



**SUMMARY PLAN  
DESCRIPTION**  
for  
**Blount County Government**  
**Employee Benefit Plan**  
AS SET FORTH IN PLAN DOCUMENT  
NO. SF-102767

(Effective January 1, 2008)

**BLOUNT COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN  
SUMMARY PLAN DESCRIPTION  
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## PREFERRED PROVIDER

The benefits available under this Plan to you and your dependents are available through Preferred Provider Organizations. By using the Preferred Providers, you can reduce your out-of-pocket expense and still choose from among the finest hospitals and physicians. Although you are not required to use Preferred Providers, there are many unique advantages if you use the Preferred Provider Organization (PPO). These advantages include:

- **Quality** – The extensive PPO Network consists of leading hospitals and respected physicians, each with a strong reputation for providing quality care.
- **Freedom of Choice** – Unlike other health care plans, you are free to select the physician or hospital of your choice. You can use a Non-Preferred Provider if you wish, but your benefits are better and you will pay fewer out-of-pocket expenses if you use a Preferred Provider. However, the choice is always up to you.
- **Affordability** – You will save money when you use the Preferred Providers. Since the Preferred Provider Organizations have negotiated preferred rates from its hospitals and physicians, you pay a lower fee for most health care.

Remember, when you use a Blount Preferred or Cariten Participating Provider, you will receive better benefits from the Plan than when a Non- Participating Provider is used. **It is your choice as to which Provider to use.** If you choose a Non-Participating Provider you will be subject to balance billing.

In order to receive Preferred benefits, always present your Identification card each time you visit the Preferred Provider.

To find out if your provider is in the Blount Preferred or Cariten Network use the online provider directory at [www.cariten.com](http://www.cariten.com)

**BLOUNT COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN**  
**Effective January 1, 2008**

The following is a summary of benefits under this Plan. The Summary is subject to all other Provisions, Conditions, Limitations and Exclusions of this Plan. Benefits are only payable under this Plan for expenses which are "Covered Expenses" arising from Medically Necessary treatment of an and which are "Usual and Customary" charges, both of which terms are defined in the Plan Document.

**SUPPLEMENTAL ACCIDENT BENEFIT**

(Deductible Waived)

First \$300 paid at 100%

**COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS**

- Tier I PPO/Blount Preferred and Children's Hospital
- Tier II PPO/Cariten Healthcare PPO Network
- Tier III Non-PPO/Out of Network Provider

**Lifetime Maximum Benefit**

Per Covered Person \$2,000,000

**Mental or Nervous Disorders Treatment**

Inpatient Treatment  
 Calendar Year Maximum 30 days  
 Percentage Payable - Tier I & II 80%  
 Percentage Payable - Tier III 50%

Outpatient Treatment  
 Calendar Year Maximum 20 visits  
 Percentage Payable - Tier I & II 80%  
 Percentage Payable - Tier III 50%

**Alcoholism or Chemical Dependency Treatment**

Inpatient Treatment  
 Calendar Year Maximum 30 days  
 Percentage Payable - Tier I & II 80%  
 Percentage Payable - Tier III 50%

Outpatient Treatment  
 Calendar Year Maximum 20 visits  
 Percentage Payable - Tier I, II, & III 50%

**Calendar Year Deductible**

PPO Provider (Tier I & II)  
 Per Covered Person \$250  
 Per Family (Aggregate) \$500

Non-PPO Provider (Tier III)  
 Per Covered Person \$500  
 Per Family (Aggregate) \$1,000

The Calendar Year Deductible Applies to all covered expenses unless otherwise stated. The Calendar Year Deductible does not apply to the first \$300 of any covered expense resulting from an accidental injury.

Charges attributable to the calendar year deductibles of participating family members will be combined to meet the Family deductible. If a charge toward a deductible is incurred during the last quarter of the calendar year, that charge will carry over and be applied to the following year's deductible.

**Percentage Payable**

Preferred Provider (PPO)	
Tier I	90%
Tier II	80%
Non-Preferred Provider (Non-PPO)	
Tier III	50%

The Percentage Payable applies to all Covered Expenses unless otherwise stated.

**Out-of-Pocket Maximums\***

Preferred Provider (PPO)	
Tier I & II	\$1,500
Non-Preferred Provider (Non-PPO)	
Tier III	\$5,000

\*No Family Out-of-Pocket Maximum\*

The Out-of-Pocket Maximum excludes Deductibles, Mental or Nervous Disorders Treatment and Alcoholism or Chemical Dependency Treatment charges and Cost Containment penalties.

**COST CONTAINMENT PROVISIONS**

**Room & Board Benefit**

Semi-Private	Up to Hospital's Actual Charge
Intensive Care	3 times the Hospital's Most Common Semi Private Room Rate
Private	Up to Hospital's Most Common Semi-Private Room Rate plus \$4

When the Hospital has only Private Room accommodations and does not have a Most Common Semi-Private Rate, the room and board benefit will be 3 times the Most Common Semi-Private Room Rate for that geographic area.

**Pre-Admission Testing (Outpatient) - within 5 days prior to hospital admission**

Percentage Payable	
Tier I (Deductible Waived)	90%
Tier II (Deductible Waived)	80%
Tier III	50%

**Second Surgical Opinion Consultation**

Percentage Payable	100% up to \$100 per opinion
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The Calendar Year Deductible is waived for the initial \$100 benefit. Any expenses exceeding \$100 are subject to the Calendar Year Deductible and applicable percentage payable.

**Pre-Admission Certification** - If Pre-Admission Certification is NOT obtained for a Hospital confinement, all eligible Hospital expense benefits will be reduced by 20%. The additional reduction will NOT apply towards satisfying any other plan deductibles or the Out-of-Pocket Maximum. For example, if a Covered Person does not obtain pre-admission certification for an inpatient hospital confinement, benefits for covered expenses will be reimbursed at 70% after deductible for a Tier I provider instead of 90% after deductible. The 20% difference that the Covered Person would have to pay for the penalty would not apply toward their deductible or out-of-pocket maximum.

**Weekend Hospital Admission: Admissions for Inpatient Hospital Confinement** are not eligible for reimbursement under the Plan when admission takes place after twelve (12) noon on Friday or before twelve (12) noon on Sunday. This provision does not apply to admissions for a Medical Emergency or if surgery is performed within twenty-four (24) hours of the admission.

**OTHER PLAN PROVISIONS**

**Physician Expenses**

Office Visit Charges & Hospital Inpatient Surgery	
Percentage Payable	
Tier I	90%
Tier II	80%
Tier III	50%

**Outpatient Surgery Expenses**

Physician Expenses (Hospital or Physician's Office)	
Percentage Payable	
Tier I (Deductible Waived)	90%
Tier II (Deductible Waived)	80%
Tier III	50%

Hospital Expenses	
Percentage Payable	
Tier I (Deductible Waived)	90%
Tier II (Deductible Waived)	80%
Tier III	50%

Ambulatory Surgical Facility	
Percentage Payable	
Tier I (Deductible Waived)	90%
Tier II (Deductible Waived)	80%
Tier III	50%

**Hospital Expenses**

Emergency Room Services	
Co-pay (waived if admitted)	\$50
Subject to Deductible after Co-pay	
Tier I	90%
Tier II	80%
Tier III	50%

Emergency Room Co-pay will be waived for medical emergencies that include chest pains, severe bleeding, broken bones, breathing problems, or if referred to the emergency room by a physician.

Inpatient Expenses	
Tier I	90%
Tier II	80%
Tier III	50%

Any services not available with a Tier I hospital provider, but are available with a Tier II provider will be paid at the Tier I level of benefits.

**Pregnancy/Maternity (Limited to Employee or Spouse)**

Percentage Payable	Same as Illness
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<b>Chiropractic Care (All Services)</b>	
Percentage Payable	80%
Maximum Benefit Payable per visit (excluding 1st visit)	\$50
Calendar Year Maximum	25 visits

Only the In Network Deductible applies. X-rays are covered for the initial visit only.

**Physical Therapy** - Must obtain authorization after 20 visits

**Breast Forms & Prosthetic Bra**

Percentage Payable	80%
Amount Allowable in a 24 consecutive month period	\$300
Maximum Number of forms in a 24 consecutive month period	2

**Artificial Limb (Prosthetic Device)**

Percentage Payable	80%
Additional limits apply; refer to covered medical expenses for details.	

**Lifetime Maximum Benefit for a Wig Following  
Chemotherapy or Radiation Treatment**

\$100

**Lifetime Maximum Benefit for Non-Surgical  
Temporomandibular Joint (TMJ) Treat**

\$600

**Hospice Care**

Overall Maximum Benefit	\$50,000
Maximum Benefit per day	\$150
Percentage Payable	
Tier I (Deductible Waived)	90%
Tier II (Deductible Waived)	80%
Tier III	50%

**Home Health Care**

Calendar Year Maximum	80 visits
Percentage Payable	
Tier I (Deductible Waived)	90%
Tier II (Deductible Waived)	80%
Tier III	50%

**Skilled Nursing Facility**

Calendar Year Maximum	28 days
Percentage Payable	
Tier I	90%
Tier II	80%
Tier III	50%

**ROUTINE PREVENTIVE SERVICES** 100%

Routine Physical Examination	
Percentage Payable	
Tier I (Deductible Waived)	100%
Tier II (Deductible Waived)	100%
Tier III	No Benefits Available

Examinations are limited per Covered Person as follows:

Under Age 6 years	Exams are not limited
Age 6 years to age 30	1 Exam every 3 Calendar Years
Age 30 to age 40	1 Exam every 2 Calendar Years
Age 40 and Over	1 Exam per Calendar Year

Routine preventive care services are those services for routine medical care for which there is no diagnosis due to an illness or injury. A routine physical exam can include office visit and eligible charges incurred on the same day as the office visit, such as routine immunizations, booster shots, and vaccinations.

In the event an employee or eligible family member cannot complete their routine physical examination under the care of one Physician, the plan will allow one additional visit to a health care specialist.

The following routine benefits will be paid at 100%, deductible waived, regardless of the above frequency limits: (a) all routine childhood immunizations required by the health department for dependent children to attend schools; and (b) flu shots for both adults and children.

**Routine Mammogram**

Tier I and II (Deductible Waived)	100%
Tier III	No Benefits Available
Between Age 35 and 40	1 Baseline
Age 40 to age 50	1 Screening Mammogram every 2 years or more frequently based on recommendation of the Physician
Age 50 and Over	1 Screening Mammogram Per Calendar Year

**Well Woman Exam \***

Tier I and II (Deductible Waived)	1 per Calendar Year
Tier I and II (Deductible Waived)	100%
Tier III	No Benefits Available

\*Includes exam, Pap smear, and lab work

**Routine Prostate Screening**

Age 40 and Over	1 per Calendar Year
Tier I and II (Deductible Waived)	100%
Tier III	No Benefits Available

**Routine Colonoscopy**

Tier I and II (Deductible Waived)	100%
Tier III	No Benefits Available
Age 50 and over	1 every 10 years or more frequently, based on the recommendation of the Physician

## MISCELLANEOUS PROVISIONS

When a covered person receives treatment or services as a result of a Medical Emergency, eligible expenses will be paid on the basis of a Tier II provider, whether or not such services were performed by a Tier II provider.

When covered services are rendered in a Tier I or II Hospital by an anesthesiologist, radiologist or pathologist who is a Tier III Provider, the benefit percentage will be the same as that for services rendered by a Tier I or II Provider dependent upon the Hospital where the services are rendered.

When covered services are rendered within the PPO Service Area by a Tier III Provider and such services are not available from a Tier I or II Provider, the benefit percentage will be the same as that for services rendered by a Tier I Provider.

When covered services are received: (1) outside the geographic Service Area of the Tier I or II provider network; (2) by a dependent child who lives in another state with a divorced parent; or (3) by a retiree, the percentage payable for eligible charges will be the same as that stated in the Schedule of Benefits for Tier II Providers. However, if the covered person travels outside the geographic Service Area for the purpose of obtaining medical care, which is available from a Tier I or II provider, the percentage payable by the Plan will be the same as that for a Tier III provider as stated in the Schedule of Benefits.

## PRESCRIPTION DRUG BENEFIT

Retail (Walk-In) Pharmacy (up to a 34 day supply)

Co-Payments:

Generic Prescriptions	\$5
Name Brand Prescriptions	\$25
Percentage Payable after Co-Payment	100% of balance

Mail Order (up to a 100 day supply)

Co-Payments:

Generic Prescriptions	\$10
Name Brand Prescriptions	\$50
Percentage Payable after Co-Payment	100% of balance

The co-payment for prescriptions will apply only to the out-of-pocket annual maximum if the covered participant files the applicable co-payment amounts with the TPA within six (6) months of purchase date (retail or mail order). If you have other prescription drug coverage that is primary, please see the coordination with other prescription drug plans provision under COORDINATION OF BENEFITS.

If the Covered Person requests a Brand name drug when a Generic drug is available, the Covered Person must pay the price difference between the Brand name drug and the Generic drug, plus the Brand name co-payment.

## LIFE INSURANCE

**Class:** All Full-Time Eligible Employees  
**Coverage:** Life Insurance: 1 x salary to maximum of \$50,000; minimum \$6,000  
Accidental Death & Dismemberment (AD&D): 1 x salary if due to accident

**Class:** All Retired Eligible Employees\*  
**Coverage:** Life Insurance: \$10,000  
Accidental Death & Dismemberment (AD&D) \$10,000 if due to accident  
\* Benefit terminates at age 65.

## WEEKLY ACCIDENT AND SICKNESS BENEFITS

### Class 1 Plan Outline:

#### Description of Eligible Classes

All full-time active Highway Department Employees

Full-time active Board of Education employees classified: Cafeteria Employees

#### Maximums

Amount of Weekly Benefits           \$60

Maximum Period of Benefits        52 weeks

#### Waiting Period

Disability due to accidental bodily injury: The greater of any accumulated sick days plus a 0 day waiting period.

Disability due to a sickness: The greater of any accumulated sick days plus a 7 day waiting period.

### Class 2 Plan Outline:

#### Description of Eligible Classes

All full-time, active General County Employees

Full-time, active Board of Education employees except: Cafeteria Employees

#### Maximums

Amount of Weekly Benefits           \$60

Maximum Period of Benefits        52 weeks

#### Waiting Period

Disability due to accidental bodily injury: The greater of any accumulated sick days plus a 30 day waiting period.

Disability due to a sickness: The greater of any accumulated sick days plus a 30 day waiting period.

## HOW TO OBTAIN BENEFITS

Once you become eligible, this Plan has the responsibility for seeing that you receive all the benefits to which you are entitled. In order to receive these benefits as quickly as possible, you must also assume some responsibility. To receive your maximum benefit, please choose a Preferred Provider. Preferred Providers will file claims for you. If you incur a claim from a **Non-Participating Provider** it will be your responsibility to provide your claim form. You must follow the steps below.

All claims must be submitted within ninety (90) days after the period during which they were incurred.

### WHEN YOU HAVE A CLAIM:

- Step 1** Secure the proper claim form from your Employer or the Claims Office. You must submit at least one (1) claim form per Covered Person per Calendar Year.
- Step 2** Have your Physician fill out his/her portion of the form. Please make sure the Physician completes all of the information requested. If your Physician provides his/her own claim form, you may submit it in place of the form provided by this Plan provided the form contains basically the same information.
- Step 3** In the case of Hospital confinement, a form provided by the Hospital must be itemized by the Hospital.
- Step 4** Attach all bills or receipts relative to the services provided. Make sure the bill clearly identifies what services were performed and what the charge was for each service.
- Step 5** If you have any questions regarding Steps 1–4, call for assistance at (865) 470-7681 or (866) 753-8451
- Step 6** If the claim is for a dependent, follow the first four (4) steps above and be sure to complete the portion of the claim form relating to your dependent.
- Step 7** Forward completed claim forms and all related bills to:

Cariten TPA Services  
P.O. Box 22987  
Knoxville, TN 37933

## DATES OF ELIGIBILITY AND COVERAGE

### Employee Coverage

**Eligibility for Coverage and Waiting Period** - All Full-Time Employees and their Dependents are eligible to enroll in the Plan, for coverage on the first (1st) day following thirty (30) days of consecutive employment. This is the Eligibility Waiting Period.

Employees and their Dependents who were eligible for coverage with the previous Plan being replaced by this Plan on January 1, 2008 will be eligible under this Plan.

