Local Government Plan Document

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

January 2004

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INTRODUCTION

The State of Tennessee Comprehensive Medical and Hospitalization Program was established pursuant to Chapter 27 of Title 8 of the Tennessee Code Annotated. The Health Maintenance Organization, Point of Service, Preferred Provider Organization and Preferred Provider Organization Limited plans are all healthcare options available as part of a comprehensive medical and hospitalization program for eligible employees. This document contains the terms and conditions of the plans as of January 1, 2004. The following provisions shall be administered as specified below, unless a different meaning or provision is prescribed in the applicable section attached hereto.

Assignment.

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

Choice of Laws.

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and regulated in all respects under the laws of the State of Tennessee, except insofar as they shall have been superseded by the provisions of federal law.

Conflict of Provisions.

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

Execution of the Plan.

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

Fraud.

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

Liability of Employer.

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

Plan Is Not a Contract of Employment.

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

ARTICLE I
DEFINITIONS

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

1.01 "Benefit Analysis"

Benefit analysis shall mean the process of benefit review by the claims administrator.

1.02 "Certificate of Creditable Coverage"

Certificate of creditable coverage shall mean written notification from previous employer or health insurance issuer, on company letterhead, describing the prior creditable coverage for each plan participant. The certification must identify the period of creditable coverage under the prior plan and the name of each covered person(s).

1.03 "Claims Administrator"

Claims administrator shall mean the entity/organization contractually designated by the state to provide claims adjudication and/or medical management program review and/or provider contracting and/or such other services necessary to assure the proper and efficient administration of the plan.

1.04 "COBRA"

COBRA (Consolidated Omnibus Budget Reconciliation Act) shall mean the federal law that allows employees, spouses, and/or dependents who are losing their health or dental benefits to continue the same insurance for a specific length of time under certain conditions pursuant to Section 4.07.

1.05 "COBRA Participant"

COBRA participant shall mean a qualified beneficiary pursuant to Section 4.07 who continues his or her dental and/or health care coverage under the provisions of the federal guidelines in the Consolidated Omnibus Budget Reconciliation Act of 1985 and Public Health Service Act as amended.

1.06 "Committee"

Committee shall mean the individuals comprising the Local Government Insurance Committee to whom the administrative duties and responsibilities of the plan are delegated pursuant to Section 6.01 and shall include any authorized representative of the committee. The committee shall be the plan administrator of each respective plan. The Local Government Insurance Committee is composed by law of the Commissioner of Finance and Administration, the Comptroller of the Treasury, the State Treasurer, a member to be appointed by the Tennessee Municipal League, and a member to be appointed by the Tennessee County Services Association.

1.07 "Coverage(s)"

Coverage(s) shall mean:

(A) Employee Only - Coverage for the employee only.

(B) Family - Coverage for the employee, his/her spouse and/or dependents.

1.08 "Covered Expenses"

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

1.09 "Covered Person"

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

1.10 "Creditable Coverage"

Creditable coverage shall mean coverage under an individual or group health plan (including Medicare, Medicaid, governmental, public health and church plans) provided that such coverage is not followed by a significant break in coverage, and excludes coverage for accident or disability income insurance, liability insurance or a supplement to liability insurance, workers compensation insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, limited scope dental or vision benefits, benefits for long-term care, nursing home care, home health care, community-based care or a combination thereof, or specified disease coverage, hospital indemnity or other fixed indemnity insurance, if offered as an independent, non-coordinated benefit, or Medicare supplemental health insurance and/or other supplemental type benefits provided under a group health plan, if offered as a separate insurance policy.

1.11 "Custodial Care"

Custodial care shall mean services for personal care such as help in walking and getting out of bed, assistance in bathing, dressing, feeding, using the toilet, supervision over medication which can usually be self-administered and services which do not entail or require the continuing attention of trained medical or paramedical personnel. Other examples of custodial care include changing of dressings, diapers, protective sheets, administration of oxygen, care or maintenance in connection with casts, braces or other similar devices, feeding by tube, including cleaning and care of the tube site and care in connection with ostomy bags or devices or indwelling catheters.

1.12 "Dependents"

Dependents shall mean:

(A) A legally married spouse; or

(B) An unmarried child under the age of nineteen (19) who meets at least one (1) of the following five (5) criteria:

(1) Natural or adopted children regardless of where they live; adopted children, in connection with any placement for adoption of a child with any person, means the assumption of a legal obligation of total or partial support of a child in anticipation of adoption. The obligation may be determined by court records, federal income tax records or other appropriate documentation as determined by the insurance committee or its representative;

(2) Stepchildren for whom the employee or spouse has legal custody, joint custody or shared parenting if employee or spouse is in receipt of a permanent parenting plan giving the employee or spouse rights and responsibilities equivalent to joint custody. The permanent parenting plan must be duly authorized and signed by a judge.

(3) Children living in the home for twelve (12) months a year for whom the employee is the legal guardian;

(4) Any other dependent child living in the employee's home twelve (12) months a year who is dependent upon the employee for support and maintenance as evidenced by the child being claimed as a dependent on the employee's federal income taxes; or

(5) An employee's child named as an alternate recipient with respect to such employee under a qualified medical child support order. If a court so stipulates,

pursuant to TCA 36-5-501, a qualified medical child support order requiring an employee's child to be enrolled in a health insurance plan, is eligible. The employee must be enrolled in the state-sponsored Preferred Provider Organization (PPO) or Preferred Provider Organization Limited (PPO Limited) coverage when covering court ordered out of state or out of service area dependents.

(C) Unmarried dependents between the ages of 19-24 who meet the criteria in 1.11(B) of this section must also be either (a) a full-time student at an accredited (licensed) school, college or university or (b) dependent upon the employee for at least fifty-one (51) percent support as evidenced by the dependent being claimed on the employee's federal income tax. A full-time student is defined as one who is registered for at least the number of credit hours which the institution requires in its definition of full-time student status, **and** who attends classes for two (2) out of three (3) semesters or three (3) out of four (4) quarters in any twelve (12) month period. An annual student verification from the institution may be required by the Division of Insurance Administration.

(D) Unmarried dependents over twenty-four (24) years old who are incapacitated, (mentally or physically incapable of earning a living regardless of age, provided the child is incapable of self-sustaining employment and is chiefly dependent upon the employee for support and maintenance) when the incapacity existed before their twenty-fourth (24) birthday and they were already insured by a state-sponsored plan. The child must meet the requirements for dependent eligibility listed in this section. A request for extended coverage must be provided to the Division of Insurance Administration within ninety (90) days of the dependent's twenty-fourth (24) birthday, and annual proof may also be required. Determination and approval of the incapacitation request is reviewed by the claims administrator for the covered person's plan.

Dependents not eligible for coverage include:

(A) Children who are married;

(B) Foster children;

(C) Dependents not listed in the above definitions;

(D) Parents;

(E) Dependent children in the armed services on a full-time basis;

(F) Ex-spouse; and

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

An employee may not be enrolled as both head of contract and dependent within the Local Government Plan.

1.13 "Durable Medical Equipment"

Durable medical equipment shall mean equipment, which is:

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

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

(C) Appropriate for use within the home.

The purchase or rental of durable medical equipment must be medically necessary as determined by the claims administrator and prescribed by a physician. Attachment C of the HMO section and Attachment D of the PPO, PPO Limited and POS sections located at the back of the *Plan Document* provide a list of durable medical equipment.

1.14 "Eligibility Date"

Eligibility date shall mean the date on which an employee or dependent becomes eligible to participate in the plan pursuant to the applicable provision of Article II, hereof.

1.15 "Emergency"

Emergency shall mean a situation in which a prudent layperson, who possesses an average knowledge of health and medicine, as a medical condition that develops itself by symptoms of sufficient severity, including severe pain. Failure to provide such treatment could reasonably be expected to result in serious impairment of bodily functions; serious dysfunction of a body organ or part; could reasonably be expected to place the person's health in serious jeopardy; threat to the health and safety of a pregnant woman who is having contractions or to an unborn child; or danger to self (including psychiatric conditions and intoxication).

1.16 "Employee"

Employee shall mean:

(A) Any person employed by the employer, who is regularly scheduled to work not less than thirty (30) hours per week in a non-seasonal, non-temporary position;

(B) A member of the chief legislative body of the county or municipal government; or

(C) All other individuals cited in state statute or approved as an exception by the Local Government Insurance Committee.

(D) Board members and commissioners are not considered employees for purposes of the plan and are not eligible for coverage (i.e. school board members, gas and water board members, highway commissioners, and all others not defined above).

1.17 "Employee Assistance Program (EAP) Services Administrator"

Employee assistance program (EAP) services administrator shall mean the entity/organization contractually designated by the state to provide counseling services and/or referral services to all covered persons who are eligible for health insurance coverage.

1.18 "Employer"

(A) Employer shall mean one of the following local government and quasi-governmental organizations which participates in the plan and meets one of the following criteria:

(1) Any county, municipality, special district or other unit, designated as a unit of local government by statue;

(2) Any not-for-profit agency receiving state funding or grant and sponsored by an agency of state government. An agency that is under contract by the state is not eligible.

(3) Members of the Tennessee Municipal League, and;

(4) Any association that participates or is eligible to participate in the Tennessee Consolidated Retirement System.

(B) Employer's Additional Requirements for Plan Participation:

(1) The participating employer must agree to have monthly premiums deducted from their bank account via automated clearinghouse (ACH) debit process;

(2) A minimum of fifty (50) percent plus one (1) of all eligible employees must participate in the Local Government Plan. Agencies with fewer than twenty (20) employees must have fifty (50) percent of all eligible employees enroll;

(3) The participating employer must agree to provide eligibility information on all employees, enroll employees in the plan, adhere to all plan provisions as set forth by the Local Government Insurance Committee and collect applicable premiums according to established procedures;

(4) The participating employer must designate one individual (the local government agency's insurance preparer) to serve as liaison with Insurance Administration for the purpose of carrying out the responsibilities of plan administration;

(5) The participating employer must offer to eligible employees only those health insurance options sponsored by the Local Government Insurance Committee; and

(6) A minimum of two (2) years participation in the Local Government Plan is required; if the employer ceases to participate, a sixty (60) day notice indicating the agency's intent to cancel participation is required and that employer is prohibited from rejoining the plan for twenty-four (24) months from the date of their termination.

(C) Employer's Effective Date of Participation who satisfies the conditions set forth in Section 1.18(A) and 1.18(B) shall be the later of the following:

(1) The first day of the month following the approval of the employer as an eligible participant in the plan by the committee, or its representative; and

(2) The first date of the month following the enrollment period for all eligible employees in the plan.

1.19 "Family and Medical Leave"

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

1.20 "Formulary"

Formulary shall mean a listing of prescription medications which are preferred for use by the plans and which will be dispensed by participating pharmacies to covered employees and their covered dependents. Such a list is subject to periodic review and modification by the claims administrator. A claims administrator that adopts an open or voluntary formulary allows coverage for both formulary and non-formulary medications. A claims administrator that adopts a managed or mandatory formulary limits coverage to those drugs on the formulary.

1.21 "HIPAA"

HIPAA (Health Insurance Portability Accountability Act) shall mean the federal law pertaining to portability between health plans, pre-existing conditions, and has special enrollment

provisions that may allow employees, spouses, and/or dependents to enroll under certain conditions pursuant to Section 2.08 (C).

1.22 "HMO Acts"

HMO Acts shall mean the Federal Health Maintenance Organization Act of 1973, as described pursuant to P.L. 93-222, as amended, and the State Health Maintenance Act, as described pursuant to Chapter 32 of Title 56 of the Tennessee Code Annotated, as amended.

1.23 "Health Maintenance Organization (HMO) Plan"

Health Maintenance Organization (HMO) plan shall mean the State of Tennessee Health Maintenance Organization plan. An HMO is a managed care health plan that permits plan participants to utilize physicians and facilities that have agreed to the program's conditions for a fixed co-payment. The delivery of healthcare services is required to be coordinated by a primary care physician (PCP) who is selected by the participant. The employee's county of residence or work determines eligibility for the Health Maintenance Organization program.

1.24 "Illness"

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

1.25 "Injury"

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

1.26 "Inpatient"

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

1.27 "In-Network"

In-network shall mean the services received and the reimbursement level available when rendered by doctors, caregivers, and medical facilities participating in an agreement with the state's contracted claims administrators. Services provided are subject to specific terms and rates. The

benefit level when using providers in a health plan's network is referred to as "in-network" on the benefit summary chart.

Under the HMO plan services are considered "in-network" when a covered person is provided medical care by his/her PCP or by a specialist or other covered healthcare provider with a valid referral from the PCP. In situations where a covered person receives services or supplies that do not require a referral, but rather a physician's order or certification of medical necessity, then the in-network level of benefits is available when those services or supplies are delivered by a network participating provider.

1.28 "Insurance Administration"

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

1.29 "Joint Custody"

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

1.30 "Leave of Absence"

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

1.31 "Legal Custody"

Legal custody shall mean that the employee or spouse has sole custody of a child or has responsibility, by court order, to provide the majority of a child's support as evidenced by the employee's or spouse's federal income tax return.

1.32 "Legal Guardian"

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

1.33 "Life Threatening Emergency"

Life threatening emergency shall mean the sudden onset of a medical condition of sufficient severity (as determined by the claims administrator based on diagnosis) that, in the absence of immediate medical attention, could result in:

(A) Death;

(B) Permanently placing a covered person's health in jeopardy;

(C) Serious impairment to body functions;

(D) Serious or permanent dysfunction of any body organ or part; or

(E) Other serious medical consequences.

1.34 "Local Government Agency" (LGA)

Local government agency (LGA) shall mean a local government agency pursuant to TCA 49-3-302.

1.35 "Medical Management Program"

Medical management program shall mean:

(A) The organization chosen by the committee to provide medical management services for the HMO plan; and/or

(B) The mental health and substance review organization chosen by the committee to provide mental health/substance abuse management services for the HMO plan.

1.36 "Medically Necessary" or "Clinically Necessary"

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

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

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

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

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

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

1.37 "Medical Supplies"

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

(A) Prescribed by the patient's physician;

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

(C) Consistent with the diagnosis;

(D) Recognized as therapeutically effective; and

(E) Not for environmental control, personal hygiene, comfort or convenience. Examples of medical supplies that are covered include: oxygen facemasks, sheepskin (lambs wool pads), glucose strips and sitz bath.

1.38 "Medicare"

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

1.39 "Non-Standard Referral"

Non-standard referral shall mean any referral request, which falls outside of the standard referral protocols with respect to the HMO and designated POS plans. This includes, but is not limited to, referrals made to non-network specialists and referrals for services covering atypical time periods as determined by the claims administrator. These non-standard referrals must be requested and approved by the claims administrator in advance of the services being rendered.

1.40 "Out-of-Network"

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

1.41 "Out-of-Pocket Expenses"

Out-of-pocket expenses shall mean the sum of any copayments required or incurred for any covered expense under the plans, except those expenses incurred for the treatment of mental health disorders

and substance abuse, pharmacy prescription copayments, and expenses incurred for any services not in compliance with the medical management program.

1.42 "Outpatient"

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

1.43 "Outpatient Surgery"

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

1.44 "Plan"

Plan shall mean the applicable State of Tennessee Point of Service Comprehensive Medical and Hospitalization Program, or the State of Tennessee Preferred Provider Organization Comprehensive Medical and Hospitalization Program, or the State of Tennessee Health Maintenance Organization Comprehensive Medical and Hospitalization Program, subject to the provisions of Section 2.09.

1.45 "Plan Year"

Plan year shall mean the twelve (12) month period beginning January 1 and ending December 31.

1.46 "Point of Service (POS) Plan"

Point of Service (POS) plan shall mean the State of Tennessee Point of Service Comprehensive Medical and Hospitalization Program. The employee's county of residence or work determines eligibility for the POS plan. The POS plan is a managed care health plan that permits POS plan participants to utilize physicians, facilities and other healthcare providers who have agreed to the program's conditions for a fixed copayment. If designated, the delivery of healthcare services is required to be coordinated by a PCP who is selected by the participant. Care can be accessed outside the network of participating providers without the approval of the PCP, but the benefits provided are a percentage of the maximum allowable charge, which is not dependent upon actual charges.

1.47 "Positive Pay Status"

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

1.48 "Preferred Provider Organization (PPO) and PPO Limited Plan"

Preferred Provider Organization (PPO) and Preferred Provider Organization Limited (PPO Limited) plan shall mean the State of Tennessee Preferred Provider Organization Medical and Hospitalization Program. This is a health insurance plan where PPO and PPO Limited plan participants choose a network provider or a non-network provider. A network provider accepts a maximum allowable charge after the deductible has been satisfied. The participant is responsible for a percentage of the maximum allowable charge. When a patient utilizes a non-network provider, care is paid at a percentage of the maximum allowable charge after the deductible has been satisfied and charges above the maximum allowable charge are the patient's responsibility.

1.49 "Pre-existing"

Pre-existing shall mean a condition for which a covered person received treatment or advice during the six (6) month period immediately prior to coverage with a state-sponsored plan. Treatment for conditions determined to be pre-existing shall not be considered eligible expenses until six (6) months following the hire date for the employee and six (6) months following the effective date for dependents. The pre-existing condition clause does not apply to pregnancy, newborns, adopted children, children placed for adoption or employees and dependents enrolled in a state-sponsored plan. The pre-existing condition clause will be waived for enrollees who had previous health insurance coverage which had not lapsed longer than sixty-three (63) days prior to their employment hire date under this plan (effective date for dependents). Employees and dependents qualifying for this waiver of the pre-existing condition clause must present a certificate of coverage letter to their employer at the time they enroll in coverage under a state-sponsored plan. Employees and dependents who did not have previous health coverage during the sixty-three (63) days immediately prior to their employment hire date (or effective date for dependents) in a state-sponsored plan will be required to satisfy the six (6) month pre-existing condition requirement if applicable.

1.50 "Pregnancy"

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

1.51 "PCP" or "Primary Care Physician"

PCP or primary care physician shall mean the physician that the covered person selects as his/her primary caregiver and coordinator for all medical care. The PCP must be selected from the network participating list of available PCPs (internal medicine, family practice, general practice, pediatrics). Each covered person in an HMO must select a PCP. Each covered person in a POS must select a PCP if such designation is required. OB-GYNs may be considered a PCP or specialist depending upon the claims administrator.

1.52 "Provider"

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

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

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

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

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

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

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

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

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

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

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

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

(4) Provides facilities for the full-time care of five (5) or more patients;

(5) Maintains clinical records on all patients; and

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

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

(G) Health Service Practitioners (HSP) shall mean psychologists defined and licensed as health service providers (TCA 63-11-101 through TCA 63-11-223). This definition includes two (2) levels of psychological practice: one is psychological examiner and the other is psychologist (TCA 63-11-202), both of which are covered under the plan within the following guidelines.

The psychological examiners licensed under this provision have at least two (2) academic years of graduate level training in psychology, including a master's degree, from an accredited educational institution and passed applicable exams (TCA 63-11-207). The practice of the psychological examiner includes interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality characteristics, for such purposes as psychological evaluation or for educational or vocational selection, guidance or placement. In the provision of the aforementioned services the psychological examiner may act as an autonomous provider of health services. The examiner may also provide over-all personality appraisal or classification, personality counseling, psychotherapy or personality readjustment techniques, but only under the qualified supervision (TCA 63-11-202).

Psychologists licensed under this provision have: a doctorate in psychology from an accredited educational institution recognized by the HSP board as maintaining satisfactory standards; passed applicable examinations; has had at least one (1) year of internship in an approved health services program; and has had at least one (1) year of postdoctoral experience delivering health services within Tennessee under the

supervision of a licensed HSP psychologist or has received equivalent experience outside of the state as determined by the HSP board. For purposes of this provision health services are defined as the delivery of direct, preventive, assessment and therapeutic intervention services to individuals whose growth, adjustment or function is actually impaired or may be at risk of impairment (TCA 63-11-208).

All individuals previously licensed as a psychologist under TCA 63-11 as a school, clinical or counseling psychologist were provided the opportunity to also be designated as a health services practitioner along with other licensed psychologists who were able to properly document at least two (2) years of experience providing health services (TCA 63-11-222). It should be noted that persons licensed by the State Board of Education in areas of school psychology, school psychologist or school psychological services and employed by an educational institution are not required to also be licensed as a health service provider; however, these individuals are not recognized as eligible providers unless they obtain a license as a health services provider (TCA 63-11-205).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Q) Physician Assistant (P.A.) shall mean a graduate of a professional academic center as a P.A., working under a physician's supervision.

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

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

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

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

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

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

1.53 "Qualified Beneficiary"

Qualified beneficiary shall mean any employee or dependent who is defined under Section 4.07 of the plan.

1.54 "Qualifying Event"

Qualified event as pertaining to COBRA shall mean:

(A) The death of a covered employee;

(B) A covered employee's termination of employment or reduction in work hours of an employee's employment to less than (30) hours per week;

(C) The divorce or legal separation of a covered employee and his/her spouse;

(D) A covered employee becoming entitled to Medicare Part A; or

(E) A covered dependent child ceasing to meet the definition of an eligible dependent.

1.55 "Referral"

Referral shall mean a formal recommendation made by a POS or HMO covered person's PCP or another approved provider to receive care from a different physician, facility or other covered provider of service. Referrals are not applicable to a POS where no PCP designation is required. The referral must be approved by the claims administrator before it is valid and the care will be covered based on the covered expenses of the plan. The referral must be submitted within the program specified timeframe and within the program specified allowable parameters of duration of care. (See also non-standard referral in Section 1.39.)

1.56 "Retiree"

Retiree shall mean a former employee who has retired from the employer and receives a benefit from the Tennessee Consolidated Retirement System, or an employee who has retired from the employer and participated in an optional retirement plan; both categories of retirees must meet the guidelines in Section 4.06 to continue to participate in the plan. An individual cannot be classified as a retiree and maintain insurance as an active employee under the plan.

1.57 "Significant Break in Coverage"

Significant break in coverage means a period of sixty-three (63) (or more) consecutive days without creditable coverage. Periods of no coverage during a waiting period shall not be taken into account for purposes of determining whether a significant break in coverage has occurred.

1.58 "Shared Parenting"

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

1.59 "Specialist"

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

1.60 "State"

State shall mean the State of Tennessee.

1.61 "Urgent Care Symptoms"

Urgent care symptoms shall mean those experienced by a person covered under the plan that are usually marked by a rapid onset of persistent or unusual discomfort associated with an illness. Some examples of urgent care symptoms include, but not limited to, moderate difficulty in breathing, prolonged nosebleed, short-term high fever and cuts requiring stitches.

1.62 "Utilization Review Organization"

Utilization review organization shall mean

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

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

ARTICLE II
ELIGIBILITY AND ENROLLMENT

2.01 Employee Eligibility.

(A) Eligibility. All employees pursuant to Section 1.16 shall be eligible for coverage.

(B) Eligibility Date. The eligibility date of any employee shall be:

(1) When the employee completes one (1) full calendar month of active service with the employer or the first day of the calendar month following completion of the local government agency's probationary period, whichever is later. An agency's probationary period must be the same for **all** their eligible employees;

(2) The first day of the month following a transfer of coverage from the state or local education plan. A transfer between plans is allowed if an employee who is head of a contract in one plan loses eligibility or terminates employment and applies within one (1) full calendar month following the termination of insurance coverage;

(3) Any other date established by the committee for a class of employees; or

(4) The first day of the month following the employee's status change from part-time to full-time provided the employee has worked one (1) full calendar month.

2.02 Eligibility of Re-Hired Employees.

An employee may not be terminated and then re-hired by the same employer within sixty (60) days and be eligible for insurance coverage as a newly hired employee, except as outlined in Section 2.08 or Section 3.05.

2.03 Employee Enrollment and Effective Date of Coverage.

(A) Enrollment. The committee, or its representative, shall provide an employee with enrollment forms prior to the employee's eligibility date. Such forms must be completed and returned to the committee's representative, indicating the desired health care option and appropriate type of coverage, pursuant to Section 1.07, prior to the employee's eligibility date if such employee is to begin coverage as of the effective date described under subsection 2.03(B).

(B) Effective Date of Coverage for an Employee. The effective date of coverage for any employee who satisfies the conditions set forth in Section 2.01(A) shall be:

(1) The employee's eligibility date, provided that the employee has completed the enrollment forms required pursuant to Section 2.03(A);

(2) The first day of the two (2) months following the employee's eligibility date, whichever the employee chooses, provided the employee has completed the enrollment forms; or

(3) The date the eligible employee returns to active work, if such employee is absent from work on the date his/her participation would otherwise take effect, or;

(4) The employee's eligibility date, in the event that an employee is injured while performing job-related duties and has been approved by the employer; or

(5) The first of the month following the Division of Insurance Administration's approval of the late applicant requirements (HIPAA) as defined in Section 2.08.

2.04 Dependent Eligibility.

(A) Eligibility. Each dependent of a covered person, as defined in Section 1.12, shall also be eligible for coverage.

(B) Eligibility Date. The eligibility date of each dependent shall be the later of the following:

(1) The eligibility date of the employee, or

(2) The date the dependent becomes an eligible dependent of the covered person.

2.05 Dependent Enrollment and Effective Date of Coverage.

(A) Enrollment. Eligible dependents of the employee on the employee's eligibility date must be included on the enrollment form submitted by the employee pursuant to Section 2.03(A). Written application to add a dependent(s) to a covered person's coverage must be made to the committee or its representative. If the addition of the dependent constitutes a change in type of coverage, the application must be made by the employee within sixty (60) days following the date the dependent is acquired.

The date a dependent is acquired is determined as outlined below:

(1) Legally married spouse - date of marriage;

(2) Natural child - birth date;

(3) Legally adopted child - date of legal obligation or support of such child;

(4) In connection with any placement for adoption of a child with any person, means the assumption of a legal obligation of total or partial support of a child in anticipation of adoption. The child's placement terminates upon the termination of the legal obligation. The obligation may be determined by court records, federal income tax returns or other appropriate documentation as determined by the insurance committee or its representative.

(5) Child for whom an employee is the legal guardian - date legal guardianship granted;

(6) Children residing in an employee's home who meet the definition of dependent in Section 1.12 - date employee first became eligible to claim dependent on federal tax return;

(7) Stepchildren for whom the employee or spouse has legal or joint custody or shared parenting - date legal guardianship granted; and

(8) In connection with a child named as an alternate recipient under a qualified medical child support order as defined in Section 1.12 of the plan, date specified in such order or, if none, the date of the order.

(B) Effective Date of Coverage for a Dependent. The effective date of coverage for any eligible dependent, based upon receipt of application pursuant to Section 2.05(A), shall be the later of the following:

(1) The effective date of the employee's coverage hereunder pursuant to Section 2.03(B);

(2) The date the dependent becomes an eligible dependent of the covered person if the employee is enrolled in family coverage. The employee may choose the first day of the month in which the dependent was acquired or the first day of the subsequent month to elect family coverage. Application to add a dependent must be submitted within sixty (60) days of the acquire date in order for coverage to be effective as outlined above. In the event that the employee maintained family coverage on the date the eligible dependent was acquired, the effective date may be retroactive to the dependent's acquire date even if beyond the sixty (60) day enrollment period provided the employee did not have a break in family coverage;

(3) The day following discharge from the hospital, if any dependent (other than a newborn child) is confined to a hospital on the date coverage would have otherwise become effective; or

(4) The date of placement in the home in the event of adoption of a dependent.

2.06 Substantiation of Dependent Eligibility.

The committee or its representative may, at its discretion, require marriage certificates, birth certificates, adoption papers, legal guardianship papers, divorce decrees, federal income tax returns or proof of full-time student status. Failure to provide the requested information will suspend a dependent's eligibility until such information is provided to the committee or its representative.

2.07 Husband and Wife Both Employed by the Employer.

In the event that two employees are married, and both are eligible for coverage under the plan, they will have two (2) options.

(A) They may each elect individual coverage, if they have no dependents; or

(B) One (1) employee may elect family coverage and cover the spouse as a dependent under the family coverage.

In no event, may a participant be covered under more than one contract in the same plan. Coverage for a dependent child or children may not be elected by more than one (1) eligible employee (including divorced parents or parents who were never married to each other who both work for the employer).

In the event that one of the married covered employees terminates employment with the employer, the spouse still employed by the employer shall be required to contact the committee's representative within one (1) full calendar month of the spouse's employment termination date, in order to change to family coverage and provide coverage to his/her spouse as a dependent under the plan. An employee may not be enrolled as both head of contract and dependent within the Local Government Plan.

2.08 Late Applicant Requirements.

An employee or dependent who did not enroll during their initial eligibility period as outlined in Section 2.01(B) for employees and 2.04(B) for dependents, shall be required to apply for coverage by means of medical underwriting (Section A) or through a special enrollment provision (Section B), pursuant to the Health Insurance Portability and Accountability Act of 1996.

(A) Medical Underwriting. Employees and dependents who wish to prove insurable and enroll through this provision must complete the appropriate health care evaluation application for each applicant. The application can be obtained from the employee's insurance preparer. The cost of the evaluation is the responsibility of the employee. If additional information is requested from the employee, the requested information must be returned to the medical underwriter within three (3) months of the date of the request or it will no longer be valid, and the employee must reapply. After completion of the application, the information should be returned to the medical underwriter listed on the application. The non-refundable application fee must be submitted in the form of a money order or cashier's check. The application will be evaluated through the medical underwriting process. The employee will be notified by letter of the underwriter's decision. Employees and dependents that are

approved should contact their insurance preparer within sixty (60) days of the date of the approval letter. The employee (head of contract) must be approved, or already participating in the plan before any dependents can be added for coverage. The employee and dependents may apply for coverage as many times as they wish should their medical condition change. An application fee must be submitted each time an employee or dependent applies for coverage. Whether approved or denied coverage, employees and dependents will not receive a refund of the application fee. Denials for coverage cannot be appealed through the plan's appeals process. Misrepresentations or fraudulent statements made on the health care evaluation form are subject to review and resulting action through the plan integrity process.

