech - Language Pathologist or Audiologist

Out of Network shall mean drugs, devices, procedures, services, treatments or supplies which are not provided by a Participating Provider or approved by any of the TICUA Benefit Consortium's contracted managed care Networks.

Out of Pocket shall mean any amount of Deductible and Copercentage expense that the Covered Person pays for any Covered Service.

When the total of all eligible Out of Pocket expenses incurred during one Plan Year by: (a) One Covered Person; or (b) Covered members of a Family that reach their limit specified in the Schedule of Benefits, the Plan covered percentage will automatically increase to 100% for any additional Covered Services incurred during that Plan Year.

Note: Certain payments will not be applied toward the Plan's Out of Pocket Limits, but will be applied toward the ACA/IRS OOP Limits. See Schedule of Benefits.

Out of Pocket Limits or Out of Pocket Maximum shall mean the maximum amount of Deductible and Copercentage expenses during any Plan Year that the Covered Person or Family shall pay before the Plan pays 100% of Covered Services for that Plan Year. The Plan's Out of Pocket (OOP) Limits are less than those allowed under the ACA and the IRS for a Qualified High Deductible Health Plan. The ACA/IRS OOP Limits are the lower of the Out of Pocket Limits as set by the IRS and the ACA, which in 2017 are $6,550 for an Individual and

$13,100 for a Family. Expenses incurred for the following will not be applied toward the Plan's or the ACA/IRS OOP Limits: (1) Non-Covered Services, as set forth in the Limitations and Exclusions section of this Plan document, (2) Premiums and (3) Balance Billing. Additionally, Copayments and precertification penalties will not be applied towards the Plan's OOP Limits, but will be applied towards the ACA/IRS OOP Limits. Under § 1302(c)(1) of the ACA the Individual OOP limit applies to each Individual, regardless of whether the Individual is enrolled in Individual coverage or Family coverage.

Outpatient shall mean a Covered Person who receives drugs, devices, procedures, services, treatments or supplies while not confined as an Inpatient.

Outpatient Care shall mean Medical Care provided to a Covered Person while the Covered Person is an Outpatient.

Outpatient Surgical Services shall mean surgical services provided to the Covered Person while the Covered Person is an Outpatient.

Part Time Employee shall mean:

- An Employee regularly scheduled to work at a position for a minimum of 1,000 hours per year or equivalent, but less than 1,560 hours per year or equivalent; or
- A faculty member under an academic year contract for a minimum of 12, but less than 18 undergraduate semester credit hours or equivalent during the academic year with the Member.

  (For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers, and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)

The term *Part Time Employee* shall not include:

- Leased employees or collectively bargained employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals; or

A *Part Time Employee* must properly enroll in the Plan, continuously meet the requirements for eligibility and pay the required contributions on a timely basis, as described in the Enrollment Contributions Section.

Participant shall mean an Employee, Part Time Employee or Eligible Retiree who meets the requirements for eligibility, properly enrolls in the Plan, and continuously meets the requirements for eligibility.

Participating Provider shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the TICUA Benefit Consortium's contracted managed care Networks. The participation status may change from time to time. A current list of PPO Network providers is available, without charge, through the website located at www.ticua.org/tbc. Covered Persons may also contact the PPO Network at the phone number on the Plan ID card.

Physician shall mean a properly licensed person holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.) or Doctor of Chiropractic (D.C.) or Doctor of Dental Surgery (D.D.S.).

Plan, The Plan or This Plan shall mean the Tennessee Independent Colleges and Universities Association Benefit Consortium, Inc. Health Plan.

Plan Administrator shall mean the Executive Director of the Consortium or such other individual as appointed by the Board of Directors.

Plan Year shall mean May 1 through April 30 each year.

Prenotified/Prenotification shall mean the pre-approval of a Covered Service as set forth in the Cost Containment Procedures Section.

Prescription Drugs shall mean drugs or medicines obtainable only upon a Physician's written prescription, including any medication compounded by the pharmacist that contains a prescription legend drug, insulin and insulin needles and syringes.