Retired Employees are covered under the plan as specified below:

**Rehiring a Terminated Employee** - A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage with Blount County, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

**Retired Employees** - An employee (including eligible dependents covered under the Plan at the time of the employee's retirement) of Blount County whose salary is funded and paid under the department heading Blount County General, Education Department, or Highway Department who retires after age 60 with 10 years of service, or who retires with 30 years of service with Blount County. Coverage may be continued until attainment of age 65.

Dependent coverage for the spouse and eligible dependent children may be continued beyond the date the retired employee attains age 65. Coverage may continue under the Plan until the spouse reaches the age of sixty-five (65), provided the required contributions are made.

The benefits available under the Plan will be the benefits then in effect for retired employees at the time the expenses are incurred.

**When You are Eligible** - You are eligible for coverage on:

1. the Plan Effective Date, if you have completed the Eligibility Waiting Period; or
2. the 1st day following the date you complete the Eligibility Waiting Period.

**When You are Covered** - Your coverage under the Plan shall become effective with respect to an eligible Employee on the date of your eligibility, provided written application for such coverage is made on or before such date or within thirty-one (31) days of such date. If application is made after the initial date of eligibility, the Employee shall be a Late Enrollee and, except as provided under the Special Enrollment Provision, coverage for the Employee shall become effective on the next Open Enrollment Date.

**Enrollment** - To enroll for coverage, you must complete and sign a group enrollment form which is acceptable to the Plan along with the appropriate payroll deduction authorization and deliver it to the Employer.

## Dependent Coverage

**Eligible Persons** - Each Person who is eligible for Employee Coverage will be eligible for Dependent Coverage.

**When You Become Eligible** - You will be Eligible for Dependent coverage on the later of:

1. the date you become eligible for Employee Coverage; or
2. the date you acquire your first Dependent.

**When You are Covered** - A Dependent will be considered eligible for coverage on the date the Employee becomes eligible, subject to all limitations and requirements of this Plan, and in accordance with the following:

- A. Newborn Children of a Covered Employee will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Employee within thirty-one (31) days of the child's date of birth. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother.
- B. A Spouse will be considered an Eligible Dependent from the date of marriage, provided the Spouse is properly enrolled as a Dependent of the Employee within thirty-one (31) days of the date of marriage.
- C. If a Dependent is acquired other than at the time of his/her birth, due to a court order, decree or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree or marriage, provided that this new Dependent is properly enrolled as a Dependent of the Employee within thirty-one (31) days of the court order, decree or marriage.
- D. A child may become eligible for Dependent Coverage as set forth in a Qualified Medical Child Support Order. The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a Qualified Medical Child Support Order. The Plan Administrator 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.
- E. Effective date for adopted children is as follows:
  1. Coverage will be effective for child(ren) upon placement for adoption provided, the child(ren) is properly enrolled as a Dependent of the Employee within thirty-one (31) days of the placement for adoption.
  2. Pre-Existing Condition limitations at time of placement for adoption will be waived.
  3. Definitions – For purposes of this subsection:
    - a. Child – The term "child" means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained age eighteen (18) as of the date of such adoption or placement for adoption.
    - b. Placement for Adoption – The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. This child's placement with such person terminates upon the termination of such legal obligation.

**Dependent Effective Date** - A Dependent of an Employee who makes written request for Dependent Coverage hereunder, on a form approved by the Employer, shall, subject to the provisions of this section, become covered as follows:

- A. If the Employee makes such written request on or before the date or within thirty-one (31) days of the date he/she becomes eligible for Dependent Coverage, he/she shall become covered, with respect to those persons who are then his/her Dependents, on the date he/she becomes eligible for Dependent Coverage.
- B. Except as otherwise provided under "Dependent Eligibility", (i.e., for newborn, adopted, and newly acquired Dependents) or as provided under "Special Enrollment Period" below, if the Employee makes such written request

after the date on which he/she is eligible for Dependent Coverage, those persons who are then his/her Dependents shall be Late Enrollees and shall become covered on the next Open Enrollment Date.

- C. If all Eligible Dependents have coverage in effect at the time an Employee acquires an additional Eligible Dependent, coverage of such Dependent will be effective upon the date he/she or she is acquired. Separate application to cover such Dependent is required.

**Enrollment** - To enroll for coverage, you must complete and sign a group enrollment form which is acceptable to the Plan along with the appropriate payroll deduction authorization and deliver it to the Employer.

**Coverage Status Change** - A Covered Person may not be covered as both a Dependent and an Employee. If a covered Dependent is eligible to be enrolled as an Employee, enrollment may be effective on the date of the change in status.

Any changes in coverage status do not interrupt participation in the Plan and do not change a Covered Person's effective date of coverage for purposes of the Pre-Existing Condition definition.

**Employee Contribution** - The Employer may require a contribution from Employees to maintain Employee participation and the participation of any Dependents in the Plan. Eligible Employees will be advised of any required contributions at the time they apply for enrollment in the Plan. Employees in the Plan will be notified by the Employer prior to an increase in the required contribution amount. Employees in a Plan that does not require an Employee contribution at the time they enrolled will be notified by the Employer prior to the date a contribution requirement is made effective.

## TERMINATION OF COVERAGE

**Employee Termination Date of Coverage** - Your coverage will terminate on the earliest of:

1. The date on which your eligibility in an eligible class ceases;
2. The date on which your employment with the Plan Sponsor ceases;
3. The date on which you or the Plan Sponsor cease premium payments for your coverage;
4. The date the Plan ceases.

**Dependent Termination Date of Coverage** - A Covered Dependent's coverage will terminate on the earliest of:

1. The date on which the Employee is no longer in a class eligible for Dependent coverage;
2. The date on which the Employee's Dependent ceases to be an eligible Dependent;
3. The date all Dependent coverage under the Plan is cancelled;
4. The date the Employee's coverage ceases;

## CONTINUANCE OF COVERAGE DUE TO LEAVE OF ABSENCE FOR ILLNESS OR INJURY

A person may continue to be a Covered Employee for benefits under the Plan if the person ceases active work as a result of an approved leave of absence as a result of.

Coverage may be continued at the Employer's option, subject to payment of any required contributions during the leave of absence for illness or injury up to the Covered Employee's retirement date or twelve (12) months, whichever is earlier.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

## SPECIAL ENROLLMENT PERIOD

The Special Enrollment period for loss of other coverage is available to Employees and their Dependents who meet the following certain requirements:

1. The Employee or Dependent must otherwise be eligible for coverage under the terms of the plan;
2. When the coverage was previously declined, the Employee or Dependent must have been covered under another group health plan or must have had other health insurance coverage; and
3. When coverage in the plan was previously declined, the Employee must have signed the written waiver form provided at initial enrollment declining coverage under the Plan because of other health coverage. The special enrollment rights may apply with respect to an Employee, a Dependent of the Employee, or both.

An Employee who has not previously enrolled can enroll under these rules if it is the Employee who loses other coverage. An Employee's Dependent can be enrolled under these rules if it is the Dependent who loses other coverage and the Employee is already enrolled. In addition, both the Employee and a Dependent can be enrolled together under these rules if either the Employee or the Dependent loses other coverage.

A person who enrolls during a special enrollment period (even if the period also corresponds to a regular open enrollment period) is not treated as a late enrollee. (Accordingly, the plan may not impose a preexisting condition exclusion period longer than 12 months with respect to the person.)

A person is considered a Special Enrollee when he/she experiences:

1. a loss of coverage as a result of divorce, legal separation, death, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), termination of employment or reduction in hours, or
2. a loss of coverage as a result of cessation of employer contributions for other coverage; or
3. a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual); or
4. a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or
5. a loss of coverage due to loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
6. a loss of coverage when a plan no longer offers coverage to a class of similarly situated individuals (for example, part-time employees); or
7. a loss of coverage as a result of exhaustion of COBRA coverage, or
8. a family status change (such as birth, marriage, adoption, or placement for adoption).

"Loss of coverage" does not include loss due to failure to pay premiums on a timely basis, a voluntary election to terminate such coverage, or termination of coverage for cause (such as making a fraudulent claim).

The Employee and/or the Employee's eligible Dependents, may be enrolled in the plan as a Special Enrollee for coverage effective the first day following the date other health coverage ends, provided written request for coverage is made within thirty-one (31) days after the date of such loss.

The Employee and/or the Employee's eligible Dependents may be enrolled in the plan as a Special Enrollee for coverage effective on the date of the family status change, provided written request for coverage is made within thirty-one (31) days after the date of the change in family status as outlined above. For example, coverage with respect to a birth, adoption or placement for adoption is effective on the date of the birth, adoption or placement for adoption, respectively.

Proof of such family status change or loss of other coverage will need to be provided along with your written request for coverage before coverage can become effective.

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS (“QMCSOs”)

1. **Coverage of Children or Alternate Recipients Named or Designated in QMCSOs**  
Notwithstanding anything in this Plan to the contrary, the Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order received by the Plan and determined by the Plan to be qualified.
2. **Medical Child Support Orders**  
A Medical Child Support Order is a court order which:
  - 1) provides for child support or health benefit coverage with respect to a child of a participant under the Plan;
  - 2) is made pursuant to a state domestic relations law;
  - 3) either relates to benefits under the Plan; or
  - 4) enforces a law relating to medical child support under Section 1908 of the Federal Social Security Act.
3. **Qualified Medical Child Support Orders**  
A Qualified Medical Child Support Order is a medical child support order which:
  - 1) creates, assigns and recognizes a child’s right to receive benefits for which a participant is eligible under the Plan;
  - 2) clearly specifies the name and last known mailing address of the participant and the child;
  - 3) clearly specifies the type of coverage that is to be provided by the Plan to the child;
  - 4) clearly specifies the time period for which the order applies;
  - 5) clearly specifies the Plan or Plans to which the order applies; and
  - 6) does not require the Plan to provide any benefits not already provided (except as specified in Section 1908 of the Social Security Act).
4. **Procedures for Medical Child Support Orders and Qualified Medical Child Support Orders**
  - 1) Within ten (10) days of receipt of a Medical Child Support Order, the Plan administrator shall notify the participant and each child named in the Medical Child Support Order (“alternate recipient”) that a Medical Child Support Order has been received.
  - 2) The notice shall inform the participant and each alternate recipient of the Plan’s procedures for determining whether Medical Child Support Orders are qualified applying the standards set out in paragraphs (B) and (C) above.
  - 3) The Plan Administrator then within thirty (30) days, shall determine whether the Medical Child Support Order is qualified applying the standards set out in paragraphs (B) and (C) above. The administrator may seek the assistance of Plan legal counsel in making this decision.
  - 4) If the Plan Administrator determines that information in the Order is insufficient or the Order is otherwise deficient, the Plan Administrator shall notify the participant and alternate recipient of the deficiency, in order to allow the Medical Child Support Order to be corrected.
  - 5) If the Order is resubmitted, it shall again be reviewed by the Plan Administrator for compliance in accordance with the standards set out in paragraphs (B) and (C) above and pursuant to the other provisions set out herein. Upon resubmission, the Plan Administrator shall have fifteen (15) days to determine whether the resubmitted order is qualified.
  - 6) Upon determining whether the Order is qualified, the Plan Administrator shall notify the participant and each alternate recipient of that determination.
  - 7) If the Medical Child Support Order is deemed qualified, the participant and the alternate recipient shall be notified of the eligibility of the alternate recipient for benefits and of the Plan’s procedures for providing benefits.
  - 8) At the time that the alternate recipient is notified of eligibility, the alternate recipient shall also be notified of their right to designate a representative to receive copies of notices sent with respect to the Medical Child Support Order. All notices shall also be sent to the enrolled parent who is a participant in the Plan.

## FAMILY AND MEDICAL LEAVE ACT OF 1993

An Employee may continue to be covered for benefits under the Plan during a period of qualified leave under the Family and Medical Leave Act of 1993. Up to twelve (12) weeks of coverage is available to Employees who have been employed for at least one (1) year, worked at least 1,250 hours over the previous twelve (12) months and request leave for one (1) of the following reasons:

1. to care for the Employee's child after birth, or placement for adoption or foster care;
2. to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; or
3. for a serious health condition that makes the Employee unable to perform the Employee's job.

The Employee is required to provide advance leave notice and medical certification. Leave may be denied if the following requirements are not met:

1. the Employee ordinarily must provide thirty (30) days advance notice when the leave is foreseeable; and
2. the Employer may require medical certification to support a request for leave because of a serious health condition, or may require a second and third opinion (at the Employer's expense).
3. the Employer may request a fitness for duty report in order to return to work.

For the duration of leave under the Family and Medical Leave Act of 1993, the Employer will maintain the Employee's coverage under this Plan on the same basis as prior to the leave, provided any required contributions are paid.

## CONTINUATION OF COVERAGE UNDER COBRA

1. **Definitions** - For purposes of Continuation of Coverage Under COBRA provision, the following definitions apply:
  - A. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
  - B. "Code" means the Internal Revenue Code of 1986, as amended.
  - C. "Continuation of Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA
  - D. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations hereunder.
  - E. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations hereunder.
  - F. "Qualified Beneficiary" means:
    - 1) A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan; and
    - 2) A covered spouse or Dependent who becomes ineligible for coverage under the Plan due to a Qualifying Event, as defined below; and
    - 3) A newborn or newly adopted child of a Covered Employee who is continuing coverage under COBRA.
  - G. "Qualifying Event" means the following events which, but for Continuation Coverage, would result in the loss coverage of a Qualified Beneficiary:
    - 1) Termination of a Covered Employee's employment (other than for gross misconduct) or reduction in his/her hours of employment;
    - 2) The death of the Covered Employee;
    - 3) The divorce or legal separation of the Covered Employee from his/her spouse;
    - 4) The Covered Employee becoming entitled to Medicare coverage;
    - 5) A child ceasing to be eligible as a Dependent child under the terms of the Plan; or
    - 6) Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Blount County Government and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.
    - 7) "Totally Disabled" or "Total Disability" means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

2. **Right to Elect Continuation Coverage** - If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event, he/she may elect to continue coverage under the Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Employer. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:
  - A. The date of the Qualifying Event; or
  - B. The date he/she was notified of his/her right to continue coverage.
  
3. **Temporary Extension of COBRA Election Period for Certain Individuals.**
  - A. In general, in the case of a non-electing Trade Adjustment Assistance (TAA)-eligible individual and notwithstanding 2. Right to Elect Continuation Coverage above, such individual may elect continuation coverage under this part during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.
  - B. Commencement of coverage; no reach-back. Any continuation coverage elected by a TAA-eligible individual under 3A, shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.
  - C. Preexisting conditions. With respect to an individual who elects continuation coverage pursuant to 3A, the period
    - 1) beginning on the date of the TAA-related loss of coverage, and
    - 2) ending on the first day of the 60-day election period described in paragraph 3A, shall be disregarded for purposes of determining the 63-day periods referred to in section 701(c)(2), section 2701(c)(2) of the Public Health Service Act, and section 9801 (c)(2) of the Internal Revenue Code of 1986.
  - D. Definitions. For purposes of this subsection:
  - E. "Nonelecting TAA-Eligible Individual" means a TAA-eligible individual who
    - 1) has a TAA-related loss of coverage; and
    - 2) did not elect continuation coverage under this part during the TAA-related election period.
  - F. "TAA-Eligible Individual" means
    - 1) an eligible TAA recipient (as defined in paragraph (2) of section 35(c) of the Internal Revenue Code of 1986), and
    - 2) an eligible alternative TAA recipient (as defined in paragraph (3) of such section).
  - G. "TAA-Related Election Period" means, with respect to a TAA-related loss of coverage, the 60-day election period under this part which is a direct consequence of such loss.
  - H. "TAA-Related Loss Of Coverage" means, with respect to an individual whose separation from employment gives rise to being a TAA-eligible individual, the loss of health benefits coverage associated with such separation.
  
4. **Notification of Qualifying Event** - If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Plan, the Qualified Beneficiary must notify the Employer of the Qualifying Event within sixty (60) days of the qualifying event or the date on which the qualified beneficiary would lose coverage because of the qualifying event, whichever is later, in order for coverage to continue. In addition, a Totally Disabled Qualified Beneficiary must notify the Employer in accordance with the section below entitled "Total Disability" in order for coverage to continue. An individual who becomes eligible to elect assistance from the Trade Assistance Act must notify the Employer in accordance with the section above entitled "Temporary Extension of COBRA Election Period for Certain Individuals" in order for coverage to continue. Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.
  