Retirees who wish to enroll under the medical underwriting provision had to be a covered person on the medical insurance at the time they retired and were eligible to continue coverage by their length of service and length of participation in the plan.

(B) Medical Underwriting Approval Effective Date. The effective date of coverage for an employee or dependent approved through the medical underwriting process shall be one of the following:

(1) First of the month or subsequent month following approval by the committee or its representative;

(2) First of the month following the sixty (60) day period after approval of the application.

(C) Special Enrollment Provision. Per HIPAA regulations, to qualify for a special enrollment provision, the employee must submit appropriate documentation to substantiate:

(1) That the employee and/or dependent were covered under another group health plan or medical insurance plan at the time of:

(a) Death of a spouse or ex-spouse;

(b) Divorce;

(c) Legal separation;

(d) Loss of eligibility (does not include a loss due to failure to pay premiums or termination of coverage for cause);

(e) Termination of spouse's or ex-spouse's employment (voluntary and non-voluntary);

(f) Employer's discontinuation of contribution to the spouse's, ex-spouse's, or dependent's insurance coverage (total contribution, not partial);

(g) Spouse's or ex-spouse's work hours reduced causing loss of eligibility for insurance coverage;

as evidenced by written documentation from the employer on company letterhead providing the names of covered participants, the date coverage ended and the reason why coverage ended; or

(h) Loss of TennCare other than non-payment of premium as evidenced by the certificate of creditable coverage providing the names of covered participants and the date the coverage ended.

(2) That the employee or dependents may not continue coverage under that employer's group health or medical insurance plan; and

(3) The date of the death as evidenced by a death certificate, or the date of the divorce as evidenced by the final signed divorce decree, or agreed order of legal separation, or the date of employment termination as evidenced by the employment termination notice, or the date the total contribution amount changed, or the date the loss of eligibility occurred; or

(4) The date of the birth or placement for adoption of a child or date of marriage as evidenced by a birth certificate, marriage certificate or adoption documents.

Additional provisions for special enrollment for employees without coverage or with single coverage include:

(a) Acquires a new dependent - spouse (and adding other previously eligible dependents)

(b) Acquires a new dependent - newborn (and adding other previously eligible dependents)

(c) Acquires a new dependent - adoption/legal custody.

(D) Special Enrollment Period. Application for these exceptions to the special enrollment rules must be made to the committee's representative within sixty (60) days of the loss of the insurance coverage. Notwithstanding other provisions of this section, if the employee or employee's dependent(s) had COBRA continuation coverage under another plan and COBRA continuation coverage has since been exhausted, enrollment requirements shall be waived if application is received within sixty (60) days of the loss of coverage.

(E) Special Enrollment Provision Effective Date. The effective date of coverage for an employee or dependent approved through a special enrollment provision shall be one of the following:

(1) First of the month in which other coverage was lost, if other coverage was lost in the middle of the month (double coverage); or

(2) First of the month following loss of other coverage if other coverage was lost at the end of the month;

(3) First of the month or subsequent month following approval by the committee or its representative;

(4) Day on which the event occurred, if enrollment is waived due to marriage, birth, adoption or placement for adoption; or

(5) First of the month following the sixty (60) day period of the loss of insurance coverage.

(F) Special Enrollment for Retirees. In order for a retiree to be eligible to enroll for medical insurance under the provision of the Health Insurance Portability and Accountability Act, the retiree must have been a covered person under a state-sponsored plan at the time they retired and must have been eligible to continue coverage by their length of service and length of participation in the plan, as outlined in Section 4.06.

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

2.09 Election of a Plan Option.

(A) Election of Option. Covered persons shall have the option of electing membership in one of the state plans. If a covered person elects membership in any one of the state plans in accordance with rules established by the committee, applicable participation in the non-elected plans for such covered persons shall terminate on the day preceding the date membership in the newly elected plan becomes effective. Covered persons may transfer between any plan, during the annual enrollment and transfer period established by the committee with coverage selected to take effect the first day of the next plan year. Additional transfer periods may also be held on other dates. HMO and POS plans are established in geographic service areas. To join an HMO or POS plan, the individual must live or work in one of the counties in the HMO or POS service area. If a covered person no longer lives in the HMO or POS service area, he/she must transfer his/her coverage from the HMO or POS to the PPO, PPO Limited or another HMO or POS, if one is available in the service area no later than the first day of the month after the covered person no longer lives or works in the service area.

(B) Rejoining a Plan. If a covered person has elected membership in a plan and subsequently elects applicable participation under another plan, application shall be made during the annual enrollment and transfer period and such applicable participation shall become effective the first day of the next plan year.

(C) Enrollment Procedures. A covered person wishing to enroll in a plan must complete an application and such other forms as may be required by the applicable committee. Covered persons who join a plan must submit the appropriate forms to the committee or its representative within one (1) full calendar month of active service with the employer. Any changes in dependent coverage or changes in marital status must be in writing and submitted to the committee or its representative within sixty (60) days of the dependent's acquired date.

ARTICLE III

PARTICIPATION DURING APPROVED LEAVE AND REINSTATEMENTS

3.01 Continuation of Coverage During Leave of Absence.

An employee on an approved leave of absence that is not covered under the Family and Medical Leave Act of 1993 (Section 1.19) may continue coverage as described in this subsection. An employee on an approved leave of absence may continue coverage under the plan for two (2) continuous years provided he/she pays the full monthly premium (both the employer and employee portions as described in Article VIII) during such leave of absence.

Employees who return to work after a two (2) year leave of absence must be in a positive pay status for one (1) full calendar month before they may be eligible for a subsequent leave of absence to continue coverage. If an employee does not return to active work status and has completed a two (2) year leave of absence, coverage will be discontinued and COBRA continuation coverage will not be offered.

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

If an employee and his/her spouse both work for the employer and are both covered under a state-sponsored plan, and one spouse goes on a leave of absence, the spouse, as a covered person may change his/her type of coverage pursuant to Section 1.07 in order to cover his/her spouse as a dependent. The employee adding his/her spouse must contact his/her insurance preparer and change to family coverage by completing the enrollment/change forms.

3.03 Suspension of Coverage During Leave of Absence.

If the employee decides not to continue coverage while on leave, he/she must apply to suspend coverage by signing the leave without pay insurance options form while the coverage is still active and premiums are current. Coverage will terminate on the last day of the month in which the employee has paid his/her premium(s). When the employee returns from leave, to re-enroll in coverage, the insurance preparer must be contacted by the employee and enrollment forms completed and the insurance premium paid. The employee has one (1) full calendar month from the end of the leave to reinstate the coverage; otherwise, the employee will be subject to the late applicant requirements of Section 2.08.

Individuals returning from military leave shall have ninety (90) days from the end of their leave of absence to reinstate coverage.

3.04 Reinstatement of Coverage Following Suspension of Coverage.

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

(A) If an employee returns to covered employment with the employer during a time period equal to or less than six (6) months of the date coverage previously suspended, he/she shall have his/her coverage reinstated on the first day of the calendar month following the date the employee returns to work without:

(1) Satisfying the waiting period required of new employees;

(2) Satisfying the pre-existing conditions for the PPO, PPO Limited and POS plans; and

(3) Satisfying the late applicant requirements of Section 2.08, provided the employee meets the other eligibility requirements of Section 2.01.

(B) If an employee returns to work with the employer after a period greater than six (6) months of the date coverage previously suspended, he/she shall have coverage reinstated after working one (1) full calendar month and satisfying the eligibility requirements of Section 2.01, including the applicable waiting period for new employees. The employee must satisfy the pre-existing condition clause (for the PPO, PPO Limited and POS plans) unless the employee provides a certificate of creditable coverage letter reflecting other coverage while on leave and there has not been a sixty-three (63) day lapse in coverage.

3.05 Reinstatement of Coverage Following Termination of Employment.

If employment is terminated with the employer and the employee returns to work with the employer within one (1) full calendar month of insurance termination, the employee may reinstate his/her insurance if all other eligibility requirements are met. This reinstatement will be made and coverage will continue as previously enrolled. The insurance preparer must be contacted and enrollment forms completed for coverage to be reinstated.

3.06 Reinstatement for Military Personnel Returning from Active Service.

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

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

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

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

(D) The first of the month following the military person's return to the employer's active payroll.

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

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

ARTICLE IV
COVERAGE TERMINATION AND CONTINUATION

4.01 Termination of Covered Employee's Participation.

(A) Voluntary Coverage Termination. A covered employee may voluntarily terminate his/her participation in the plan by completing the appropriate forms. The termination shall take effect at midnight on the last day of any subsequent month in which the cancellation is requested.

An employee who wishes to re-enroll at a later date will be subject to the late applicant requirements in Section 2.08.

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

(1) At the end of the calendar month during which the employee ceases to meet the eligibility requirements of Section 1.16;

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

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

(4) The date the plan is terminated; or

(5) The last day of the month in which the local government agency participates in the Local Government Plan.

4.02 Termination of Dependent Participation.

Except as otherwise expressly provided in the plan, participation in the plan by a dependent (as a dependent) shall terminate at the end of the month in which the dependent ceases to be an eligible dependent as defined in Section 1.12. It is the responsibility of the employee to notify the committee's representative of any event that would cause a dependent to become ineligible for coverage. Claims paid in error for any reason will be recovered from the employee. If termination is for anticipation of divorce, the dependent spouse cannot be terminated until the divorce is final with the exception of divorce on the sole grounds of irreconcilable differences.

4.03 Continuation of Dependent's Participation upon Death of a Covered Person.

Notwithstanding anything herein to the contrary, in the event of the death of a covered person who elected family coverage, the participation under the plan of such covered person's dependent(s) (at the time of his/her death) may continue for six (6) months after such covered person's death, subject to the terms and conditions of the plan. The contribution for this coverage is the sole responsibility of the plan. Participation in the plan during the six (6) months of extended coverage due to death shall be in addition to continued coverage available through the provisions of COBRA pursuant to Section 4.07. If the employee dies in active service, the covered dependents must be eligible for and must accept a lifetime monthly benefit from the Tennessee Consolidated Retirement System in order to continue coverage beyond the six (6) months free coverage. If the covered dependents are not eligible for a lifetime monthly benefit, COBRA may be offered. Dependents must continue to meet the definition of an eligible dependent.

If a retiree dies (already receiving monthly benefit), covered dependents may continue beyond the six (6) months free coverage. If the dependent receives a benefit, premiums will be deducted by the Tennessee Consolidated Retirement System. If no benefit is continued or if the premium exceeds the monthly benefit, the premium must be submitted to the Division of Insurance Administration each month. Dependents must continue to meet the definition of an eligible dependent.

4.04 Continuation After Covered Employee's Work-Related Injury.

An employee who leaves the employer's payroll because of a work-related injury, and who was participating in a state-sponsored health plan at the time the work-related injury occurred, may continue participation in the plan during the period of such temporary disability. If the workers compensation benefits cease or the employer does not provide workers compensation coverage, the employee may continue coverage as described in Section 3.01. See applicable sections for specific plan provisions.

4.05 Continuation of Coverage for Disabled Employees.

(A) If a covered employee incurs a disability while enrolled in the PPO or PPO Limited plan and employment is terminated, the former employee may continue coverage, for that condition only, for a period not to exceed one (1) year. No contribution is required by the employee for this coverage. Participation in this plan shall be in lieu of other continuation options under this plan. This continuation provides benefits only for the claims associated with the disability as determined by the claims administrator. This continuation of coverage

must be requested, in writing, within thirty (30) days of the date insurance coverage is terminated.

(B) If a covered employee with five (5) years of service with their present local government employer incurs a work-related injury and is totally and permanently disabled as determined by the Tennessee Consolidated Retirement System, the former employee may continue coverage until such time as he/she is eligible for Medicare. The contribution for this coverage is the responsibility of the former employee and shall be the same premium as required for a retiree.

(C) Disability retirees who were participants in the Local Government Plan at the time of the injury or illness which resulted in their disability may continue coverage by meeting either the requirements of Section 4.06(B)(1)(a),(b),(c) or (d) or by having at least five (5) years of employment with the employer immediately prior to final termination due to disability and, for such retirees, the date retirement benefits commence (retirement date) must immediately follow the employee's date of final termination from employment with the employer.

4.06 Continuation of Coverage for Retirees.

Definitions used in interpreting these policies are as follows:

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

"Employment with the Employer" is defined as employment with the local government agency from which the employee is retiring. Service with any other local government agency cannot be combined to meet these requirements. For purposes of this plan, accumulated unused sick leave is defined as employment with the employer.

For the purpose of this plan, the following are **not** defined as employment with the employer: military service that did not interrupt employment, educational leave, leave of absence, employment with an agency participating in the state or local education plans, or services with another local government agency.

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

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

(A) Retirees and their dependents may not continue coverage in the plan if eligible for Medicare except for individuals who are grandfathered into the plan by the Local

Government Insurance Committee. Benefits will be provided for individuals who were covered as retirees under their previous policy (prior to joining the plan) but who did not meet the plan eligibility requirements for retirees when their employer joined the plan. For these individuals, the plan shall pay secondary benefits to Medicare after the deductible or copayment amount listed in Attachment A has been met.

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

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

(a) The retiree must be age fifty-five (55) and have at least ten (10) years of employment with the local government agency from which they are retiring, with three (3) continuous years of insurance coverage in the plan immediately prior to final termination for retirement.* For such retirees, the continuation of insurance must immediately follow the employee's date of final termination from employment with the employer (retirement date).* The immediate continuation of insurance requirement will be waived for employees leaving the Local Government Plan and becoming employed by an agency participating in one of the other state-sponsored health plans; or,

(b) The retiree must be age fifty-five (55) and must have at least twenty (20) or more total years of employment with the local government agency from which they are retiring with one (1) year of insurance coverage in the plan immediately prior to final termination for retirement.* For such retirees, the continuation of insurance must immediately follow the employee's date of final termination from employment with the employer (retirement date).* The immediate continuation of insurance requirement will be waived for employees leaving the Local Government Plan and becoming employed by an agency participating in one of the other state-sponsored health plans; or,

(c) For those local government agencies that have a retirement system other than the Tennessee Consolidated Retirement System, eligibility for the continuation of health insurance will be made available to those public safety employees (police and fireman) who are age fifty (50) and have at

least twenty-five (25) years of creditable service and have been covered by the Local Government Plan for at least (1) full year prior to retirement. The individual should be required to be qualified for an unreduced benefit to be eligible to continue insurance coverage.

(d) The retiree must have at least thirty (30) years of service with the local government agency from which they are retiring and be covered under the plan for one (1) year immediately prior to final termination of retirement. For such retirees, the continuation of insurance must immediately follow the employee's date of final termination from employment with the employer (retirement date).* This immediate continuation of insurance requirement will be waived for employees leaving the Local Government Plan and becoming employed by an agency participating in one of the other state-sponsored health plans.

(C) Retirees eligible to continue insurance coverage in the plan, pursuant to this section, must elect to continue coverage within one (1) full calendar month of application after the effective date of retirement.* At the expiration of this one (1) full calendar month period, eligible retirees may continue only if qualified through the special enrollment provisions of Section 2.08 or through the provision of COBRA. In order to enroll through the special enrollment provisions, the retiree and/or eligible dependents must have had medical coverage at the time they retired and be eligible to continue that coverage by virtue of their length of service and length of participation in the plan. Retirees who will receive a monthly benefit from the Tennessee Consolidated Retirement System shall have premiums deducted from their benefit check provided the agency does not elect to pay a portion of the premium. Retirees whose insurance premiums exceeds their monthly benefit or who do not receive a monthly benefit shall submit their premiums directly to the Division of Insurance Administration each month provided the agency does not elect to pay a portion of the premium.

Agencies who elect to pay all or a portion of their retiree's premiums will be billed by the Division of Insurance Administration for the entire premium. The retiree is responsible for paying their portion of the premium to the agency from which they retired.

All retirees and/or dependents covered under the plan will no longer be eligible to participate should the agency from which he/she retires cease participation in the plan.

When a retiree is no longer eligible for the plan because he/she is entitled to Part A of Medicare, his/her covered dependents may continue coverage. This coverage shall continue until the dependents no longer meet the eligibility requirements or until the dependents are entitled to Part A of Medicare.

When coverage is discontinued for a retiree or dependent due to Medicare entitlement, the retiree or dependent shall be given an opportunity to convert to a Medicare supplement policy. The plan will suspend coverage on any participating local government plan retiree who will not provide information to the Division of Insurance Administration concerning Medicare eligibility upon request. Participation in either the Plan 1 or Plan 2 Medicare supplement policy requires the retiree or dependent to be eligible to receive a monthly benefit from the Tennessee Consolidated Retirement System. If a retiree or dependent is not participating in the Tennessee Consolidated Retirement System, he/she may elect the Plan 3 Medicare maintenance of benefits plan only.

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

If a covered retiree dies before a covered dependent, the dependent is entitled to six (6) months extended coverage without charge. If the covered dependent(s) continues to meet the dependent definition as either a spouse or a dependent child who is either a full-time student or incapacitated as outlined in Section 1.12, insurance may be continued after six (6) months extended coverage until the dependent(s) no longer meets the definition of an eligible dependent. The dependent will be responsible for the appropriate premium.

Upon retirement, if the retiree's spouse is an active employee of the employer, participating in the plan, the active employee may insure the retiree under his/her coverage until such time as that employee leaves employment. Upon the spouse's termination of employment, the retiree would revert his/her participation to the retiree group under the provisions of Section 4.06.

Retirees who are not eligible to continue insurance coverage because of the service requirements may continue coverage pursuant to Section 4.07 (COBRA) or convert to a direct payment plan offered by the claims administrator at retirement, pursuant to Section 4.08.

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

4.07 Limited Continuation of Coverage (COBRA).

For purposes of this Section 4.07, a qualified beneficiary is any individual who, on the day before a qualifying event, is covered under the plan by virtue of being on that day either the covered employee, the spouse of the covered employee, or a dependent child of the covered employee.

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

A covered employee for purposes of this Section 4.07 is any individual who is (or was) provided coverage under this group health plan by virtue of being or having been an employee.

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

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

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

In the case of a qualifying event described in Section 4.07(A)(1) or (2) above that occurs fewer than eighteen (18) months after the date the covered employee became entitled (enrolled) to benefits under title XVIII of the Social Security Act, the period of coverage for qualified beneficiaries other than the covered employee shall not terminate before the close of the thirty-six (36) month period beginning on the date the covered employee became so entitled. The thirty-six (36) month time period excludes any time covered under a retiree's coverage.

If a qualified beneficiary is determined to have been disabled under Title II or Title XVI of the Social Security Act at any time during the first sixty (60) days of COBRA continuation coverage, any qualified beneficiary will be entitled to elect an additional

eleven (11) months (total of up to twenty-nine [29] months from the date of the qualifying event) of COBRA continuation coverage. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first sixty (60) days of COBRA continuation coverage is measured from the date of birth or placement for adoption. This same eleven (11) month disability extension applies to each qualified beneficiary entitled to COBRA because of a qualifying event described in Section 4.07(A)(1) or (2) above. To qualify for this extension of coverage, the qualified beneficiary must have been disabled within the time periods described above, and must obtain a social security determination to that effect. The qualified beneficiaries affected by the qualifying event in Section 4.07(A)(1) or (2) must notify the committee's representative of the disability determination within sixty (60) days after the date the determination is issued and prior to the expiration of the initial eighteen (18) month period.

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

(1) Death of the covered employee;

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

(3) The covered employee becomes entitled to Medicare benefits; or

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

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

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

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

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

An election is considered to be made on the date that it is sent to the Division of Insurance Administration.

(C) Premiums. The monthly cost of COBRA coverage must be paid by the qualified beneficiary to the Division of Insurance Administration. The monthly cost shall be one hundred two (102) percent of the cost to the plan for coverage of a similarly situated employee whose coverage had not otherwise terminated. When a qualified beneficiary has a special continuation period due to a certified disability, as described in subsection 4.07(A), the monthly cost during the additional eleven (11) months shall be, in general, one hundred fifty (150) percent of the cost to the plan.

The qualified beneficiary must pay the required costs for the initial continuation of coverage period within forty-five (45) days of the date of the election. The monthly cost for coverage **following** the period after the initial election must be made in monthly payments in the manner prescribed by the committee or its representative. Without further notice from the employer, the qualified beneficiary must pay the monthly cost by the last day of each month for the following month's coverage. No claims will be paid pursuant to this Section 4.07 until the Division of Insurance Administration receives the applicable monthly premium for the qualified beneficiary's coverage.

(D) Notice. A covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of a qualifying event that is either a divorce or legal separation of the covered employee, or a dependent child ceasing to be a dependent as defined by the plan. Notice must be provided to the plan administrator within sixty (60) days after the later of the date of the qualifying event or the date the qualified beneficiary would lose coverage on account of the qualifying event.

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

(1) The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes covered under any other group health plan, unless the qualified beneficiary has a condition for which coverage under the new plan is limited due to a pre-existing condition clause and that clause is not satisfied by prior periods of creditable coverage under the Health Insurance Portability and

Accountability Act of 1996 (HIPAA). The continuation period shall not exceed the date the qualified beneficiary is no longer subject to the new plan's pre-existing condition clause;

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

(3) The end of an additional eleven (11) month disability extension period as described in Subsection 4.07(A). The continuation period shall not exceed the first day of the month following one (1) full calendar month after a final determination that the qualified beneficiary is no longer disabled;

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

(5) The date the qualified beneficiary fails to make timely payment of the monthly premiums. Timely payment shall be considered to be receipt of payment within one (1) full calendar month of the due date; or

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

4.08 Conversion Privileges.

(A) If an employee's participation under the plan terminates due to termination of employment, the employee may obtain from an insurance company or underwriting organization selected by the committee, an individual policy (the "converted policy"), which may or may not provide benefits identical to those provided under the plan. The conversion is subject to the conditions set forth in this section and to any other applicable provisions herein. The converted policy shall, except as herein provided, cover the former employee and any of the former employee's dependents participating under the plan on the date of such termination of participation.

(B) A converted policy, as provided above, shall also be available to a qualified beneficiary at the end of the period of continued coverage pursuant to Section 4.07. Provided, however, that any person obtaining a converted policy must satisfy the conditions of Section 4.08. The committee must provide the qualified beneficiary with the option of electing a converted policy during the one hundred eighty (180) day period that ends on the date that continued coverage, pursuant to Section 4.07, would end.

(C) The effective date of the converted policy shall be the day following termination of participation.

(D) The premium established by the insurance company or underwriting organization for the converted policy shall be that applicable to the ages of such persons, to the forms and amount of coverage provided, and to the class of risk to which the individual or individuals belong on the later of the effective date of the converted policy or the date application for the converted policy is made.

(E) In order to obtain a converted policy under this section, the person to whom such policy would be issued must make written application for the converted policy to the insurance company or underwriting organization and agree to pay the required premiums for the converted policy by the 31st day after such termination of participation.

ARTICLE V
COORDINATION OF MEDICAL BENEFITS

5.01 General.

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

5.02 Definitions.

As used in this article, the following terms shall have the meanings indicated, unless the context clearly requires a different construction:

(A) "Allowable Expense" means any necessary, maximum allowable expense, at least a portion of which is covered under at least one (1) of the other plans covering the person for whom claim is made. When another plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

(B) "Claim Determination Period" means the calendar year (January 1 through December 31), but excluding, for any person, any portion occurring prior to the later of the date this provision becomes effective and the first day the person is covered for benefits subject to this provision.

(C) "Maximum Allowable Charge" means the highest dollar amount of reimbursement allowed by either the primary or secondary plan for a particular covered service. Such amount is based on the fees negotiated between the claims administrator and certain physicians, health care professionals or other providers and whether covered services are received from providers contracting with the claims administrator or not contracting with the claims administrator. Reimbursement for services provided by non-contracting providers will be the stated percentage of the maximum allowable charge or billed charges, whichever is less. Contracting providers shall mean providers contracting with the claims administrator or one of its affiliates.

(D) "Other Plans" means any plan or plans primarily providing benefits or services for, or by reason of, medical care or treatment, which benefits or services are provided by:

(1) Group, blanket or franchise insurance coverage;

(2) Hospital service prepayment plan, a medical service prepayment plan, a group practice and other prepayment coverage, except that for which the subscription

charge or premium payment is made directly by the person covered to the organization providing the coverage;

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

(4) Any coverage under governmental programs and any coverage required or provided by any statute, except coverage provided, or coverage which could have been obtained, by appropriate application or enrollment under Medicare;

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

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

(E) "Primary Plan" means the plan that determines its benefit payments first and pays its full allowance without regard to other coverages or other plans.

(F) "Secondary Plan" means the plan that determines its benefit payments after the other plan or plans.

5.03 Effects on Benefits.

(A) This provision shall apply in determining the benefits as to a person covered under this plan during any claim determination period if, for the allowable expense incurred as to such person during such period, the sum of:

(1) The benefits that would be payable under this plan in the absence of this provision; and

(2) The benefits that would be payable under all other plans, in the absence therein of provisions of similar purpose to this provision;

would exceed such allowable expense.

(B) As to any claim determination period with respect to which this provision is applicable, the benefits that would be payable under the plan in the absence of this provision for the allowable expenses incurred as to such person during such period shall be reduced to that extent necessary so that the sum of such reduced benefits and all of the benefits payable for allowable expenses under all other plans except as provided in item (C) of this section, shall not exceed the total of such allowable expenses. Benefits payable under other plans include the benefits that would have been payable had claim been duly made therefore.

(C) The rules establishing the order of benefit determination are as follows:

(1) The benefits of a plan, which does not include a coordination of benefits provision, shall be determined before the benefits of a plan that does provide a coordination of benefits provision.

(2) The benefits of a plan, which covers the patient as an employee, shall be determined before the benefits of a plan that covers such person as a dependent.

(3) The benefits of a plan which covers the patient as a dependent child of the employee whose birthday comes first in the calendar year shall be determined before the benefits of a plan which covers such person as a dependent child of the covered employee whose birthday comes last in the calendar year, except in the case of a dependent child of separated or divorced parents.

(a) If parents are divorced or separated and there is a court decree, which establishes financial responsibility for medical expenses for the dependent, the plan covering the dependent of the parent who has that financial responsibility shall be considered the primary plan.

(b) If there is no court decree, the plan which covers the dependent of the parent with custody shall be the primary plan.

(c) If there is no court decree and the parent with custody has remarried, the order of benefits determination shall be as follows:

(i) First, the plan of the natural parent with custody shall be the primary plan.

(ii) If the natural parent does not have medical plan coverage, then the plan of the step-parent with custody shall be the primary plan.

(iii) If the natural parent and the step-parent with custody do not have medical plan coverage, then the plan of the parent without custody shall be the primary plan.

(4) The plan covering an individual as an employee (or as the employee's dependent) who is neither laid-off nor retired pays benefits first. The plan covering that individual as a laid-off or retired employee (or as that individual's dependent) pays benefits second.

(5) The plan covering an individual as an employee (or as a dependent of the employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under another plan, and such other plan pays benefits second for such an individual. Conversely, this plan pays secondary benefits for any individual who is provided COBRA continuation under this plan and who also

is covered simultaneously under another plan as an employee (or as a dependent of an employee). In the event of conflicting coordination provisions between this plan and any other plan, this plan will pay primary benefits for an individual only if this plan has provided coverage for a longer period of time.

(6) As to plans for which rules (a) through (c) do not establish an order of benefit determination, the benefits of a plan which has covered the person, for whom allowable expenses are being coordinated for the longer period of time, shall be determined before the benefits of a plan which has covered such person the shorter time.

(D) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during any period, each benefit that would be payable in the absence of this provision shall be reduced either proportionately or in such other equitable manner as the committee shall determine.

(E) Upon attaining age sixty-five (65) or otherwise becoming entitled to Medicare benefits, benefits for active employees shall continue under this plan and Medicare shall be considered the secondary plan for:

(1) Active employees; and

(2) Dependent spouses of active employees.

(F) For individuals who were covered by the plan as a covered employee and became Medicare eligible due to end stage renal disease, the plan will pay primary benefits for a period not to exceed thirty (30) months.

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

5.04 Subrogation.

The plan assumes and is subrogated to a covered person's rights to recovery of any payments made by it for medical expenses where the covered person's illness or injury resulted from the action or fault of a third party. The plan has the right to recover through their right to subrogation amounts equal to its payments by suit, settlement or otherwise from the insurance of the injured party, from the person who caused the illness or injury or his/her insurance company, or any other source such as uninsured motorist coverage.

In order to facilitate the plan's right to subrogation, the covered person is required to provide information and assistance to the plan and sign the necessary papers required. If this is not done

or if the covered person settles any claim without the plan's written consent, the plan will be entitled to recover from any judgment, settlement or suit all payments for medical expense made by the plan plus reasonable attorney's fees and court costs in trying to recover such payments.

5.05 Right of Reimbursement.

Separate from the plan's right to subrogation, the covered person agrees to reimburse the plan, up to the amount paid by the plan, from any money such covered person (or such covered person's family) receives specifically for the medical expenses. The covered person will reimburse the plan the amount of money recovered for medical expenses through judgment or settlement from a liable third party (or the insurer of the third party).