Primary Care Provider shall mean a provider responsible for managing and coordinating the full scope of a Covered Person's Medical Care, including but not limited to performing routine evaluations and treatment, arranging for referrals to Specialists, ordering laboratory tests and x-ray examinations, prescribing necessary medications and arranging for a Covered Person's hospitalization or other services when appropriate. Primary Medical Care includes these medical specialties: Internal Medicine (general), Pediatrics, Family Practice and Obstetrics/Gynecology (OB/GYN) and a Nurse Practitioner acting within the scope of their license and authority. Mental Health Primary Care Providers include Psychiatric Nurse Practitioner, Licensed Clinical Social Worker (LCSW), Licensed Master's Social Worker (LMSW) working under LCSW supervision, Licensed Professional Counselor with or without Mental Health Services Provider (HSP) Designation, Licensed Psychological Examiner under supervision of Licensed Psychologist with HSP designation and a Licensed Senior Psychological Examiner.

Qualified High Deductible Health Plan means a "high deductible health plan" as defined in IRC § 223(c)(2), as may be amended from time to time.

Reconstructive Surgery Following Mastectomy shall mean surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes all stages of reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery shall also include augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

Retiree shall have the same meaning as Eligible Retiree.

Skilled Nursing Care shall mean services provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), provided that the care is Medically Necessary and the treating Physician has prescribed such care.

Skilled Nursing Facility shall mean an institution which:

- Is duly licensed as an Extended Care Facility or convalescent facility, and operates in accordance with governing laws and regulations;
- Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;
- Is staffed with a Physician or Registered Nurse on duty 24 hours a day;
- Operates in accordance with medical policies supervised and established by a Physician other than the patient's own Physician;
- Regularly maintains a daily medical record for each patient;

- Is not, other than incidentally, a place for the aged, a Substance Use Disorder Treatment Facility, or a place for Custodial Care; and
- Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

Special Enrollee shall mean an Employee or Dependent who is entitled to and who requests Special Enrollment as described in the Enrollment and Contributions Section.

Specialist shall mean Physicians who generally specialize in one field of medicine (*i.e.* Cardiologist, Neurologist, Psychologist, Psychiatrist).

Substance Use Disorder shall mean the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

Substance Use Disorder Treatment Facility shall mean a facility, other than an acute care Hospital, established to care and treat those who need Inpatient Medical Care due to alcoholism or drug abuse. The institution must have permanent facilities on the premises for Inpatient Medical Care. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located or it must be accredited by the American Hospital Association. It must keep daily medical records on all patients. A Substance Use Disorder Treatment Facility shall not include an institution, or part of one, used mainly for rest care, nursing care, care of the aged or Custodial Care.

Terminal Illness or Terminally Ill shall mean a life expectancy of 6 months or less.

Termination of Employment or Terminates Employment shall mean the severance of an Employee's employment relationship with a Member and all other affiliates, or the expiration of an Approved Leave of Absence, Approved Sabbatical or leave mandated by the Family and Medical Leave Act from a Member without the Employee returning to the employment of such Member or any affiliate.

Utilization Review Procedures/Utilization Criteria shall have the definition as set forth in the Cost Containment Procedures Section.

Waiting Period shall mean the period that must pass under this Plan before an Employee or Dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, if an Employee or Dependent enrolls as a Late Enrollee, or Special Enrollee on a Special Enrollment Date, any period before such late or Special Enrollment is not a Waiting Period.

You or Your shall mean the Participant Employee.

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NOTICES UNDER FEDERAL LAW

NOTICE OF NEWBORN'S ACT DISCLOSURE

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Your Physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for out of pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your Out of Pocket costs, You may be required to obtain Prenotification. For information on Prenotification, contact the Plan Administrator or the Prenotification Provider.

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On January 1, 1999, a new federal law, the Women's Health and Cancer Rights Act of 1998, became effective for the Plan. The law requires group health plans to provide coverage for mastectomies and to also provide coverage for reconstructive surgery and prosthesis following mastectomies. The law mandates that a Participant or Dependent who is receiving benefits on or after the law's effective date for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be provided in consultation with the Covered Person and the Covered Person's attending Physician and will be subject to the same annual Deductible, Copercentage and/or Copayment provisions otherwise applicable under the Plan. If You have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact the Plan Administrator.