5. **Length of Continuation of Coverage**
  - A. A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Plan for up to eighteen (18) months from the date of the Qualifying Event.
  - B. A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, legal separation or entitlement to Medicare, and Dependent children who have become ineligible for coverage may continue coverage under the Plan for up to thirty-six (36) months from the date of the Qualifying Event.

6. **Total Disability**
- A. In a case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled within sixty (60) days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), the Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer prior to the end of eighteen (18) months of Continuation Coverage and within sixty (60) days of the determination that he/she was disabled within sixty (60) days of the date of the Qualifying Event.
  - B. The Employer will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond eighteen (18) months pursuant to this section.
  - C. If during the period of extended coverage for Total Disability (Continuation Coverage months 19–29) a Qualified Beneficiary is determined to be no longer Totally Disabled:
    - 1) The Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and
    - 2) Continuation of Coverage shall terminate on the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.
7. **Termination of Continuation Coverage** - Continuation Coverage will automatically end earlier than the applicable eighteen (18), twenty-nine (29), or thirty-six (36) month period for a Qualified Beneficiary if:
- A. The required monthly contribution for coverage is not received by the Employer within thirty (30) days following the date it is due;
  - B. The Qualified Beneficiary is or becomes covered under any other Group Health Plan as an Employee or otherwise. If the other Group Health Plan contains an exclusion or limitation relating to a Pre-Existing Condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the Pre-Existing Condition applies to the Qualified Beneficiary (or, if sooner, until the expiration of the applicable eighteen (18), twenty-nine (29), or thirty-six (36) month COBRA period).
  - C. For Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of the final determination by the Social Security Administration that such Beneficiary is no longer Totally Disabled;
  - D. The Qualified Beneficiary is or becomes eligible for Medicare benefits; or
  - E. The Employer ceases to offer any Group Health Plans.
8. **Multiple Qualifying Events** - If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) or twenty-nine (29) months, and a second Qualifying Event occurs during the eighteen (18) or twenty-nine (29) month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage", to continue coverage under the Plan for up to thirty-six (36) months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was a Covered Employee becomes entitled to benefits under Medicare (whether or not this is a Qualifying Event), a Qualified Beneficiary (other than the Covered Employee) may elect to continue coverage for a maximum of thirty-six (36) months from the date of the initial Qualifying Event, to the extent another period of Continuation Coverage is not required by law under COBRA.
9. **Continuation Coverage** - The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Plan offered to similarly situated Covered Employees and their Dependents.
- The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add Dependents for Continuation Coverage, such Dependents must meet the definition of Dependent under the Plan.
10. **Carryover of Deductibles and Plan Maximums** - If Continuation Coverage under the Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and co-payment features for the year will be carried forward into the Continuation Coverage elected for that year. Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the

Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

11. **Payment of Premium**

- A. The Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actual basis and considering such factors as the Secretary of Labor may describe.
  - 1) The Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.
  - 2) For Qualified Beneficiaries whose coverage is continued pursuant to the section entitled "Total Disability" of this provision, the Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for continuation coverage months 19 – 29.
  - 3) Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments.
- B. If Continuation Coverage is elected, the monthly contribution for coverage for those months up to and including the month in which the election is made must be made within forty-five (45) days of the date of election.
- C. Without further notice from the Employer, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Employer within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage", subsection 1. This thirty (30) day grace period does not apply to the first contribution required under b. above.
- D. No claim will be payable under this Provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

## **EMPLOYEES ON MILITARY LEAVE**

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- 1. The maximum period of coverage of a person under such an election shall be the lesser of:
  - A. The twenty-four (24) month period beginning on the date on which the person's absence begins; or
  - B. The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- 2. A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- 3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

## **NOTICE TO ACTIVE FULL-TIME EMPLOYEES AND THEIR SPOUSES WHO ARE ELIGIBLE FOR MEDICARE**

In accordance with current federal laws and regulations, coverage under the Plan is made available to all active Full-Time Employees age sixty-five (65) and over, and to Spouses age sixty-five (65) and over of active Full-Time Employees, under the same conditions as coverage is made available to active Full-Time Employees and Spouses under age sixty-five (65). In addition, federal statutes currently provide that any persons age sixty-five (65) or older are entitled to select Medicare for their primary health insurance coverage in place of any group health plan offered by their Employer. We would therefore urge you, if you are an active Full-Time Employee under the Plan and eligible for Medicare benefits, to read the following applicable sections.

### **FOR ACTIVE FULL-TIME EMPLOYEES AGE 65 AND OVER**

If you are eligible under the Plan due to your active employment, and are age sixty-five (65) or over, you may elect whether your primary health coverage will be provided by Medicare or by this Plan. In other words, you may determine whether you wish for Medicare to pay benefits in your behalf, in which case this Plan cannot supplement those benefits, or you may decide that this Plan will be your primary coverage and Medicare will supplement these benefits.

Please remember, in order for Medicare to pay any of your benefits whether as primary payor or secondary payor, you must be enrolled for Medicare coverage. Before deciding whether to select this Plan or Medicare for your primary health benefit coverage, you should carefully compare the benefits offered under each Plan. The benefits provided by this Plan are of course outlined in this booklet. A description of Medicare benefits can be obtained from your local Social Security office.

In order to have Medicare as your primary health coverage, you must file a written election notice with the Employer. If you do not file such an election this Plan will be the primary payor of benefits in your behalf and Medicare will be the secondary payor.

If you do not elect Medicare as your primary coverage, there will be a change in the way your claims are filed. In the past, your claims were first filed with Medicare. That procedure is now reversed, with your claims being filed with this Plan and then with Medicare once this Plan has paid benefits in your behalf.

Please contact the Plan Administrator for assistance and information regarding this notice.

### **FOR ELIGIBLE SPOUSES AGE 65 AND OVER OF ACTIVE FULL-TIME EMPLOYEES**

If you are the spouse of an Active Full-Time Employee and you are age sixty-five (65) or over, you may elect whether your primary health coverage will be provided by Medicare or by this Plan. For an explanation of this provision, and other pertinent information, please read the previous section addressed to Active Full-Time Employees age sixty-five (65) or over.

**Please note: These provisions do not apply to retired participants.**

### **"HIPAA PRIVACY RULE" AND "504" PROVISIONS**

The terms of the Plans shall be construed and administered in a manner calculated to meet the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, including the regulations referred to as the "HIPAA Privacy Rule" and "the "504" provisions".

## DEFINITIONS

The terms listed if used will have these meanings:

**AMBULATORY SURGICAL FACILITY** - A legally operated facility which:

- is approved by the appropriate State regulatory authority;
- is capable of performing surgery on the same day basis;
- maintains a medical staff;
- maintains continuous medical care for the patient while confined; and
- is not used primarily as an office or clinic for Physicians or other professional private practice.

Ambulatory Surgical Facility benefits do not include surgery performed in a Physician's office or at home.

**BIRTHING CENTER** - Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**CERTIFICATE OF CREDITABLE COVERAGE** - The certification of coverage that must be provided to the Covered Person when coverage under this Plan ceases, including when the lifetime maximum benefit for all covered expenses has been met. The certification must be provided automatically within a reasonable time period after coverage ceases and in the twenty-four (24) month period after coverage ceases, upon request.

**CO-INSURANCE** – The portion of charges you pay until the Maximum Out of Pocket has been satisfied

**CO-PAYMENT** - That portion of eligible expenses which is payable by the Covered Person.

**COVERED MEDICAL EXPENSE** - Those expenses which are actually incurred by a Covered Person for treatment of an Illness, Injury or congenital defect, or in connection with the pregnancy of an Eligible Employee or the spouse of an Eligible Employee, subject to all the limitations of the Plan. Further, "Covered Medical Expense" shall be limited to those expenses which are Medically Necessary, as defined below, and which are Reasonable, Usual and Customary Expenses, as defined below.

**COVERED PERSON** - The "Eligible Employee" and/or the "Eligible Dependent" who have become covered under the plan.

**CREDITABLE COVERAGE** - Coverage of the Employee or Dependent under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees Health Benefit program, a state children's health insurance program, a public health plan as defined in regulations and any health benefit plan of the Peace Corps Act.

**CUSTODIAL CARE** - Care that helps you meet your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of Custodial Care are assistance in walking and getting in and out of bed, aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication which usually can be self-administered. Custodial care is not covered under this Plan.

**DATE CLAIM INCURRED** - The incurred date of a claim for a Covered Person is the first date on which the Covered Person is under the care of a Physician and/or has incurred expense which is payable by the Plan for that particular expense.

**DENTIST** - A Doctor of Dental Surgery (D.D.S.) and Doctors of Dental Medicine (D.M.D.).

**DURABLE MEDICAL EQUIPMENT** – Equipment that:

- can only be used to serve the medical purpose for which it is prescribed;
- is not useful to the patient or other person in the absence of illness or injury;
- is able to withstand repeated use; and
- is appropriate for use within the home.

Durable medical equipment shall not include personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, whirlpools, spas, elevators, wheel-chair ramps, and non-hospital adjustable beds. Such Equipment will not be considered a Covered Service, even if it is prescribed by a Physician or Other Provider, simply because its use has an incidental health benefit.

**ELIGIBLE DEPENDENT** - Those persons eligible for coverage as Eligible Dependents on the date the Eligible Employee becomes eligible or on the date they acquire dependent status, as defined below:

1. A Spouse (if not legally separated). The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.
2. Unmarried natural child living in the same household as the Employee, adopted child or child placed with a Covered Employee in anticipation of adoption or Foster Child. Step-child who resides in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household. Such children must be primarily dependent upon the Employee in a regular parent-child relationship for their support and maintenance and have not reached age twenty-four (24). When a child reaches the limiting age, coverage will end on the child's birthday.

If a Covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as Covered Dependents.

A "foster child" is also eligible if:

- The child resides with the Employee in a regular parent-child relationship; and
- The child is not covered by another plan, including the agency through which the child is placed.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. See Qualified Medical Child Support Orders Provisions for details.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

3. Eligibility for adopted children: Adopted children shall be treated the same as natural children for the purposes of eligibility in this Plan. Therefore, adopted children shall be treated as being dependents under this Plan. All adopted children shall be provided benefits under the same terms and conditions as apply in the case of dependent children who are natural children of participants.

Coverage for adopted children shall become effective upon placement of the child for adoption. Thus, said children are eligible for coverage irrespective of whether the adoption has become final. Should the court, which has exercised jurisdiction over the adoption proceeding, later determine that the child shall not be adopted, coverage shall then be terminated upon receipt by the Plan of the court order ruling that the adoption shall not take place.

The Plan shall not restrict coverage for the dependent child adopted by a participant or placed with a participant for adoption, solely on the basis of a pre-existing condition of such child at the time that the child will otherwise become eligible for coverage under the Plan if the adoption or placement for adoption occurs while a participant is eligible under the Plan.

For the purposes of this provision, the term "child" means an individual who has not attained the age of eighteen (18) as of the date of the adoption or placement for adoption.

The term "placement" or being "placed" for adoption for the purposes of this provision means the assumption by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with such person terminates upon such termination of such legal obligation.

4. A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Custody, guardianship, adoption, and/or foster care must be established by valid court order or decree entered after the petition for same has been filed. Only certified copies of actual legal documents issued by the respective court(s) will be considered acceptable documentation.

A spouse or child who is covered under the Plan as an Employee will not be eligible as a Dependent. If the Employee and the Employee's spouse are both covered Employees under the Plan, the Employee's children may be considered as Dependents of either the Employee or the Employee's spouse, but not of both. The plan will not be primary AND secondary for any employee or covered dependent.

Any Dependent who is on active duty with any branch of the military or who has permanent residence outside the United States of America is not eligible under the Plan.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

**ELIGIBLE EMPLOYEE** - Any person who satisfies the Rules of Eligibility.

**EMPLOYER** – Blount County Government, including any division, department or constitutional office named in this document.

**ENROLLMENT DATE** - The first day of the waiting period except in the case of a Late Enrollee, the Enrollment Date is the first day of coverage.

**ERISA** - The term "ERISA" means The Employee Retirement and Income Security Act of 1974, as amended.

**EXPERIMENTAL AND INVESTIGATIVE EXPENSE** - The use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet generally recognized as accepted medical practice and any of such items requiring federal or other governmental agency approval and for which such approval had not been granted at the time the services were rendered.

Charges for any technology, including any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceutical, or chemical compounds which are determined by the Plan Administrator, in its sole discretion, to be Experimental or Investigational, or obsolete or ineffective.

1. The term "Experimental" or "Investigational" means that the technology is either:
  - A. Not of proven benefit for the particular diagnosis or treatment of the Covered Person's condition; or
  - B. Not generally recognized by the medical community, as reflected in the published peer-reviewed literature as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition.
2. Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis of a Covered Person's particular condition.
3. The Plan Administrator may, in its sole discretion, apply any or all of the following criteria in determining whether a technology is Experimental or Investigational, obsolete or ineffective:
  - A. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition.
  - B. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug, or biological product for another diagnosis or condition may require that any or all of these criteria be met.
  - C. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes. This evidence must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects and is possible in standard conditions of medical practice, outside clinical investigatory settings.

**EXTENDED CARE FACILITY** - An institution which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Illness, and which:

1. Is approved by and is a participating Extended Care Facility of Medicare;
2. Has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or registered graduate nurses;
  - A. Maintains daily clinical records on each patient and has available the services of a Physician under an established agreement;
  - B. Provides appropriate methods for dispensing and administering drugs and medicine; and
  - C. Has transfer arrangements with one (1) or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one (1) Physician; excluding any institution which is other than incidentally a rest home, a home for the aged, or a place for the treatment of mental illness, chemical dependency or alcoholism.

**FULL-TIME EMPLOYEE** - An Employee of the Employer who is:

1. performing all the normal duties of his/her job; and
2. regularly scheduled to work at least thirty (30) hours per week, 50 weeks per year, and
3. is on the regular payroll of the Employer for that work.

A "Full-Time Employee" also includes an Employee of the Employer who is:

1. A teacher who works at least thirty (30) hours per week performing all the normal duties of his/her job and is on the regular payroll of the employer for that work.
2. A cafeteria employee who works at least thirty (30) hours per week for at least nine (9) months per year performing all the normal duties of his/her job and is on the regular payroll of the employer for that work.

**HOME HEALTH AGENCY** - A public or private agency or organization, or its subdivision which:

1. is mainly engaged in providing skilled nurse care and other therapeutic services;
2. uses policies and standards set by associated professional people;
3. is supervised by one (1) or more: (1) qualified Physicians (M.D.); and (2) registered nurses (R.N.);
4. keeps clinical records of all patients; and
5. is licensed or approved by state or local law as a Home Health Agency.

"Home Health Agency" does not include any agency or organization which is mainly for the care and treatment of mental illness.

**HOSPICE CARE** - The Medically Necessary medical services provided to a terminally ill patient in a Hospital or rendered in a home environment. Services must be provided by a medically supervised team of professionals and volunteers on a twenty-four (24) hour on-call basis. Bereavement services to the family are available.

**HOSPITAL** - Only a lawfully operated institution that provides:

1. twenty-four (24) hour nursing services by registered nurses;
2. a staff of one (1) or more Physicians licensed to practice medicine;
3. inpatient therapeutic and diagnostic services for Injury or Illness; and
4. facilities for major surgery or has a formal arrangement with another institution for surgical facilities.

In no event will "Hospital" include a rest or nursing home, home for the aged, convalescent home, rehabilitation facility, or skilled nursing facility.

**INPATIENT ADMISSION** - A person shall be deemed to be confined in a Hospital or in a Non-Hospital Facility/Treatment Facility, if a room and board charge has been made or if he/she has been confined for a period of twenty-three (23) hours or more.

**ILLNESS** - A disorder or disease of the mind or body; or a pregnancy. All Illnesses which are due to the same cause or causes will be deemed to be one (1) Illness.

**INJURY** - A bodily Injury caused by accidental, external means.

**LATE ENROLLEE** - An individual who is enrolled for coverage after the date the individual was initially eligible to enroll.

**MEDICAL EMERGENCY** - The term "Medical Emergency" means a sudden and unexpected medical condition that without immediate medical attention could result in death or serious impairment of the Covered Person's health. For example, a medical emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**MEDICALLY NECESSARY** - Those services, treatments or supplies provided by, or under the direction of, a Hospital or Physician that are required in the judgement of the Plan, to identify or treat an Injury or Illness and which are:

1. consistent with the symptoms or diagnosis and treatment of the Covered Person's condition, illness, ailment or Injury;
2. appropriate according to standards of good medical practice;
3. not solely for the convenience of a Covered Person, Physician, or Hospital; and
4. the most appropriate which can be safely administered to the Covered Person.