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

5.06 Recovery of Payment.

Whenever payments have been made under the plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this article, the committee shall have the right to recover such payments to the extent of such excess from one or more of the following, as the committee shall determine:

(A) Any person to, for or with respect to whom such payments were made;

(B) Any insurance companies; or

(C) Any other appropriate organizations or entities.

5.07 Dependents Previously Covered as Employees and Employees Previously Covered as Dependents.

Benefits payable on behalf of a dependent previously covered under the plan as an employee for hospital, surgical and medical expenses incurred during a period which began while the dependent was insured as an employee shall not exceed the maximum limitation of benefits that would have been payable during such period the dependent remained insured as an employee. The provisions of Section 5.05 also apply for employees previously covered by the plan as dependents.

5.08 Plan Purpose.

The purpose of the plan is to help the covered person pay his/her medical bills. It is not intended that insurance benefits from all sources exceed the medical expenses the covered person incurs. For this reason, if the covered person is covered under "other plans" as defined in this article and total benefits would exceed "allowable expenses," the medical care benefits provided under this plan will be reduced so that the total benefits the covered person receives from all plans will not exceed the actual eligible costs. In other words, the two plans coordinate benefits together and pay up to one hundred (100) percent of the eligible charges, but do **not** pay more than one hundred (100) percent.

ARTICLE VI
PLAN ADMINISTRATION AND FIDUCIARIES

6.01 General.

The committee shall have the responsibility for the administration of the plan pursuant to Chapter 27 of Title 8 of the Tennessee Code Annotated. The committee shall have only those specific powers, duties, responsibilities and obligations as are specifically given them under this plan. The committee shall be composed by law pursuant to TCA 8-27-207, *et seq.*

6.02 Liability of the Committee.

Members of the committee are absolutely immune from liability for acts or omissions within the scope of the committee member's office in serving the committee, except for willful, malicious, or criminal acts or omissions or for acts or omissions done for personal gain, pursuant to TCA 9-8-307(h). Committee members shall be considered "state officers" or "employees" as the meaning is set forth in TCA 8-42-101(3).

6.03 Authority and Powers of the Committee.

The committee shall exercise such authority and responsibility as it deems appropriate in order to comply with the Tennessee Code Annotated. The committee shall have such duties and powers as may be necessary to administer the plan, and to delegate as necessary to other representatives of the employer, including but not limited to the following duties and powers:

(A) To construe and interpret the plan, decide all questions of eligibility, and determine the amount, manner and time of payment of any benefits hereunder;

(B) To prescribe procedures to be followed by covered persons, beneficiaries or other persons filing applications for benefits;

(C) To prepare and distribute, in such manner as the committee determines to be appropriate, information explaining the plan;

(D) To receive from the employer, covered persons and other persons such information as shall be necessary for the proper administration of the plan;

(E) To receive, review and keep on file (as it deems convenient or proper) records pertaining to the plan;

(F) To provide for the financing of the plan;

(G) To establish the benefit levels and premium rates for the plan; and

(H) To appoint or employ individuals or companies to assist in the administration of the plan and any other agents it deems advisable.

6.04 Fiduciary Duties and Responsibilities.

Each fiduciary who is allocated specific duties or responsibilities under the plan, or any fiduciary who assumes such a position with the plan, shall discharge his/her duties solely in the interest of covered persons and for the exclusive benefit purpose of providing the benefits provided for in the plan to such covered persons, or defraying reasonable expenses of administering the plan. Each fiduciary, in carrying out such duties and responsibilities, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims and in accordance with the documents and instruments governing the plan.

A fiduciary may allocate any of his/her responsibilities for the operation and administration of the plan. In limitation of this right, a fiduciary may not allocate any responsibilities as contained herein relating to the management or control of the fund except through the employment of an investment manager as agreed upon by the committee. In the event that an insurance contract is utilized to fund any portion of this plan, the insurance company shall be responsible for the management and control of that portion of the fund which is provided through such contract and a fiduciary may not allocate any responsibilities as contained herein relating to the management or control of that portion of the fund which is provided through an insurance contract.

The committee may adopt such rules as it deems necessary, desirable or appropriate. The committee shall be entitled to rely upon information or advice furnished by a covered person, qualified beneficiary, employer, legal counsel, or other agents when discharging its duties.

6.05 Appeals Provision.

A covered person may request an appeal of a decision made by the claims administrator relative to the disposition of a claim, the medical management program or utilization review guidelines, or as determined by the Division of Insurance Administration, administrative decisions made on behalf of the plan. The appeal must be requested in writing within two (2) years of the claim determination or decision. The covered person must first exhaust any and all appeals/grievance processing available through the claims administrator before initiating an appeal at the state level. The covered person should first call the claims administrator at the telephone number listed on his/her insurance card. If the covered person has received correspondence pertaining to an inquiry, the covered person should ask for the correspondent by name to discuss the appeal. If the covered person's

complaint cannot be resolved on an informal basis, they may complete and file an "enrollee complaint form" or other form as designated by the claims administrator. The covered person may obtain this form by calling the claims administrator at the telephone number listed on his/her insurance card. A written complaint must be filed with the claims administrator within ninety (90) days from the date the problem in question occurred. Within thirty (30) days of receipt of the written complaint, the claims administrator will issue a written decision to all of the parties involved. If the covered person is not satisfied with the outcome of the complaint process, the covered person is entitled to file a formal appeal to the claims administrator. This appeal must be filed within thirty (30) days from the date the claims administrator issued a decision as a result of the covered person's written complaint. The covered person's appeal will be reviewed by a committee as designated by the claims administrator. The decision of the committee completes the complaint and grievance process established by the claims administrator. The covered person may then pursue their appeal further by contacting the appeals coordinator in the Division of Insurance Administration as outlined in their member handbook. The Division of Insurance Administration determines what issues can be appealed to the Staff Review Appeals Committee.

ARTICLE VII
CLAIM PROVISIONS

7.01 Proof of Claim.

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

7.02 Payment of Benefits.

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

7.03 Examination of Claimants.

The committee or its representative, at its own expense, shall have the right and opportunity to examine any person whose illness or injury is the basis of claim when and so often as it may reasonably require during the pendency of the claim.

7.04 Disputed Claim.

To ensure that payment of claims is in accordance with plan provisions and that payment reduction is not the result of errors in claim processing, miscommunication or misinterpretation of policies, the following should be followed when a covered person disagrees with a denial or reduction of benefits.

The health care provider, covered person (or representative), or the committee's representative should contact the claims administrator to determine why a claim(s) has been reduced or denied. If not a processing error, the claims administrator will explain why the claim reduction or denial occurred. If the claim(s) was incurred with a contracted provider, the claims administrator will explain the "hold harmless" provision of the contract and advise the caller of the patient's liability for the claim. If the claim(s) was with a non-contracted provider, or if there were both contracted and non-contracted claims, the caller will be advised to write the claims administrator and request a review of the claim(s). The claims administrator will review the written request and respond in writing within thirty (30) days of receipt of the request. After review, if claims are still reduced or

denied, a detailed written explanation will be given to the covered person of the reasons for the reduction or denial. At this time, the covered person will be advised that additional levels of review are available by request to the staff of the committee. Such request shall be made in writing and filed with the staff within two (2) years after delivery to the covered person of written notice of the reasons for the reduction or denial.

If the dispute regarding the claims cannot be resolved at the claims administrator level, the covered person can initiate an appeal. Such appeal is to be made in accordance with both the policies and the rules and regulations of the committee. The committee is authorized to promulgate such rules and regulations necessary to process appeals.

7.05 Liability for Benefits.

To the extent that benefits under any part of the plan are provided by the purchase of insurance from an insurance company, only the insurance company and not the plan, the employer nor any other person or entity, shall be liable for the payment of such benefits. To the extent that benefits under any plan are not provided by the purchase of insurance from an insurance company, only the employer and any trust established by it for the purpose of funding such benefits, and not the plan nor any other person or entity, shall be liable for the payment of such benefits.

7.06 Overpayments and Incorrect Payments.

The committee, or its representative, has the responsibility and authority to recover any benefit payments made in error or in excess of contract liability from the person to, or for, or with respect to whom such payments were made, or from another insurance company or other organization, provider of service due to misrepresentation of eligibility or expense on the part of a covered person or employee.

ARTICLE VIII
CONTRIBUTIONS

8.01 Employee Contributions.

Contributions by covered employees are required as a condition of participating in the plan. By completing an enrollment application, an employee shall authorize the employer to deduct the employee's share of the monthly cost from his/her pay. The employees' share of the monthly cost shall be an amount equal to the difference between the monthly cost for the type medical coverage elected pursuant to Section 1.07, and any portion contributed by the employer.

Employees or dependents who submit payment for the monthly cost of coverage, and the payment is returned by the employee's or dependent's financial institution, shall be required to resubmit payment in the form of a money order or cashier's check within the time period specified. Should an employee or dependent submit two (2) consecutive payments that are not honored by their financial institution, coverage will be terminated retroactively to the last paid date with no provision for reinstatement.

8.02 Employer Contributions.

For employees defined in Section 1.16, the employer (LGA) may make a contribution on behalf of the employee.

8.03 Funding Medium.

(A) The choice of insurance companies or claims administrators under the plan, the timing and amount of any payment to such company, and the timing and amount of any contribution to any trust established under the plan, shall be at the sole discretion of the committee. Benefits under any part of the plan that are not fully insured, to the extent not insured, may, at the employer's sole discretion, be unfunded and may be paid by the employer solely from its general assets and the employer shall have no obligation to establish any trust or reserve in respect of such benefits, except as may otherwise be required by applicable law and regulations there under. The employer may, however, at its sole discretion, establish one or more trusts to hold such assets and such trust(s) may or may not, as determined by the employer, contain such provisions as are necessary to qualify for exemption from federal, state, local and other taxes.

Contributions by the employer, the state, covered employees, COBRA participants and retired employees shall be made to an expendable trust fund established to provide funding

of the plan. All contributions under this plan shall be applied toward the payment of benefits provided by plan and reasonable expenses of administering the plan.

On behalf of the covered persons, the employer shall establish and maintain an expendable trust fund from which benefit payments as provided under this plan shall be made. The fund will receive, invest and administer all contributions made under this plan in accordance with state law and accounting policies in effect for the receipt, investment and disbursement of state funds. The fund, resulting from contributions, earnings, profits, increments and accruals thereon, may only be used for the exclusive benefit of covered persons or the payment of reasonable expenses of administering the plan.

Although it is anticipated that no insurance coverage will be utilized, the plan may be funded in whole or in part by such insurance coverage as from time to time may be authorized by the committee. In the event that any payments pursuant to the plan shall be made by any insurance company directly, such payments shall be deemed to have been made by the fund.

(B) Premium refunds will be limited to three (3) months from the date of notification to the Division of Insurance Administration with the following guidelines:

(1) Employee fails to notify local government agency of eligibility change: Employees who do not notify about a change in their insurance enrollments in a timely manner will receive a three (3) month refund of their portion of the premium, from the date of notification to the agency unless the employee owes the plan for claims paid inappropriately. The agency will receive its entire portion.

(2) Local government agency fails to follow through on employee request for change: Employees who notify their employer, timely, to change insurance enrollments and the employer fails to follow through on the request will receive their entire portion of the refund. The agency will receive three (3) months of refund from the date of notification to the Division of Insurance Administration.

(3) Local government agency fails to report employment terminations: Agencies that fail to report employment terminations are limited to a three (3) month refund from the time of notification to the Division of Insurance Administration.

(4) Fraud cases: When the office of the State Comptroller has determined that fraud exists, the employee will forfeit their portion of a refund. The agency will receive its entire portion.

ARTICLE IX
AMENDMENT AND TERMINATION

9.01 Plan Modification and Amendment of Plan.

The plan may be modified and amended at any time by the committee upon its due approval of such modification or amendment. The modification or amendment shall be effective at the date of approval or at such later date as the committee may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the plan.

9.02 Plan Termination.

The plan may be terminated at any time by the committee upon due authorization of such termination effective as of the date of such authorization or at such later date as the committee may provide. In the event of such termination, the employer shall have no obligation under the plan beyond paying the difference between the claims incurred (even though filed up to thirteen [13] months after incurred) and expenses of the plan due up to the date of termination plus extended benefits, if any, provided under the plan and the funds available to pay such claims and expenses and extended benefits. Such claims and expenses shall be paid from the funds in the plan. In the event there shall be excess funds in the plan left after the payment of such claims and expenses, then the plan shall continue and from such funds there shall be paid in the following priority:

(A) The expenses of such continuation;

(B) Extended benefits, if any; and

(C) Current claims as the same shall arise, until the funds in the plan are ultimately exhausted.

Current claims received in any one month may be accumulated for later payment, and, in the event of such procedure and there ultimately being insufficient funds to pay in full such claims accumulated for a month after payment of expenses, then the funds remaining on hand may be distributed ratably among those claims accumulated for each month. The committee shall incur no liability for its failure to make payment of any claim or to make ratable distribution on any claim without regard to the reasons therefore, the committee having the responsibility for determining claims and directing payment thereof. The committee shall have the right to employ fiduciaries under the plan to aid it in the discharge of its duties hereunder.

9.03 Local Government Agency Termination.

An employer may terminate participation in the plan by providing written notification to the committee or its representative. Notification should be given sixty (60) days prior to the termination

date. Any agency that ceases participation with the plan is prohibited from rejoining the plan for two (2) years. If an agency ceases to participate in the plan, currently enrolled employees and dependents as well as COBRA participants and retirees associated with that agency once again become the responsibility of that agency.

ARTICLE X
PRIVACY OF PROTECTED HEALTH INFORMATION

10.01 Local Government Insurance Committee Certification of Compliance.

Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Government Insurance Committee (sponsor) unless the Local Government Insurance Committee certifies that the *Plan Document* has been amended to incorporate this article and agrees to abide by this article.

10.02 Purpose of Disclosure to Local Government Insurance Committee.

(A) The plan and any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Government Insurance Committee only to permit the Local Government Insurance Committee to carry out plan administration functions for the plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and it implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Local Government Insurance Committee of plan participants' protected health information will be subject to and consistent with the provisions of Sections 10.03 and 10.04 of this article.

(B) Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Government Insurance Committee unless the disclosures are explained in the privacy practices notice distributed to the plan participants.

(C) Neither the plan nor any health insurance issuer or business associate servicing the plan will disclose plan participants' protected health information to the Local Government Insurance Committee for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Local Government Insurance Committee.

10.03 Restrictions on Local Government Insurance Committee Use and Disclosure of Protected Health Information.

(A) The Local Government Insurance Committee will neither use nor further disclose plan participants' protected health information, except as permitted or required by the *Plan Document*, as amended, or as required by law.

(B) The Local Government Insurance Committee will ensure that any agent, including any subcontractor, to which it provides plan participants' protected health information, agrees to the restrictions and conditions of the *Plan Document*, including this article, with respect to plan participants' protected health information.

(C) The Local Government Insurance Committee will not use or disclose plan participants' protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Local Government Insurance Committee.

(D) The Local Government Insurance Committee will report to the plan any use or disclosure of plan participants' protected health information that is inconsistent with the uses and disclosures allowed under this article promptly upon learning of such inconsistent use or disclosure.

(E) The Local Government Insurance Committee will make protected health information available to the plan or to the plan participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

(F) The Local Government Insurance Committee will make plan participants' protected health information available for amendment, and will on notice amend plan participants' protected health information, in accordance with 45 Code of Federal Regulations § 164.526.

(G) The Local Government Insurance Committee will track disclosures it may make of plan participants' protected health information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

(H) The Local Government Insurance Committee will make its internal practices, books, and records relating to its use and disclosure of plan participants' protected health information available to the plan and to the U.S. Department of Health and Human Services to determine the plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

(I) The Local Government Insurance Committee will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all plan participant protected health information, in whatever form or medium, received from the plan or any health insurance issuer or business associate servicing the plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow

identification of any participant who is the subject of the protected health information, when the plan participants' protected health information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all plan participant protected health information, the Local Government Insurance Committee will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any plan participant protected health information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

10.04 Adequate Separation Between the Local Government Insurance Committee and the Plan.

(A) The following employees or classes of employees or other workforce members under the control of the Local Government Insurance Committee may be given access to plan participants' protected health information received from the plan or a health insurance issuer or business associate servicing the plan:

(1) Employees within the State of Tennessee Department of Finance and Administration, Division of Insurance Administration who have the responsibility for administering the plan.

(2) Other employees or subcontractors designated by the Local Government Insurance Committee.

This list includes the class of employees or other workforce members under the control of the Local Government Insurance Committee who may receive plan participants' protected health information relating to payment under, health care operations of, or other matters pertaining to the plan in the ordinary course of business.

(B) The classes of employees or other workforce members identified in Section 10.04(A) of this article will have access to plan participants' protected health information provided to the Local Government Insurance Committee by the plan only to perform the plan administration functions that the Local Government Insurance Committee provides for the plan.

(C) The classes of employees or other workforce members identified in Section 10.04(A) of this article will be subject to the appropriate personnel policies of the State of Tennessee regarding disciplinary action for any use or disclosure of plan participants' protected health information provided to those employees by the Local Government Insurance Committee in its capacity as plan sponsor in breach or violation of or noncompliance with the provisions of this article. The Local Government Insurance Committee will

promptly report such breach, violation or noncompliance to the plan, as required by Section 10.03(D) of this article, and will cooperate with the plan to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.

PREFERRED PROVIDER ORGANIZATION

(PPO)

ARTICLE XI
MEDICAL BENEFITS
(PPO)

Each reference to an attachment in this article shall mean one of the applicable PPO attachments. Each reference to a specific section shall mean the applicable section within this PPO article unless otherwise specified.

11.01 Amount of Benefits.

The amount of medical benefits provided by the plan is outlined in Attachment A, "Schedule of Benefits," which is attached to and made a part of the plan. Upon receipt of proof of loss, the plan shall pay (unless otherwise specified herein) a percent, pursuant to Section 11.03, of covered expenses incurred within each plan year and which are in excess of the deductible requirement, as described in Section 11.02. The amount of the medical benefits is further subject to the stop loss provisions of Section 11.05.

11.02 Deductible Amount.

The deductible amount is specified in Attachment A, and is required to be paid by each covered person prior to payment of any covered medical expenses (excluding prescription drugs) under the plan. For individuals who transfer between plans, the deductible met under the local education or state plan shall be considered when determining the maximum plan year deductible. For individuals who continue insurance coverage through retirement or the provisions of COBRA, the deductible met while an employee shall be considered when determining the maximum plan year deductible.

(A) Individual Deductible. In the event that the covered person has incurred covered expenses equal to the deductible dollar amount shown in the Attachment A in a plan year, such covered person shall have satisfied the deductible requirement of the plan for such plan year and shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 11.03. There is a separate deductible for mental health and substance abuse benefits shown in Attachment B.

(B) Family Deductible. In the event that covered persons of the same family independently incur covered expenses in a plan year so that the total of which would satisfy the family deductible outlined in Attachment A, then the deductible requirement of the plan shall have been satisfied for such plan year and each and every covered person of such family shall be

entitled to receive reimbursement for additional covered expenses pursuant to Section 11.03.

(C) Common Accident Deductible. If two (2) or more individuals who are members of one (1) family incur covered expenses as a result of injuries sustained in the same accident while coverage for medical care expense benefits pursuant to the plan is in force with respect to each of them, the applicable deductible shall be applied only once to the total of their covered expenses incurred during the plan year in which such accident occurred.

(D) Deductible Credit for Pregnancy. If a pregnant covered person registers in the voluntary babies first program pursuant to Section 13.03(B)(3) before the end of her first trimester, a $50 credit toward her deductible for the applicable plan year will be given. If the deductible has been satisfied for the plan year, the participant will be issued a check in the amount of $50.

11.03 Coinsurance.

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

(A) PPO Expenses - Hospital and Physician. In the event of covered expenses for those services received from and payable to a health care provider affiliated with the PPO, the applicable coinsurance percentage shall be the percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met.

(B) Non-PPO Expenses - Hospital and Physician. In the event of covered expenses which are not described in subparagraph (A), the applicable coinsurance percentage shall be the percentage as indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met.

(C) Unique Care. Highly specialized treatment, which is determined not to be available through a PPO provider (as determined by the claims administrator), and as such may be provided by a non-PPO provider, is paid as if a PPO expense. The covered person is responsible for expenses determined not to be medically necessary and expenses that exceed the maximum allowable charge. These exceptions must be pre-approved by the claims administrator. A continuous care exception may be granted when a covered person is undergoing an active

treatment plan for a serious medical condition, including pregnancy. The claims administrator determines the time frame in which continuous care can be covered.

(D) Non-Compliance with Utilization Management Program. In the event that the guidelines of the utilization management program, as outlined in Section 11.07, have not been followed, as applicable, the applicable coinsurance percentage is the percentage as indicated in Attachment A, after the deductible has been met. Expenses incurred at non-PPO providers that are determined not to be medically necessary as determined by the claims administrator will not be reimbursed by the plan, but will be the responsibility of the covered person.

(E) Non-Hospital and Non-Physician Expenses. In the event of covered expenses for non-hospital and non-physician services, the applicable coinsurance percentage is the percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met. Expenses incurred in conjunction with this subsection E include, but are not limited to the following: physical therapy, occupational therapy, speech therapy, ambulance, dialysis clinics, sitters, private duty nursing, and dentists.

(F) Hospital-Based Providers. In the event of covered expenses incurred with hospital-based providers, reimbursement will be made at the PPO level of benefits. The covered person will not be responsible for any expenses which exceed the maximum allowable charge for any providers of service that are hospital based providers. Hospital-based providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists, and pathologists.

(G) Emergency Out-of-State. In the event of covered expenses for emergency care as outlined in Section 1.15 (threat to life or limb) outside Tennessee, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, benefits will be paid at the non-PPO level.

(H) Emergency Inside Tennessee. In the event of covered expenses for emergency care as outlined in Section 1.15 (threat to life or limb) in a non-PPO hospital in Tennessee, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, benefits will be paid at the non-PPO level.

The claims administrator will determine if an emergency situation exists and, if so, when the medical condition became an emergency situation. Benefits will be reduced to non-PPO levels if the patient is not transferred to a PPO facility once the medical condition allows.

(I) Out-of-State Retirees, Employees, Spouses, Dependent Children and COBRA Participants. Retirees and their dependents, COBRA participants, and spouses and dependent children who permanently reside out of state should utilize the out of area program as established by the claims administrator. This program allows covered persons of the plan to utilize participating network physicians, facilities and agencies that participate in the network established by the claims administrator within each state. Plan participants who choose a network participating provider will receive benefits as outlined in Attachment A. Employees and their dependents who are stationed outside of Tennessee on a job assignment and continue to be paid as an employee should also utilize the out of area program to obtain maximum benefits under this plan. Employees and dependents who reside out of state and work in Tennessee will receive benefits as indicated in Attachment A for PPO and non-PPO expenses.

(J) Out-of-Country Benefits. In the event that expenses are incurred for medically necessary services rendered while a covered person is out of the country, benefits shall be paid as indicated in Attachment A. Should charges be incurred in a non-English speaking country, claims should be translated to standard English at the covered person's expense before being submitted to the claims administrator. The current exchange rate should also be provided.

(K) Pharmacy Program. In the event that expenses are incurred for prescription drugs, the applicable copayment shall be paid by the employee or dependent as indicated in Attachment A.

(L) Geographic Areas Where the Committee Has Determined the PPO Network to Be Insufficient. The committee retains the right to determine if the covered persons in a specific geographic area do not have adequate access to PPO providers (either in total or specific specialties). If this determination is made at any time, the committee will direct the claims administrator to provide benefits in these areas, at a reimbursement level as determined by the committee even when non-PPO providers are utilized.

11.04 Emergency Room Visit Copayment.

The covered person is responsible for payment of a copayment equal to the dollar amount shown in Attachment A for each visit to a hospital emergency room. This amount is waived if the visit results

in an admission (of more than twenty-three [23] hours) to the hospital with a bed assignment, a walk-in clinic is used, or the visit to the emergency room is subsequent to an initial visit to an emergency room for the same episode of an injury or illness within forty-eight (48) hours. The deductible amount shown in Attachment A applies whether the covered person is admitted to the hospital or not. The copayment applies to the stop loss provision, but not to the deductible.

11.05 Stop Loss Provision.

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

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

(C) Limitation on Stop-Loss Coverage. Notwithstanding the foregoing, for purposes of subsections (A) and (B) of this section, covered expenses shall not include expenses (inpatient or outpatient) for treatment of mental health disorders and/or substance abuse, after the applicable deductible has been met, prescription drug copayments, or expenses incurred for any services not in compliance with the guidelines of the utilization management program.

11.06 Maximum Benefits.

There is no dollar amount lifetime maximum benefit applied to the Preferred Provider Organization plan.

11.07 Utilization Management Program(s).

The utilization management programs shall include requirements governing pre-admission certification, post-certification of emergency admissions, weekend admissions, optional second

surgical opinions, mandatory outpatient procedures, home health, case management, private duty nursing, durable medical equipment and pharmacy program. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. In order to assure the necessity, appropriateness and quality of the hospital care a covered person receives, the committee shall retain a utilization review organization to review all general hospital admissions to certify medical necessity and length of stay.

Non-emergency hospital admissions are to be reviewed prior to being admitted to the hospital in accordance with the procedures found in this document.

Emergency admissions must be reviewed within twenty-four (24) hours or one (1) working day after admission. However, even if an emergency admission procedure is not followed, the hospital pre-admission certification procedure shall be deemed to have been followed if the utilization review organization later determines that the hospital admission was medically necessary as determined by the claims administrator.

In order to satisfy the guidelines of the utilization management program, the utilization review organization shall require elective admissions to begin on a weekday unless there is sufficient justification that the admission be made on a weekend.

Tests and other procedures that can be safely and effectively performed on an outpatient basis will be required to be administered in an outpatient setting to satisfy the guidelines of the utilization management program.

If the review decision differs from those of the covered person's attending physician and the differences are not resolved through the appeals process described in Section 6.05, the covered person and his/her attending physician shall be notified that the plan shall not provide benefits for the length of stay which exceeds the limits set forth by the utilization review organization. These charges will normally be the responsibility of the covered person; however, if part of the contracted PPO network, such providers have, by separate contract with the claims administrator, agreed not to bill the covered person if the claims administrator determines that service(s) were not medically necessary, or if the PPO provider has not followed applicable utilization management guidelines, such as obtaining pre-admission certification. PPO providers have agreed to accept the maximum allowable amount as payment in full for such services and hold the covered person harmless (from

any balance of charges), except with respect to deductibles, coinsurance and non-covered expenses of the covered person's coverage.

The ultimate choice of a provider is solely up to each covered person.

The claims administrator does not furnish covered services directly but rather pays benefits according to the plan. The claims administrator, the committee, the employer and the plan shall not be responsible for any claims, injuries or damages whatsoever caused by or which arise from the acts or failure to act of any provider. None of the entities listed above shall be liable for a provider's refusal or failure to render services on behalf of a covered person.

Whether a provider is a PPO or non-PPO provider shall not be taken as a recommendation or endorsement with respect to a particular provider's qualifications, skills, or competence.

(B) Optional Second Surgical Opinion. The covered person may receive a second surgical opinion from a qualified surgeon, if the suggested procedure is listed in Attachment C. The second opinion must be obtained from a surgeon qualified to perform the surgical procedure but who is not in the same medical group as the physician who originally recommended surgery. The charges for the second opinion and any tests performed in obtaining the second opinion shall be paid in full by the plan regardless of whether or not the covered person's deductible has been met.

(C) Mandatory Outpatient Procedures. In order to satisfy the guidelines of the utilization management program, the plan shall require certain procedures be performed on an outpatient basis. The pre-admission certification process will determine which procedures should be performed in the outpatient setting. These procedures should be performed in the outpatient department of a hospital or in an ambulatory surgical center unless deemed to be medically necessary as determined by the claims administrator, and as approved by the utilization review organization, to be performed on an inpatient basis.

(D) Home Health. Covered persons may receive home health benefits if prior approval is received from the claims administrator. These benefits should be obtained based upon a referral from the covered person's physician and should be obtained from a provider participating in the network of home health agencies established by the claims administrator.

(E) Case Management. Notwithstanding any contract provision, rider or endorsement to the contrary, the utilization review organization will consider alternative treatment plans proposed by the covered person or provider, committee or employer on behalf of a covered person and may elect to offer alternative benefits for services not otherwise specified as covered expenses hereunder.

The claims administrator and/or utilization review organization will identify potential cases, evaluate proposed alternative treatment plans, and will otherwise coordinate the delivery of alternative benefits when the committee, or its representative, upon consultation with the utilization review organization, determines that alternative treatment is medically necessary and cost effective. Such benefits will be offered only in accordance with a plan of alternative treatment with which the covered person (or the covered person's legal guardian) and the attending physician concur. Alternative benefits will be made available on a case-by-case basis to individuals. Under no circumstances does a covered person acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer of, or confirmation of, alternative benefits in one instance shall not obligate the plan to provide the same or similar benefits for any other covered person in another instance. In addition, nothing herein shall be deemed a waiver of the right of the plan to enforce this plan in strict accordance with its express terms and conditions. No benefits of any type will be payable, however, beyond the date the contract or covered person's coverage terminates.