**NON-HOSPITAL FACILITY/TREATMENT FACILITY** - A legally operated institution which is primarily engaged in providing treatment for a mental illness or disorder or for the treatment of alcoholism or drug addiction, which meets these requirements:

1. has rooms for resident inpatients;
2. is equipped to treat mental disease or disorders, or alcoholism or drug addiction;
3. has a resident Psychiatrist/Physician on duty or on call at all times; and
4. charges the patient for the expense of confinement.

**NON-OCCUPATIONAL** - With respect to Injury, an Injury which does not arise out of, and in the course of, any employment for wage, profit or remuneration and, with respect to illness, means an illness in connection with which the person is not entitled to benefits under any Worker's Compensation Law or similar legislation.

**OPEN-ENROLLMENT DATE** - January 1 of each Plan Year provided enrollment is requested during the month of October prior thereto.

**PHYSICIAN** - A doctor who is duly qualified and legally licensed to practice medicine and who is legally authorized to and does use the designation M.D.; or who is a duly licensed doctor of osteopathy who uses the designation D.O. The term includes surgeons and other specialists who meet the preceding definition. Also considered "Physician" under this Plan for purpose of benefit payments are:

1. a duly licensed podiatrist (chiropractist) for the treatment of foot conditions covered by this Plan;
2. a duly licensed dentist for any dental work or oral surgery covered by this Plan;
3. a duly licensed optometrist;
4. a duly licensed psychologist;
5. a duly licensed chiropractor;
6. a certified licensed nurse-midwife;
7. a licensed professional counselor; or
8. a member of the clinical staff of a community mental health center, who is licensed and who has a master's degree in psychology, nursing or social work for purpose of outpatient treatment at a community health center of nervous and mental conditions.

Services rendered must be within the scope and limitations of the license of the Physician or practitioner performing the service and the service is covered under this Plan.

"Physician" does not include the Covered Person or any member of their immediate family: spouse, parent, child, grandparent, grandchild, or sibling by blood, marriage or adoption.

**PLAN ADMINISTRATOR** – The Employer. The Employer may delegate to another party the authority to handle the day to day administrative functions of the Plan.

**PRE-EXISTING CONDITION** - A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the Enrollment Date. Medical advice, diagnosis, care or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law. Genetic information shall not be treated as a condition in the absence of a diagnosis of a specific condition.

Pregnancy shall not be considered a Pre-Existing Condition under the Plan. In addition, Pre-Existing Condition exclusions will not apply to newborns or children who are adopted or placed for adoption and enrolled in the Plan within thirty-one (31) days.

**REASONABLE, USUAL AND CUSTOMARY EXPENSE** - (or "Reasonable Expense") - The lesser of the usual, reasonable and customary fees for the covered services rendered and the covered supplies furnished, as determined for the geographical area in which such services are rendered or supplies are furnished and the charge usually made by the Provider for the services or supplies furnished.

**REHABILITATION FACILITY** - A legally operating institution or distinct part of an institution which has a transfer agreement with one (1) or more Hospitals, and which is primarily engaged in providing comprehensive, multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

A "Rehabilitation Facility" does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such facility by the Joint Commission of the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation.

**SURGICAL PROCEDURE** – Includes, but is not limited to, the following: (1) A cutting operation; (2) Suturing of a wound; (3) Treatment of a fracture; (4) Reduction of a dislocation; (5) Radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor; (6) Electro cauterization; (7) Diagnostic and therapeutic endoscopic procedures; or (8) Injection treatment of hemorrhoids and varicose veins.

**TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)** - The term "temporomandibular joint syndrome" or "TMJ" means the symptoms associated with, or exhibited as a malfunction of, the temporomandibular joint. These are frequently caused by but not exclusive to:

1. Improper or incorrect space between the maxilla and mandible;
2. Improper dental occlusion; and
3. Muscular spasm in the TMJ area.

**TOTALLY DISABLED** - With respect to Employees, disability to the extent that the Employee is not able to perform any of the usual and customary duties of his/her occupation; and with respect to Dependents, cannot perform any of the usual functions, duties or activities of a person in good health and of the same age and gender.

## **COST CONTAINMENT PROVISIONS**

**CASE MANAGEMENT** - In cases where the patient's condition is expected to be or is of a serious nature, the Plan Administrator may at its discretion arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care.

Benefits provided under this Section are subject to all other Plan provisions. Alternate care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability, with respect to you or any other Covered Person.

**PRE-ADMISSION CERTIFICATION** - If a Covered Person anticipates a hospital admission, the person should make sure that Pre-Admission Certification is obtained.

Elective hospital admissions must be certified at least one (1) day in advance of the scheduled admission. Pre-admission certification of hospital days is a pre-service claim.

Pre-admission certification is required for all admissions, except urgent care admissions and normal obstetrical admissions. See claims appeal procedure section for a definition of urgent care and other information relating to urgent care.

Urgent care admissions or normal obstetrical admissions must be telephoned to the clinical evaluators by the admitting physician within seventy-two (72) hours or the first working day after admission. Outpatient procedures are exempt from the pre-admission certification process.

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than forty-eight (48) hours; or following a cesarean section, to less than ninety-six (96) hours; or require that a provider obtain authorization from the Plan for prescribing any length of stay not in excess of the above. However, for maternity admissions that exceed these time periods, pre-admission certification is required prior to the end of the forty-eight (48) hour period for vaginal deliveries or the ninety-six (96) hour period for a cesarean section.

It is important the Covered Person discuss this provision of the medical Plan with the Physician. It is the Covered Person's responsibility to provide the Physician with the Pre-Admission Certification numbers.

The admitting Physician obtains pre-admission certification by calling to seek a medical necessity/appropriateness decision prior to the admission. If admission cannot be certified by the clinical evaluator, it will be reviewed by a Physician advisor(s) for a medical necessity decision.

After admission is certified, the clinical evaluator assigns the length of stay based upon the patient's condition, using expected recovery times for specific diagnoses and procedures given the patient's age and sex. If the patient needs to be hospitalized beyond the initial length of stay determined at pre-admission, the attending Physician must call for a length of stay extension before additional hospital days are used.

The length of the patient's hospitalization directly correlates to the patient's course of recovery and is modified as necessary. Whenever the clinical evaluator cannot certify continued stay, the Physician advisor(s) will consult with the attending Physician and render a medical necessity determination.

**Note:** A Pre-Admission Certification is to be done for each admission. If a Covered Person is admitted to the hospital without having followed the above procedures, THE PENALTY OUTLINED IN THE SCHEDULE OF BENEFITS WILL BE ENFORCED.

**WEEKEND ADMISSIONS** - When admission takes place after twelve (12) noon on Friday or before twelve (12) noon on Sunday, benefits will be payable for expenses incurred on that Friday, Saturday and/or Sunday only if the admission is for:

1. a Medical Emergency; or
2. surgery which is performed within twenty-four (24) hours of the admission.

"Medical Emergency" means a severe condition which (in the opinion of the Plan Administrator):

1. results in symptoms which occur suddenly and unexpectedly; and
2. requires immediate physician's care to prevent death or serious impairment of the covered person's health.

**SECOND SURGICAL OPINION** - When an elective non-emergency surgical procedure is recommended, the covered person may obtain a second opinion. The second opinion and any related tests obtained from the Physician of the covered person's choice will be paid as shown in the Schedule of Benefits of the Usual and Customary charge as determined by the Plan Administrator. The second opinion does not have to agree with the first opinion. The covered person may also obtain a third opinion and it will be covered the same as the second opinion.

The Physician giving the second or third opinion(s) must not be associated with the Physician(s) who gave the previous opinion(s). All surgical opinions must be rendered by a Physician specializing in the appropriate field.

**PREFERRED PROVIDER ORGANIZATION** - This Preferred Provider Option is a health care benefit program designed to give the Covered Person a financial incentive to use a designated group of Hospitals and Physicians. The choice of Preferred Providers is based on a range of services, geographic locations, cost-effectiveness, and quality health care.

Under this option, the Covered Person will continue to have a complete freedom of choice of Hospitals and Physicians. However, the Major Medical Percentage Payable may be greater if he/she uses the services of a Preferred Provider.

#### **DEFINITIONS:**

**PROVIDER** – means any health care facility (for example, a Hospital) or person (for example, a Physician) duly licensed to render covered medical care or services.

**PREFERRED PROVIDER** - means a Provider who has entered into an agreement with the Preferred Provider Organization, to provide services to individuals enrolled as members of the organization.

**NON-PREFERRED PROVIDER** - means a Provider that does not meet the definition of Preferred Provider.

**EMERGENCY** - means a sudden unexpected serious medical condition that, without immediate medical attention could result in death or cause serious impairment of the covered person's health.

When a covered person receives treatment or services as a result of a Medical Emergency, eligible expenses will be paid on the basis of a Tier II provider, whether or not such services were performed by a Tier II provider.

When covered services are rendered in a Tier I or II Hospital by an anesthesiologist, radiologist or pathologist who is a Tier III Provider, the benefit percentage will be the same as that for services rendered by a Tier I or II Provider dependent upon the Hospital where the services are rendered.

When covered services are rendered within the PPO Service Area by a Tier III Provider and such services are not available from a Tier I or II Provider, the benefit percentage will be the same as that for services rendered by a Tier I Provider.

When covered services are received: (1) outside the geographic Service Area of the Tier I or II provider network; (2) by a dependent child who lives in another state with a divorced parent; or (3) by a retiree, the percentage payable for eligible charges will be the same as that stated in the Schedule of Benefits for Tier II Providers. However, if the covered person travels outside the geographic Service Area for the purpose of obtaining medical care, which is available from a Tier I or II provider, the percentage payable by the Plan will be the same as that for a Tier III provider as stated in the Schedule of Benefits.

**PRE-ADMISSION TESTING** - Benefits will be paid at 100% for required testing prior to a scheduled surgical admission to the Hospital. These tests may be performed at a Hospital on an outpatient basis. Tests not related to the surgery will not be covered. This benefit will not be subject to the deductible amount.

Benefits will still be paid if:

1. the Hospital or Doctor cancels or postpones the admission; or
2. The admission is cancelled because the Utilization Management Company did not certify the confinement.

Benefits will not be paid if the Covered Person cancels or postpones the admission. Pre-Admission Testing must be done within five (5) days prior to admission.

## SUPPLEMENTAL ACCIDENT EXPENSE BENEFIT

If a Covered Person incurs medical charges as a result of an accidental bodily injury and treatment is incurred within three (3) months from the date of the accident, the Plan will pay for reasonable and customary charges up to the Maximum Benefit shown in the Schedule of Benefits. Covered expenses will be paid at 100% without a deductible for:

1. surgery or medical attention performed by a legally qualified doctor of medicine or Dentist for covered dental expenses;
2. hospital care;
3. nursing care provided by a registered graduate nurse; and
4. drugs and medical supplies

## WEEKLY ACCIDENT AND SICKNESS BENEFIT

### CLASS 1 BENEFITS:

Plan will pay benefits to Covered Employee while he/she is disabled as stated in the Schedule of Benefits. The disability must result from an injury or illness and prevent the Covered Employee from doing every duty of his/her occupation.

#### 1. **WHEN BENEFITS ARE PAYABLE**

There is a Waiting Period at the start of disability. The length of the waiting period is shown in the Schedule of Benefits. Benefits become payable if the Covered Employee is still disabled at the end of the waiting period. Disability payment calculation will begin on the 8th day an employee is without pay for disabilities due to a sickness. On the 1st day for disabilities due to accidental bodily injury. The term "without pay" includes any payment(s) received from the sick-pay plan. Benefits will be payable during continuous disability up to the Maximum Period shown in the Schedule of Benefits.

#### 2. **CONTINUOUS DISABILITY**

Successive periods of disability are considered continuous and subject to the same waiting and maximum periods unless: the later disability results from a different injury or sickness; or the disabilities are separated by at least 14 days during which you are actively at work full-time.

3. **EXCLUSIONS** - Plan will not pay benefits for any period of disability:
  - A. during which Employee is not under a doctor's care;
  - B. caused by war or act of war, whether or not Employee is in the Armed Services;
  - C. caused by participation in a riot, fighting or violating the law;
  - D. caused by intentional self-inflicted injury while sane, or intentional self-inflicted injury while insane;
  - E. covered by workers' compensation or similar law; or
  - F. caused by a job-related injury.

## **CLASS 2 BENEFITS:**

Plan will pay benefits to Covered Employee while he/ she is disabled as stated in the Schedule of Benefits. The disability must result from an injury or illness and prevent Covered Employee from doing every duty of his/her occupation.

### **1. WHEN BENEFITS ARE PAYABLE**

There is a Waiting Period at the start of disability. The length of the waiting period is shown in the Schedule of Benefits. Benefits become payable if Covered Employee is still disabled at the end of the waiting period. After 30 days without pay a claim for disability benefits may be filed. Disability payment calculation will begin on the 31st day an employee is without pay for disabilities due to a illness or accidental bodily injury. The term "without pay" includes any payment(s) received from the sick-pay plan. Benefits will be payable during continuous disability up to the Maximum Period shown in the Schedule of Benefits.

### **2. CONTINUOUS DISABILITY**

Successive periods of disability are considered continuous and subject to the same waiting and maximum periods unless: the later disability results from a different injury or sickness; or the disabilities are separated by at least 14 days during which you are actively at work full-time.

### **3. EXCLUSIONS** - Plan will not pay benefits for any period of disability:

- A. during which Employee is not under a doctor's care;
- B. caused by war or act of war, whether or not Employee is in the Armed Services;
- C. caused by participation in a riot, fighting or violating the law;
- D. caused by intentional self-inflicted injury while sane, or intentional self-inflicted injury while insane;
- E. covered by workers' compensation or similar law; or
- F. caused by a job-related injury.

## COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

Comprehensive Major Medical Expense Benefits become payable if you or your dependents incur Covered Medical Expenses which are not payable elsewhere under the Plan and are in excess of the Deductible or Co-Pay Amount(s).

After the Deductible has been satisfied, the Plan will pay the "Percentage Payable" as set forth in the Schedule of Benefits for the rest of the Calendar Year. The Employee will have to pay the balance for each individual Covered Person.

**DEDUCTIBLE** - The Deductible is the amount of Covered Medical Expenses that each Covered Person must satisfy each Calendar Year before benefits become payable under the Plan. The Deductible amount is stated in the Schedule of Benefits. In addition, should a Covered Person incur expenses during the last three (3) months of a Calendar Year and such Covered Expenses are used towards satisfying all or a part of this Deductible, for that Calendar Year, then the Deductible for the next Calendar Year will be reduced by the amount of such Covered Expenses.

**FAMILY LIMIT ON DEDUCTIBLES** - No more than the total amount per family unit as stated in the Schedule of Benefits is required to be paid in a given Calendar Year. After that, the deductible for each Covered Person in that family will be considered as having been satisfied for that Calendar Year.

**MULTIPLE BIRTH DEDUCTIBLE** - When two or more children are born as a result of a multiple birth, only one Calendar Year Deductible will be applied for that calendar year for all covered charges related to: a premature birth; abnormal congenital condition; or Illness beginning or Injury received within 30 days of the birth.

**MAXIMUM "OUT-OF-POCKET" EXPENSES** - The maximum out-of-pocket expense for any Calendar Year is outlined in the Schedule of Benefits. Covered Medical Expenses in excess of this amount will be paid at 100% for the rest of the Calendar Year. The following expenses do not count towards the out-of-pocket amount: cost containment penalties and/or limits, treatment of mental and nervous disorders/alcoholism and chemical dependency, deductibles, expenses exceeding any plan maximums, or other non-covered items, nor will these items ever be paid at 100%.

**LIFETIME MAXIMUM BENEFIT** - The Plan's Lifetime Maximum Benefit is stated in the Schedule of Benefits and consists of all Plan payments for a Covered Person during that person's entire lifetime after satisfaction of annual deductibles, co-pays and co-insurance percentages. Benefits paid are deducted from the Lifetime Maximum Benefit.

**COMMON ACCIDENT – OTHER MEDICAL SERVICES** - If any two (2) or more members of the family unit, while eligible for this coverage, sustain injuries in the same accident and incur covered expenses as a result of such injuries, the largest of the cash deductibles applicable to the persons sustaining injuries in that accident shall be applied, but only once with respect to those covered expenses which are received by such persons as a result of such injuries.

**BENEFITS FOR EXPENSES DUE TO PREGNANCY** - Benefits are payable for pregnancy-related expenses on the same basis as any illness.

Group health plans generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

There is no coverage of Pregnancy for a Dependent child.

**COVERED MEDICAL EXPENSES** - Covered Medical Expenses are the Reasonable, Usual and Customary charges incurred by the Eligible Employee or Eligible Dependent for the services and supplies listed below which are required in connection with the treatment of the Covered Person and which are Medically Necessary. The service or supply must be furnished upon the recommendation and approval of the attending Physician.

Covered Medical Expenses are those charges listed below:

1. Charges made by the Hospital for room and board, not to exceed the Hospital's actual charge for a semi-private room, unless confinement is in an Intensive Care or Cardiac Care Unit in which case, up to 3 times the Hospital's most common semi-private room rate will be considered as a Covered Expense. A private room, up to the Hospital's most common semi-private room rate plus \$4 will be considered as a Covered Expense. However, when a hospital has only Private Room accommodations and does not have a Most Common Semi-Private Room Rate, the room and board benefit will be 3 times the Most Common Semi-Private Room rate for that geographic area.
2. Charges made by the Hospital for services and supplies required for treatment of Illness and Injury rendered to a bed patient in a Hospital, including professional medical visits rendered by a Physician for the usual professional services (admission, discharge and daily visits). Covered Expenses also include consultations with a Physician requested by the Covered Person's Physician.
3. Physician's fees and surgery performed by a Physician.

If more than one surgical procedure is performed during one operative session in the same operative field, the following will be considered a covered expense: the Usual and Customary Charge for the first procedure, 50% of the Usual and Customary Charge for the second procedure, and 25% of the Usual and Customary Charge for the third procedure.

Surgery also includes tissue and organ transplants. (SEE TISSUE AND ORGAN TRANSPLANT PROVISION).

Cosmetic surgery is excluded under this Plan unless it is performed to:

- A. reconstruct the breast on which a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance, prosthesis and physical complications, and treatment of physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with attending physician and the patient. External breast forms and bra are limited as stated in the Schedule of Benefits. An internal prosthesis is limited to the initial placement.
  - B. breast reduction surgery if documented to be medically necessary by Plan Administrator;
  - C. reconstructive surgery, i.e., reparative or therapeutic surgery done after an illness or injury to restore the patient's appearance.
  - D. cosmetic surgery deemed necessary as a result of a congenital defect affecting bodily function of a child;
  - E. A vasectomy or tubal ligation procedure performed on an Employee or his/her spouse. However, reversal of a vasectomy or tubal ligation procedure is not a Covered Expense.
4. Dental services rendered by a Physician for removal of:
    - A. impacted teeth (only dentist fee and anesthesia charges for such treatment is covered), or
    - B. for the treatment injury to sound natural teeth, including replacement of the teeth, provided treatment is completed within twelve (12) months of and as a result of an accident;

Also covered under the comprehensive medical expense benefits will be charges for anesthesia for dental surgery performed on a covered person eight (8) years of age or younger at a hospital, as well as hospital charges incurred while hospital confined for such surgery, where such procedure cannot safely be provided in a dental office setting.

5. Nursing services rendered by a Registered Nurse, or by a Licensed Practical Nurse if a Registered Nurse is not available, provided, in either case, the Nurse is not a close relative. The term "close relative" includes the Covered Person, the spouse, child, grandchild, brother, sister or parent of the Covered Person;

Private duty nursing services while the covered person is confined as an inpatient in a Hospital. Such services must be recommended and approved by the attending Physician. Private duty nursing services are limited to two 8-hours shifts in any 24-hour period.

6. Diagnostic x-ray examinations and laboratory examinations and other diagnostic services;
7. Prescription drugs and medicines, including insulin and syringes used for its administration;
8. Diabetic supplies not covered under the prescription drug card, including but not limited to, blood glucose monitors, insulin pumps, and infusion devices and attachments. Diabetic supplies covered under the prescription drug card will not be considered eligible expenses under the Comprehensive Major Medical Expense Benefits.
9. Outpatient Self-Management Training and Medical Nutrition Counseling for Diabetes Management required by a patient's Physician will be considered a Covered Expense for the patient if visits are certified medically necessary by the Physician upon diagnosis, significant change in a patient's symptoms or condition, or re-education or refresher training.
10. Surgical supplies, surgical dressings;
11. Orthotic appliances, including but not limited to casts, splints, trusses, braces (except dental braces), and shoe inserts. Benefits for shoe inserts are limited to orthotics prescribed and certified as being medically necessary by a licensed physician, for conditions resulting from diabetes and circulation or organic impairments, which are custom made for the covered person by a medical supply company.

Benefits will not be provided in the following instances:

- A. when the prescribing physician, or a physician in a group practice with the prescribing physician, also makes the shoe insert;
- B. or for ready made inserts purchased over the counter;
- C. or for inserts required for the treatment of weak, unstable or flat feet.

12. Blood and blood plasma (if not replaced);
13. Charges made for an anesthetic and the administration of the anesthetic;
14. The initial purchase of an artificial limb (prosthetic device) necessary due to an illness or injury and subsequent purchases due to physical growth for a covered dependent through age 18. One additional limb prosthesis past age 18 will be covered if additional surgery has altered the size or shape of the stump, or if a severe medical condition could result from improper fitting of the initial prosthesis. Charges for the initial purchase of an artificial limb (prosthetic device) necessary due to an illness or injury for covered employees and dependents who are age 18 or over shall also be covered. Charges for replacement prosthetic due to normal wear and tear or physical development, with approved preauthorization through medical necessity.

Also considered as a covered medical expense for an artificial limb (prosthetic device) will be the charge incurred for surgical supplies required to aid any impaired physical organ or limb in its natural body function.

15. The lesser of the rental or purchase price of durable medical equipment, provided a Physician certifies that it is essential in the treatment of an Injury or Illness under a treatment plan which is from time to time reviewed and updated. The equipment will be provided on a rental basis or, at the Plan's option, purchased.
16. Charges for transportation service by professional ambulance:
  - A. from the Covered Person's home or the scene of an accident or medical Emergency to the nearest Hospital where appropriate medical or surgical services are available;
  - B. between Hospitals; and
  - C. between a Hospital and an Extended Care Facility.

Air ambulance will be covered in cases of life threatening emergencies from the place where the injury or illness occurred to the nearest hospital, which has equipment to furnish special treatment required for such. Transportation by commercial airline is not covered.

17. Charges for services made by a Home Health Agency (See HOME HEALTH AGENCY PROVISION);

18. Charges for a Physician made for second surgical opinions and, when necessary, for third surgical opinions;
19. Charges for an Extended Care Facility (See EXTENDED CARE FACILITY PROVISION):
20. Charges for specific type of hospice services when provided by a licensed participating hospice or licensed approved hospice (See HOSPICE CARE PROVISION);
21. Charges for chiropractic care and treatment for diathermy, subluxations or misplacement of vertebrae, or strains and sprains of soft tissue related to the spine when performed by a licensed chiropractor. Such charges shall be limited as stated in the Schedule of Benefits.
22. Charges for treatment rendered to a newborn child prior to initial discharge from the Hospital for:
  - A. An abnormal congenital condition;
  - B. An Illness contracted at birth;
  - C. An Illness related to prematurity; or
  - D. Well baby care for a newborn child placed in a well child care unit of a Hospital up to 3 days following birth.

Well baby care consists of:

  - A. Hospital charge for nursery care;
  - B. Hospital special charges;
  - C. Surgeon's charges for circumcision; and
  - D. Doctor's charges for visits during this Hospital confinement.
23. Charges for non-surgical treatment or services for Temporomandibular Joint Dysfunction or TMJ pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope. Treatment is limited to diagnostic procedures and Dental appliances to correct jaw joint problems, craniomandibular disorder or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves and other tissues related to that joint. It does not include dental fixed or removable bridgework or dentures, inlays, onlays, crowns, implants or equilibrations. Such charges will be limited as stated in the Schedule of Benefits.
24. Charges by a licensed birthing center or ambulatory surgical center for Medically Necessary treatment and supplies for a covered surgical procedure;
25. Therapy Services:
  - A. Charges for Outpatient Rehabilitation Therapy (services and counseling) when prescribed by the physician for medically necessary treatment of cardiac or pulmonary conditions or other conditions based on the patient's medical status, current treatment plan, projected treatment plan and effectiveness of care;
  - B. Charges for Chemotherapy including supplies and services of technicians;
  - C. Charges for Radiation Therapy including supplies and services of technicians;
  - D. Charges by licensed Physical Therapist or qualified Occupational Therapist. Charges must be:
    - 1) in accordance with a Physician's exact orders as to type, frequency and duration; and
    - 2) to improve a bodily function;
  - E. Charges by a licensed Speech Pathologist or Therapist to:
    - 1) treat a pathological condition;
    - 2) restore speech lost due to an injury; or
    - 3) restore speech lost due to a congenital defect for which the person first had surgery.

No payment will be made for any type of therapy if either the prognosis or history of the individual receiving treatment or therapy does not indicate to the Plan a reasonable chance of improvement.

26. Charges for initial contact lens or initial eye glasses following cataract surgery.
27. Charges for Routine Preventive Care Services provided by a Tier I or Tier II provider are covered as stated in the Schedule of Benefits. Preventive Care includes care by a Physician that is not for Injury or Illness. Immunizations and tests performed during the physical examination will be considered a part of the physical examination. In the

event an employee or eligible family member can not complete their routine physical examination under the care of one Physician, the plan will allow one additional visit to health care specialist. The following routine benefits will be paid at 100%, deductible waived, regardless of the above frequency limits: (a) all routine childhood immunizations required by the health department for dependent children to attend schools; and (b) flu shots for both adults and children.

Eligible expenses will not include examinations given while an inpatient in a Hospital or other health care facility; medicines, appliances, equipment or supplies; psychiatric, psychological personality or emotional testing or examination; employment, premarital, vision hearing or dental examinations.

28. Charges for total enteral and parenteral nutrition;
29. Wig following chemotherapy or radiation treatment up to the maximum benefit stated in the Schedule of Benefits;
30. Oxygen and rental of equipment for administration of oxygen;
31. Expenses incurred for the initial testing to determine the cause and diagnosis of sleep disorders. Subsequent treatment is limited to only those charges for (1) outpatient treatment of acute insomnia disorders (but not chronic insomnia), (2) charges for inpatient and outpatient treatment of life threatening sleep disorders, (3) CPAP machine if patient is diagnosed with sleep apnea and machine is prescribed by a physician who specializes or treats sleep apnea.

## HOSPICE CARE BENEFITS PROVISION

This benefit is to cover specific types of services that are related to the care of a terminally ill patient. "Terminally ill" means life expectancy is six (6) months or less. The diagnosis of terminal illness must be certified by the patient's primary or attending Physician. Such person will be eligible for up to six (6) months of Hospice Care in a Hospice Care Facility or by a Hospice Care Agency payable as stated in the Schedule of Benefits.

If the covered person lives more than 6 months, the attending Physician must again certify in writing that the covered person is still terminally ill and as to the life expectancy. Extension of coverage under this section must be approved by the Employer. If, at any time, the terminally ill patient is deemed no longer terminally ill and thus does not qualify for Hospice benefits, the covered person will be eligible for other home care services if skilled care is required.

### TERMS

- Hospice home care means the medically necessary medical services provided to a terminally ill patient and rendered in a home environment. Services must be provided by a medically supervised team of professionals and volunteers on a twenty-four (24) hour on-call basis. Bereavement services to the family must be available.
- Participating hospice means a Tennessee hospice that has entered into a participating hospice agreement.
- Approved hospice means a hospice located outside the State of Tennessee that meets all the requirements of a participating hospice and must be licensed by and possess a Certificate of Need, if required, in the state in which it is operating, be certified as a Home Health Care Agency under Title XVIII and Title XIX of the Social Security Act, be eligible for accreditation by the Joint Commission of Accreditation of Hospitals as a Hospice, and, provide in-home health care services which conform to the standards of a Hospice Program of Care as adopted by the Board of Directors of the National Hospice Organization.
- Plan of care means home plan consisting only of services that are eligible to be covered under this benefit. The plan must be orderly and detailed, be developed by the hospice, and approved by the patient's primary or attending Physician.

**COVERED SERVICES** - This Plan will pay for specific types of home care and specified types of services when provided by a licensed participating hospice or licensed approved hospice as follows:

- A. charges by an approved Hospice Facility;
- B. skilled nursing by a Registered Nurse, a Licensed Practical Nurse, or a Nurse's Aide working under the supervision of a Registered Nurse;
- C. medical social services by a social worker that is certified by the state in which the hospice is operating and employed by the hospice agency and under the direction of the patient's Physician;
- D. reasonable expense for medication prescribed for the control or palliation of the patient's terminal illness, necessary medical equipment and supplies provided by the approved hospice;
- E. home health aide services furnished by the hospice and supervised by a Registered Nurse. Home health aides to provide personal care services that are necessary for the maintenance of safe and sanitary conditions in the areas of the house used by the patient;
- F. physical therapy and inhalation therapy provided for the purposes of symptom control or to enable the patient to maintain activities of living at home and basic functional skills; and
- G. bereavement counseling consisting of services provided to the patient's immediate family after the patient's death. Counseling is limited to two (2) visits per family unit and must be given within six (6) months after the patient's death.

**LIMITATIONS** - The following are to be excluded:

- A. charges for services greater than the rate set in advance by the participating or approved hospice agreement;
- B. housekeeping services, delivered or prepared meals, and convenience and comfort items not related to the palliation or management of the patient's terminal illness;
- C. comfort items not directly related to relieving pain or managing the patient's terminal illness;
- D. supportive environmental items such as air conditioners, air fresheners, ramps, handrails, or intercom systems;

- E. transportation, chemotherapy, radiation therapy, enteral and parenteral feeding, home hemodialysis, and other services supportive to research, diagnosis and lengthening patterns of treatment;
- F. visits made to the home by a Physician;
- G. psychiatric care; and
- H. services provided by volunteer agencies or pastoral counseling services and items, services or expenses not specifically stated as covered under this benefit.

## TISSUE AND ORGAN TRANSPLANT PROVISION

Expenses incurred in connection with any organ or tissue transplant in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized medical review specialist subject to the Lifetime Maximum Benefit as stated in the Schedule of Benefits. See Limitations and Exclusions to Medical Expense Benefits for Transplant Exclusions.

**What is Covered** - Eligible expenses for tissue and human organ transplants if Medically Necessary, and certain donor expenses related to the following human organ transplant procedures:

Heart	Lung
Heart/Lung combined	Liver
Kidney	Bone Marrow
Cornea	Pancreas
Joint Replacements	

Eligible charges include expenses incurred for tissue and donor organ procurement, inpatient and outpatient hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy. Other covered expenses include transportation to and from the transplant site for the transplant patient and one adult if the recipient is a minor.

Eligible charges for donor expenses will be covered as follows:

When the donor is covered under another plan and the recipient is a covered person under this Plan, this Plan will pay as secondary for the donor's eligible expenses.

When the donor is a covered person under this Plan and the recipient is not, this Plan will pay as secondary for the donor expenses.

When both the donor and the recipient are covered persons under this Plan, eligible expenses will be charged to the recipient.

If the recipient is covered under this Plan, benefits paid to the donor are treated as though they were paid to the recipient for purposes of deductible, co-payment percentages, Plan maximums, etc.

If the donor is not covered by any plan and the recipient is covered under this Plan, the donor's charges will be charged to the recipient and paid by this Plan.

In all cases when expenses are covered by another organization, this Plan will pay its benefits as secondary.

## HOME HEALTH CARE PROVISION

Home Health Care charges for a Covered Person will be eligible as described in this Provision. The benefits payable under this Provision are subject to the Major Medical Deductible and Percentage Payable shown in the Schedule of Benefits.

A Home Health Care Plan is a program for continued care and treatment of the covered person which is established and approved in writing by such covered person's attending Physician. The Home Health Care Plan must be in place of or begins following termination of a hospital confinement as a resident inpatient and is for the same or related condition for which the person was or would have been hospitalized.

The attending Physician must certify that the proper treatment of the illness or injury would require admission to or continued confinement as a resident in-patient in a hospital in the absence of the services and supplies provided as part of the Home Health Care plan.

This provision will pay for eighty (80) visits in each calendar year. Up to four (4) hours of Home Health Aide care will count as one (1) visit.