If medically appropriate, the claims administrator and/or utilization review organization may exceed the established plan limitations on outpatient therapy for covered persons under the plan, who, because of their injury or illness, require additional speech, occupational and/or physical therapy beyond the plan limitations. Covered persons of the plan requiring outpatient therapy beyond plan limitations must be under active case management.

(F) Private Duty Nursing. The claims administrator, based upon available medical information, may determine that a covered person needs the services of private duty nursing. The claims administrator will review medical charts documenting services provided by the nursing staff and will determine the duration for which reimbursement will be provided for this service.

(G) Durable Medical Equipment. In the event that it is determined that a covered person requires the use of durable medical equipment, such equipment should be obtained through a provider in the network established by the claims administrator. The covered person should have a written prescription from a PPO provider for such durable medical equipment. The level of reimbursement is in Attachment A.

(H) Pharmacy Program. In order to receive maximum benefits of the pharmacy program available, covered persons should utilize the prescription home delivery program. Covered persons may also utilize a pharmacy in the network established by the claims administrator. If the prescription is filled through the home delivery program or at a participating retail

pharmacy, a copayment is required as outlined in Attachment A. A covered person should present their insurance identification card at the time of purchase, along with the applicable copayment as outlined in Attachment A. When a participating pharmacy is utilized, the charges for the prescription will be electronically filed with the claims administrator. If a participating or non-participating pharmacy is utilized and the claim is filed by the covered person, amounts exceeding the maximum allowable charge are the responsibility of the covered person. Prescriptions are generally limited to a thirty-four (34) day supply at the retail pharmacy level with some having additional limitations and pre-authorization requirements. Certain medications can be purchased through the home delivery program for up to a one hundred and two (102) day supply with one copayment from the covered person. Refer to Attachment A for pharmacy program stop-loss benefit limitations.

(I) Procedures. The utilization review organization shall establish procedures for administering the utilization management program and the committee shall communicate such procedures to all covered employees and qualified beneficiaries. If benefits are reduced due to non-compliance with the procedures established for administering the utilization management program, and the covered person wishes to dispute such reduction, such covered person may request that his/her claim be reconsidered pursuant to Section 6.05.

The reconsideration shall ensure that covered persons who, in good faith, attempt to comply with the utilization management program procedures are provided benefits at the same level as if those procedures had been followed.

A covered person has the responsibility to notify his/her physician and hospital that he is a covered person under the PPO and of the plan's certification requirements for hospital admissions. This notification by the covered person can be by presentation of the plan identification card by the covered person or if the covered person verbally informs the provider.

If the covered person notifies the PPO provider that he/she is a covered person under the PPO before the admission, it will be the provider's responsibility to contact the utilization review organization for certification. If certification is not obtained, the plan and the covered person shall be held harmless from the reduction resulting from not satisfying the utilization management program by the provider.

On an elective admission, if a covered person does not notify the PPO provider that he/she is a covered person under the PPO, or does not give the PPO provider correct information or the covered person will not admit to being covered by the plan when asked by the PPO

provider, the plan will be held harmless if certification is not obtained. The covered person will be responsible for the full payment.

On an emergency admission, if a covered person does not inform the hospital of his/her participation in the PPO or of the utilization management program guidelines, the provision under subsection 11.07(A) shall apply and determine what benefits will be provided by the plan when certification is not obtained. If it is determined by the claims administrator that the admission was not an emergency, the plan shall be held harmless. The covered person will be responsible for the full payment.

During a stay at a PPO facility, if the hospital utilizes the services of a non-PPO hospital-based provider for the care of the covered person, the plan will provide benefits at the PPO level (see Attachment A). The covered person is only responsible for the PPO level of coinsurance (see Attachment A) and any charges above the maximum allowable charge, and the plan is held harmless.

A provider may obtain certification by writing to the utilization review organization (no more than thirty [30] days in advance) or by calling the appropriate utilization review organization on the pre-certification toll-free line during normal business hours. If the provider contacts the utilization review organization when the office is closed, the caller will get a recorded message asking the caller to call again during office hours. It is the responsibility of the provider to call back to obtain certification or extension of days, unless the admission is an emergency.

When the call is received during office hours, the utilization review organization will approve or deny the certification at that time, unless additional information is needed before the certification is determined. Once all of the information is received by the utilization review organization, certification will be denied or approved within one (1) working day.

When the certification is approved or denied, the utilization review organization will send a letter to the covered person (or his/her guardian), physician and hospital advising them of the approval or denial of the certification. This letter will be sent no later than one (1) working day after the certification is denied or approved.

When determining certification for elective or emergency admissions, medical personnel under the direction of a physician will review the timing and setting of the medical care. The utilization review organization will not question the medical necessity of the care. The utilization review organization will not verify eligibility under the plan or if the benefits are eligible expenses under the plan.

When certification is approved, the utilization review organization will notify the provider of the number of days that are being certified for the inpatient stay. If the hospitalization is in a PPO facility, it will be the facility's responsibility to contact the appropriate utilization review organization if the physician wants to request additional days. If the benefits for additional inpatient days are denied, the utilization review organization will notify the patient, the physician and hospital on what date inpatient benefits will cease.

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

When determining if additional inpatient days should be certified, the utilization review organization will review the health care services delivered during the confinement to make sure they meet community standards of quality and are consistent with the patient's needs. If the utilization review organization determines that, after reviewing the hospital records, the health care is not medically necessary, benefits for the additional inpatient days will be denied.

If a covered person is transferred from one facility to another, certification at the second facility must be obtained under the certification guidelines in subsection 11.07(A).

ARTICLE XII
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS
(PPO)

Each reference to an attachment in this article shall mean one of the applicable PPO attachments. Each reference to a specific section shall mean the applicable section within this PPO article unless otherwise specified.

For the purpose of interpreting these provisions, the following definitions will apply:
"Eligible Providers" shall mean those providers considered eligible to provide mental health/substance abuse services or employee assistance services. For mental health/substance abuse services, eligible professional providers include psychiatrists, psychologists, licensed professional counselors, registered nurse clinical specialists and licensed clinical social workers, as defined herein. For employee assistance program (EAP) services, eligible providers are those considered eligible by the claims administrator for those services.

"Provider-Referral" shall mean a referral made by the claims administrator for a covered person for treatment of mental health/substance abuse, which is determined to be medically necessary and/or clinically necessary. Such referral is made based upon a request by the covered person and made to a provider chosen by the claims administrator.

"Self-Referral" shall mean a referral requested by a covered person for treatment of mental health/substance abuse, which is determined to be medically necessary and/or clinically necessary. Such referral is based upon the covered person seeking treatment from an eligible provider that has not been recommended by the claims administrator.

12.01 Amount of Benefits.

The amount of benefits provided by the plan is outlined in Attachment B, "Schedule of Mental Health/Substance Abuse Benefits," which is attached to and made a part of the plan. Upon receipt of proof of loss, the plan shall pay (unless otherwise specified herein) a percent, pursuant to Section 12.03, of covered expenses incurred within each plan year and which are in excess of the deductible requirement, as described in Section 12.02.

12.02 Deductible Amount.

For purposes of determining the amount of benefits under Section 12.01, a covered person must first satisfy the deductible requirement outlined in Attachment B. This deductible is separate and distinct from the medical deductible under Section 11.02.

12.03 Coinsurance.

The plan will pay a percentage of covered expenses incurred within each plan year, and which are in excess of the deductible requirement of Section 12.02. Out-of-pocket and coinsurance costs incurred for mental health and substance abuse benefits are not applicable to the out-of-pocket medical plan limits. Mental health and substance abuse benefits are not payable at the one hundred (100) percent level.

(A) Inpatient Benefits. The plan will pay the following benefits for mental health and substance abuse treatment received in an inpatient setting.

(1) Referred. In the event of covered expenses for those inpatient services received from and payable to a provider affiliated with **and** specifically referred by the mental health and substance abuse utilization review organization the coinsurance percentage is indicated in Attachment B, provided the deductible has been met.

(2) Non-Referred - Authorized. In the event of covered expenses for those inpatient services received from and payable to a provider authorized by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, the coinsurance percentage is indicated in Attachment B, provided the deductible has been met.

(3) Non-Referred - Non-Authorized. In the event of covered expenses for those inpatient services received without authorization by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, the coinsurance percentage is indicated in Attachment B, provided the deductible has been met.

(4) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those inpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

(B) Outpatient. The plan will pay the following benefits for mental health and substance abuse treatment received in an outpatient setting:

(1) Referred. In the event of covered expenses for those outpatient services received from and payable to a provider referred by the mental health and substance abuse utilization review organization, benefits are payable once the deductible has been met.

(2) Non-Referred - Authorized. In the event of covered expenses for those outpatient services received from and payable to a provider authorized by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, benefits are payable once the deductible has been met.

(3) Non-Referred - Non-Authorized. In the event of covered expenses for those outpatient services received without authorization by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, benefits are payable once the deductible has been met.

(4) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those outpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

12.04 Benefits for Detoxification.

In the event of covered expenses for a detoxification program, benefits will be paid at the level indicated in Attachment B. The limitations on the number of days and length of stay allowed will be as outlined in Attachment B.

12.05 Stop Loss.

For the purposes of mental health and substance abuse benefits, the plan does not contain a stop loss provision. There is no maximum amount of out-of-pocket expenses that a covered person may incur for treatment of mental health and substance abuse.

12.06 Maximum Benefits.

(A) Lifetime Maximum. There are no lifetime dollar maximums under the plan for mental health/substance abuse.

(B) Annual Maximum. Inpatient care for mental health treatment is limited to forty-five (45) days per year. Outpatient care for mental health treatment is limited to forty-five (45) visits per year.

12.07 Utilization Management.

The utilization management programs described in this Section 12.07 shall include requirements governing pre-admission certification, outpatient referrals, case management and EAP benefits. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. A utilization management function that occurs at or prior to admission to determine whether or not the admission is both medically necessary and appropriate for the individual patient. The result is a recommendation for treatment.

(B) Outpatient Referrals. The process in which a patient is introduced to a health provider for treatment.

(C) Case Management. A process that evaluates the medical necessity and appropriateness of treatment.

(D) EAP Benefits. Employee assistance program (EAP) services are available at no cost to all full-time employees and covered dependents, retirees and COBRA participants enrolled in a state-sponsored health plan. Services consist of short-term counseling (up to six [6] sessions per episode) for problems such as marital or family, emotional, substance abuse, stress, job and financial loss. Legal consultation via telephone is also available. If an employee or dependent is determined to need greater assistance, they will be referred to other resources. All EAP services must be pre-authorized.

(E) Procedures. In order to receive maximum benefits, all inpatient and outpatient mental health, substance abuse and EAP services must be pre-authorized by the utilization review organization.

ARTICLE XIII
COVERED EXPENSES
(PPO)

Each reference to an attachment in this article shall mean one of the applicable PPO attachments. Each reference to a specific section shall mean the applicable section within this PPO article unless otherwise specified.

13.01 Conditions.

All medical services, medical treatment and medical expenses will be considered covered expenses pursuant to this plan if:

(A) They are listed in Sections 13.02 or 13.03;

(B) They are not excluded under the exclusions from coverage under Section 13.04;

(C) They are determined to be medically necessary and/or clinically necessary by the claims administrator;

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

(E) Are consistent with plan policies and guidelines.

The committee, or its representative, shall make determinations regarding whether expenses will be considered covered expenses pursuant to (A) and (B) above. Medical specialists shall be consulted to determine whether a medical service, treatment or expense is medically necessary and/or clinically necessary. All medical claims from a hospital, physician or other provider shall be examined to determine whether the services, treatment and expenses were medically necessary and/or clinically necessary. If the medical specialist determines the treatment was not medically necessary and/or clinically necessary, the physician of the covered person for whom the claim is submitted can choose to provide additional information. If after examining the additional information it is determined that the service, treatment or expense was not medically necessary and/or clinically necessary, the claim shall not be considered as a covered expense by the plan, and the covered person may be responsible for payment of all of the bills associated with that claim, subject to the appeal process as described in Section 6.05.

13.02 Covered Expenses - Generally.

The charges for the following services and supplies are eligible covered expenses under the PPO plan:

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

(B) Services and supplies furnished to the eligible covered persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an injury or illness, including consultations with a physician requested by the covered person's physician.

(C) Charges for "surgical procedures." Surgical procedures shall mean the generally accepted operative and cutting procedures rendered by a physician for the necessary diagnosis and treatment of an injury or illness, including treatment of fractures or dislocations, maternity care, any diagnosis of burns and abrasions and any endoscopic procedure (i.e. sigmoidoscopy, cystoscopy, etc.). During one operation, a physician may perform two (2) or more surgical procedures through the same incision. In this situation, payment is equal to the full benefit amount for the most expensive procedure plus one-half of the benefit amount for the other procedure.

(D) Office visits to a physician that are due to an injury or illness.

(E) Private-duty or special nursing charges (including intensive nursing care) for medically necessary and/or clinically necessary treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative, if prescribed by the attending physician.

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

(G) Charges for diagnostic laboratory and x-ray services including, but not limited to: laboratory examinations, metabolism tests, cardiographic examinations and encephalographic examinations.

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

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

(J) Charges for speech therapy by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. There is no limitation on speech therapy benefits for covered persons under the PPO plan, providing said therapy is deemed to be medically necessary.

(K) Charges for treatment received by a licensed doctor of podiatric medicine provided treatment was within the scope of his/her license.

(L) Charges for chemotherapy and radiation therapy when medically necessary as determined by the claims administrator.

(M) Charges for hemodialysis.

(N) Charges for the taking or the reading of an x-ray, CAT scan, MRI (upon approval of the claims administrator) or laboratory procedure, including physician charges and hospital charges. Positron emission tomography (PET) is a covered expense when determined to be medically necessary by the claims administrator. PET scan technology is currently considered experimental and investigative in many applications. Covered persons or their provider should verify medical necessity and benefit eligibility prior to incurring charges for use of this technology.

(O) Charges for laser procedures, other than those specifically excluded in Section 13.04.

(P) Charges for lithotripter treatment.

(Q) Charges for transfusion services for autologous blood and blood components.

(R) Lab charges and associated office visits for pap smears (annually).

(S) Cryosurgical ablation of the prostate is covered only when approved by the claims administrator.

(T) Charges for esophageal PH monitoring for the diagnosis of gastroesophageal reflux when the patient meets specific criteria as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator for these services.

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

(1) Knee replacement surgery; and

(2) Anterior cruciate ligament repair.

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

(V) Percutaneous lumbar discectomy (PLD) is a covered outpatient procedure only when the patient meets specific criteria, as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator.

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

(1) Single Pharmacy Limitation.

If the claims administrator or administrative services organization (ASO) has the reasonable belief that a covered person is receiving covered services in an excessive, dangerous, or medically inadvisable amount, and this belief is based upon the professional opinion of a medical doctor and a pharmacist, the claims administrator may impose a limitation on services providing that the covered person may only receive services from one specific pharmacy. The covered person must receive advance written notification of any such restriction stating the reasons for this restriction. The restriction must provide an exception for emergency services. The covered person has the right to request removal or modification of such restriction. The claims administrator will respond in writing to any written request for removal or modification. The covered person also has the right to appeal such restriction pursuant to Section 6.05.

(2) Drugs and medicines (unless excluded under Section 13.04) requiring written prescription of a physician, approved for use by the Food and Drug Administration

and dispensed by a licensed pharmacist or physician. This includes over-the-counter drugs that require pharmacist preparation prior to patient use. Investigational new drugs (FDA designation), if published peer review literature indicates beneficial and effective patient care;

(3) "Off-label" (FDA approved but not for treatment of the condition for which it is prescribed) prescription drugs;

(4) Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:

(a) Prescription must be written by a licensed physician;

(b) Prescriptions are for a ninety (90) day period only; and

(c) Benefit is allowable once per year, with a maximum lifetime benefit of two (2) ninety (90) day periods.

(5) Surgical supplies including bandages and dressings;

(6) Insulin, the related syringes (including needle-free syringes when medically necessary as determined by the claims administrator based on the patient's age, weight, skin and medical condition and/or the frequency of injections), home blood glucose monitors and related supplies for the treatment of diabetes as approved by a physician;

(7) Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to $250 per calendar year. Coverage for additional training and education is available when a significant change occurs in the patient's symptoms or condition which necessitates a change in the patient's self-management or when a physician determines that re-education or refresher training is needed and determined to be medically necessary;

(8) Blood plasma or whole blood;

(9A) Artificial eyes - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness;

(9B) Artificial limbs - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness, with the following exceptions:

(a) One (1) additional limb prosthesis past age eighteen (18) if additional surgery has altered the size or shape of the stump; or

(b) Replacement of the original limb prosthesis if a severe medical condition to the stump could result from improper fitting of the initial prosthesis as determined by a physician. Replacement must be within twelve (12) months of the initial purchase of the limb prosthesis and proof of medical severity must be furnished to the claims administrator. The claims administrator must furnish written approval to the covered person prior to the replacement purchase.

(9C) Replacement prosthesis - As determined by the claims administrator, benefits are available for the purchase, fitting, necessary adjustment, repairs and replacement of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding artificial heart and dental appliances). Replacement costs will be covered only if the prosthetic appliance was used by the employee or dependent of the employee in the manner and for the purpose for which such appliance was intended and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. Benefits are not available for prosthetic appliances to replace those, which are lost, damaged, stolen or prescribed as a result of improvements in technology.

(10) Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, surgical collars, lumbosacral supports, corsets-back and special surgical, trusses, and rigid back or leg braces. Orthopedic shoes for the correction of a deformity or abnormality of the musculoskeletal system are only considered for coverage when attached to a brace;

(11) Foot orthotics, devices or rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions, including shoes for diabetic conditions, when prescribed by a physician and are medically necessary as determined by the claims administrator. Examples of items **not** considered to be a foot orthotic are:

(a) Inner soles (foam rubber, leather, flexible, etc.);

(b) Corn plasters (pads, etc.); and

(c) Foot padding (adhesive moleskin, etc.);

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

(13) X-ray, radium and other radioactive substances;

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

(15) Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus;

(16) If elected by the covered person following a mastectomy, coverage shall include:

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

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

(c) Prostheses, pursuant to Section 13.02(W)(9C), and physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year;

(17) The purchase or rental (not to exceed the total maximum allowable charge for purchase) of durable medical equipment as outlined in the applicable section and attachment;

(18) Immunizations, including hepatitis B immunizations, unless the employer is mandated to pay for the immunization;

(19) Transrectal prostatic ultrasound, when a physical examination of the prostate indicates the presence of nodules;

(20) Family planning and infertility services including history, physical examination, laboratory tests, advice and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing and treatment for organic impotence. If fertility services are initiated (including, but not limited to artificial insemination or in-vitro fertilization) benefits will cease;

(21) Bone density scans when medically necessary.

(X) Charges for treatment by a licensed doctor of chiropractic provided treatment was within the scope of his/her license under the PPO plan.

(Y) Ketogenic diet counseling (must be enrolled in case management).

13.03 Other Covered Expenses.

(A) Convalescent Care. Upon receipt of proof that a covered person has incurred medically necessary expenses related to convalescent care, the plan shall pay for charges for convalescent facility room, board and general nursing care, provided:

(1) A physician recommends confinement for convalescence;

(2) The covered person is under the continuous care of a physician during the entire period of confinement;

(3) The confinement is required for other than custodial care; and

(4) Services were pre-authorized by the claims administrator.

Eligible charges for convalescent facility room, board and general nursing care shall only include:

(1) Charges not to exceed the charge for its greatest number of semi-private rooms; and

(2) Charges up to and including the one-hundredth (100th) day of confinement during any plan year.

(B) Maternity Benefits. The plan provides coverage for pregnancy, childbirth or related medical conditions on the same basis as any other illness, unless the covered person is acting as a surrogate mother (carrying a fetus to term for another woman) in which case no benefits will be payable. Hospital admissions for maternity coverage and childbirth will be available for a minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a caesarean delivery. No additional approval or authorization is needed for lengths of stay that fall within these timeframes. A covered person is not required to stay in the hospital for a fixed period of time following the birth of her child. New benefits will apply if transferring to another health plan prior to delivery.

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

(2) Newborn Care. Coverage for a newborn child shall be provided to covered employees who have elected family coverage or coverage pursuant to Section 2.05(A). The pre-existing condition requirements of the PPO plan shall not apply to newborn children who are covered under the PPO plan at birth, or legally adopted children or children placed for adoption.

Covered expenses of a newborn child shall include:

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

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

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

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

(3) Babies First Program. This is a voluntary prenatal education program for PPO plan pregnant employees and eligible dependents. Once registered, covered persons will receive information on how to care for themselves during pregnancy to increase the chances of delivering a healthy baby. Pregnant patients must register with babies first by calling the Division of Insurance Administration before the end of their first trimester. Under the PPO plan, once registered, the patient will receive a $50 credit toward their deductible for the applicable plan year, or if their deductible has already been satisfied, they will receive a check in the amount of $50.

(C) Mammogram Screening. The plan provides coverage for mammogram screenings within the following guidelines:

(1) Once as a baseline mammogram for ages 35-39;

(2) Once every year for ages 40 and over; or

(3) When prescribed by a physician.

(D) Cochlear Implantation. The plan provides coverage for cochlear implantation using FDA-approved cochlear implants provided **all** of the following criteria are met:

Adults (Age 18+).

(1) Diagnosis of post-lingual profound deafness;

(2) Patient has achieved little or no benefit from a hearing aid;

(3) Patient is free from middle ear infection, has an accessible cochlear lumen that is structurally suited to implantation and is free from lesions in the auditory nerve and acoustic areas of the central nervous system;

(4) Patient has the cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and

(5) Patient has no contraindications to surgery.

Children (Age 2-17).

(1) Diagnosis of bilateral profound sensorineural deafness; and

(2) Patient has achieved little or no benefit from a hearing or vibrotactile aid, as demonstrated by the inability to improve on an age-appropriate closed-set word identification task.

An electrophysiological assessment should be performed to corroborate behavioral evaluation in very young children who cannot be adequately evaluated by standard audiometry tests. This assessment may consist of an auditory brain stem evoked response or similar test which would be covered when medically necessary as determined by the claims administrator.

A minimum six (6) month trial with appropriate amplification (hearing aid or vibrotactile aid) and rehabilitation should be performed for children to ascertain the potential for aided benefit.

(E) Hospice Care Program. When approved by the claims administrator, the plan shall provide hospice care, as provided in the applicable section, designed to provide covered persons who are terminally ill (a person whose life expectancy is six [6] months or less) with dignified, comfortable and less costly care the few months or weeks prior to death. This program shall be administered through an approved hospice. Care provided shall include physical, psychological, social and spiritual for dying persons and their families, rendered by a medically supervised interdisciplinary team of professionals and volunteers on a twenty-four (24) hour on-call basis.

(F) Home Health Care. The plan shall provide benefits for the services of part-time or intermittent home nursing care, given or supervised by a registered nurse (R.N.), but only if the services are certified as medically necessary and pre-authorized by the claims administrator. Home health aide care is also a covered service with the following limitations:

(1) No more than thirty (30) visits per plan year;

(2) A visit shall be four (4) or fewer hours;

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

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

(5) The home health aide service is in conjunction with medically necessary skilled care.

Intravenous (I.V.) therapy administered in the home during these visits is a covered service, provided the medication is approved for use by the Federal Drug Administration. Case management services will be requested by the physician, patient or employer for home health cases requiring extensive care.

(G) Rehabilitation Therapy. The plan shall provide pre-authorized inpatient and/or outpatient physical therapy benefits for services for conditions resulting from illness or injury, or prescribed immediately following surgery related to the condition. Outpatient benefits under the plans are limited to a maximum of forty-five (45) visits, per condition, per plan year according to a prescription from a physician concerning the nature, frequency and duration of treatment. Therapy shall include functional, physical and occupational therapy to the extent such therapy is performed to regain use of the upper or lower extremities, or if the covered person is a child, as long as improvement in the covered person's condition continues (subject to the limitations contained in this Section 13.03). Occupational therapy shall not include vocational therapy or vocational rehabilitation, nor educational or recreational therapy on an outpatient basis.

Phase I and Phase II (as defined below) cardiac rehabilitation services will be a covered expense provided they meet the following criteria:

(1) Phase I includes inpatient rehabilitation services that begin during hospitalization and extended until discharge; and

(2) Phase II includes supervised ambulatory services that follow discharge and extend until the patient becomes sufficiently independent to perform prescribed exercise and carry out any recommended long-term lifestyle changes. Phase II services are limited to three (3) sessions per week for a maximum of twelve (12) weeks.

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

(H) Sitter. A sitter who is not a relative (i.e. spouse, parent, child, brother or sister by blood, marriage or adoption or member of the household) of the covered person may be used in those situations where the covered person is confined to a hospital as a bed patient and certification is made by a physician that an R.N. or L.P.N. is needed and neither (R.N. or L.P.N.) is available.

(I) Covered Dental Expenses.

(1) Charges for orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function of a covered person. Covered persons in the PPO plan must meet the pre-existing condition clause or qualify for a waiver of the pre-existing condition clause.

(2) Charges for extraction of impacted wisdom teeth, excision of solid based oral tumors, treatment of accidental injury (other than by eating or chewing) to sound natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary as determined by the claims administrator) providing the accident occurred while the individual was covered under a state-sponsored plan and has remained continuously covered.

(3) Charges for the facility and related medical services when hospitalization for dental services is determined medically necessary by the claims administrator.

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

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

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

(c) Mental illness or handicap precludes dental/surgical management in an office setting;

(d) When general anesthesia is used or;

(e) For children eight (8) years and younger benefits will be provided for anesthesia (inpatient or outpatient) and any expenses associated with a dental procedure that cannot be safely provided in the office. Benefits will be available for anesthesia regardless of whether or not the base procedure is covered by the insurance program.

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

(a) History, exams and office visits;

(b) X-rays of the joint;

(c) Diagnostic study casts;

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

(e) Medications; and

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

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

(a) Prosthodontic treatments (dentures, bridges);

(b) Restorative treatment (fillings, crowns);

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

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

(J) Organ Transplants. Organ transplant benefits will be paid for covered medical expenses related to transplants of the: heart, heart/lung, lung, liver, kidney, pancreas, pancreas/kidney, cornea, small bowel, small bowel/kidney and certain bone marrow transplants. Transplant services or supplies require pre-authorization before any pre-transplant evaluation or any covered service is performed. Coverage will include expenses incurred for donor search and organ procurement by the transplant center or hospital facility and all inpatient and outpatient hospital/medical expenses for the transplant procedure and related pre- and post-operative care, including immunosuppressive drug therapy. Should a transplant request fall outside those addressed and covered by the state *Plan Document*, the claims administrator will review the information provided and render a decision based on acceptable medical practices on behalf of the state insurance program. The claims administrator will notify the Division of Insurance Administration of its decision prior to approving such services. If the service(s) or procedure(s) does not meet the claims administrator's accepted medical standards, the covered person will be notified of their option to appeal the decision as described in Section 6.05. If a network facility is utilized for the transplant, travel and living expenses will be covered from the initial evaluation to one year after the transplant (for medically necessary visits only as determined by the claims administrator). Air transportation, if necessary, will be paid at commercial coach fare. Ground travel will be paid at the State of Tennessee approved mileage rate. Additionally, hotel and meal expenses will be paid up to $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.

If the donor is not a covered person and the recipient is covered under the plan, the donor will be considered eligible for coverage for expenses which are incurred during hospitalization for the transplant procedure and which are not covered by another group

health plan. Covered services include those services and supplies directly related to the transplant service itself such as removal of the organ from the donor's body, preservation of the organ and transportation of the organ to the site of transplant. The aggregate limit for organ procurement is $10,000 per covered procedure. No benefits are payable for donor services for recipients who are not covered under the plan. These services are ineligible even when the recipient does not provide reimbursement for the donor's expenses. Bone marrow transplantation will fall into one (1) of three (3) categories: syngeneic, allogeneic or autologous.

Expenses eligible for coverage include the charge to harvest bone marrow for covered persons diagnosed with any covered malignant condition or any conditions approved for coverage by the claims administrator. Coverage for harvesting, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow will be covered when re-infusion is scheduled within three (3) months or less. Autologous bone marrow transplantation is considered investigational in the treatment of other malignancies, including primary intrinsic tumors of the brain.

(K) Well-Baby, Well-Child Care. Physician office visits for routine check-ups and immunizations are covered expenses for children through age five (5) under the PPO plan, and a total of twelve (12) routine visits are covered.

(L) Prostate Screening. The plan will cover PSA (prostate specific antigen) and transrectal ultrasound for the following conditions:

(1) Annually in men who have been treated for prostate cancer with radiation therapy, surgery or chemotherapy;

(2) Annually in men over the age of forty-five (45) who have enlarged prostates as determined by rectal examination; and

(3) Annually in men of any age with prostate nodules or other irregularity noted on rectal exam.

The plan will cover PSA for the primary screening of men over the age of fifty (50) and will cover transrectal ultrasound in these individuals with an elevated PSA.

(M) Biofeedback Therapy. The plan shall provide benefits for biofeedback therapy, which is determined to be medically necessary with a maximum benefit of five (5) sessions per calendar year for each of the following conditions:

(1) Chronic pain;

(2) Incontinence;

(3) Migraine headaches; and

(4) Incapacitating stress.