Major Medical Charges for Home Health Care will include:

1. services on a part-time or intermittent basis by a Registered Nurse, Licensed Practical Nurse or Home Health Aide;
2. service performed by a Licensed Physical, Occupational, Speech and/or Respiratory Therapist, in accordance with the provisions stated in Covered Medical Expenses; or
3. medical support services and supplies such as drugs and medicines prescribed by the Physician, laboratory services and other supplies that would have been covered under the Plan if the Covered Person had remained in the Hospital or Extended Care Facility.

In addition to charges not covered by the LIMITATIONS AND EXCLUSIONS PROVISIONS of the Plan, charges for the following Home Health Care services are not covered:

1. services during any period in which the patient is not under the care of a Physician;
2. services or supplies not included in the Home Health Care treatment plan;
3. food, housing, homemaker services and home delivered meals; or
4. services provided by a person who ordinarily resides in the patient's home, or is a member of the family.

## SKILLED NURSING CARE FACILITY PROVISION

An Extended Care Facility is a facility that is primarily engaged in providing skilled nursing care and other therapeutic services. The facility must be licensed by the state in which it is located and be an eligible Provider of Medicare and Medicaid nursing care services.

Benefits will be paid to a Covered Person for the first twenty-eight (28) days of confinement each Calendar Year provided:

1. Only charges for room and board, skilled nursing care and other per day charges are covered;
2. The charges will be considered Covered Expenses only if:
  - A. confinement is in place of or begins following a covered person's discharge from a Hospital confinement for a covered condition. The confinement in the Skilled Nursing Facility must be for treatment of the same condition that caused or would have resulted in the Hospital confinement. A Physician must actually visit in the physical presence of the covered person at least once each 30 days.
  - B. a Physician certified that confinement is required due to a need for skilled nurse care;
  - C. the care of the patient is supervised by a Physician at all times; and
  - D. the confinement is not for custodial or domiciliary care.

## PRESCRIPTION DRUG BENEFIT PROVISION

**PHARMACY DRUG CHARGE** - Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

**CO-PAYMENT** - The co-payment is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. The co-payment amount is a covered charge under the medical Plan. Any one pharmacy prescription is limited to a 34-day supply at retail, or up to a 100 day supply through mail order if applicable.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

**PERCENTAGES PAYABLE** - The percentage payable amount is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. This amount is not a covered charge under this Plan or the medical plan.

**COVERED PRESCRIPTION DRUGS** - Drugs prescribed by a Physician that require a prescription either by federal or state law, but excludes any drugs stated as not covered under this Plan.

All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

**LIMITS TO THIS BENEFIT** - This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.

**EXPENSES NOT COVERED** - This benefit will not cover a charge for any of the following:

- A. **Administration.** Any charge for the administration of a covered Prescription Drug.
- B. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- C. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- D. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- E. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- F. **FDA.** Any drug not approved by the Food and Drug Administration.
- G. **Immunization.** Immunization agents or biological sera.
- H. **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- I. **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- J. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- K. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- L. **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- M. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

## ALCOHOL AND CHEMICAL DEPENDENCY PROVISION

Except as provided in this special provision, Major Medical Benefits for treatment of alcoholism and chemical dependency are payable on the same basis as any other illness.

After the Deductible is satisfied, benefits for treatment of alcoholism and chemical dependency are payable as shown in the Schedule of Benefits.

Covered Medical Expense for professional charges for treatment of alcoholism and chemical dependency, while not confined in a hospital, is limited to charges made by a licensed clinical social worker, licensed professional counselor, licensed psychiatrist or licensed psychologist.

Charges made by certified addiction counselors are also covered medical expenses, but only if the treatment is rendered in connection with an accredited outpatient substance abuse treatment program. Charges made by marriage and family therapists are not covered medical expenses.

Two days of partial hospitalization provided by a Hospital or other licensed facility for medically intensive or intermediate short-term psychiatric treatment will be counted as one inpatient day. Partial hospitalization is treatment for at least three (3) hours but not more than twelve (12) hours in any twenty-five (25) hour period.

## MENTAL AND NERVOUS DISORDER PROVISION

Except as provided in this special provision, Major Medical Benefits for treatment of mental and nervous disorders are payable on the same basis as any other illness.

After the Deductible is satisfied, benefits for treatment of mental and nervous disorders are payable as shown in the Schedule of Benefits.

Covered Medical Expenses for professional charges for treatment of mental and nervous disorders while not confined in a hospital or community mental health center is limited to charges made by a licensed psychiatrist, licensed psychologist, licensed professional counselor or licensed clinical social worker. Charges made by marriage and family therapists are not covered medical expenses.

Two days of partial hospitalization provided by a Hospital or other licensed facility for medically intensive or intermediate short-term psychiatric treatment will be counted as one inpatient day. Partial hospitalization is treatment for at least three (3) hours but not more than twelve (12) hours in any twenty-five (25) hour period.

## PRE-EXISTING CONDITIONS EXCLUSION

**PRE-EXISTING CONDITION EXCLUSION PERIOD** - Claims resulting from Pre-Existing Conditions, as defined in the Plan, are excluded from coverage under the Plan except as specified below:

1. The maximum Pre-Existing Condition exclusion period shall be twelve (12) consecutive (eighteen (18) in the case of a Late Enrollee) months from the Covered Person's Enrollment Date minus the Covered Person's period of Creditable Coverage. After this period, the Pre-Existing Conditions Exclusion will no longer apply and any eligible expenses incurred thereafter will be considered. Periods of Creditable Coverage before a sixty-three (63) day period of no Creditable Coverage (other than a period of no Creditable Coverage attributable to this Plan's waiting period) shall not reduce the Pre-Existing Condition exclusion period.

2. "Creditable Coverage" shall have that definition contained in ERISA Section 701(c). Under this provision, Creditable Coverage generally includes coverage under an individual or group comprehensive health insurance plan (including Medicare, Medicaid, Governmental and church plans). Creditable Coverage does not include liability, dental, vision, specified illness and/or other supplemental-type benefits.

**EXCEPTIONS TO THE PRE-EXISTING CONDITIONS EXCLUSION** - The exclusion of coverage due to the above Pre-Existing Condition provision of this Plan shall be modified to the following extent for those persons covered on the effective date of this Plan and covered on the immediately preceding day under the coverage this Plan replaced, whether such coverage replaced was written by an insurer or under a similar self-funded plan:

1. If the Covered Person incurs an expense that would be covered under the Plan except for the Pre-Existing Condition Exclusion and such expense would have been covered under the coverage replaced had that coverage been continued in force rather than replaced by this Plan, this Plan will pay the lesser of the amount payable for expenses under:
  - A. The coverage replaced; or
  - B. This Plan disregarding the Pre-Existing Conditions Exclusion.
2. In no event shall the total amount payable under this exception exceed the maximum amount payable under this Plan as if the Pre-Existing Conditions Exclusion were not present.
3. No item of expense incurred before the effective date of this Plan shall be payable under this Plan.
4. In no event shall the term "this Plan" be construed to include the coverage replaced.

## LIMITATIONS AND EXCLUSIONS TO MEDICAL EXPENSE BENEFITS

Benefits shall be limited or excluded under the Comprehensive Major Medical Expense Benefits for the following:

1. **ABORTION** - No payment will be made for any charges incurred in connection with abortion procedures or pregnancy related conditions resulting in abortion unless such procedures are therapeutic in nature and are medically necessary to protect the life of the mother or if pregnancy is due to rape or incest.

However, in the event of medical complications arising from elective abortion procedures, charges resulting from treatment of such complications will be payable under the terms of this Plan.

In any event, no benefits will be paid for dependents other than the employee's covered spouse.

2. **ACUPUNCTURE/HYPNOSIS/BIOFEEDBACK** - No payment will be made for any charges incurred as the result of, or in connection with, acupuncture, hypnosis or biofeedback, whether or not administered by a medical doctor.
3. **BIRTH CONTROL** - No payment will be made for any charges for oral contraceptive or birth control of any form unless use is deemed necessary by attending physician for treatment of a medical condition.
4. **BREAST ALTERATION** - No payment will be made for any expense in connection with altering the size or shape of the breast, male or female, whether voluntary or otherwise, except to the extent specifically set forth in Covered Medical Expenses.
5. **CIVIL DISTURBANCE** - No payment will be made for any expenses incurred as a result of participating in a riot or civil disturbance, or while committing or attempting to commit an assault or felony.
6. **CLAIM FORMS** - No payment will be made for any charge made by a Doctor or other provider of medical services for completing claim forms required by the Plan for the processing of claims.
7. **CONVENIENCE ITEMS** - No payment will be made for any food supplements, equipment or supplies made or used for physical fitness, enrollment in a health athletic or similar club, athletic training or general health up keep, regardless of the diagnosis.
8. **CUSTODIAL CARE** - No payment will be made for any charges for any type of custodial care or charges incurred while a person is confined in an institution which is primarily a place of rest, a place for the aged or a nursing home.
9. **DENTAL EXPENSES** - No payment will be made for any charges for any expenses incurred for dental work, except for those stated in Covered Medical Expenses.
10. **DRUGS (NON-PRESCRIPTION)** - No payment will be made for any charges for nonprescription, non-legend medicines, vitamins, nutrients and food supplements, even if prescribed or administered by a Physician.
11. **EDUCATIONAL TRAINING** - No payment will be made for any charges for educational therapy or training, except following a stroke, illness, injury, or surgery involving the vocal cords or as deemed Medically Necessary.
12. **ELECTIVE SERVICES / COSMETIC SERVICES** - No payment will be made for any charges incurred for any treatment or surgical procedure or service performed that is of an elective nature. This exclusion applies to such items as cosmetic surgery and breast implants.

This exclusion does not apply to:

- A. reconstruct the breast on which a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance, prosthesis and physical complications, and treatment of physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with attending physician and the patient. External breast forms and bra are limited as stated in the Schedule of Benefits. An internal prosthesis is limited to the initial placement.

- B. breast reduction surgery if documented to be medically necessary by Plan Administrator;
  - C. reconstructive surgery, i.e., reparative or therapeutic surgery done after an illness or injury to restore the patient's appearance.
  - D. cosmetic surgery deemed necessary as a result of a congenital defect affecting bodily function of a child;
  - E. A vasectomy or tubal ligation procedure performed on an Employee or his/her spouse. However, reversal of a vasectomy or tubal ligation procedure is not a Covered Expense.
13. **EXPERIMENTAL/INVESTIGATIONAL** - No payment will be made for any charges which are experimental or investigational in nature or any treatment not recognized as generally accepted medical practice by the medical profession the United States on the date the service or supply is rendered or received.
  14. **FAMILY SERVICES** - No payment will be made for any services rendered to a Covered Person by his/her spouse; parent(s) or parent(s) in law; child (ren); brother(s) or brother(s) in law; sister(s) or sister(s) in law; or grandparents.
  15. **FERTILITY / INFERTILITY** - No payment will be made for any charges incurred as the result of, or in connection with, in-vitro fertilization or embryo transfer or fertility or infertility testing, beyond the initial diagnosis.
  16. **FOOT CARE / PODIATRY** - No payment will be made for any expenses for routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails (except for removal of nail matrix or root), fallen arches, weak feet, and chronic foot strain, unless the treatment is an approved surgical procedure or medically necessary. However, custom made shoe inserts are covered as stated under Covered Medical Expenses.
  17. **GOVERNMENT COVERAGE** - No payment will be made for any charges that are incurred while the individual is confined in any Hospital that is operated by the United States Government or any agency of the United States government, unless excluding them is prohibited by law.
  18. **GOVERNMENT / MILITARY** - No payment will be made for any expenses incurred as a result of, or in connection with, the care or treatment of an injury or illness due to war or any act of war; "war" includes armed aggression resisted by the armed forces of any country, combination of countries, or international organization, whether or not war is declared.
  19. **HEARING AIDS** - No payment will be made for expenses for hearing aids or charges for their examination or fittings.
  20. **LEARNING DISABILITY THERAPY** - No payment will be made for any expenses for learning disability therapy.
  21. **MATERNITY-RELATED ULTRASOUNDS / AMNIOCENTESIS/ ECHOGRAMS** - No payment will be made for any ultrasound, echogram or amniocentesis procedures related to pregnancy unless such procedures are necessitated by a complication of pregnancy and Medically Necessary. Testing for the purpose of fetal age or sex or solely because of maternal age shall not be considered a complication of pregnancy. (Exception: The Plan will cover one (1) routine ultrasound per pregnancy.) In any event, no benefits will be paid for dependents other than the employee's covered spouse.
  22. **NO ATTENDING PHYSICIAN** - No payment will be made for any charges for any services or supplies which are not recommended and approved by an attending Physician.
  23. **NO OBLIGATION TO PAY** - No payment will be made for any charges which are incurred by an individual for which the individual or Eligible Employee is not legally required to pay, or for which no charge would be made in the absence of insurance.
  24. **NON-COVERED SERVICES / NOT MEDICALLY NECESSARY** - No payment will be made for any charges that are not Medically Necessary. The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself make it Medically Necessary or make the charge a Covered Expense even though it is not specifically listed as an exclusion.

25. **NON-COVERED PROVIDER** - No payment will be made for services or supplies received from a Physician or a Hospital that does not meet the definition of a Physician or a Hospital as set forth in the definition section of this Plan.
26. **NON-COVERED PHYSICAL OR PSYCHOLOGICAL THERAPIES METHODS** - No payment will be made for charges for physical or psychological therapy where art, play, music, dance, drama, reading, nutrition, home economics, recreational activities, or other similar activity is the method of treatment.
27. **NON-TIMELY FILING** - No payment will be made for any charges submitted more than 12 months after the charges were incurred.
28. **NOT COVERED UNDER PLAN** - No payment will be made for any expenses incurred while a person is not covered under this Plan.
29. **NOT SPECIFICALLY LISTED** - No payment will be made for any charges incurred for services, supplies, or other care which are not specifically listed as Covered Expenses under this Plan.
30. **OBESITY** - No payment will be made for any charges which are incurred for services, treatment, or surgical procedures rendered in connection with any overweight condition, regardless of the diagnosis. No payment will be made for charges for nutritional counseling in connection with obesity or weight reduction or for gastric bypass (stomach stapling) or similar procedure, regardless of the diagnosis.
31. **PERSONAL COMFORT ITEMS** - No payment will be made for any charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, rest cures, or expenses actually incurred by other persons.
32. **PRE-EXISTING CONDITIONS** - No payment will be made for pre-existing conditions except as outlined under the Pre-Existing Conditions Exclusion Provision.
33. **PREGNANCY OF DEPENDENT CHILD** - No payment will be made for any charges for pregnancy, childbirth, or related medical conditions for a dependent child.
34. **REASONABLE AND CUSTOMARY** - No payment will be made for any otherwise Covered Medical Expense in excess of the Reasonable and Customary fees or charges.
35. **ROUTINE PHYSICAL OR PREMARITAL EXAMS** - No payment will be made for any charges for routine physical or premarital examinations other than as stated in the Schedule of Benefits.
36. **SELF-INFLICTED INJURY / ILLNESS** - No payment will be made for any charges incurred as the result of, or in connection with, intentionally self-induced illness or intentionally self-inflicted injury or voluntarily taking of drugs except those taken as prescribed by a Physician. However, such charges will be payable if they are incurred due to a medical condition (physical or mental) or domestic violence.
37. **SEX TRANSFORMATION** - No payment will be made for any charges incurred as a result of any surgical sex transformations or any experimental or clinical investigative procedures.
38. **SEXUAL DYSFUNCTION / INADEQUACIES** - No payment will be made for any charges incurred as the result of, or in connection with, services or supplies related to sexual dysfunctions or inadequacies including, but not limited to, Viagra or charges for penile prosthesis.
39. **TEMPOROMANDIBULAR JOINT SYNDROME NOT LISTED AS COVERED** - No payment will be made for charges for TMJ treatment except to the extent specifically listed as covered under Covered Medical Expenses.
40. **TRANSPLANT EXCLUSIONS** - No payment will be made for any charges incurred for or related to transplant or implant of a human organ or tissue for a) artificial or mechanical implants or transplants; or non-human organ transplants b) any services or supplies which are considered experimental or investigative in nature; c) donor

expenses for meals and lodging; d) expenses eligible to be repaid under a private or public research fund, other group health plan or expenses covered by another organization, (the patient is required to apply for any other benefits for which they may be eligible); e) payment to an organ donor or organ donor's family as compensation for an organ or for the written consent needed to obtain an organ.