(N) Bariatric Surgery (weight reduction). The plan will cover as outlined below, two (2) surgical procedures for treatment of morbid obesity:

(1) Vertical banded gastroplasty accompanied by gastric stapling

(2) Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum

The following criteria must be met before benefits are available for the two (2) surgical procedures listed above:

(1) Presence of morbid obesity that has persisted for at least five (5) years, defined as either:

(a) Body mass index (BMI) exceeding forty (40); or

(b) More than one hundred (100) pounds over one's ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or

(c) BMI greater than thirty-five (35) in conjunction with the following severe co-morbidities that are likely to reduce life expectancy:

1. Coronary artery disease; or

2. Type 2 diabetes mellitus; or

3. Obstructive sleep apnea; or

4. Three or more of the following cardiac risk factors:

a. Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)

b. Low high-density lipoprotein cholesterol (HDL less than 40mg/dL)

c. Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)

d. Current cigarette smoking

e. Impaired glucose tolerance (2-hour blood glucose>140 mg/dL on an oral glucose tolerance test)

f. Family history of early cardiovascular disease in first-degree relative (myocardial infarction at age under fifty [50] in male relative or at age under sixty-five [65] for female relative)

g. Age greater than forty-five (45) years in men and fifty-five (55) years in women

(2) History of failure of medical/dietary therapies (including low calorie diet, increased physical activity, and behavioral reinforcement). This attempt at conservative management must be within two (2) years prior to surgery, and must be documented by an attending physician who does not perform bariatric surgery. (Failure of conservative therapy is defined as an inability to lose more than ten [10] percent of body weight over a six [6] month period and maintain weight loss.)

The claims administrator will determine if all the criteria have been met before approving surgery.

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

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

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

(3) Routine screenings among the elderly is considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

(P) Hearing Impairment Screening and Testing. The plan will cover, as determined by the claims administrator, medically necessary hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The claims administrator has determined eligibility of many of the tests/screenings to be specific to infants. Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.

(Q) Nutritional Treatment of Inborn Errors of Metabolism. The plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup urine disease, homocystinuria, methylmalonic acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the claims administrator.

13.04 Exclusions and Limitations.

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

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

(2) Drugs and medicines which can be obtained without a written prescription (over-the-counter), except as covered pursuant to Section 13.02(W)(2);

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

(4) Services and supplies (notwithstanding organ donations) provided by an immediate family member of an eligible employee or covered dependent. Immediate family members include spouse, parent, child, brother or sister, by blood, marriage or adoption;

(5) Services rendered prior to the effective date of coverage;

(6) Services incurred after the covered person's coverage under this plan is terminated;

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

(8) Charges for the removal of corns or calluses, or trimming of toenails;

(9) Treatment of an injury or illness due to declared or undeclared war;

(10) Charges incurred outside the United States (including those for drugs and medicines subject to FDA approval and federal law) unless the charges are incurred while traveling on business or for pleasure by a covered person who is a resident of the United States and a medical emergency arises;

(11) Charges which the claims administrator determines to be in excess of the maximum allowable charge for that procedure or supply and for charges made which are not medically necessary as determined by the claims administrator;

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

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

(14) Expenses incurred for contact lenses, eyeglasses, sunglasses or for examinations for prescription or fitting of eyeglasses or contact lenses, except as may be allowed pursuant to Section 13.02;

(15) Expenses incurred for hearing aids or for examinations for prescription or fitting of hearing aids (except as previously defined in Section 13.02);

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

(a) The covered person experienced a traumatic injury or illness, while covered by a state-sponsored plan, which requires the cosmetic surgery;

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

(c) If elected by the covered person following a mastectomy:

(i) Reconstruction of the breast on which the mastectomy has been performed,

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) Prostheses, pursuant to Section 13.02(W)(9C) and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year;

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

(17) Arch supports and other foot support devices, except for orthotic devices as defined in Section 13.02(W)(11);

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

(19) Garter belts;

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

(21) Hotel charges or travel expense incurred while receiving treatment as an inpatient or outpatient, (other than defined in Section 13.03J or Attachment A);

(22) Unapproved sitters;

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

(24) Non-surgical services, including prescription medication for weight control or reduction (obesity). Surgical services are also excluded unless specifically listed in Section 13.03;

(25) Experimental/investigational medical or surgical procedures and prescription drugs as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency;

(26) Organ transplants involving artificial implants and non-human organs, as well as any services or supplies in connection with experimental or investigational treatment, drugs or procedures;

(27) Reversal of sterilization procedures;

(28) Services or supplies for which there is no charge to the covered person, or for which the covered person would not have been charged if not covered by this plan;

(29) Surgery or treatment for, or related to, sex transformations or sexual dysfunctions or inadequacies, including penile prosthesis due to psychogenic impotence;

(30) Services or supplies in connection with artificial insemination, in vitro-fertilization or any procedure intended to create a pregnancy;

(31) Telephone consultations;

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

(33) Durable medical equipment not specified in Sections 13.02, 13.03 or Attachment C or Attachment D, as applicable;

(34) The purchase or rental of any device, mechanical aid or other contrivance which may be required for the transportation of an individual on a public conveyance; roadway or other means of transportation, with the exception of those items specifically included as an eligible medical expense;

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

(36) Custodial care (as defined in Section 1.11);

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

(38) Services of a private-duty nurse which would normally be provided by hospital nursing staff;

(39) Diapers (incontinent pads);

(40) Cranial prosthesis (wig);

(41) Nutritional supplements and vitamins (except injectable B-12 for the treatment of pernicious anemia). Nutritional treatment of inborn errors of metabolism is not excluded under this clause as noted in Section 13.03(Q);

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

(43) Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, collection and handling fees, or telephone consultations.

(B) Excluded Dental Expenses.

(1) Any dental care and treatment and oral surgery relating to the teeth and gums including but not limited to dental appliances; dental prostheses such as crowns, bridges or dentures; implants; orthodontic care except as provided in Section 13.03(I); operative restoration of teeth (fillings); dental extractions (except impacted wisdom teeth); endodontic care; treatment of dental carries, gingivitis or periodontal disease.

(2) Any other expenses incurred relating to the teeth and gums except those specifically provided as covered expenses pursuant to Section 13.03(I);

(C) On the Job Injuries and Illnesses. The plan will not be responsible for expenses for injuries or illnesses incurred on the job.

(D) Excluded Mental Health/Substance Abuse Expenses. In addition to relevant exclusions noted in Section 13.04(A), the following are specifically excluded under the mental health/substance abuse benefit:

(1) Court or employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the claims administrator.

(2) Services for disorders not included in the *American Psychiatric Association Diagnostic & Statistical Manual*, 4th Edition, on Axis I or II.

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

(4) Conditions classified as developmental disorders such as mental retardation, learning disabilities, pervasive developmental disorders, including autism and Asberger's, and academic or motor skill disorders.

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

(6) Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.

(7) Ecological or environmental medicine, diagnosis and/or treatment.

(8) Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes, and related expenses for reports, including report presentation and preparation.

(9) Services given by a pastoral counselor.

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

ATTACHMENT A

SCHEDULE OF PPO MEDICAL BENEFITS

	In-Network	Out-of-Network
DEDUCTIBLES		
Individual Maximum per Plan Year (See Section 11.02 A)	$300	
Family Maximum per Plan Year (See Section 11.02 B)	$750	
COINSURANCE (See Section 11.03)		
PPO Expenses (See Section 11.03 A)	90% of MAC	
Non-PPO Expenses (See Section 11.03 B)		70% of MAC
Non-PPO Expenses Not Satisfying Utilization Management Program (See Section 11.03 D)		50% of MAC
Approved/Accredited Rehabilitation Facility		
Inpatient Rehabilitation Facility	90% of MAC	70% of MAC
Outpatient Rehabilitation Facility	90% of MAC	70% of MAC
Skilled Nursing Facility (Limited to 100 days per year following approved hospitalization. Prior authorization required.)	90% of MAC	70% of MAC
Home Health Care (See Section 13.03 F)	90% of MAC	70% of MAC
Non-Hospital & Non-Physician Services (See Section 11.03 E)		
Independently Practicing Physical Therapists, Speech Therapists, Occupational Therapists, Dialysis Clinics, Oral Surgeons, or Audiologists	90% of MAC (in-state)	70% of MAC
Non-Contracted Providers (Vary based on the network/services area outside of Tennessee)		
Sitters, Midwife Services (must be hospital based), Dentists (not oral surgeons)	80% of reasonable charges	
Transportation Charges if Approved for Unique Exception (See Section 13.02 H)	80% of reasonable charges	
Transportation Charges if Approved for Transplant (See Section 13.03 J)	100% subject to applicable limits	
Prescription Drugs (See Section 11.07 H)		
Generic	$5 copayment (or cost if less)	
Preferred Brand	$20 copayment (or cost if less)	
Non-Preferred Brand	$40 copayment (or cost if less)	
Retail Pharmacy up to a 34-day supply and Home Delivery up to a 102-day supply for one copay		
Second Surgical Opinion (See Section 11.07 B)		
Regardless of whether of not the covered person's deductible has been met	100% of MAC if on Attachment C	

ATTACHMENT A (Continued)

SCHEDULE OF PPO MEDICAL BENEFITS

	In-Network	Out-of-Network
Hospice (See Section 13.03 E)		
Regardless of whether of not the covered person's deductible has been met, preauthorization required	100% of MAC	100% of MAC
Emergency Services		
Out-of-State Emergency Requiring Hospitalization (See Section 11.03 G)	90% of MAC	
Certain In-State Emergencies (See Section 11.03 H)	90% of MAC	
Life Threatening Situations (as determined by the claims administrator utilizing non-PPO providers in-state or out-of-state)	90% of reasonable charge	
Emergency Room Visit Copayment (See Section 11.04) - waived if admitted for more than 23 hours or if readmitted within 48 hours of the initial visit for the same episode of an illness or injury	$25 copayment per visit	
Out-of-Country Charges		
	90% of MAC	70% of MAC (unless life threatening
Ambulance Services		
Air Ambulance	80% of reasonable charge	
Ground and Other Ambulance Service	80% of reasonable charge	
Appliances & Equipment		
Durable Medical Equipment	90% of MAC	70% of MAC
Maximum Out-of-Pocket Expense (See Section 11.05)		
Individual	$1,300	$3,900
Family	$2,600	$7,800
Pharmacy (changes annually as per pharmacy rate of inflation)	$1,000 per individual	

MAC = Maximum Allowable Charge

Covered persons will be responsible for payment of charges above the maximum allowable charge if non-PPO providers are used.

If preauthorization is required but not obtained, benefits will be reduced to 50% of MAC for out-of-network providers. No benefits will be paid for network providers.

ATTACHMENT B

SCHEDULE OF PPO MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

	Referred	Self-Referred
DEDUCTIBLES		
Individual Maximum per Plan Year	$150	
COINSURANCE (See Section 12.03)		
Inpatient - Preauthorized (the preauthorization process must be followed or benefits are reduced to 50% of the MAC of the 90/70% levels indicated)	90% of MAC	70% of MAC
Outpatient (copayments will not exceed actual session charge)	Sessions 1-15: $5 copay per visit Sessions 16-45: $25 copay per visit	Preauthorized Sessions 1-15: $20 copay per visit Sessions 16-45: $50 copay per visit Not-Preauthorized Sessions 1-15: $40 copay per visit Sessions 16-45: $100 copay per visit
Expenses determined not to be medically necessary by the utilization review organization	$0	

Intermediate Care
Halfway houses, residential treatment facilities, partial hospitalization – treated as one-half inpatient day subject to plan total of applicable days.

Substance Abuse Limitations (See Section 12.06)

- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay
- Lifetime maximum: Two stays for detoxification – maximum of 5 days per stay

Additional Mental Health Limitations (See Section 12.06)

- Inpatient care limit of 45 days per year (a daycare program is considered to be one-half day for purposes of this limitation).
- Outpatient care limit of 45 visits per year is for mental health/substance abuse combined.

Covered persons will be responsible for payment of charges above the maximum allowable charge if non-network providers are used.

ATTACHMENT C

PPO OPTIONAL SECOND SURGICAL OPINION PROCEDURES

Inclusion on this list does not imply that a procedure is automatically approved for benefits.

Procedure

- Bone and Joint Surgery of the Foot
- Cataract Extraction with and without Implant
- Cholecystectomy
- Hysterectomy
- Knee Surgery
- Septoplasty/Sub-Mucous Resection
- Prostatectomy
- Spinal and Disc Surgery
- Tonsillectomy and Adenoidectomy
- Mastectomy
- Elective C-Section

ATTACHMENT D

LIST OF PPO DURABLE MEDICAL EQUIPMENT

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

ATTACHMENT D (Continued)

LIST OF PPO DURABLE MEDICAL EQUIPMENT

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

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

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

POINT OF SERVICE

(POS)

ARTICLE XI
MEDICAL BENEFITS
(POS)

Each reference to an attachment in this article shall mean one of the applicable POS attachments. Each reference to a specific section shall mean the applicable section within this POS article unless otherwise specified.

11.01 Amount of Benefits.

The amount of medical benefits provided by the POS plan is outlined in Attachment A, "Schedule of Benefits," which is attached to and made a part of the POS plan. Upon receipt of proof of loss, the POS plan shall pay (unless otherwise specified herein) a percent, pursuant to Section 11.03, of in-network and out-of-network covered expenses incurred within each plan year and which are in excess of the deductible requirement, if applicable, as described in Section 11.02 or the required copayment amount listed in Attachment A.

11.02 Out-of-Network Deductible Amount.

The deductible amount is specified in Attachment A and is required to be paid by each covered person prior to payment of any out-of-network covered medical expenses under the POS plan. For individuals who transfer between POS plans, the deductible met under the local education or state plan shall be considered when determining the maximum plan year deductible. For individuals who continue insurance coverage through retirement or the provisions of COBRA, the deductible met while an employee shall be considered when determining the maximum plan year deductible.

(A) Out-of-Network Individual Deductible. In the event that the covered person has incurred out-of-network covered expenses equal to the deductible dollar amount shown in Attachment A in a plan year, such covered person shall have satisfied the deductible requirement of the POS plan for such plan year and shall be entitled to receive reimbursement for additional out-of-network covered expenses pursuant to Section 11.03.

(B) Out-of-Network Family Deductible. In the event that covered persons of the same family independently incur out-of-network covered expenses in a plan year so that the total of which would satisfy the family deductible outlined in Attachment A, then the deductible requirement of the POS plan shall have been satisfied for such plan year and each and every covered person of such family shall be entitled to receive reimbursement for additional out-of-network covered expenses pursuant to Section 11.03.

(C) Out-of-Network Common Accident Deductible. If two (2) or more individuals who are members of one (1) family incur out-of-network covered expenses as a result of injuries sustained in the same accident while coverage for medical care expense benefits pursuant to the POS plan is in force with respect to each of them, the applicable deductible shall be applied only once to the total of their out-of-network covered expenses incurred during the plan year in which such accident occurred.

(D) Deductible Credit for Pregnancy. **Under Middle and West POS options,** if a pregnant covered person registers in the voluntary babies first program pursuant to Section 13.03(B)(3) before the end of her first trimester, a $50 credit toward her deductible will be applied if out-of-network services are being used. If the out-of-network deductible has been satisfied for the plan year, the participant will be issued a check in the amount of $50. If the covered person is receiving in-network services, a check will be issued in the amount of $50 to the covered person's home address.

11.03 Coinsurance.

The POS plan will pay a percentage (the "applicable coinsurance percentage") of covered expenses incurred within each plan year, and which are in excess of the out-of-network deductible and copayment requirements.

(A) In-Network Expenses - Hospital and Physician. The applicable coinsurance percentage shall be the percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.06, have been followed, if applicable, and the copayment has been paid.

(B) Out-of-Network Expenses - Hospital and Physician. The applicable coinsurance percentage shall be the percentage as indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.06, have been followed, and the deductible (if applicable) and any required copayment has been met.

(C) Non-Compliance with Utilization Management Program. The applicable coinsurance percentage is the percentage as indicated in Attachment A, after the deductible and any applicable copayment has been met for out-of-network services or the copayment for in-network services. Expenses incurred with out-of-network providers or in-network providers which are determined not to be medically necessary as determined by the claims administrator will not be reimbursed by the POS plan. The covered person will be responsible for the charges incurred with out-of-network providers or facilities.

(D) Non-Hospital and Non-Physician Expenses. In the event of covered expenses for non-hospital and non-physician services, the applicable coinsurance percentage is the percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.06, have been followed, if applicable, and the required out-of-network deductible or copayment has been paid. Expenses incurred in conjunction with this subsection D include, but are not limited to the following: physical therapy, occupational therapy, speech therapy, ambulance, dialysis clinics, sitters, private duty nursing, and dentists.

(E) Hospital-Based Providers. In the event of in-network covered expenses incurred with hospital-based providers, reimbursement will be made at the in-network level of benefits indicated in Attachment A. The covered person will not be responsible for any expenses which exceed the maximum allowable charge for any providers of service that are hospital-based providers. Hospital-based providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists and pathologists.

(F) Emergency Out-of-State. In the event of covered expenses for emergency care as outlined in Section 1.15 (threat to life or limb) outside Tennessee, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, benefits will be paid at the out-of-network level after the applicable copayment and deductible has been paid.

(G) Emergency Inside Tennessee. In the event of covered expenses for emergency care as outlined in Section 1.15 (threat to life or limb) in an out-of-network hospital in Tennessee, benefits will be paid at in-network levels as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, benefits will be paid at the out-of-network level. The claims administrator will determine if an emergency situation exists and, if so, when the medical condition became an emergency situation. If the employee or dependent is in a non-network facility, benefits will be reduced to out-of-network levels if the patient is not transferred to an in-network facility once the medical condition allows.

(H) Out-of-Country Benefits. In the event that expenses are incurred for medically necessary services rendered while a covered person is out of the country, benefits shall be payable at

the in-network level if considered life threatening by the claims administrator. Should charges be incurred in a non-English speaking country, claims should be translated to standard English at the covered person's expense before being submitted to the claims administrator. The current exchange rate should also be provided.

(I) Pharmacy Program. In the event that expenses are incurred for prescription drugs, the applicable coinsurance percentage shall be indicated in Attachment A, subject to a copayment if the prescription is filled at a participating pharmacy or the deductible if the prescription is filled at a non-participating pharmacy.

11.04 Emergency Room Visit Copayment.

The covered person is responsible for payment of a copayment equal to the dollar amount shown in Attachment A for each visit to a hospital emergency room. This amount is waived if the visit results in an admission (of more than twenty-three [23] hours) to the hospital with a bed assignment, a walk-in clinic is used or the visit to the emergency room is subsequent to an initial visit to an emergency room for the same episode of an injury or illness within forty-eight (48) hours.

11.05 Maximum Benefits.

There is no dollar amount lifetime maximum benefit or stop-loss provision applied to the Point of Service plan.

11.06 Utilization Management Program(s).

The utilization management programs shall include requirements governing pre-admission certification, post-certification of emergency admissions, weekend admissions, optional second surgical opinions, mandatory outpatient procedures, home health, case management, private-duty nursing, durable medical equipment and pharmacy program. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. In order to assure the necessity, appropriateness and quality of the hospital care a covered person receives, the committee shall retain a utilization review organization, to review all general hospital admissions to certify medical necessity and length of stay.

Non-emergency hospital admissions are to be reviewed prior to being admitted to the hospital in accordance with the procedures found in this document.

Emergency admissions must be reviewed within twenty-four (24) hours or one (1) working day after admission. However, even if an emergency admission procedure is not followed, the hospital pre-admission certification procedure shall be deemed to have been followed if the utilization review organization later determines that the hospital admission was medically necessary as determined by the claims administrator.

In order to satisfy the guidelines of the utilization management program, the utilization review organization shall require elective admissions to begin on a weekday unless there is sufficient justification that the admission be made on a weekend.

Tests and other procedures that can be safely and effectively performed on an outpatient basis will be required to be administered in an outpatient setting to satisfy the guidelines of the utilization management program.

If the review decision differs from those of the covered person's attending physician and the differences are not resolved through the appeals process described in Section 6.05, the covered person and his/her attending physician shall be notified that the POS plan shall not provide benefits for the length of stay which exceeds the limits set forth by the utilization review organization. These charges will normally be the responsibility of the covered person; however, if part of the contracted POS network, such providers have, by separate contract with the claims administrator, agreed not to bill the covered person if the claims administrator determines that service(s) were not medically necessary, or if the POS provider has not followed applicable utilization management guidelines, such as obtaining pre-admission certification.

POS providers have agreed to accept the maximum allowable amount as payment in full for such services and hold the covered person harmless (from any balance of charges), except with respect to coinsurance and non-covered expenses of the covered person's coverage.

The ultimate choice of a provider is solely up to each covered person.

The claims administrator does not furnish covered services directly but rather pays benefits according to the POS plan. The claims administrator, the committee, the employer and the POS plan shall not be responsible for any claims, injuries or damages whatsoever caused by or which arise from the acts or failure to act of any provider. None of the entities listed above shall be liable for a provider's refusal or failure to render services on behalf of a covered person.

Whether a provider is a POS or non-POS provider shall not be taken as a recommendation or endorsement with respect to a particular provider's qualifications, skills or competence.

(B) Optional Second Surgical Opinion. The covered person may receive a second surgical opinion from a qualified surgeon, if the suggested procedure is listed in Attachment C. The second opinion must be obtained from a surgeon qualified to perform the surgical procedure but who is not in the same medical group as the physician who originally recommended surgery. Should the covered person decide to request a second surgical opinion (after discussing the surgery with the specialist), the charges for the second opinion and any tests performed in obtaining the second opinion shall be paid in full by the POS plan if the covered person was initially referred by their PCP to a specialist for the surgery and the PCP has authorized the second opinion, if such designation was required. No copayment or deductible will be required for the second surgical opinion as long as the surgery is listed in Attachment C.

(C) Mandatory Outpatient Procedures. In order to satisfy the guidelines of the utilization management program, the POS plan shall require certain procedures be performed on an outpatient basis. The pre-admission certification process will determine which procedures should be performed in the outpatient setting. These procedures should be performed in the outpatient department of a hospital or in an ambulatory surgical center unless deemed to be medically necessary as determined by the claims administrator, and as approved by the utilization review organization, to be performed on an inpatient basis.

(D) Home Health. Covered persons may receive home health benefits if prior approval is received from the claims administrator. These benefits should be obtained based upon a referral from the covered person's PCP, if such designation is required, and should be obtained from a provider participating in the network of home health agencies established by the claims administrator to receive the in-network level of benefits. The lower out-of-network benefit level applies if no valid PCP referral was obtained or if no unique care or continuous care exception was obtained.

(E) Case Management. Notwithstanding any contract provision, rider or endorsement to the contrary, the utilization review organization will consider alternative treatment plans proposed by the covered person or provider, committee or employer on behalf of a covered person and may elect to offer alternative benefits for services not otherwise specified as covered expenses hereunder.

The claims administrator and/or utilization review organization will identify potential cases, evaluate proposed alternative treatment plans and will otherwise coordinate the delivery of alternative benefits when the committee, or its representative, upon consultation with the utilization review organization, determines that alternative treatment is medically

necessary and cost effective. Such benefits will be offered only in accordance with a plan of alternative treatment with which the covered person (or the covered person's legal guardian) and the attending physician concur.

Alternative benefits will be made available on a case-by-case basis to individuals. Under no circumstances does a covered person acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer of, or confirmation of, alternative benefits in one instance shall not obligate the POS plan to provide the same or similar benefits for any other covered person in another instance. In addition, nothing herein shall be deemed a waiver of the right of the POS plan to enforce this plan in strict accordance with its express terms and conditions. No benefits of any type will be payable, however, beyond the date the contract or covered person's coverage terminates.

If medically appropriate, the claims administrator may exceed the established plan limitations on outpatient therapy for covered persons under the plan, who, because of their injury or illness, require additional speech, occupational and/or physical therapy beyond the plan limitations. Covered persons of the plan requiring outpatient therapy beyond plan limitations must be under active case management.

(F) Private-Duty Nursing. The claims administrator determines if the private-duty nursing care, which has been ordered by a physician (primary care or other), meets the coverage requirements of the POS plan and meets the medical necessity guidelines. The claims administrator will review medical charts documenting services provided by the nursing staff and will determine the duration for which reimbursement will be provided for this service.

(G) Durable Medical Equipment. In the event that it is determined that a covered person requires the use of durable medical equipment, such equipment should be obtained through a provider in the network established by the claims administrator. The covered person should have a written prescription (certificate of medical necessity) from a POS provider for such durable medical equipment. The level of reimbursement is in Attachment A, and Attachment D provides a list of durable medical equipment.

(H) Pharmacy Program. In order to receive maximum benefits of the pharmacy program available, covered persons should utilize the prescription home delivery program. Covered persons may also utilize a pharmacy in the network established by the claims administrator. A covered person should present their insurance identification card at the time of purchase. If the prescription is filled through the home delivery program or at a participating retail pharmacy, a copayment is required as outlined in Attachment A. If a non-participating

pharmacy is utilized, benefits are reimbursed as outlined in Attachment A after the required deductible has been met. If a participating or non-participating pharmacy is utilized and the claim is filed by the covered person, amounts exceeding the maximum allowable charge are the responsibility of the covered person. Prescriptions are generally limited to a thirty-four (34) day supply at the retail pharmacy level with some having additional limitations and pre-authorization requirements. Certain medications can be purchased through the home delivery program for up to a one hundred and two (102) day supply with one copayment from the covered person.

(I) Procedures. The utilization review organization shall establish procedures for administering the utilization management program and the committee shall communicate such procedures to all covered employees and qualified beneficiaries. If benefits are reduced due to non-compliance with the procedures established for administering the utilization management program, and the covered person wishes to dispute such reduction, such covered person may request that his/her claim be reconsidered pursuant to Section 6.05.

The reconsideration shall ensure that covered persons who, in good faith, attempt to comply with the utilization management program procedures are provided benefits at the same level as if those procedures had been followed.

A covered person has the responsibility to notify his/her physician and hospital that he is a covered person under the POS and of the POS plan's certification requirements for hospital admissions. This notification by the covered person can be by presentation of the POS plan identification card by the covered person or if the covered person verbally informs the provider.

If the covered person notifies the POS provider that he/she is a covered person under the POS before the admission, it will be the provider's responsibility to contact the utilization review organization for certification. If certification is not obtained, the POS plan and the covered person shall be held harmless from the reduction resulting from not satisfying the utilization management program by the provider.

On an elective admission, if a covered person does not notify the POS provider that he/she is a covered person under the POS, or does not give the POS provider correct information or the covered person will not admit to being covered by the POS plan when asked by the POS provider, the plan will be held harmless if certification is not obtained. The covered person will be responsible for the full payment.

On an emergency admission, if a covered person does not inform the hospital of his/her participation in the POS or of the utilization management program guidelines, the provision

under subsection 11.06(A) shall apply and determine what benefits will be provided by the POS plan when certification is not obtained. If it is determined by the claims administrator that the admission was not an emergency, the POS plan shall be held harmless. The covered person will be responsible for the full payment.

During a stay at a POS facility, if the hospital utilizes the services of a non-POS hospital based provider for the care of the covered person, the POS plan will provide benefits at the in-network level. The covered person is only responsible for the in-network copayment (see Attachment A) and shall not be billed for the difference of any charges above the maximum allowable charge. The POS plan is held harmless.

A provider may obtain certification by writing to the utilization review organization (no more than thirty [30] days in advance) or by calling the appropriate utilization review organization on the pre-certification toll-free line during normal business hours. If the provider contacts the utilization review organization when the office is closed, the caller will get a recorded message asking the caller to call again during office hours. It is the responsibility of the provider to call back to obtain certification or extension of days, unless the admission is an emergency.

When the call is received during office hours, the utilization review organization will approve or deny the certification at that time, unless additional information is needed before the certification is determined. Once all of the information is received by the utilization review organization, certification will be denied or approved within (1) one working day.

When the certification is approved or denied, the utilization review organization will send a letter to the covered person (or his/her guardian), physician and hospital advising them of the approval or denial of the certification. This letter will be sent no later than one (1) working day after the certification is denied or approved.

When determining certification for elective or emergency admissions, medical personnel under the direction of a physician will review the timing and setting of the medical care. The utilization review organization will not verify eligibility under the POS plan or if the benefits are eligible expenses under the POS plan.

When certification is approved, the utilization review organization will notify the provider of the number of days that are being certified for the inpatient stay. If the hospitalization is in a POS facility, it will be the facility's responsibility to contact the appropriate utilization review organization if the physician wants to request additional days. If the benefits for

additional inpatient days are denied, the utilization review organization will notify the patient, the physician and hospital on what date inpatient benefits will cease.

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

When determining if additional inpatient days should be certified, the utilization review organization will review the health care services delivered during the confinement to make sure they meet community standards of quality and are consistent with the patient's needs. If the utilization review organization determines that, after reviewing the hospital records, the health care is not medically necessary, benefits for the additional inpatient days will be denied. If a covered person is transferred from one facility to another, certification at the second facility must be obtained under the certification guidelines in subsection 11.06(A).

ARTICLE XII
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS
(POS)

Each reference to an attachment in this article shall mean one of the applicable POS attachments. Each reference to a specific section shall mean the applicable section within this POS article unless otherwise specified.

For the purpose of interpreting these provisions, the following definition will apply:
"Eligible Providers" - those providers considered eligible to provide mental health/substance abuse services or employee assistance services. For mental health/substance abuse services, eligible professional providers include psychiatrists, psychologists, licensed professional counselors, registered nurse clinical specialists and licensed clinical social workers, as defined herein. For employee assistance program (EAP) services, eligible providers are those considered eligible by the claims administrator for those services.

12.01 Amount of Benefits.

The amount of benefits provided by the POS plan is outlined in Attachment B, "Schedule of Mental Health/Substance Abuse Benefits," which is attached to and made a part of the POS plan. Upon receipt of proof of loss, the POS plan shall provide benefits, pursuant to Section 12.03, of covered expenses incurred within each plan year and which are in excess of the copayment requirements, as described in Section 12.02 and listed in Attachment B.

12.02 Copayment Amount.

For purposes of determining the amount of benefits under Section 12.01, a covered person must first satisfy the copayment requirements outlined in Attachment B.

12.03 Coinsurance.

The POS plan will pay a portion of in-network covered expenses incurred within each plan year, and which are in excess of the copayment requirements of Section 12.02 as outlined in Attachment B. Mental health and substance abuse benefits are not payable at the one hundred (100) percent level.

(A) Inpatient Benefits. The POS plan will pay the following benefits for mental health and substance abuse treatment received in an inpatient setting.

(1) In-Network. In the event of covered expenses for those inpatient services received from and payable to a provider affiliated with **and** specifically referred by the mental health and substance abuse utilization review organization, the reimbursement percentage is indicated in Attachment B, provided the copayment has been paid.

(2) Out-of-Network. In the event of covered expenses for those out-of-network inpatient services received without authorization by the mental health and substance abuse utilization review organization based upon the covered person's self-referral for those services, no benefits will be payable.

(3) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those inpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the POS plan will make no benefit payments.

(B) Outpatient. The POS plan will pay the following benefits for mental health and substance abuse treatment received in an outpatient setting:

(1) In-Network. In the event of covered expenses for those in-network outpatient services received from and payable to a provider referred by the mental health and substance abuse utilization review organization, the reimbursement percentage is indicated in Attachment B, provided the copayment has been met.

(2) Out-of-Network. In the event of covered expenses for those out-of-network outpatient services received without authorization by the mental health and substance abuse utilization review organization based upon the covered person's self-referral for those services, no benefits will be payable.

(3) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those outpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the POS plan will make no benefit payments.

12.04 Benefits for Detoxification.

In the event of covered expenses for a detoxification program, benefits will be paid at the level indicated in Attachment B. The limitations on the number of days and length of stay allowed will be as outlined in Attachment B.

12.05 Stop Loss.

For the purposes of mental health and substance abuse benefits, the POS plan does not contain a stop loss provision. There is no maximum amount of out-of-pocket expenses that a covered person may incur for treatment of mental health and substance abuse.

12.06 Maximum Benefits.

(A) Lifetime Maximum. There are no lifetime dollar maximums under the POS plan for mental health/substance abuse.

(B) Annual Maximum. Inpatient care for mental health treatment is limited to thirty (30) days per year. Outpatient care for mental health treatment is limited to forty-five (45) visits per year.

12.07 Utilization Management.

The utilization management programs described in this Section 12.07 shall include requirements governing pre-admission certification, outpatient referrals, case management, and EAP benefits. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. A utilization management function which occurs at or prior to admission to determine whether or not the admission is both medically necessary and/or clinically necessary and appropriate for the individual patient. The result is a recommendation for treatment.

(B) Outpatient Referrals. The process in which a patient is introduced to a health provider for treatment.

(C) Case Management. A process that evaluates the medical necessity and appropriateness of treatment.

(D) EAP Benefits. Employee assistance program services are available at no cost to all full-time employees and covered dependents, retirees and COBRA participants enrolled in a state-sponsored health plan. Services consist of short-term counseling (up to six [6] sessions per episode) for problems such as marital or family, emotional, substance abuse, stress, job and financial loss. Legal consultation via telephone is also available. If an employee or dependent is determined to need greater assistance, they will be referred to other resources. All EAP services must be pre-authorized.

(E) Procedures. In order to receive benefits, all inpatient and outpatient mental health, substance abuse and EAP services must be pre-authorized by the utilization review organization.

ARTICLE XIII
COVERED EXPENSES
(POS)

Each reference to an attachment in this article shall mean one of the applicable POS attachments. Each reference to a specific section shall mean the applicable section within this POS article unless otherwise specified.

13.01 Conditions.

All medical services, medical treatment and medical expenses will be considered covered expenses pursuant to this plan if:

(A) They are listed in Sections 13.02 or 13.03;

(B) They are not excluded under the exclusions from coverage under Section 13.04;

(C) They are determined to be medically necessary and/or clinically necessary by the claims administrator;

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

(E) Are consistent with plan policies and guidelines.

The committee, or its representative, shall make determinations regarding whether expenses will be considered covered expenses pursuant to (A) and (B) above. Medical specialists shall be consulted to determine whether a medical service, treatment or expense is medically necessary and/or clinically necessary. All medical claims from a hospital, physician or other provider shall be examined to determine whether the services, treatment and expenses were medically necessary and/or clinically necessary. If the medical specialist determines the treatment was not medically necessary and/or clinically necessary, the physician of the covered person for whom the claim is submitted can choose to provide additional information. If after examining the additional information it is determined that the service, treatment or expense was not medically necessary and/or clinically necessary, the claim shall not be considered as a covered expense by the plan, and the covered person may be responsible for payment of all of the bills associated with that claim, subject to the appeal process as described in Section 6.05.

13.02 Covered Expenses - Generally.

The charges for the following services and supplies are eligible covered expenses under the POS plan:

(A) Hospital room and board charges for a semi-private room up to the claims administrator's maximum allowable charge normally based on a daily per-diem rate which includes all room, board and ancillary services for the type of care provided as authorized through the utilization review for the POS plan. Additional charges for a private room will only be considered when isolation of the patient is medically necessary and/or clinically necessary as determined by the claims administrator to reduce the risk of receiving or spreading infection. The plan will pay the most prevalent room rate charge when the unit or facility does not provide semi-private rooms. Hospital services must be pre-authorized by a PCP, if such designation is required, or within twenty-four (24) hours if an emergency under the POS plan.

(B) Services and supplies furnished to the eligible covered persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an injury or illness, including consultations with a physician requested by the covered person's physician.

(C) Charges for "surgical procedures." Surgical procedures shall mean the generally accepted operative and cutting procedures rendered by a physician for the necessary diagnosis and treatment of an injury or illness, including treatment of fractures or dislocations, maternity care, any diagnosis of burns and abrasions and any endoscopic procedure (i.e. sigmoidoscopy, cystoscopy, etc.). During one operation, a physician may perform two (2) or more surgical procedures through the same incision. In this situation, payment is equal to the full benefit amount for the most expensive procedure plus one-half of the benefit amount for the other procedure.

(D) Office visits to a physician that are due to an injury or illness.

(E) Private-duty or special nursing charges (including intensive nursing care) for medically necessary and/or clinically necessary treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative, if prescribed by the attending physician.

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

(G) Charges for diagnostic laboratory and x-ray services including, but not limited to: laboratory examinations, metabolism tests, cardiographic examinations and encephalographic examinations.

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

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

(J) Charges for speech therapy by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. Speech therapy benefits are limited to a maximum of forty-five (45) visits, per condition, per plan year according to a prescription from a physician concerning the nature, frequency and duration of treatment under the plan.

(K) Charges for treatment received by a licensed doctor of podiatric medicine provided treatment was within the scope of his/her license.

(L) Charges for chemotherapy and radiation therapy when medically necessary as determined by the claims administrator.

(M) Charges for hemodialysis.

(N) Charges for the taking or the reading of an x-ray, CAT scan, MRI (upon approval of the claims administrator) or laboratory procedure, including physician charges and hospital charges. Positron emission tomography (PET) is a covered expense when determined to be medically necessary by the claims administrator. PET scan technology is currently considered experimental and investigative in many applications. Covered persons or their provider should verify medical necessity and benefit eligibility prior to incurring charges for use of this technology.

(O) Charges for laser procedures, other than those specifically excluded in Section 13.04.

(P) Charges for lithotripter treatment.

(Q) Charges for transfusion services for autologous blood and blood components.

(R) Lab charges and associated office visits for pap smears (annually).

(S) Cryosurgical ablation of the prostate is covered only when approved by the claims administrator.

(T) Charges for esophageal PH monitoring for the diagnosis of gastroesophageal reflux when the patient meets specific criteria as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator for these services.

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

(1) Knee replacement surgery; and

(2) Anterior cruciate ligament repair.

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

(V) Percutaneous lumbar discectomy (PLD) is a covered outpatient procedure only when the patient meets specific criteria, as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator.

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

(1) Single Pharmacy Limitation.

If the claims administrator or administrative services organization (ASO) has the reasonable belief that a covered person is receiving covered services in an excessive, dangerous, or medically inadvisable amount, and this belief is based upon the professional opinion of a medical doctor and a pharmacist, the claims administrator may impose a limitation on services providing that the covered person may only receive services from one specific pharmacy. The covered person must receive advance written notification of any such restriction stating the reasons for this restriction. The restriction must provide an exception for emergency services. The covered person has the right to request removal or modification of such restriction. The claims administrator will respond in writing to any written request for removal or modification. The covered person also has the right to appeal such restriction pursuant to Section 6.05.

(2) Drugs and medicines (unless excluded under Section 13.04) requiring written prescription of a physician, approved for use by the Food and Drug Administration and dispensed by a licensed pharmacist or physician. This includes over-the-counter drugs which require pharmacist preparation prior to patient use. Investigational new drugs (FDA designation), if published peer review literature indicates beneficial and effective patient care;

(3) "Off-label" (FDA approved but not for treatment of the condition for which it is prescribed) prescription drugs;

(4) Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:

(a) Prescription must be written by a licensed physician;

(b) Prescriptions are for a ninety (90) day period only; and

(c) Benefit is allowable once per year, with a maximum lifetime benefit of two (2) ninety (90) day periods.

(5) Surgical supplies including bandages and dressings;

(6) Insulin, the related syringes (including needle-free syringes when medically necessary as determined by the claims administrator based on the patient's age, weight, skin and medical condition and/or the frequency of injections), home blood glucose monitors and related supplies for the treatment of diabetes as approved by a physician;

(7) Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to $250 per calendar year. Coverage for additional training and education is available when a significant change occurs in the patient's symptoms or condition which necessitates a change in the patient's self-management or when a physician determines that re-education or refresher training is needed and determined to be medically necessary;

(8) Blood plasma or whole blood;

(9A) Artificial eyes - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness;

(9B) Artificial limbs - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness, with the following exceptions:

(a) One (1) additional limb prosthesis past age eighteen (18) if additional surgery has altered the size or shape of the stump; or

(b) Replacement of the original limb prosthesis if a severe medical condition to the stump could result from improper fitting of the initial prosthesis as determined by a physician. Replacement must be within twelve (12) months of the initial purchase of the limb prosthesis and proof of medical severity must be furnished to the claims administrator. The claims administrator must furnish written approval to the covered person prior to the replacement purchase.

(9C) Replacement prosthesis - As determined by the claims administrator, benefits are available for the purchase, fitting, necessary adjustment, repairs and replacement of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding artificial heart and dental appliances). Replacement costs will be covered only if the prosthetic appliance was used by the employee or dependent of the employee in the manner and for the purpose for which such appliance was intended and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. Benefits are not available for prosthetic appliances to replace those which are lost, damaged, stolen or prescribed as a result of improvements in technology.

(10) Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, surgical collars, lumbosacral supports, corsets-back and special surgical, trusses, and rigid back or leg braces. Orthopedic shoes for the correction of a deformity or abnormality of the musculoskeletal system are only considered for coverage when attached to a brace;

(11) Foot orthotics, devices or rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions, including shoes for diabetic conditions, when prescribed by a physician and are medically necessary as determined by the claims administrator.

Examples of items **not** considered to be a foot orthotic are:

(a) Inner soles (foam rubber, leather, flexible, etc.);

(b) Corn plasters (pads, etc.); and

(c) Foot padding (adhesive moleskin, etc.);

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

(13) X-ray, radium and other radioactive substances;

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

(15) Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus;

(16) If elected by the covered person following a mastectomy, coverage shall include:

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

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

(c) Prostheses, pursuant to Section 13.02(W)(9C), and physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year.

(17) The purchase or rental (not to exceed the total maximum allowable charge for purchase) of durable medical equipment as outlined in the applicable section and attachment;

(18) Immunizations, including hepatitis B immunizations, unless the employer is mandated to pay for the immunization;

(19) Transrectal prostatic ultrasound, when a physical examination of the prostate indicates the presence of nodules;

The following shall pertain to in-network services only:

(20) Vision and hearing screening annually;

(21) Family planning and infertility services including history, physical examination, laboratory tests, advice and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing and treatment for organic impotence. If fertility services are

initiated (including, but not limited to artificial insemination or in-vitro fertilization) benefits will cease;

(22) Nutritional guidance and other health educational services when medically appropriate as determined by the claims administrator; and

(23) In-network preventative care including annual routine health assessments, bone density scans, routine women's health (including mammography [see limitations in Section 13.03C], chlamydia and cervical cancer screening) and childhood immunizations.

(X) Charges for treatment by a licensed doctor of chiropractic provided treatment was within the scope of his/her license under the POS plan. This benefit may not be available under all options.

(Y) Ketogenic diet counseling (must be enrolled in case management).

13.03 Other Covered Expenses.

(A) Convalescent Care. Upon receipt of proof that a covered person has incurred medically necessary expenses related to convalescent care, the plan shall pay for charges for convalescent facility room, board and general nursing care, provided:

(1) A physician recommends confinement for convalescence;

(2) The covered person is under the continuous care of a physician during the entire period of confinement;

(3) The confinement is required for other than custodial care; and

(4) Services were pre-authorized by the claims administrator.

Eligible charges for convalescent facility room, board and general nursing care shall only include:

(1) Charges not to exceed the charge for its greatest number of semi-private rooms; and

(2) Charges up to and including the one-hundredth (100th) day of confinement during any plan year.

(B) Maternity Benefits. The plan provides coverage for pregnancy, childbirth or related medical conditions on the same basis as any other illness, unless the covered person is acting as a surrogate mother (carrying a fetus to term for another woman) in which case no benefits will be payable. Hospital admissions for maternity coverage and childbirth will be available for a minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a

caesarean delivery. No additional approval or authorization is needed for lengths of stay that fall within these timeframes. A covered person is not required to stay in the hospital for a fixed period of time following the birth of her child. New benefits will apply if transferring to another health plan prior to delivery.

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

(2) Newborn Care. Coverage for a newborn child shall be provided to covered employees who have elected family coverage or coverage pursuant to Section 2.05(A). The pre-existing condition requirements of the POS plan shall not apply to newborn children who are covered under the POS plan at birth, or legally adopted children or children placed for adoption.

Covered expenses of a newborn child shall include:

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

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

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

(d) The newborn child's usual and ordinary nursery and pediatric care at birth are covered. However, a newborn child who is a covered person under the POS plan must meet the individual deductible of Section 11.02(A) or the family deductible of Section 11.02(B) of the POS section if receiving out-of-network services.

(3) Babies First Program. This is a voluntary prenatal education program for pregnant employees and eligible dependents under Middle and West POS options. Once registered, covered persons will receive information on how to care for themselves during pregnancy to increase the chances of delivering a healthy baby. Pregnant patients must register with babies first by calling the Division of Insurance Administration before the end of their first trimester. Under the Middle and West

POS options, once registered, the patient will received a $50 credit toward their deductible if utilizing out-of-network providers. If their deductible has already been satisfied, they will receive a check in the amount of $50. If the covered person is receiving in-network care, a check in the amount of $50 will be mailed to the home address.

(C) Mammogram Screening. The plan provides coverage for mammogram screenings within the following guidelines:

(1) Once as a baseline mammogram for ages 35-39;

(2) Once every year for ages 40 and over; or

(3) When prescribed by a physician.

(D) Cochlear Implantation. The plan provides coverage for cochlear implantation using FDA-approved cochlear implants provided **all** of the following criteria are met:

Adults (Age 18+).

(1) Diagnosis of post-lingual profound deafness;

(2) Patient has achieved little or no benefit from a hearing aid;

(3) Patient is free from middle ear infection, has an accessible cochlear lumen that is structurally suited to implantation and is free from lesions in the auditory nerve and acoustic areas of the central nervous system;

(4) Patient has the cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and

(5) Patient has no contraindications to surgery.

Children (Age 2-17).

(1) Diagnosis of bilateral profound sensorineural deafness; and

(2) Patient has achieved little or no benefit from a hearing or vibrotactile aid, as demonstrated by the inability to improve on an age-appropriate closed-set word identification task.

An electrophysiological assessment should be performed to corroborate behavioral evaluation in very young children who cannot be adequately evaluated by standard audiometry tests. This assessment may consist of an auditory brain stem evoked response or similar test which would be covered when medically necessary as determined by the claims administrator.

A minimum six (6) month trial with appropriate amplification (hearing aid or vibrotactile aid) and rehabilitation should be performed for children to ascertain the potential for aided benefit.

(E) Hospice Care Program. When approved by the claims administrator, the plan shall provide hospice care, as provided in the applicable section, designed to provide covered persons who are terminally ill (a person whose life expectancy is six [6] months or less) with dignified, comfortable and less costly care the few months or weeks prior to death. This program shall be administered through an approved hospice. Care provided shall include physical, psychological, social and spiritual for dying persons and their families, rendered by a medically supervised interdisciplinary team of professionals and volunteers on a twenty-four (24) hour on-call basis.

(F) Home Health Care. The plan shall provide benefits for the services of part-time or intermittent home nursing care, given or supervised by a registered nurse (R.N.), but only if the services are certified as medically necessary and pre-authorized by the claims administrator and referred by a PCP, if such designation is required, under the POS plan. Visits under the POS plan are limited to one hundred twenty-five (125) per plan year. Home health aide care is also a covered service with the following limitations:

(1) No more than thirty (30) visits per plan year;

(2) A visit shall be four (4) or fewer hours;

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

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

(5) The home health aide service is in conjunction with medically necessary skilled care.

Intravenous (I.V.) therapy administered in the home during these visits is a covered service, provided the medication is approved for use by the Federal Drug Administration. Case management services will be requested by the physician, patient or employer for home health cases requiring extensive care.

(G) Rehabilitation Therapy. The plan shall provide pre-authorized inpatient and/or outpatient physical therapy benefits for services for conditions resulting from illness or injury, or prescribed immediately following surgery related to the condition. Outpatient benefits under the plans are limited to a maximum of forty-five (45) visits, per condition, per plan year according to a prescription from a physician concerning the nature, frequency and duration of treatment. Therapy shall include functional, physical and occupational therapy to the extent such therapy is performed to regain use of the upper or lower extremities, or if the covered person is a child, as long as improvement in the covered person's condition continues (subject to the limitations contained in this Section 13.03). Occupational therapy

shall not include vocational therapy or vocational rehabilitation, nor educational or recreational therapy on an outpatient basis.

Phase I and Phase II (as defined below) cardiac rehabilitation services will be a covered expense provided they meet the following criteria and prior authorization is given by the claims administrator:

(1) Phase I includes inpatient rehabilitation services that begin during hospitalization and extended until discharge; and

(2) Phase II includes supervised ambulatory services that follow discharge and extend until the patient becomes sufficiently independent to perform prescribed exercise and carry out any recommended long-term lifestyle changes. Phase II services are limited to three (3) sessions per week for a maximum of twelve (12) weeks.

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

(H) Sitter. A sitter who is not a relative (i.e. spouse, parent, child, brother or sister by blood, marriage or adoption or member of the household) of the covered person may be used in those situations where the covered person is confined to a hospital as a bed patient and certification is made by a physician that an R.N. or L.P.N. is needed and neither (R.N. or L.P.N.) is available.

(I) Covered Dental Expenses.

(1) Charges for orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function of a covered person. Covered persons in the POS plan must meet the pre-existing condition clause or qualify for a waiver of the pre-existing condition clause.

(2) Charges for extraction of impacted wisdom teeth, excision of solid based oral tumors, treatment of accidental injury (other than by eating or chewing) to sound natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary as determined by the claims administrator) providing the accident occurred while the individual was covered under a state-sponsored plan and has remained continuously covered.

(3) Charges for the facility and related medical services when hospitalization for dental services is determined medically necessary by the claims administrator.

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

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

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

(c) Mental illness or handicap precludes dental/surgical management in an office setting;

(d) When general anesthesia is used or;

(e) For children eight (8) years and younger benefits will be provided for anesthesia (inpatient or outpatient) and any expenses associated with a dental procedure that cannot be safely provided in the office. Benefits will be available for anesthesia regardless of whether or not the base procedure is covered by the insurance program.

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

(a) History, exams and office visits;

(b) X-rays of the joint;

(c) Diagnostic study casts;

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

(e) Medications; and

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

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

(a) Prosthodontic treatments (dentures, bridges);

(b) Restorative treatment (fillings, crowns);

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

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

(J) Organ Transplants. Organ transplant benefits will be paid for covered medical expenses related to transplants of the: heart, heart/lung, lung, liver, kidney, pancreas, pancreas/kidney, cornea, small bowel, small bowel/kidney and certain bone marrow transplants. Transplant services or supplies require pre-authorization before any pre-transplant evaluation or any covered service is performed. Coverage will include expenses incurred for donor search and organ procurement by the transplant center or hospital facility and all inpatient and outpatient hospital/medical expenses for the transplant

procedure and related pre- and post-operative care, including immunosuppressive drug therapy. Should a transplant request fall outside those addressed and covered by the *Plan Document*, the claims administrator will review the information provided and render a decision based on acceptable medical practices on behalf of the state insurance program. The claims administrator will notify the Division of Insurance Administration of its decision prior to approving such services. If the service(s) or procedure(s) does not meet the claims administrator's accepted medical standards, the covered person will be notified of their option to appeal the decision as described in Section 6.05. If a network facility is utilized for the transplant, travel and living expenses will be covered from the initial evaluation to one (1) year after the transplant (for medically necessary visits only as determined by the claims administrator). Air transportation, if necessary, will be paid at commercial coach fare. Ground travel will be paid at the State of Tennessee approved mileage rate. Additionally, hotel and meal expenses will be paid up to $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.

If the donor is not a covered person and the recipient is covered under the plan, the donor will be considered eligible for coverage for expenses which are incurred during hospitalization for the transplant procedure and which are not covered by another group health plan. Covered services include those services and supplies directly related to the transplant service itself such as removal of the organ from the donor's body, preservation of the organ and transportation of the organ to the site of transplant. The aggregate limit for organ procurement is $10,000 per covered procedure. No benefits are payable for donor services for recipients who are not covered under the plan. These services are ineligible even when the recipient does not provide reimbursement for the donor's expenses. Bone marrow transplantation will fall into one (1) of three (3) categories: syngeneic, allogeneic or autologous.

Expenses eligible for coverage include the charge to harvest bone marrow for covered persons diagnosed with any covered malignant condition or any conditions approved for coverage by the claims administrator. Coverage for harvesting, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow will be covered when re-infusion is scheduled within three (3) months or less. Autologous bone marrow transplantation is considered investigational in the treatment of other malignancies, including primary intrinsic tumors of the brain.

(K) Well-Baby, Well-Child Care. Physician office visits for routine check-ups and immunizations are covered expenses for children through age five (5) under the POS plan, and a total of twelve (12) routine visits are covered. Said services must be received in-network for the POS plan.

(L) Prostate Screening. The plan will cover PSA (prostate specific antigen) and transrectal ultrasound for the following conditions:

(1) Annually in men who have been treated for prostate cancer with radiation therapy, surgery or chemotherapy;

(2) Annually in men over the age of forty-five (45) who have enlarged prostates as determined by rectal examination; and

(3) Annually in men of any age with prostate nodules or other irregularity noted on rectal exam.

The plan will cover PSA for the primary screening of men over the age of fifty (50) and will cover transrectal ultrasound in these individuals with an elevated PSA.

(M) Biofeedback Therapy. The plan shall provide benefits for biofeedback therapy which is determined to be medically necessary with a maximum benefit of five (5) sessions per calendar year for each of the following conditions:

(1) Chronic pain;

(2) Incontinence;

(3) Migraine headaches; and

(4) Incapacitating stress.

(N) Bariatric Surgery (weight reduction). The plan will cover as outlined below, two (2) surgical procedures for treatment of morbid obesity:

(1) Vertical banded gastroplasty accompanied by gastric stapling

(2) Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum

The following criteria must be met before benefits are available for the two (2) surgical procedures listed above:

(1) Presence of morbid obesity that has persisted for at least five (5) years, defined as either:

(a) Body mass index (BMI) exceeding forty (40); or

(b) More than one hundred (100) pounds over one's ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or

(c) BMI greater than thirty-five (35) in conjunction with the following severe co-morbidities that are likely to reduce life expectancy:

1. Coronary artery disease; or
2. Type 2 diabetes mellitus; or
3. Obstructive sleep apnea; or
4. Three or more of the following cardiac risk factors:
   a. Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)
   b. Low high-density lipoprotein cholesterol (HDL less than 40mg/dL)
   c. Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)
   d. Current cigarette smoking
   e. Impaired glucose tolerance (2-hour blood glucose>140 mg/dL on an oral glucose tolerance test)
   f. Family history of early cardiovascular disease in first-degree relative (myocardial infarction at age under fifty [50] in male relative or at age under sixty-five [65] for female relative)
   g. Age greater than forty-five (45) years in men and fifty-five (55) years in women

(2) History of failure of medical/dietary therapies (including low calorie diet, increased physical activity, and behavioral reinforcement). This attempt at conservative management must be within two (2) years prior to surgery, and must be documented by an attending physician who does not perform bariatric surgery. (Failure of conservative therapy is defined as an inability to lose more than ten [10] percent of body weight over a six [6] month period and maintain weight loss.)

The claims administrator will determine if all the criteria have been met before approving surgery.

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

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

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

(3) Routine screenings among the elderly is considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

(P) Hearing Impairment Screening and Testing. The plan will cover, as determined by the claims administrator, medically necessary hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The claims administrator has determined eligibility of many of the tests/screenings to be specific to infants. Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.

(Q) Nutritional Treatment of Inborn Errors of Metabolism. The plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup urine disease, homocystinuria, methylmalonic acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the claims administrator.

13.04 Exclusions and Limitations.

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

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

(2) Drugs and medicines which can be obtained without a written prescription (over-the-counter), except as covered pursuant to Section 13.02(W)(2);

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

(4) Services and supplies (notwithstanding organ donations) provided by an immediate family member of an eligible employee or covered dependent. Immediate family members include spouse, parent, child, brother or sister, by blood, marriage or adoption;

(5) Services rendered prior to the effective date of coverage;

(6) Services incurred after the covered person's coverage under this plan is terminated;

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

(8) Charges for the removal of corns or calluses, or trimming of toenails;

(9) Treatment of an injury or illness due to declared or undeclared war;

(10) Charges incurred outside the United States (including those for drugs and medicines subject to FDA approval and federal law) unless the charges are incurred while traveling on business or for pleasure by a covered person who is a resident of the United States and a medical emergency arises;

(11) Charges which the claims administrator determines to be in excess of the maximum allowable charge for that procedure or supply and for charges made which are not medically necessary as determined by the claims administrator;

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

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

(14) Expenses incurred for contact lenses, eyeglasses, sunglasses or for examinations for prescription or fitting of eyeglasses or contact lenses, except as may be allowed pursuant to Section 13.02;

(15) Expenses incurred for hearing aids or for examinations for prescription or fitting of hearing aids (except as previously defined in Section 13.02);

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

(a) The covered person experienced a traumatic injury or illness, while covered by a state-sponsored plan, which requires the cosmetic surgery;

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

(c) If elected by the covered person following a mastectomy:

(i) Reconstruction of the breast on which the mastectomy has been performed,

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) Prostheses, pursuant to Section 13.02(W)(9C) and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year;

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

(17) Arch supports and other foot support devices, except for orthotic devices as defined in Section 13.02(W)(11);

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

(19) Garter belts;

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

(21) Hotel charges or travel expense incurred while receiving treatment as an inpatient or outpatient, (other than defined in Section 13.03J or Attachment A);

(22) Unapproved sitters;

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

(24) Non-surgical services, including prescription medication for weight control or reduction (obesity). Surgical services are also excluded unless specifically listed in Section 13.03;

(25) Experimental/investigational medical or surgical procedures and prescription drugs as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency;

(26) Organ transplants involving artificial implants and non-human organs, as well as any services or supplies in connection with experimental or investigational treatment, drugs or procedures;

(27) Reversal of sterilization procedures;

(28) Services or supplies for which there is no charge to the covered person, or for which the covered person would not have been charged if not covered by this plan;

(29) Surgery or treatment for, or related to, sex transformations or sexual dysfunctions or inadequacies, including penile prosthesis due to psychogenic impotence;

(30) Services or supplies in connection with artificial insemination, in vitro-fertilization or any procedure intended to create a pregnancy;

(31) Telephone consultations;

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

(33) Durable medical equipment not specified in Sections 13.02, 13.03 or Attachment C or Attachment D, as applicable;

(34) The purchase or rental of any device, mechanical aid or other contrivance which may be required for the transportation of an individual on a public conveyance; roadway or other means of transportation, with the exception of those items specifically included as an eligible medical expense;

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

(36) Custodial care (as defined in Section 1.11);

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

(38) Services of a private-duty nurse which would normally be provided by hospital nursing staff;

(39) Diapers (incontinent pads);

(40) Cranial prosthesis (wig);

(41) Nutritional supplements and vitamins (except injectable B-12 for the treatment of pernicious anemia). Nutritional treatment of inborn errors of metabolism is not excluded under this clause as noted in Section 13.03(Q);

(42) Programs considered primarily educational, and materials such as books or tapes, except as stated as specifically covered in the covered expenses section of this *Plan Document*.