41. **TRAVEL** - No payment will be made for any charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance benefits and those outlined under the TISSUE AND ORGAN TRANSPLANT PROVISION.
42. **VISION CARE** - No payment will be made for any services or supplies for routine vision care (i.e. eye glasses, contacts or eye exams), for radial keratotomy or similar procedure for the correction of a refractive error of the eye when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
43. **WELL BABY CARE** - No payment will be made for any charges for well baby care, except as outlined under covered medical expenses and routine preventive care services.
44. **WEEKEND ADMISSIONS** - No payment will be made for charges incurred as a result of a weekend hospital admission, charges incurred on any such weekend day(s), except for Emergency Confinement, unless surgery is scheduled on that day, or the following day.
45. **WORKERS' COMPENSATION** - No payment will be made for any charge that is incurred as the result of an accident, injury, illness or sickness which arises out of or in the course of employment, or for which benefits are payable under any Worker's Compensation Act or any Occupational Illness Act or any such similar law.

This plan is not in lieu of, and does not affect, any requirement by any Workers Compensation Law.

Should the Plan pay benefits and it is later determined that such benefits should not have been paid based on the exclusions mentioned above, the Plan explicitly reserves the right to recover any and all benefits paid in error.

## COORDINATION OF BENEFITS

The objective of this Coordination of Benefits provision is to limit the reimbursement from this Plan and any other plan providing benefits up to 100% of Covered Medical and Dental Expenses. Payments made by the Plan cannot be more than what would normally be paid if this provision did not exist.

When benefits are coordinated, they are reduced so that the maximum amount that is payable from this Plan and any other plan does not exceed 100% of covered expenses.

Benefits are coordinated with other group Plans including the following coverage:

- A. group, blanket, franchise insurance coverage;
- B. hospital or medical service organizations, group practice and other prepayment coverage;
- C. any coverage under any labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- D. any coverage under governmental programs, except Medicaid coverage provided by any state, or any coverage required or provided by any statute, including no fault auto insurance, by whatever name it is called, when not prohibited by law.

**ALLOWABLE EXPENSES:** Benefits are paid under the Coordination of Benefits provision only for Allowable Expenses. In addition to expenses covered under this Plan, "Allowable Expenses" include any necessary, reasonable and customary expense that is covered under another plan. This does not infer that this Plan would normally pay benefits for such expenses. It means that, when expenses are calculated to determine the Coordination of Benefits payment, any charge that is covered under another plan, but is not considered covered under this Plan, will, for this purpose only, be considered an Allowable Expense.

**CLAIMS DETERMINATION PERIOD:** The Coordination of Benefits provision is administered on a Calendar Year basis. This Calendar Year basis for administration of the Coordination of Benefits provision is referred to as the "Claims Determination Period". Any benefit savings resulting from this Coordination of Benefits provision in any Calendar Year will be held in a benefit account for that individual for that calendar year. Credits will be released from the benefit account during that Calendar Year, if necessary, to give reimbursement of 100% of Allowable Expenses.

**BENEFIT DETERMINATION:** When the other plan does not have a Coordination of Benefits provision, it shall be considered primary and shall always pay first. This Plan will then pay second and will coordinate payment with the amount paid by the other plan.

If it is determined the other plan does contain a Coordination of Benefits provision and the Eligible Employee is the named insured under the other plan, the plan which has been in effect the longest will be considered primary and shall always pay first. The other plan will pay second and will coordinate its payment with the first payment.

When the other plan covers the spouse as the named insured and it does have a Coordination of Benefits provision, and the claim is on the dependent spouse, the order of benefit payments will be determined as follows:

- A. The other plan – the plan covering the spouse as an employee – will pay first.
- B. This Plan – which covered the spouse as an Eligible Dependent – will pay second and will coordinate with the other plan.

In claims involving children, the order of benefit payment will be as follows:

1. Except in cases involving dependent children whose parents are separated or divorced, this paragraph shall apply. When the other plan has adopted rules similar to intent to (a) below, (a) shall apply. Otherwise, subparagraph (b) below shall be used in determining the order of benefit payment.
  - A. The plan covering the parent whose date of birth occurs earlier in a calendar year shall pay first and the other plan shall pay second. If both parents have the same date of birth, the plan which has been in effect the longest shall pay first.
  - B. The plan covering the father as an employee shall pay first, and the plan covering the mother as an employee shall pay second.
2. When the parents of a child are separated or divorced, and the parent with custody of the child has not remarried, the plan covering the parent who has custody of the child shall pay first, and the plan covering the parent without custody will pay second.
3. When the parents of the child are divorced, and the parent with custody of the child has remarried, the plan covering the parent with custody will pay first, the plan covering the step parent of the child shall pay second, and the plan covering the parent without custody shall pay last.
4. In the event of a claim on a dependent child whose parents are separated or divorced, where there is a court decree establishing financial responsibility for the health care expenses of such child, the plan covering the parent with financial responsibility shall pay first, and the other plan shall pay last, regardless of paragraphs 2. and 3. above.

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

The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

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

**COORDINATION OF BENEFITS WITH MEDICARE:** If this Plan is secondary to Medicare, the total payments from Medicare plus the payment from the Plan will not exceed the Plan's normal benefits.

**COORDINATION WITH OTHER PRESCRIPTION DRUG PLANS:** If another prescription drug card is primary to this plan and a covered person files a claim for such prescription drug purchased under a separate drug card under this plan, this plan will credit benefits for the co-payment amount only and the major medical expense out-of-pocket, provided the claim is filed within six (6) months of purchase date.

**COORDINATION WITH STATE MEDICAID PROGRAMS:** Payments for benefits shall be made in accordance with any assignment required by a State Medicaid or Medical Assistance Plan.

Participants shall be enrolled in this Plan without regard to whether they are then eligible for or receiving medical assistance from a State.

To the extent that payment has been made under a state plan for medical assistance in any case for where the Plan has a legal liability to make payment for items or services constituting such medical assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to the participant and such payment for such items or services.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan, or any provision of similar purposes of any other plan, this Plan may, without consent of, or notice to, any person, release to or obtain from any insurance company, or other organization or person, any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming any benefits under this Plan shall be required to furnish to the Plan such information as may be necessary to implement this provision.

**RIGHT OF RECOVERY:** Whenever payments have been made by the Plan, with respect to allowable expenses, in a total amount which is, in excess of the maximum amount of payment necessary, at that time, to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, from among one (1) or more of the following, as the Plan shall determine: any person(s) to, or for, or with respect to, whom such payments were made, any insurance companies, any other organizations or any further claims made to this Plan by the Covered Person.

**GENERAL:** Under the Coordination of Benefits provisions, it is necessary that claim be made for any benefits the individual may be entitled to from any source. Whether or not claim is made to these other sources, the Coordination of Benefits provision will be fully operable as if claim were made.

## GENERAL PLAN PROVISIONS

**SUMMARY PLAN DESCRIPTION:** The Employer will make available to each covered Employee a Summary Plan Description. The Summary Plan Description will state: the benefits provided; to whom the benefits will be paid; and limitations or requirements of the Plan that may apply to the Covered Person.

The Summary Plan Description is not a part of the Plan Document.

**NOTICE AND PROOF OF CLAIM – 90 DAYS:** If a Covered Person claims benefits as a result of hospital confinement, proof of claim must be furnished to the Plan Administrator in the ninety (90) days following the end of the hospital confinement.

If a Covered Person claims benefits which do not result from hospital confinement, proof of claim must be furnished to the Plan Administrator within the ninety (90) days following the date of loss.

A notice given to the Plan with sufficient information to identify the Covered Person shall be considered as compliance with this provision. If the individual does not furnish notice and data within the time provided by the Plan, such lack of notice will not jeopardize the claim if it is shown that it was not reasonably possible to furnish such notice when required and such notice was furnished as soon as it was reasonably possible, but no later than twelve (12) months following the date of loss.

**PAYMENT OF CLAIM:** All benefits are payable to the Covered Employee. If such benefits are not paid as of the date the Covered Employee dies, or if the Covered Employee is a minor, or in the Plan Administrator's judgment, is not capable of giving a legally binding receipt for payment of any benefit, the Plan Administrator at its option, may pay the benefit to:

- A. any person appearing to the Plan Administrator to be entitled to the payment by reason of having incurred funeral or other expenses for the last illness or death of the Covered Employee; or
- B. one (1) or more of the following relatives of the Covered Employee: spouse, parent(s), child(ren), brother(s) or sister(s).

Any payments made in this manner will discharge the Plan Administrator of its duty to the extent of such payments. The Plan Administrator will not be liable as to the application of such payment.

If a Covered Person submits due proof of claim and so requests, the Plan Administrator will pay on a weekly basis any accrued daily hospital benefits during any period for which it is liable for such claims. When the Plan Administrator receives due proof, it will pay the balance for which it is liable as of the end of the period.

The Plan Administrator has the right to allocate:

- A. the Comprehensive Medical Expense Benefit Deductible Amount, if any to any eligible charges; and
- B. the benefits to any assignee. Such actions will be binding of the Covered Persons and the assignees.

Any benefits or portion thereof provided by the Plan for hospital, nursing, medical or surgical services may, at the Plan Administrator's option, be paid directly to the hospital or person rendering such services, but it is not required that the services be ordered by a particular hospital or person.

**EXAMINATION:** The Plan Administrator will have the right at its own expense to have a physician examine the person of any Employee or Dependent whose illness or injury is the basis of a claim under the Plan. Such examination will be performed as often as the Plan Administrator may reasonably require while a claim is pending.

The Plan Administrator will have the right and opportunity to have a physician make an autopsy where not prohibited by law.

**STATEMENTS:** In the absence of fraud, all statements made by a Covered Person relating to eligibility for coverage hereunder will be deemed to be representations and not warranties. No such representations will void the benefits or be used in defense to a claim under the Plan unless a copy of the instrument which contains such representation is or has been furnished to the Covered Person or to a beneficiary, if any.

**CLAIM REVIEW AND APPEALS PROCEDURE:** The Plan's claims procedures vary depending on the type of claim filed. The Covered Person's claims may be any one of the following four (4) types of claims:

- Pre-Service Claim – a Pre-Service Claim is a claim for medical care under the Plan for which prior approval for the care, in whole or in part, is a condition to receiving the medical care.
- Concurrent Care Claim – a previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.
- Post-Service Claim – a claim for medical care for which the medical care has already been received by the covered person.
- Urgent Care Claim – a Claim in which the application of the time period for making a determination of a Pre-Service Claim or Concurrent Care Claim would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum capacity (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the Covered Person's medical condition) or will subject the Covered Person to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the Covered Person's condition). An Urgent Care Claim also includes a Claim for Emergency care or an admission made pursuant thereto. **This Plan does not require prior approval for Emergency or Urgent Care Claims.**

In each situation below where we reference "you", we also mean a third party representative who has been authorized to file claims on your behalf in accordance with the Plan's internal policies and procedures. In the case of an Urgent Care Claim, the health care professional with knowledge of the Covered Person's condition will always be considered an authorized representative.

### Pre-Service Claim

If you submit a Pre-Service Claim, you will be notified of the benefit determination (whether adverse or not) within a reasonable period of time but not later than fifteen (15) days after the Plan's Supervisor's receipt of the Pre-Service Claim. This period may be extended one (1) time for up to fifteen (15) days for reasons beyond the control of the claims reviewer if you are notified, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If you fail to provide sufficient information to decide the claim, the claim will be denied or the time for response will be extended. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the specified information. If you fail to properly submit the claim in accordance with the Plan procedures for filing a claim, you will be notified orally or in writing within five (5) days of the date that you attempted but failed to properly file a claim in accordance with the applicable rules and regulations and given instructions on how to properly file a claim. You may request that the notification be given in writing. The only claims that will qualify as Pre-Service Claims under this Plan are non-urgent hospital admissions and non-urgent kidney transplants.

### Urgent Care Claim (Pre-Service)

Except as provided below, if you submit a Pre-Service Claim that is also an Urgent Care Claim, you will be notified of the claims reviewer's benefit determination (whether adverse or not) as soon as possible, but not later than seventy-two (72) hours after the claims reviewer receives your claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, you will be notified as soon as possible, but not later than twenty-four (24) hours after receipt of the claims reviewer's receipt of your Urgent Care Claim by the Plan, of the specific information necessary to complete your Urgent Care Claim. You will be given at least forty-eight (48) hours to provide the specified information. You will be notified of the claims reviewer's benefit determination as soon as possible but no later than forty-eight (48) hours after the earlier of (i) the receipt of the requested information, or (ii) the end of the forty-eight (48) hour period, whichever occurs first. If you fail to properly submit the claim in accordance with the Plan's procedures for filing a claim, you will be notified orally or in writing within twenty-four (24) hours of the time that you attempted but failed to properly file a claim in accordance with the applicable rules and regulations and given instructions on how to properly file a claim. **This Plan does not require prior approval for Emergency or Urgent Care Claims.**

### Concurrent Care Claim

If an ongoing course of treatment has been approved under the terms of the Plan, any reduction or termination of your ongoing course of treatment (other than by Plan amendment or Plan termination) before the end of such course of treatment is an adverse benefit determination. You will be notified of any determination to reduce or stop the ongoing course of treatment within a reasonable amount of time prior to the reduction or termination to allow you to appeal and obtain a determination prior to the effective date of the reduction or termination of your ongoing course of treatment.

If you request to extend an ongoing course of treatment beyond the period of time or number of treatments originally approved and your request involves an Urgent Care Claim, you will be notified of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of your claim by the claims reviewer, provided that your claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the ongoing course of treatment. If the last day of approved ongoing treatment falls on Saturday, Sunday or Monday of a regular work week or the first though the last day of a business holiday or the first business day after a business holiday, this Plan does not require prior approval to extend such ongoing treatment through the next business day. Any stay so extended will be subject to retrospective review, however.

### Post-Service Claim

If you submit a Post-Service Claim that is denied in whole or part, you will be notified within a reasonable period of time but not later than thirty (30) days after receipt of your claim. This period may be extended up to fifteen (15) days if an extension is necessary due to matters beyond the control of the claims reviewer and you are notified, prior to the end of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which a decision will be rendered. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information that is missing, and you shall be given at least forty-five (45) days from receipt of the notice to provide the specified information.

The period of time within which a benefit determination is required to be made shall begin at the time your claim is filed. A claim is properly filed when submitted electronically or by mail to the address on the Covered Person's I.D. card and received by the Plan Supervisor. If the period of time to make a benefit determination is extended due to your failure to

submit information necessary to decide a claim other than an Urgent Care Claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to you until you respond to the request for additional information whichever is earlier.

#### **NOTICE OF BENEFIT DETERMINATION**

If your claim is denied in whole or in part, the claims reviewer will provide the covered person with a written or electronic notification setting forth the following information:

1. The specific reason or reasons for the denial;
2. The specific provisions of the Plan on which the denial is based;
3. A description of any additional material or information necessary for you to perfect your claim, together with an explanation as to why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review;
5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such a rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to you upon request;
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. If the claim was an Urgent Care Claim, a description of the expedited review process applicable to such claims.

If your Urgent Care Claim was denied in whole or part, the notice may be provided to you orally; however, a written or electronic notification will be provided to you not later than three (3) days after the oral notification.

For Pre-Service Claims or claims involving Urgent Care, if your claim is approved you will receive a written or electronic notice that the claim has been approved.

#### **APPEALING AN ADVERSE BENEFIT DETERMINATION/ DENIED CLAIM**

If your claim for benefits has been denied in whole or in part by the claims reviewer, you may file an appeal with the Plan Supervisor within one hundred eighty (180) days of the denial. However, if your claim is a Concurrent Care Claim, a special rule applies. You will be notified of the time period in which you must file an appeal of an adverse benefit determination for a Concurrent Care Claim before benefits will be discontinued. This period of time will be less than the one hundred eighty (180) days that normally applies. After you appeal an adverse benefit determination, the Plan Supervisor will:

1. Provide you the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits;
2. Provide that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
3. Provide for a review that takes into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination;
4. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by the Plan Administrator of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal or the subordinate of such individual;
5. Provide that, in deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional may not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
7. Provide, in the case of an Urgent Care Claim, for an expedited review process pursuant to which (i) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious methods.

8. The period of time within which a benefit determination on review is required to be made varies by the type of claim. Notwithstanding the type of claim, the time period for making a determination will begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

#### **Pre-Service/Concurrent Care Claim**

In the case of a Pre-Service Claim or Concurrent Care Claim, the Plan Administrator will notify you of the Plan's benefit determination on review not later than thirty (30) days after receipt by the Plan Administrator of your request for review of an adverse benefit determination.

#### **Urgent Care Claim**

In the case of an appeal of an adverse benefit determination for a Pre-Service Claim or Concurrent Care Claim that is an Urgent Care Claim, the Plan Supervisor will notify you of the Plan's benefit determination on review not later than seventy-two (72) hours after receipt by the Plan Administrator of your request for review of an adverse benefit determination by the Plan.

#### **Post Service Claim**

The Plan Supervisor will notify you of the Plan's benefit determination on review within a reasonable time, but not later than sixty (60) days after receipt by the Plan Administrator of your request for review of an adverse benefit determination.

#### **Notice of Adverse Benefit Determination Upon Review**

The Plan Administrator will provide you with written or electronic notification of the Plan's benefit determination on review. If your claim is denied on review, the Plan Administrator shall provide you with a written or electronic notification setting forth the following information:

1. The specific reason or reasons for the denial;
2. The specific provisions of the Plan on which the denial is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
4. A statement describing the Plan's voluntary appeal process, if any;
5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such a rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to you upon request;
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. A statement that you and the Plan may have voluntary alternative dispute resolutions options available.

#### **Miscellaneous Information Regarding Claims**

**Necessary Documentation** - The Plan Supervisor occasionally will need information and documentation in addition to the actual claim for benefits in order to be able to process and approve a claim. This information and documentation may be in the possession of the Covered Person, the health care provider or the employer. If the necessary documentation is not submitted with the claim, the Plan Supervisor will request the necessary documentation in accordance with the provisions of the Claims Review and Appeals Procedures. If such information is not provided within the time permitted, the Plan Supervisor may deny the claim with an explanation of what further information or documentation is required. If a Cariten form is the documentation that is required, a copy of that form will be included with the denial. Such information and documentation may include, but is not limited to the following: surgical notes; a claim form (Benefit Submission Form); accident details/third party liability information; an itemized bill; dates of procedures and other significant dates; full-time student verification information; assignment of benefits; documentation of other coverage; medical records; diagnosis or diagnosis code; documentation of medical necessity; a UB-92 or HCFA 1500 form; physician's office notes; provider's credentials, name, address, tax identification number; physician's signature, physician's release to return to work; other coverage information; documentation of financial dependency of children; certificate of creditable coverage or other pre-existing condition information; admission and discharge summary; physical therapy notes; Emergency room notes; anesthesia time; invoice for device, prosthesis or implant. All necessary Cariten TPA Services forms are available on the Cariten website at [www.cariten.com](http://www.cariten.com).

**Claim Filing Period** – Notwithstanding any provision of this Plan to the contrary, no benefits shall be payable under this Plan to any Covered Person or provider who fails to submit a claim for benefits within the Non-Timely Filing Limit, set forth in the Limitations and Exclusions to Comprehensive Major Medical Expense Benefits. The Plan Administrator (or its delegate for claims-payment purposes), however, in its sole discretion, may accept a claim after such time has elapsed if extenuating circumstances or excusable neglect prevented the Covered Person or provider from making a claim during such period or if any such circumstances or neglect prevented a claim from being timely received by the Plan Supervisor. In the event this Plan has an arrangement with one (1) or more Preferred Provider Organizations (PPO), a longer claim filing period specified in a contract between the PPO and the providers included in the PPO may be honored by this Plan in the discretion of the Plan Administrator. Each Covered Person, beneficiary or other interested person shall file with the Plan Administrator such pertinent information as the Plan Administrator may specify, and in such manner and form as the Plan Administrator may specify or provide.

**Disability Determination** - If the Plan offers an extension of coverage for those participants on the basis of disability (as set forth in the Schedule of Benefits) and the Plan Supervisor is responsible for making the determination as to whether a participant is indeed disabled, the following different rules apply to the disability determination:

1. The claims reviewer will notify you of an adverse benefit determination within forty-five (45) days of receipt of the claim. The claims reviewer may take two (2) extensions of thirty (30) days each if for reasons beyond the control of the claims reviewer.
2. You will have one hundred eighty (180) days in which to appeal the adverse benefit determination to the Plan Administrator.
3. The Plan Supervisor will notify you of an adverse benefit determination within forty-five (45) days of the date the Plan Supervisor received the appeal. The Plan Administrator may take a forty-five (45) day extension if for reason beyond the control of the Plan Administrator.

**ILLEGAL OCCUPATION OR COMMISSION OF FELONY:** The Plan will not be liable for loss to which a contributing cause was the commission of or an attempt to commit a felony by the person whose injury or sickness is the basis of claims, or to which a contributing cause was such person's being engaged in an illegal occupation.

**SUBROGATION:** In the event of any payment under this Plan, the Plan shall be subrogated to all the rights of recovery thereof of either an Eligible Employee or an Eligible Dependent against any person or entity, including any person or entity causing the injury or sickness for which the payment of benefits is made by the Plan, and the Eligible Employee or Eligible Dependent shall execute and deliver instruments and papers and whatsoever else is necessary to secure such rights. Neither the Eligible Employee or Eligible Dependent shall do anything to prejudice such rights. The purpose of this provision is to avoid making duplicate payments involving the same hospital and medical expenses.

If requested in writing by the Plan, the Eligible Employee or Eligible Dependent shall take, through any representative designated by the Plan, such legal action as may be necessary or appropriate to recover such payment as damages from any person or entity, said action to be taken in the name of the Eligible Employee or the Eligible Dependent. In the event of a recovery or settlement, the Plan shall be reimbursed out of such recovery or settlement for expenses, costs and attorneys' fees incurred by them in connection therewith.

The receipt of any payment by an Eligible Employee or Eligible Dependent shall be specifically conditioned upon an agreement by the Eligible Employee or Eligible Dependent acknowledging this Subrogation provision and the agreement of the Eligible Employee or Eligible Dependent to repay any sums expended by the Plan in full.

**REIMBURSEMENT:** If Benefits are paid under this Plan and an Eligible Employee or Eligible Dependent recovers from a third party settlement, judgment, or otherwise, the Plan has the right to be reimbursed 100% of all amounts paid by it to or on behalf of the Eligible Employee or Eligible Dependent. This right of Reimbursement gives the Plan a direct and contractual right of repayment against the Eligible Employee or Eligible Dependent upon recovery of any amounts by said Employee or Dependent from a third party settlement, judgment, or otherwise.

The receipt of any payment by an Eligible Employee or Eligible Dependent shall be specifically conditioned upon an agreement by the Eligible Employee or Eligible Dependent acknowledging this Reimbursement provision and the agreement of the Eligible Employee or Eligible Dependent to repay any sums expended by the Plan in full.

**ATTORNEYS' FEES:** The amounts to which this Plan is entitled in accordance with its right to Subrogation, its right to Reimbursement, or its rights under any other Section of the Plan shall not be offset by the Eligible Employee's or Eligible Dependent's legal fees, expenses, and/or costs attributable to recovery of payments made to the Eligible Dependent or Eligible Employee.

The amount to which the Plan is entitled under the aforementioned provisions shall not be offset by the Eligible Employee's or Eligible Dependent's costs attributable to recovery without regard to whether the Plan exercises its right to intervene in the proceedings brought by the Eligible Employee or Eligible Dependent against a third party(ies).

**PLAN'S RIGHT OF RECOVERY:** With regard to the Plan's right to recover amounts paid to an Eligible Employee or Eligible Dependent under the Sections of this Plan governing Subrogation, Reimbursement, Attorneys' Fees or any other Section of this Plan, the Plan shall be entitled to reimbursement in full for 100% of all amounts paid by the Plan from the first dollars to be paid to or received by an Eligible Employee or Eligible Dependent from a settlement or judgment from a third party.

Under those provisions governing Subrogation, Reimbursement, Attorneys' Fees or any other Section of this Plan, the Plan shall be entitled to reimbursement from the first dollars paid without regard to whether the total amount to be paid to or received by an Eligible Employee or Eligible Dependent is less than the actual amount suffered, that is, the Plan is entitled to full reimbursement or 100% of all amounts paid by the Plan, without regard to whether the Eligible Employee or Eligible Dependent is made whole by the amount recovered from any third party(ies).

Further, the Plan shall be entitled to recover 100% of all amounts paid by the Plan under the Sections governing Subrogation, Reimbursement, Attorneys' Fees or any other Section of this Plan whether the recovery to be paid or received by the Eligible Employee or Eligible Dependent is characterized as medical expense, pain and suffering, damages for emotional stress, damages calculated in consideration of future medical expenses, damages for loss of consortium or any other type of damages. The Subrogation and/or Reimbursement to which this Plan is entitled includes rights against any insurance carrier, including an uninsured or underinsured motorist carrier, even if such coverage was purchased by the Eligible Employee or Eligible Dependent.

**CLERICAL ERROR:** Clerical errors or delays in record keeping will not invalidate coverage that would have been in force had the error or delay not been made. If the error or delay would affect contributions, an equitable adjustment will be made.

**ENTIRE CONTRACT: AMENDMENT:** The Plan Document constitutes the entire contract and it may be amended at any time in writing by the Employer, without the consent of the Covered Employee or their beneficiaries, if any.

**TERMINATION OF PLAN DOCUMENT:** The full, absolute and discretionary right is reserved in the Plan for the Plan Sponsor to amend, modify, suspend, withdraw, discontinue or terminate the Plan in whole or in part at any time for any and all participants of the Plan.

**NO CONVERSION PRIVILEGE:** Because of the self-funded status of the Plan, the benefits provided hereunder cannot be converted to individual coverage.

**FUNDING:** Except as provided below, this Plan shall be funded by the Employer. The Employer's share of the required funding of this Plan shall be determined by the Employer.

Covered Persons, as a condition of coverage under this Plan, may be required to make contributions to the Plan. The required amount of contribution, if any, shall be communicated by the Employer to the Employees and their Dependents. The Employer hereby reserves the right to increase or decrease Employee or Dependent contributions from time to time.

All benefits payable under this Plan, whether funded by the Employer or by Employee or Dependent contributions, shall be paid either from a trust specifically designed for the purpose of paying benefits hereunder or from the general assets of the Employer or from both.

**PLAN DOCUMENT CONTROLS:** The Plan Document contains all provisions of the Plan. Any conflict or ambiguity arising between the Plan Document and this Summary Plan Description shall be resolved in favor of the Plan Document.

## RESPONSIBILITIES FOR PLAN ADMINISTRATOR

**PLAN ADMINISTRATOR:** Blount County Government Employee Benefit Plan is the benefit plan of Blount County Government. Blount County Government is the Plan Administrator, also called the Plan Sponsor. The Blount County Government Employee Benefit Plan is to be administered by the Plan Administrator in accordance with the Provisions of ERISA. An individual may be appointed by Blount County Government to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Blount County Government shall appoint a new Plan Administrator as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

**DUTIES OF THE PLAN ADMINISTRATOR:** (1) To administer the Plan in accordance with its terms; (2) To interpret the Plan including the right to remedy possible ambiguities, inconsistencies or omissions; (3) To decide disputes which may arise relative to a Plan's Participants rights; (4) To prescribe procedures for filing a claim for benefits and to review claim denials; (5) To keep and maintain the Plan Documents and all other records pertaining to the Plan; (6) To appoint a Claims Processor to pay claims; (7) To perform all necessary reporting as required by ERISA; (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609; (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

**PLAN ADMINISTRATOR COMPENSATION:** The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**FIDUCIARY:** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES:** A fiduciary must carry out his/her duties and responsibilities for the purpose of providing benefits to the employees and their dependent(s), and defraying reasonable expenses of administering the Plan. These duties which must be carried out: (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation; (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and (3) in accordance with the Plan documents to the extent they agree with ERISA.

**THE NAMED FIDUCIARY:** A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either: (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or (2) the named fiduciary breached its fiduciary responsibility under Section 405 (a) of ERISA.

**CLAIMS PROCESSOR IS NOT A FIDUCIARY:** A Claims Processor is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

## STATEMENT OF ERISA RIGHTS

As a participant in the employee benefit plan of your Employer, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents, including contracts and copies of all documents filed by the Plan Administrator with the U.S. Department of Labor or the Internal Revenue Service such as detailed annual reports.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator which may make a reasonable charge for the materials.
3. Receive a summary of the Plan's annual financial report, if it files an annual report, the Plan Administrator is required by law to furnish each Plan participant with a copy of this summary annual report.
4. Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

ERISA also provides that all plan participants shall be entitled to reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights to Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These persons are referred to as "fiduciaries in the law". Fiduciaries must act solely in the interest of Plan participants and they must exercise prudence in the performance of their Plan duties.

Your Employer must not discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under these Plans or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the claim reviewed and your claim reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials in writing from the Plan Administrator and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If fiduciaries are misusing the Plan's money, or if you are discriminated against for asserting your rights, you have a right to file suit in a federal court or request assistance from the U.S. Department of Labor. The court will decide who should pay court costs and legal fees. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorney's fees. If you lose, the court may order you to pay the costs and fees – for example, if he/she finds your claim is frivolous. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

## **IMPORTANT NOTICE FROM BLOUNT COUNTY GOVERNMENT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE**

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blount County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. Blount County Government has determined that the prescription drug coverage offered by the Blount County Government Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.**

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**Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

In addition, if you lose or decide to leave employer/union sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

**If you decide to join a Medicare drug plan, your Blount County Government coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.**

Your Current Prescription Benefits for Blount County Government Employee Benefit Plan are as follows:

<b>Retail (Walk-In) Pharmacy (up to a 34 day supply)</b>		
<b>Co-Payments:</b>		
<b>Generic Prescriptions .....</b>		<b>\$5*</b>
<b>Name Brand Prescriptions .....</b>		<b>\$25*</b>
<b>Percentage Payable after Co-Payment .....</b>	<b>100% of balance</b>	

<b>Mail Order (up to a 100 day supply)</b>		
<b>Co-Payments:</b>		
<b>Generic Prescriptions .....</b>		<b>\$10*</b>
<b>Name Brand Prescriptions .....</b>		<b>\$50*</b>
<b>Percentage Payable after Co-Payment .....</b>	<b>100% of balance</b>	

\*The co-payment for prescriptions will apply only to the out-of-pocket annual maximum if the covered participant files the applicable co-payment amounts with the TPA within six (6) months of purchase date (retail or mail order). If you have other prescription drug coverage that is primary, please see the coordination with other prescription drug plans provision under Coordination Of Benefits in your Summary Plan Description. If the Covered Person requests a Brand name drug when a Generic drug is available, the Covered Person must pay the price difference between the Brand name drug and the Generic drug, plus the Brand name co-payment.

**If you do decide to join a Medicare drug plan and drop your Blount County Government prescription drug coverage, you must also drop your health coverage as prescription drug coverage is not offered on a stand alone basis. Be aware that you and your dependents may not be able to get this coverage back if it is dropped.**

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. You should also know that if you drop or lose your coverage with Blount County Government and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

You should also know that if you drop or lose your coverage with Blount County Government and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

**For more information about this notice or your current prescription drug coverage...**

Contact Jodie King in our Human Resources office for further information at 865-273-5777. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Blount County Government changes. You also may request a copy.

**For more information about your options under Medicare prescription drug coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).**

Date:	January 1, 2008
Name of Entity/Sender:	Blount County Government
Contact--Position/Office:	Jodie King, HR Generalist
Address:	397 Court Street
Phone Number:	(865) 273-5777

## INFORMATION OF INTEREST

### Plan Sponsor, Plan Administrator and Named Fiduciary

Blount County Government  
397 Court Street  
Maryville, TN 37804

### Name of Plan

Blount County Government  
Employee Benefit Plan

### Plan Number

501

### Type of Employer

Single Employer

### Employer Identification Number

62-6000495

### Agent for Service of Legal Process

Blount County Government

### Plan Year

Ends June 30th of each calendar year

### Plan Document Number

SF-102767

### Plan Supervisor & Claims Processor

Cariten TPA Services  
1420 Centerpoint Blvd.  
Knoxville, TN 37932  
(865) 470-7470

**BY THIS AGREEMENT**, Blount County Government Employee Benefit Plan is hereby adopted as shown:

IN WITNESS WHEREOF, this instrument is executed for Blount County Government on or as of the day and year first below written.

By \_\_\_\_\_  
Blount County Government

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_