(43) Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, collection and handling fees, or telephone consultations.

(B) Excluded Dental Expenses.

(1) Any dental care and treatment and oral surgery relating to the teeth and gums including but not limited to dental appliances; dental prostheses such as crowns,

bridges or dentures; implants; orthodontic care except as provided in Section 13.03(I); operative restoration of teeth (fillings); dental extractions (except impacted wisdom teeth); endodontic care; treatment of dental carries, gingivitis or periodontal disease.

(2) Any other expenses incurred relating to the teeth and gums except those specifically provided as covered expenses pursuant to Section 13.03(I);

(C) On the Job Injuries and Illnesses. The plan will not be responsible for expenses for injuries or illnesses incurred on the job.

(D) Excluded Mental Health/Substance Abuse Expenses. In addition to relevant exclusions noted in Section 13.04(A), the following are specifically excluded under the mental health/substance abuse benefit:

(1) Court or employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the claims administrator.

(2) Services for disorders not included in the *American Psychiatric Association Diagnostic & Statistical Manual*, 4th Edition, on Axis I or II.

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

(4) Conditions classified as developmental disorders such as mental retardation, learning disabilities, pervasive developmental disorders, including autism and Asberger's, and academic or motor skill disorders.

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

(6) Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.

(7) Ecological or environmental medicine, diagnosis and/or treatment.

(8) Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes, and related expenses for reports, including report presentation and preparation.

(9) Services given by a pastoral counselor.

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

ATTACHMENT A

SCHEDULE OF POS MEDICAL BENEFITS

	In-Network	Out-of-Network
DEDUCTIBLES		
Individual Maximum per Plan Year	$0	$300 (See Section 11.02A)
Family Maximum per Plan Year	$0	$750 (See Section 11.02B)
COPAYMENTS & COINSURANCE (See Section 11.03)		
Inpatient Services (pre-authorization required or benefits are reduced to 50% per diem or MAC)		
Physician Services	100% benefit (See Section 11.03A)	70% of MAC after deductible (See Section 11.03B)
Hospital Services (the hospital copay is waived if readmitted within 48 hours of the initial visit for the same episode of an illness or injury)	$100 copay per admission	70% per diem after $300 deductible and $300 copay per admission
Outpatient Services		
PCP Office Visit	$20 copay	70% of MAC after deductible
Specialist Office Visit	$25 copay	70% of MAC after deductible
X-ray, Lab Diagnostics	100% benefit	70% of MAC after deductible
Home Health Care (125 visits annually) (See Section 13.03F)	$20 copay	70% of MAC after deductible
Home Infusion Therapy	$20 copay	70% of MAC after deductible
Hospice Care, preauthorization required (See Section 13.03E)	100% of MAC	100% of MAC
Chiropractors (not available in all service areas)	$20 copay	70% of MAC after deductible
Preventive Health/Well Care Services		
Well Child Care (12 visits through age 5)	100% benefit	$0
Annual Health Assessments	100% benefit	$0
Family Planning	$20 copay	$0
Annual Hearing & Vision Screening	$20 copay PCP; $25 specialist	$0
Maternity Care		
Physician Care	$20 copay per visit (maximum of $260)	70% of MAC after deductible
Hospital Care	$100 copay per admission	70% per diem after deductible and $300 copay
Midwives (must be hospital based)	$20 copay per visit (maximum of $260)	70% of MAC after deductible

ATTACHMENT A (continued)

SCHEDULE OF POS MEDICAL BENEFITS

	In-Network	Out-of-Network
Prescription Drugs		
Generic	$5 copay (or cost if less)	70% of MAC after deductible
Preferred Brand	$20 copay (or cost if less)	70% of MAC after deductible
Non-Preferred Brand	$40 copay (or cost if less)	70% of MAC after deductible
Retail Pharmacy up to a 34-day supply and Home Delivery up to a 102-day supply for one copay		
Rehabilitation Services		
Inpatient Services	100% per diem after $100 copay	70% per diem after deductible
Outpatient Services (45 visit limit per condition per plan year – speech, occupational & physician therapy)	100% of MAC after $20 copay per visit	70% of MAC after deductible
Skilled Nursing Facility (limited to 100 days per year following approved hospitalization – prior authorization required)	$25 copay per day	70% per diem after deductible
Emergency Services (See Sections 11.03F and G and 11.04)		
Emergency Room Copay (the copay is waived if admitted for more than 23 hours or if readmitted within 48 hours of the initial visit for the same episode of illness or injury)	$50 copay per visit	70% of MAC after deductible $50 copay per visit
Ambulance Services		
Air and Ground (must be medically necessary)	100% of reasonable charges	
Appliances & Equipment		
Durable Medical Equipment	100% benefit	70% of MAC after deductible
Supplies	$5 copay (34 day supply)	70% of MAC after deductible
Other (Transportation Charges)		
If Approved for Out-of-State Exception (See Section 13.02H)	80% of reasonable charges	None
If Approved for Transplant (See Section 13.03J)	100% subject to applicable limit	None

MAC = Maximum Allowable Charge

If preauthorization is required but not obtained, benefits will be reduced to 50% of MAC for out-of-network providers. No benefits will be paid for network providers.

ATTACHMENT B

SCHEDULE OF POS MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

	In-Network	Out-of-Network
COPAYMENTS & COINSURANCE (See Section 12.03)		
Inpatient – Intermediate Care Services (copayment waived if readmitted within 48 hours of the initial visit for the same episode of an illness)	100% of MAC after $100 copay per admission	No benefit
Outpatient	100% of MAC after $25 copay per visit	No benefits
Expenses determined not to be medically necessary by the utilization review organization	$0	

Intermediate Care
Halfway houses, residential treatment facilities, partial hospitalization – treated as one-half inpatient day subject to plan total of applicable days.

Substance Abuse Limitations (See Section 12.06)
- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay
- Lifetime maximum: Two stays for detoxification – maximum of 5 days per stay

Mental Health Limitations (See Section 12.06)
- Inpatient care limit of 30 days per year (a daycare program is considered to be one-half day for purposes of this limitation).
- Outpatient care limit of 45 visits per year for mental health/substance abuse combined.

Additional Limitations
- The preauthorization process must be followed for all mental health and substance abuse benefits to be payable. No benefits are payable if services are not preauthorized.
- In-network services are covered up to the maximum allowable charge by the claims review organization.

MAC = Maximum Allowable Charge

ATTACHMENT C

POS OPTIONAL SECOND SURGICAL OPINION PROCEDURES

Inclusion on this list does not imply that a procedure is automatically approved for benefits.

Procedure

- Bone and Joint Surgery of the Foot
- Cataract Extraction with and without Implant
- Cholecystectomy
- Hysterectomy
- Knee Surgery
- Septoplasty/Sub-Mucous Resection
- Prostatectomy
- Spinal and Disc Surgery
- Tonsillectomy and Adenoidectomy
- Mastectomy
- Elective C-Section

ATTACHMENT D

LIST OF POS DURABLE MEDICAL EQUIPMENT

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

ATTACHMENT D (Continued)

LIST OF POS DURABLE MEDICAL EQUIPMENT

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

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

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

HEALTH MAINTENANCE ORGANIZATION

(HMO)

ARTICLE XI
MEDICAL BENEFITS
(HMO)

Each reference to an attachment in this article shall mean one of the applicable HMO attachments. Each reference to a specific section shall mean the applicable section within this HMO article unless otherwise specified.

11.01 Selection of a PCP.

Each covered person must select a participating network PCP who shall be responsible for the coordination of all health services and for ensuring continuity of care. A custodial parent shall select a PCP for a minor enrolled dependent. Enrolling for coverage under the plan does not guarantee health services by a particular network PCP or network hospital on the list of network providers. When a provider contracting with the claims administrator is no longer in the network, the covered person must choose among remaining network providers. A covered person may change PCPs at reasonable intervals by following the claims administrator's procedures for changing PCP's. PCP changes made by a covered person are effective as determined by the claims administrator.

11.02 Health Services Rendered by Network Providers.

Covered persons are eligible for coverage for health services described in this *Plan Document* if such health services are medically necessary and are provided by or under the direction of a PCP. All coverage is subject to the terms, conditions, exclusions and limitations of the plan. Health services which are not provided by or under the direction of a PCP are not covered, except in emergency situations or referral situations authorized in advance by the claims administrator. Enrolling for coverage under the plan does not guarantee health services by a particular network provider on the list of providers. Coverage for health services is subject to payment of the premium required for coverage under the plan and payment of the copayment specified for any service.

11.03 Verification of Participation Status.

The covered person is responsible for verifying the participation status of a network physician, hospital or other provider prior to receiving such health services. The covered person must show their identification card every time they request health services. If the covered person fails to verify

participation status or to show their identification card, and that failure results in non-compliance with required plan procedures, coverage may be denied.

11.04 Referral Health Services.

All medically necessary health services must be provided by or coordinated through a PCP except for emergency health services. If the PCP is not able to provide medically necessary health services, the PCP will refer the covered person to a network specialist or other network provider. If the covered person obtains health services without a referral from a PCP, those health services are not covered under the plan. Health services recommended by a network provider are not covered until the covered person receives the required referral from a PCP. In the event that specific medically necessary health services cannot be provided by or through a network provider, the covered person is eligible for coverage of such health services obtained through non-network providers. Health services not available through network providers must be authorized in advance through a referral process as designated by the claims administrator. All health services are subject to the provisions of and other limitations and exclusions of the plan. Some health services do not require a referral. Employees and their dependents should refer to their member handbook for a list of medical services that do not require a referral.

11.05 Prior Approval.

It is the PCP's responsibility to obtain the required claims administrator's approval prior to issuing a referral for a covered person to see any other provider. The claims administrator has identified to all PCPs those health services which require prior approval and has established certain procedures for processing referrals.

11.06 Emergency Health Services.

The claims administrator provides coverage of eligible expenses for medically necessary emergency health services, subject to the terms, conditions, exclusions, and limitations of the plan. The covered person should seek care immediately for life-threatening conditions and should contact the PCP within the time frame established by the claims administrator after care has been received for emergency health services. Such health services must be medically necessary for stabilization and initiation of treatment. The health services must be provided by or under the direction of a physician.

11.07 Continuity of Care.

In the event that a covered person's physician or network inpatient facility terminates its agreement with the claims administrator or the claims administrator terminates its agreement with the provider without cause, the covered person may receive covered health services as described below if the provider agrees to continue to be bound by the terms, conditions and reimbursement rates of the provider's agreement with the claims administrator.

This provision applies to the following: A covered person who is under active treatment for a particular injury or sickness may receive covered health services for a period of time as established by the claims administrator from the date of the notice of a covered provider's termination, or a covered person who is in the second or third trimester of pregnancy may continue care until completion of postpartum care and a covered person who is being treated at a network hospital or other inpatient facility may receive covered health services at that facility until the date of discharge.

11.08 Amount of Benefits.

The amount of medical benefits provided by the plan is outlined in Attachment A, "Schedule of Benefits," which is attached to and made a part of the plan. The plan will provide benefits in full for all in-network covered expenses incurred within each plan year, which are in excess of the copayment requirements of the plan.

11.09 Emergency Out-of-State.

In the event of covered expenses for emergency care as outlined in Section 1.15 (threat to life or limb) outside Tennessee, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, no benefits will be provided. Covered persons who experience a life-threatening emergency should seek medical attention immediately and follow-up with their PCP within the time frame established by the claims administrator. Covered persons who experience urgent care situations should contact their PCP before receiving services.

11.10 Emergency Inside Tennessee.

In the event of covered expenses for life threatening emergency care as outlined in Section 1.15 (threat to life or limb) in a out-of-network hospital in Tennessee, benefits will be paid at in-network

levels as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, no benefits will be provided.

11.11 Out-of-Country Benefits.

In the event that expenses are incurred for medically necessary emergency services rendered while a covered person is out of the country, benefits shall be payable at the network level if considered life threatening by the claims administrator. Routine or urgent care services without an appropriate referral from the covered person's PCP or prior approval of services by the claims administrator will not be covered. Covered persons should contact the claims administrator to locate an eligible provider when traveling out of the country. Should charges be incurred in a non-English speaking country, claims should be translated to standard English at the covered person's expense before being submitted to the claims administrator. The current exchange rate should also be provided.

11.12 Emergency Room Visit Copayment.

The covered person is responsible for payment of a copayment equal to the dollar amount shown in Attachment A for each visit to a hospital emergency room. This amount is waived if the visit results in an admission (of more than twenty-three [23] hours) to the hospital with a bed assignment or the visit to the emergency room is subsequent to an initial visit to an emergency room for the same episode of an injury or illness within forty-eight (48) hours.

11.13 Maximum Benefits.

There is no dollar amount lifetime maximum benefit or stop-loss provision applied to the Health Maintenance Organization plan.

11.14 Medical Management Program(s).

The medical management program shall include requirements governing PCP referrals, pre-admission certification, post-certification of emergency admissions, weekend admissions, therapy pre-certifications, twenty-three (23) hour or less admissions, day surgeries, home health, case management, private-duty nursing, durable medical equipment and the pharmacy program. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Home Health. Covered persons may receive home health benefits if prior approval is received from the claims administrator. These benefits should be obtained based upon a referral from the covered person's PCP and should be obtained from a provider participating in the network of home health agencies established by the claims administrator.

(B) Case Management. Notwithstanding any contract provision, rider or endorsement to the contrary, the medical management program will consider alternative treatment plans proposed by the covered person or provider, committee or employer on behalf of a covered person and may elect to offer alternative benefits for services not otherwise specified as covered expenses hereunder.

The claims administrator and/or medical management program will identify potential cases, evaluate proposed alternative treatment plans and will otherwise coordinate the delivery of alternative benefits when the committee, or its representative, upon consultation with the medical management program, determines that alternative treatment is medically necessary and cost effective. Such benefits will be offered only in accordance with a plan of alternative treatment with which the covered person (or the covered person's legal guardian) and the attending physician concur.

Alternative benefits will be made available on a case-by-case basis to individuals. Under no circumstances does a covered person acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer of, or confirmation of, alternative benefits in one instance shall not obligate the plan to provide the same or similar benefits for any other covered person in another instance. In addition, nothing herein shall be deemed a waiver of the right of the plan to enforce this plan in strict accordance with its express terms and conditions. No benefits of any type will be payable, however, beyond the date the contract or covered person's coverage terminates.

If medically appropriate, the claims administrator may exceed the established plan limitations on outpatient therapy for covered persons under the plan, who, because of their injury or illness, require additional speech, occupational and/or physical therapy beyond the plan limitations. Covered persons of the plan requiring outpatient therapy beyond plan limitations must be under active case management.

(C) Private-Duty Nursing. The claims administrator determines if the private-duty nursing care, which has been referred by a physician (primary care or other), meets the coverage requirements of the plan and meets the medical necessity guidelines. The claims administrator will review medical charts documenting services provided by the nursing

staff and will determine the duration for which reimbursement will be provided for this service.

(D) Durable Medical Equipment. In the event that it is determined that a covered person requires the use of durable medical equipment, such equipment should be obtained through a provider in the network established by the claims administrator. The covered person should have a written prescription (certificate of medical necessity) from a provider for such durable medical equipment. Durable medical equipment requires preauthorization by the claims administrator. The level of reimbursement is outlined in Attachment A and a list of covered durable medical equipment is provided in Attachment C.

11.15 Pharmacy Program.

In the event that expenses are incurred for prescription drugs, benefits shall be provided in full as indicated in Attachment A, subject to a copayment as outlined in Attachment A. In order to receive maximum benefits of the pharmacy program, covered persons must utilize the prescription home delivery program. Covered persons may also utilize a pharmacy in the network established by the claims administrator. A covered person should present their insurance identification card at the time of purchase. Prescriptions are generally limited to a thirty (30) day supply or a thirty-four (34) day supply at the retail pharmacy level with some having additional limitations and pre-authorization requirements. Some medications can be purchased up to a one hundred (100) day supply with one copayment through the home delivery program. The plan utilizes a drug formulary. The formulary is a list of preferred prescription medications which promotes clinically useful and cost-effective drug therapy. Decisions regarding formulary inclusion and exclusion are made by the claims administrator.

ARTICLE XII
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS
(HMO)

Each reference to an attachment in this article shall mean one of the applicable HMO attachments. Each reference to a specific section shall mean the applicable section within this HMO article unless otherwise specified.

For the purpose of interpreting these provisions, the following definition will apply:
"Eligible Providers" shall mean those providers considered eligible to provide mental health/substance abuse services or employee assistance services. For mental health/substance abuse services, eligible professional providers include psychiatrists, psychologists, licensed professional counselors, registered nurse clinical specialists and licensed clinical social workers, as defined by the plan. For employee assistance program (EAP) services, eligible providers are those considered eligible by the claims administrator for those services.

12.01 Amount of Benefits.

The amount of benefits provided by the plan is outlined in Attachment B, "Schedule of Mental Health/Substance Abuse Benefits," which is attached to and made a part of the plan. Upon receipt of proof of loss, the plan shall provide benefits, pursuant to Section 12.03, of covered expenses incurred within each plan year and which are in excess of the copayment requirements, as described in Section 12.02 and listed in Attachment B.

12.02 Copayment Amount.

For purposes of determining the amount of benefits under Section 12.01, a covered person must first satisfy the copayment requirements outlined in Attachment B.

12.03 Coinsurance.

The HMO plan will pay a portion of in-network covered expenses incurred within each plan year, and which are in excess of the copayment requirements of Section 12.02 as outlined in Attachment B. Mental health and substance abuse benefits are not payable at the one hundred (100) percent level.

(A) Inpatient Benefits. The HMO plan will pay the following benefits for mental health and substance abuse treatment received in an inpatient setting.

(1) In-Network. In the event of covered expenses for those inpatient services received from and payable to a provider affiliated with and specifically referred by the mental health and substance abuse management program, the reimbursement percentage is indicated in Attachment B, provided the copayment has been paid. No benefits are payable for services rendered out-of-network unless pre-approved by the claims administrator or in a life-threatening emergency.

(2) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those inpatient services received, which are determined by the mental health and substance abuse management program not to be medically necessary and/or clinically necessary, the HMO plan will make no benefit payments.

(B) Outpatient. The HMO plan will pay the following benefits for mental health and substance abuse treatment received in an outpatient setting:

(1) In-Network. In the event of covered expenses for those in-network outpatient services received from and payable to a provider referred by the mental health and substance abuse management program, the reimbursement percentage is indicated in Attachment B, provided the copayment has been met. No benefits are payable for services rendered out-of-network unless pre-approved by the claims administrator or in a life-threatening emergency.

(2) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those outpatient services received, which are determined by the mental health and substance abuse management program not to be medically necessary and/or clinically necessary, the HMO plan will make no benefit payments.

12.04 Benefits for Detoxification.

In the event of covered expenses for a detoxification program, benefits will be paid at the level indicated in Attachment B. The limitations on the number of days and length of stay allowed will be as outlined in Attachment B.

12.05 Stop Loss.

For the purposes of mental health and substance abuse benefits, the HMO plan does not contain a stop loss provision. There is no maximum amount of out-of-pocket expenses that a covered person may incur for treatment of mental health and substance abuse.

12.06 Maximum Benefits.

(A) Lifetime Maximum. There are no lifetime dollar maximums under the HMO plan.

(B) Annual Maximum. Inpatient care for mental health treatment is limited to thirty (30) days per year. Inpatient/intermediate care for alcohol and drug dependency services is limited to two (2) five (5) day detox and one (1) twenty-eight (28) day admission per lifetime. Outpatient care for mental health/substance abuse treatment is limited to forty-five (45) combined visits per year. Intermediate care (halfway houses, residential treatment facilities, partial hospitalization) is treated as one-half inpatient day subject to the HMO plan total of applicable days.

12.07 Mental Health/Substance Abuse Management Program.

The mental health/substance abuse management programs described in this Section 12.07 shall include requirements governing pre-admission certification, outpatient referrals, case management and EAP benefits. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. A medical management function which occurs at or prior to admission to determine whether or not the admission is both medically necessary and/or clinically necessary and appropriate for the individual patient. The result is a recommendation for treatment.

(B) Outpatient Referrals. The process in which a patient is introduced to a health provider for treatment.

(C) Case Management. A process that evaluates the medical necessity and appropriateness of treatment.

(D) EAP Benefits. Employee assistance program services are available to all full-time employees and eligible dependents, retirees and COBRA participants enrolled in a state-sponsored health plan. Services consist of short-term counseling (up to six [6] sessions per episode) for problems such as marital or family, emotional, substance abuse, stress, job and financial loss. Legal consultation via telephone is also available. If an employee or dependent is determined to need greater assistance, they will be referred to other resources. All EAP services must be pre-authorized.

(E) Procedures. In order to receive benefits, all inpatient and outpatient mental health, substance abuse and EAP services must be pre-authorized by the mental health/substance abuse management program.

ARTICLE XIII
COVERED EXPENSES
(HMO)

Each reference to an attachment in this article shall mean one of the applicable HMO attachments. Each reference to a specific section shall mean the applicable section within this HMO article unless otherwise specified.

13.01 Conditions.

All medical services, medical treatment and medical expenses will be considered covered expenses pursuant to this plan if:

(A) They are listed in Sections 13.02 or 13.03;

(B) They are not excluded under the exclusions from coverage under Section 13.04;

(C) They are determined to be medically necessary and/or clinically necessary by the claims administrator;

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

(E) Are consistent with plan policies and guidelines.

The committee, or its representative, shall make determinations regarding whether expenses will be considered covered expenses pursuant to (A) and (B) above. Medical specialists shall be consulted to determine whether a medical service, treatment or expense is medically necessary and/or clinically necessary. All medical claims from a hospital, physician or other provider shall be examined to determine whether the services, treatment and expenses were medically necessary and/or clinically necessary. If the medical specialist determines the treatment was not medically necessary and/or clinically necessary, the physician of the covered person for whom the claim is submitted can choose to provide additional information. If after examining the additional information it is determined that the service, treatment or expense was not medically necessary and/or clinically necessary, the claim shall not be considered as a covered expense by the plan, and the covered person may be responsible for payment of all of the bills associated with that claim, subject to the appeal process as described in Section 6.05.

13.02 Covered Expenses - Generally.

The charges for the following services and supplies are eligible covered expenses under the HMO plan:

(A) Hospital room and board charges for a semi-private room, which includes all room, board and ancillary services for the type of care provided as authorized through the medical management program review under the HMO plan. Additional charges for a private room will only be considered when isolation of the patient is medically necessary and/or clinically necessary as determined by the claims administrator to reduce the risk of receiving or spreading infection. The plan will pay the most prevalent room rate charge when the unit or facility does not provide semi-private rooms. Hospital services must be pre-authorized by a PCP or within twenty-four (24) hours if an emergency under the HMO plan.

(B) Services and supplies furnished to the eligible covered persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an injury or illness, including consultations with a physician requested by the covered person's physician.

(C) Charges for "surgical procedures." Surgical procedures shall mean the generally accepted operative and cutting procedures rendered by a physician for the necessary diagnosis and treatment of an injury or illness, including treatment of fractures or dislocations, maternity care, any diagnosis of burns and abrasions and any endoscopic procedure (i.e. sigmoidoscopy, cystoscopy, etc.). During one (1) operation, a physician may perform two (2) or more surgical procedures through the same incision. In this situation, payment is equal to the full benefit amount for the most expensive procedure plus one-half of the benefit amount for the other procedure.

(D) Office visits to a physician that are due to an injury or illness.

(E) Private-duty or special nursing charges (including intensive nursing care) for medically necessary and/or clinically necessary treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative, if prescribed by the attending physician.

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

(G) Charges for diagnostic laboratory and x-ray services including, but not limited to: laboratory examinations, metabolism tests, cardiographic examinations and encephalographic examinations.

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

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

(J) Charges for speech therapy by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. Speech therapy benefits are limited to a maximum of forty-five (45) visits, per condition, per plan year according to a prescription from a physician concerning the nature, frequency and duration of treatment under the plans.

(K) Charges for treatment received by a licensed doctor of podiatric medicine provided treatment was within the scope of his/her license.

(L) Charges for chemotherapy and radiation therapy when medically necessary as determined by the claims administrator.

(M) Charges for hemodialysis.

(N) Charges for the taking or the reading of an x-ray, CAT scan, MRI (upon approval of the claims administrator) or laboratory procedure, including physician charges and hospital charges. Positron emission tomography (PET) is a covered expense when determined to be medically necessary by the claims administrator. PET scan technology is currently considered experimental and investigative in many applications. Covered persons or their provider should verify medical necessity and benefit eligibility prior to incurring charges for use of this technology.

(O) Charges for laser procedures, other than those specifically excluded in Section 13.04.

(P) Charges for lithotripter treatment.

(Q) Charges for transfusion services for autologous blood and blood components.

(R) Lab charges and associated office visits for pap smears (annually).

(S) Cryosurgical ablation of the prostate is covered only when approved by the claims administrator.

(T) Charges for esophageal PH monitoring for the diagnosis of gastroesophageal reflux when the patient meets specific criteria as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator for these services.

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

(1) Knee replacement surgery; and

(2) Anterior cruciate ligament repair.

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

(V) Percutaneous lumbar discectomy (PLD) is a covered outpatient procedure only when the patient meets specific criteria, as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator.

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

(1) Single Pharmacy Limitation.

If the claims administrator or administrative services organization (ASO) has the reasonable belief that a covered person is receiving covered services in an excessive, dangerous, or medically inadvisable amount, and this belief is based upon the professional opinion of a medical doctor and a pharmacist, the claims administrator may impose a limitation on services providing that the covered person may only receive services from one specific pharmacy. The covered person must receive advance written notification of any such restriction stating the reasons for this restriction. The restriction must provide an exception for emergency services. The covered person has the right to request removal or modification of such restriction. The claims administrator will respond in writing to any written request for removal or modification. The covered person also has the right to appeal such restriction pursuant to Section 6.05.

(2) Drugs and medicines (unless excluded under Section 13.04) requiring written prescription of a physician, approved for use by the Food and Drug Administration and dispensed by a licensed pharmacist or physician. This includes over-the-counter drugs which require pharmacist preparation prior to patient use. Investigational new drugs (FDA designation), if published peer review literature indicates beneficial and effective patient care;

(3) "Off-label" (FDA approved but not for treatment of the condition for which it is prescribed) prescription drugs;

(4) Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:

(a) Prescription must be written by a licensed physician;

(b) Prescriptions are for a ninety (90) day period only; and

(c) Benefit is allowable once per year, with a maximum lifetime benefit of two (2) ninety (90) day periods.

(5) Surgical supplies including bandages and dressings;

(6) Insulin, the related syringes (including needle-free syringes when medically necessary as determined by the claims administrator based on the patient's age, weight, skin and medical condition and/or the frequency of injections), home blood glucose monitors and related supplies for the treatment of diabetes as approved by a physician;

(7) Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to $250 per calendar year. Coverage for additional training and education is available when a significant change occurs in the patient's symptoms or condition which necessitates a change in the patient's self-management or when a physician determines that re-education or refresher training is needed and determined to be medically necessary;

(8) Blood plasma or whole blood;

(9A) Artificial eyes - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness;

(9B) Artificial limbs - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness, with the following exceptions:

(a) One (1) additional limb prosthesis past age eighteen (18) if additional surgery has altered the size or shape of the stump; or

(b) Replacement of the original limb prosthesis if a severe medical condition to the stump could result from improper fitting of the initial prosthesis as determined by a physician. Replacement must be within twelve (12) months of the initial purchase of the limb prosthesis and proof of medical severity must be furnished to the claims administrator. The claims administrator must furnish written approval to the covered person prior to the replacement purchase.

(9C) Replacement prosthesis - As determined by the claims administrator, benefits are available for the purchase, fitting, necessary adjustment, repairs and replacement of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding artificial heart and dental appliances). Replacement costs will be covered only if the prosthetic appliance was used by the employee or dependent of the employee in the manner and for the purpose for which such appliance was intended and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. Benefits are not available for prosthetic appliances to replace those which are lost, damaged, stolen or prescribed as a result of improvements in technology.

(10) Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, surgical collars, lumbosacral supports, corsets-back and special surgical, trusses, and rigid back or leg braces. Orthopedic shoes for the correction of a deformity or abnormality of the musculoskeletal system are only considered for coverage when attached to a brace;

(11) Foot orthotics, devices or rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions, including shoes for diabetic conditions, when prescribed by a physician and are medically necessary as determined by the claims administrator. Examples of items **not** considered to be a foot orthotic are:

(a) Inner soles (foam rubber, leather, flexible, etc.);

(b) Corn plasters (pads, etc.); and

(c) Foot padding (adhesive moleskin, etc.);

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

(13) X-ray, radium and other radioactive substances;

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

(15) Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus;

(16) If elected by the covered person following a mastectomy, coverage shall include:

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

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

(c) Prostheses, pursuant to Section 13.02(W)(9C), and physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year.

(17) The purchase or rental (not to exceed the total maximum allowable charge for purchase) of durable medical equipment as outlined in the applicable section and attachment;

(18) Immunizations, including hepatitis B immunizations, unless the employer is mandated to pay for the immunization;

(19) Transrectal prostatic ultrasound, when a physical examination of the prostate indicates the presence of nodules;

The following shall pertain to in-network services only:

(20) Vision and hearing screening annually;

(21) Family planning and infertility services including history, physical examination, laboratory tests, advice and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing and treatment for organic impotence. If fertility services are initiated (including, but not limited to artificial insemination or in-vitro fertilization) benefits will cease;

(22) Nutritional guidance and other health educational services when medically appropriate as determined by the claims administrator; and

(23) In-network preventative care including annual routine health assessments, bone density scans, routine women's health (including mammography [see limitations in Section 13.03C], chlamydia and cervical cancer screening) and childhood immunizations.

(X) Ketogenic diet counseling (must be enrolled in case management).

13.03 Other Covered Expenses.

(A) Convalescent Care. Upon receipt of proof that a covered person has incurred medically necessary expenses related to convalescent care, the plan shall pay for charges for convalescent facility room, board and general nursing care, provided:

(1) A physician recommends confinement for convalescence;

(2) The covered person is under the continuous care of a physician during the entire period of confinement;

(3) The confinement is required for other than custodial care; and

(4) Services were pre-authorized by the claims administrator.

Eligible charges for convalescent facility room, board and general nursing care shall only include:

(1) Charges not to exceed the charge for its greatest number of semi-private rooms; and

(2) Charges up to and including the one-hundredth (100th) day of confinement during any plan year.

(B) Maternity Benefits. The plan provides coverage for pregnancy, childbirth or related medical conditions on the same basis as any other illness, unless the covered person is acting as a surrogate mother (carrying a fetus to term for another woman) in which case no benefits will be payable. Hospital admissions for maternity coverage and childbirth will be available for a minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a caesarean delivery. No additional approval or authorization is needed for lengths of stay that fall within these timeframes. A covered person is not required to stay in the hospital for a fixed period of time following the birth of her child. New benefits will apply if transferring to another health plan prior to delivery.

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

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

Covered expenses of a newborn child shall include:

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

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

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

(d) The newborn child's usual and ordinary nursery and pediatric care at birth are covered.

(C) Mammogram Screening. The plan provides coverage for mammogram screenings within the following guidelines:

(1) Once as a baseline mammogram for ages 35-39;

(2) Once every year for ages 40 and over; or

(3) When prescribed by a physician.

(D) Cochlear Implantation. The plan provides coverage for cochlear implantation using FDA-approved cochlear implants provided **all** of the following criteria are met:

Adults (Age 18+).

(1) Diagnosis of post-lingual profound deafness;

(2) Patient has achieved little or no benefit from a hearing aid;

(3) Patient is free from middle ear infection, has an accessible cochlear lumen that is structurally suited to implantation and is free from lesions in the auditory nerve and acoustic areas of the central nervous system;

(4) Patient has the cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and

(5) Patient has no contraindications to surgery.

Children (Age 2-17).

(1) Diagnosis of bilateral profound sensorineural deafness; and

(2) Patient has achieved little or no benefit from a hearing or vibrotactile aid, as demonstrated by the inability to improve on an age-appropriate closed-set word identification task.

An electrophysiological assessment should be performed to corroborate behavioral evaluation in very young children who cannot be adequately evaluated by standard audiometry tests. This assessment may consist of an auditory brain stem evoked response or similar test which would be covered when medically necessary as determined by the claims administrator.

A minimum six (6) month trial with appropriate amplification (hearing aid or vibrotactile aid) and rehabilitation should be performed for children to ascertain the potential for aided benefit.

(E) Hospice Care Program. When approved by the claims administrator, the plan shall provide hospice care, as provided in the applicable section, designed to provide covered persons who are terminally ill (a person whose life expectancy is six [6] months or less) with dignified, comfortable and less costly care the few months or weeks prior to death. This program shall be administered through an approved hospice. Care provided shall include physical, psychological, social and spiritual for dying persons and their families, rendered by a medically supervised interdisciplinary team of professionals and volunteers on a twenty-four (24) hour on-call basis.

(F) Home Health Care. The plan shall provide benefits for the services of part-time or intermittent home nursing care, given or supervised by a registered nurse (R.N.), but only if the services are certified as medically necessary and pre-authorized by the claims administrator and referred by a PCP under the HMO plan. Visits under the HMO plan are limited to one hundred twenty-five (125) per plan year. Home health aide care is also a covered service with the following limitations:

(1) No more than thirty (30) visits per plan year;

(2) A visit shall be four (4) or fewer hours;

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

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

(5) The home health aide service is in conjunction with medically necessary skilled care.

Intravenous (I.V.) therapy administered in the home during these visits is a covered service, provided the medication is approved for use by the Federal Drug Administration. Case management services will be requested by the physician, patient or employer for home health cases requiring extensive care.

(G) Rehabilitation Therapy. The plan shall provide pre-authorized inpatient and/or outpatient physical therapy benefits for services for conditions resulting from illness or injury, or prescribed immediately following surgery related to the condition. Outpatient benefits under the plans are limited to a maximum of forty-five (45) visits, per condition, per plan year according to a prescription from a physician concerning the nature, frequency and duration of treatment. Therapy shall include functional, physical and occupational therapy to the extent such therapy is performed to regain use of the upper or lower extremities, or if the covered person is a child, as long as improvement in the covered person's condition continues (subject to the limitations contained in this Section 13.03). Occupational therapy shall not include vocational therapy or vocational rehabilitation, nor educational or recreational therapy on an outpatient basis.

Phase I and Phase II (as defined below) cardiac rehabilitation services will be a covered expense provided they meet the following criteria:

(1) Phase I includes inpatient rehabilitation services that begin during hospitalization and extended until discharge; and

(2) Phase II includes supervised ambulatory services that follow discharge and extend until the patient becomes sufficiently independent to perform prescribed exercise and carry out any recommended long-term lifestyle changes. Phase II services are limited to three (3) sessions per week for a maximum of twelve (12) weeks.

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

(H) Sitter. A sitter who is not a relative (i.e. spouse, parent, child, brother or sister by blood, marriage or adoption or member of the household) of the covered person may be used in those situations where the covered person is confined to a hospital as a bed patient and certification is made by a physician that an R.N. or L.P.N. is needed and neither (R.N. or L.P.N.) is available.

(I) Covered Dental Expenses.

(1) Charges for orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function of a covered person.

(2) Charges for extraction of impacted wisdom teeth, excision of solid based oral tumors, treatment of accidental injury (other than by eating or chewing) to sound natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary as determined by the claims administrator) providing the accident occurred while the individual was covered under a state-sponsored plan and has remained continuously covered.

(3) Charges for the facility and related medical services when hospitalization for dental services is determined medically necessary by the claims administrator.

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

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

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

(c) Mental illness or handicap precludes dental/surgical management in an office setting;

(d) When general anesthesia is used or;

(e) For children eight (8) years and younger benefits will be provided for anesthesia (inpatient or outpatient) and any expenses associated with a dental procedure that cannot be safely provided in the office. Benefits will be available for anesthesia regardless of whether or not the base procedure is covered by the insurance program.

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

(a) History, exams and office visits;

(b) X-rays of the joint;

(c) Diagnostic study casts;

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

(e) Medications; and

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

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

(a) Prosthodontic treatments (dentures, bridges);

(b) Restorative treatment (fillings, crowns);

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

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

(J) Organ Transplants. Organ transplant benefits will be paid for covered medical expenses related to transplants of the: heart, heart/lung, lung, liver, kidney, pancreas, pancreas/kidney, cornea, small bowel, small bowel/kidney and certain bone marrow transplants. Transplant services or supplies require pre-authorization before any pre-transplant evaluation or any covered service is performed. Coverage will include expenses incurred for donor search and organ procurement by the transplant center or hospital facility and all inpatient and outpatient hospital/medical expenses for the transplant procedure and related pre- and post-operative care, including immunosuppressive drug therapy. Should a transplant request fall outside those addressed and covered by the *Plan Document*, the claims administrator will review the information provided and render a decision based on acceptable medical practices on behalf of the state insurance program. The claims administrator will notify the Division of Insurance Administration of its decision prior to approving such services. If the service(s) or procedure(s) does not meet the claims administrator's accepted medical standards, the covered person will be notified of their option to appeal the decision as described in Section 6.05. If a network facility is utilized for the transplant, travel and living expenses will be covered from the initial evaluation to one year after the transplant (for medically necessary visits only as determined by the claims administrator). Air transportation, if necessary, will be paid at commercial coach fare. Ground travel will be paid at the State of Tennessee approved mileage rate. Additionally, hotel and meal expenses will be paid up to $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.

If the donor is not a covered person and the recipient is covered under the plan, the donor will be considered eligible for coverage for expenses which are incurred during hospitalization for the transplant procedure and which are not covered by another group health plan. Covered services include those services and supplies directly related to the transplant service itself such as removal of the organ from the donor's body, preservation of the organ and transportation of the organ to the site of transplant. The aggregate limit for organ procurement is $10,000 per covered procedure. No benefits are payable for donor services for recipients who are not covered under the plan. These services are ineligible

even when the recipient does not provide reimbursement for the donor's expenses. Bone marrow transplantation will fall into one (1) of three (3) categories: syngeneic, allogeneic or autologous.

Expenses eligible for coverage include the charge to harvest bone marrow for covered persons diagnosed with any covered malignant condition or any conditions approved for coverage by the claims administrator. Coverage for harvesting, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow will be covered when re-infusion is scheduled within three (3) months or less. Autologous bone marrow transplantation is considered investigational in the treatment of other malignancies, including primary intrinsic tumors of the brain.

(K) Well-Baby, Well-Child Care. Physician office visits for routine check-ups and immunizations are covered expenses for children and teenagers through age seventeen (17) under the HMO plan. Said services must be received in-network.

(L) Prostate Screening. The plan will cover PSA (prostate specific antigen) and transrectal ultrasound for the following conditions:

(1) Annually in men who have been treated for prostate cancer with radiation therapy, surgery or chemotherapy;

(2) Annually in men over the age of forty-five (45) who have enlarged prostates as determined by rectal examination; and

(3) Annually in men of any age with prostate nodules or other irregularity noted on rectal exam.

The plan will cover PSA for the primary screening of men over the age of fifty (50) and will cover transrectal ultrasound in these individuals with an elevated PSA.

(M) Biofeedback Therapy. The plan shall provide benefits for biofeedback therapy which is determined to be medically necessary with a maximum benefit of five (5) sessions per calendar year for each of the following conditions:

(1) Chronic pain;

(2) Incontinence;

(3) Migraine headaches; and

(4) Incapacitating stress.

(N) Bariatric Surgery (weight reduction). The plan will cover as outlined below, two (2) surgical procedures for treatment of morbid obesity:

(1) Vertical banded gastroplasty accompanied by gastric stapling

(2) Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum

The following criteria must be met before benefits are available for the two (2) surgical procedures listed above:

(1) Presence of morbid obesity that has persisted for at least five (5) years, defined as either:

(a) Body mass index (BMI) exceeding forty (40); or

(b) More than one hundred (100) pounds over one's ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or

(c) BMI greater than thirty-five (35) in conjunction with the following severe co-morbidities that are likely to reduce life expectancy:

1. Coronary artery disease; or
2. Type 2 diabetes mellitus; or
3. Obstructive sleep apnea; or
4. Three or more of the following cardiac risk factors:

a. Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)

b. Low high-density lipoprotein cholesterol (HDL less than 40mg/dL)

c. Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)

d. Current cigarette smoking

e. Impaired glucose tolerance (2-hour blood glucose>140 mg/dL on an oral glucose tolerance test)

f. Family history of early cardiovascular disease in first-degree relative (myocardial infarction at age under fifty [50] in male relative or at age under sixty-five [65] for female relative)

g. Age greater than forty-five (45) years in men and fifty-five (55) years in women

(2) History of failure of medical/dietary therapies (including low calorie diet, increased physical activity, and behavioral reinforcement). This attempt at conservative management must be within two (2) years prior to surgery, and must be documented by an attending physician who does not perform bariatric surgery.

(Failure of conservative therapy is defined as an inability to lose more than ten [10] percent of body weight over a six [6] month period and maintain weight loss.)

The claims administrator will determine if all the criteria have been met before approving surgery.

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

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

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

(3) Routine screenings among the elderly is considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

(P) Hearing Impairment Screening and Testing. The plan will cover, as determined by the claims administrator, medically necessary hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The claims administrator has determined eligibility of many of the tests/screenings to be specific to infants. Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.

(Q) Nutritional Treatment of Inborn Errors of Metabolism. The plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup urine disease, homocystinuria, methylmalonic acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the claims administrator.

13.04 Exclusions and Limitations.

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

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

(2) Drugs and medicines which can be obtained without a written prescription (over-the-counter), except as covered pursuant to Section 13.02(W)(2);

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

(4) Services and supplies (notwithstanding organ donations) provided by an immediate family member of an eligible employee or covered dependent. Immediate family members include spouse, parent, child, brother or sister, by blood, marriage or adoption;

(5) Services rendered prior to the effective date of coverage;

(6) Services incurred after the covered person's coverage under this plan is terminated;

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

(8) Charges for the removal of corns or calluses, or trimming of toenails;

(9) Treatment of an injury or illness due to declared or undeclared war;

(10) Charges incurred outside the United States (including those for drugs and medicines subject to FDA approval and federal law) unless the charges are incurred while traveling on business or for pleasure by a covered person who is a resident of the United States and a medical emergency arises;

(11) Charges which the claims administrator determines to be in excess of the maximum allowable charge for that procedure or supply and for charges made which are not medically necessary as determined by the claims administrator;

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

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

(14) Expenses incurred for contact lenses, eyeglasses, sunglasses or for examinations for prescription or fitting of eyeglasses or contact lenses, except as may be allowed pursuant to Section 13.02;

(15) Expenses incurred for hearing aids or for examinations for prescription or fitting of hearing aids (except as previously defined in Section 13.02);

(16) Charges incurred in connection with cosmetic surgery directed toward preserving or improving a patient's appearance, including but not limited to: scar revisions, rhinoplasty, prosthetic penile implants, saline injections for the treatment of varicose veins and reconstructive surgery where no significant anatomic functional

impairment exists. All services must be medically necessary as determined by the claims administrator. This exclusion will **not** apply to the following conditions:

(a) The covered person experienced a traumatic injury or illness, while covered by a state-sponsored plan, which requires the cosmetic surgery;

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

(c) If elected by the covered person following a mastectomy:

(i) Reconstruction of the breast on which the mastectomy has been performed,

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) Prostheses, pursuant to Section 13.02(W)(9C) and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year;

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

(17) Arch supports and other foot support devices, except for orthotic devices as defined in Section 13.02(W)(11);

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

(19) Garter belts;

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

(21) Hotel charges or travel expense incurred while receiving treatment as an inpatient or outpatient, (other than defined in Section 13.03J or Attachment A);

(22) Unapproved sitters;

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

(24) Non-surgical services, including prescription medication for weight control or reduction (obesity). Surgical services are also excluded unless specifically listed in Section 13.03;

(25) Experimental/investigational medical or surgical procedures and prescription drugs as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency;

(26) Organ transplants involving artificial implants and non-human organs, as well as any services or supplies in connection with experimental or investigational treatment, drugs or procedures;

(27) Reversal of sterilization procedures;

(28) Services or supplies for which there is no charge to the covered person, or for which the covered person would not have been charged if not covered by this plan;

(29) Surgery or treatment for, or related to, sex transformations or sexual dysfunctions or inadequacies, including penile prosthesis due to psychogenic impotence;

(30) Services or supplies in connection with artificial insemination, in vitro-fertilization or any procedure intended to create a pregnancy;

(31) Telephone consultations;

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

(33) Durable medical equipment not specified in Sections 13.02, 13.03 or Attachment C or Attachment D, as applicable;

(34) The purchase or rental of any device, mechanical aid or other contrivance which may be required for the transportation of an individual on a public conveyance; roadway or other means of transportation, with the exception of those items specifically included as an eligible medical expense;

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

(36) Custodial care (as defined in Section 1.11);

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

(38) Services of a private-duty nurse which would normally be provided by hospital nursing staff;

(39) Diapers (incontinent pads);

(40) Cranial prosthesis (wig);

(41) Nutritional supplements and vitamins (except injectable B-12 for the treatment of pernicious anemia). Nutritional treatment of inborn errors of metabolism is not excluded under this clause as noted in Section 13.03(Q);

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

(43) Chiropractic care;

(44) Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, collection and handling fees, or telephone consultations.

(B) Excluded Dental Expenses.

(1) Any dental care and treatment and oral surgery relating to the teeth and gums including but not limited to dental appliances; dental prostheses such as crowns, bridges or dentures; implants; orthodontic care except as provided in Section 13.03(I); operative restoration of teeth (fillings); dental extractions (except impacted wisdom teeth); endodontic care; treatment of dental carries, gingivitis or periodontal disease.

(2) Any other expenses incurred relating to the teeth and gums except those specifically provided as covered expenses pursuant to Section 13.03(I);

(C) On the Job Injuries and Illnesses. The plan will not be responsible for expenses for injuries or illnesses incurred on the job.

(D) Excluded Mental Health/Substance Abuse Expenses. In addition to relevant exclusions noted in Section 13.04(A), the following are specifically excluded under the mental health/substance abuse benefit:

(1) Court or employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the claims administrator.

(2) Services for disorders not included in the *American Psychiatric Association Diagnostic & Statistical Manual*, 4th Edition, on Axis I or II.

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

(4) Conditions classified as developmental disorders such as mental retardation, learning disabilities, pervasive developmental disorders, including autism and Asberger's, and academic or motor skill disorders.

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

(6) Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.

(7) Ecological or environmental medicine, diagnosis and/or treatment.

(8) Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes, and related expenses for reports, including report presentation and preparation.

(9) Services given by a pastoral counselor.

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

ATTACHMENT A

SCHEDULE OF HMO MEDICAL BENEFITS

	In-Network Benefits Only
COPAYMENTS & COINSURANCE	
Inpatient Services	
Physician Services	100% benefit
Hospital Services (the hospital copay is waived if readmitted within 48 hours of the initial visit for the same episode of an illness or injury)	$100 copay per admission
Outpatient Services	
PCP Office Visit	$15 copay
Specialist Office Visit	$20 copay
X-ray, Lab Diagnostics	100% benefit
Home Health Care (125 visits annually)	$15 copay per visit
Radiation, Cobalt and Radioisotope Therapy	100% benefit
Home Infusion Therapy	$15 copay per visit
Renal Dialysis	100% benefit
Hospice Care (See Section 13.03E)	100% benefit through an approved program
Allergy/Serum Injection	$0 Nurse, $15 PCP, $20 Specialist
Surgical Center Services	$15 PCP, $20 Specialist
Preventive Health/Well Care Services	
Well Child Care (Immunizations covered through age 17)	$15 copay PCP
Annual Health Assessments	$15 copay PCP
Nutritional Guidance (medically necessary)	$15 copay PCP
Family Planning/Infertility Services	$15 copay PCP, $20 Specialist
Annual Hearing & Vision Screening	$15 copay PCP, $20 Specialist
Pediatric Checkups	$15 copay PCP, $20 Specialist
Maternity Care	
Physician Care	$15 copay, 1st visit only (OB/GYN or PCP)
Hospital Care	$100 copay per admission
Midwives (must be hospital based)	100% benefit
Specialist	$20 copay
Prescription Drugs	
Generic	$5 copay (or cost if less)
Preferred Brand	$20 copay (or cost if less)
Non-Preferred Brand	$40 copay (or cost if less)
Retail Pharmacy up to a 34-day supply and Home Delivery up to a 100-day supply for one copay	

ATTACHMENT A (continued)

SCHEDULE OF HMO MEDICAL BENEFITS

	In-Network Benefits Only
Rehabilitation Services	
Inpatient Services	100% per diem after $100 copay
Outpatient Services (45 visit limit per condition per plan year – speech, occupational & physician therapy)	100% of MAC after $15 copay per visit
Skilled Nursing Facility (limited to 100 days per year following approved hospitalization – prior authorization required)	100% benefit
Emergency Services (See Sections 11.06 and 11.12)	
Emergency Room Copay (the copay is waived if admitted for more than 23 hours or if readmitted within 48 hours of the initial visit for the same episode of illness or injury)	$50 copay per visit
Ambulance Services	
Air and Ground (must be medically necessary)	100% of reasonable charges
Appliances & Equipment (See Section 11.14D)	
Durable Medical Equipment	100% benefit
Supplies	$5 copay (31 day supply)
Other	
Life Threatening Emergency (in-state or out-of-state)	100% of reasonable charges after applicable copay
Life Threatening Emergency (out-of-country)	100% of reasonable charges after applicable copay
Urgent Care Situation (in-state or out-of-state)	100% of reasonable charges if PCP referral given
Urgent Care Situation (out-of-country)	100% of reasonable charges if PCP referral given or pre-approval of services by the claims administrator
Transportation Charges if Approved for Out-of-State Exception or Transplant (See Sections 13.02H and 13.03J)	100% of reasonable charges (limits may apply)

MAC = Maximum Allowable Charge

ATTACHMENT B

SCHEDULE OF HMO MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

	In-Network Benefits Only
COPAYMENTS & COINSURANCE (See Section 12.03)	
Inpatient – Intermediate Care Services (copayment waived if readmitted within 48 hours of the initial visit for the same episode of an illness)	$100 copay per admission
Outpatient	$20 copay per visit
Expenses determined not to be medically necessary by the utilization review organization	$0

Intermediate Care
Halfway houses, residential treatment facilities, partial hospitalization – treated as one-half inpatient day subject to plan total of applicable days.

Substance Abuse Limitations (See Section 12.06)

- Lifetime maximum: One inpatient stay – maximum of 28 days per stay
- Lifetime maximum: Two stays for detoxification – maximum of 5 days per stay

Mental Health Limitations (See Section 12.06)

- Inpatient care limit of 30 days per year (a daycare program is considered to be one-half day for purposes of this limitation).
- Outpatient care limit of 45 visits per year for mental health/substance abuse combined.

Additional Limitations

- The preauthorization process must be followed for all mental health and substance abuse benefits to be payable. No benefits are payable if services are not preauthorized.

ATTACHMENT C

LIST OF HMO DURABLE MEDICAL EQUIPMENT

Item of Equipment	Covered Purchase	Covered Rental	Not Covered	Covered Under Certain Circumstances
Air conditioner			X	
Air purifier, cleaner or filter			X	
Bathroom Chairs and Stools			X	
Bathtub Handrails			X	
Bedboards				X
Bedside Commode	X			
Blood Glucose Monitor	X			
Cane	X			
Compressor, Concentrator – oxygen				X
Continuous Positive Airway Pressure				X
Crutch	X			
Dehumidifier (room or central unit)			X	
Electric chair lift			X	
Electrical stimulator for bone growth (Bi-Osteogen, etc.)				X
Electrical stimulator (TENS)				X
Exercise Equipment			X	
Heater			X	
Heating Pad			X	
Heat Lamp				X
Hospital bed, twin size, standard, Siderails Trapeze				X X X
Hospital bed, twin size, electrical or deluxe				X
Hospital bed, Kinetic, Trauma bed, Roto Rest				X
Hospital bed with siderails				X
Hot Tub			X	
Hot water bottle			X	
Humidifier (room or central unit)			X	
Hydrocollator unit				X
Hydrocollator steam packs				X
Infusion Pump (insulin, chemotherapy)				X
Infusion regulating device (IVAC, etc.)				X
Iron Lung				X
IPPB Machine				X
Massage Device			X	
Massage (as part of hospital bed)				X
Mattress (air, gel or water for alternating pressure)				X
Mattress (any other)			X	
Monitor, SIDS (apnea)				X

ATTACHMENT C (continued)

LIST OF HMO DURABLE MEDICAL EQUIPMENT

Item of Equipment	Covered Purchase	Covered Rental	Not Covered	Covered Under Certain Circumstances
Overbed table				X
Oxygen-tanks, tents, regulators, flow meters, etc.	X	X		
Paraffin bath unit, portable or standard				X
Patient lift				X
Pulse tachometer			X	
Sauna bath			X	
Sphygmomanometer with cuff			X	
Stethoscope			X	
Suction machine (gomeo)				X
Sun lamp				X
Traction		X		
Ultraviolet cabinet, stand or bulbs				X
Walker	X			
Waterbed			X	
Wheelchair, standard				X
Wheelchair, electric				X
Wheelchair, custom made				X
Whirlpool			X	

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

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

PREFERRED PROVIDER ORGANIZATION LIMITED

(PPO LIMITED)

ARTICLE XI
MEDICAL BENEFITS
(PPO LIMITED)

Each reference to an attachment in this article shall mean one of the applicable PPO Limited attachments. Each reference to a specific section shall mean the applicable section within this PPO Limited article unless otherwise specified.

11.01 Amount of Benefits.

The amount of medical benefits provided by the plan is outlined in Attachment A, "Schedule of Benefits," which is attached to and made a part of the plan. Upon receipt of proof of loss, the plan shall pay (unless otherwise specified herein) a percent, pursuant to Section 11.03, of covered expenses incurred within each plan year and which are in excess of the deductible requirement, as described in Section 11.02. The amount of the medical benefits is further subject to the stop loss provisions of Section 11.05.

11.02 Deductible Amount.

The deductible amount is specified in Attachment A, and is required to be paid by each covered person prior to payment of any covered medical expenses (excluding prescription drugs) under the plan. For individuals who transfer between plans, the deductible met under the local education or state plan shall be considered when determining the maximum plan year deductible. For individuals who continue insurance coverage through retirement or the provisions of COBRA, the deductible met while an employee shall be considered when determining the maximum plan year deductible.

(A) Individual Deductible. In the event that the covered person has incurred covered expenses equal to the deductible dollar amount shown in the Attachment A in a plan year, such covered person shall have satisfied the deductible requirement of the plan for such plan year and shall be entitled to receive reimbursement for additional covered expenses pursuant to Section 11.03. There is a separate deductible for mental health and substance abuse benefits shown in Attachment B.

(B) Family Deductible. In the event that covered persons of the same family independently incur covered expenses in a plan year so that the total of which would satisfy the family deductible outlined in Attachment A, then the deductible requirement of the plan shall have been satisfied for such plan year and each and every covered person of such family shall be

entitled to receive reimbursement for additional covered expenses pursuant to Section 11.03.

(C) Common Accident Deductible. If two (2) or more individuals who are members of one (1) family incur covered expenses as a result of injuries sustained in the same accident while coverage for medical care expense benefits pursuant to the plan is in force with respect to each of them, the applicable deductible shall be applied only once to the total of their covered expenses incurred during the plan year in which such accident occurred.

(D) Deductible Credit for Pregnancy. If a pregnant covered person registers in the voluntary babies first program pursuant to Section 13.03(B)(3) before the end of her first trimester, a $50 credit toward her deductible for the applicable plan year will be given. If the deductible has been satisfied for the plan year, the participant will be issued a check in the amount of $50.

11.03 Coinsurance.

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

(A) PPO Limited Expenses - Hospital and Physician. In the event of covered expenses for those services received from and payable to a health care provider affiliated with the PPO Limited, the applicable coinsurance percentage shall be the percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met.

(B) Non-PPO Limited Expenses - Hospital and Physician. In the event of covered expenses which are not described in subparagraph (A), the applicable coinsurance percentage shall be the percentage as indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met.

(C) Unique Care. Highly specialized treatment, which is determined not to be available through a PPO Limited provider (as determined by the claims administrator) and as such may be provided by a non-PPO Limited provider, is paid as if a PPO Limited expense. The covered person is responsible for expenses determined not to be medically necessary and expenses that exceed the maximum allowable charge. These exceptions must be pre-approved by the claims administrator. A continuous care exception may be granted when a covered person

is undergoing an active treatment plan for a serious medical condition, including pregnancy. The claims administrator determines the time frame in which continuous care can be covered.

(D) Non-Compliance with Utilization Management Program. In the event that the guidelines of the utilization management program, as outlined in Section 11.07, have not been followed, as applicable, the applicable coinsurance percentage is the percentage as indicated in Attachment A, after the deductible has been met. Expenses incurred at non-PPO Limited providers that are determined not to be medically necessary as determined by the claims administrator will not be reimbursed by the plan, but will be the responsibility of the covered person.

(E) Non-Hospital and Non-Physician Expenses. In the event of covered expenses for non-hospital and non-physician services, the applicable coinsurance percentage is the percentage indicated in Attachment A, provided that the guidelines of the utilization management program, as outlined in Section 11.07, have been followed, if applicable, and the deductible has been met. Expenses incurred in conjunction with this subsection E include, but are not limited to the following: physical therapy, occupational therapy, speech therapy, ambulance, dialysis clinics, sitters, private duty nursing, and dentists.

(F) Hospital-Based Providers. In the event of covered expenses incurred with hospital-based providers, reimbursement will be made at the PPO Limited level of benefits. The covered person will not be responsible for any expenses which exceed the maximum allowable charge for any providers of service that are hospital-based providers. Hospital-based providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists, and pathologists.

(G) Emergency Out-of-State. In the event of covered expenses for emergency care as outlined in Section 1.15 (threat to life or limb) outside Tennessee, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, benefits will be paid at the non-PPO Limited level.

(H) Emergency Inside Tennessee. In the event of covered expenses for emergency care as outlined in Section 1.15 (threat to life or limb) in a non-PPO Limited hospital in Tennessee, benefits will be paid as indicated in Attachment A. The claims administrator will determine if the admission was an emergency (when determining if an emergency situation exists, the

claims administrator will also determine when the medical condition became an emergency situation). If it is determined that it was not an emergency, benefits will be paid at the non-PPO Limited level.

The claims administrator will determine if an emergency situation exists and, if so, when the medical condition became an emergency situation. Benefits will be reduced to non-PPO Limited levels if the patient is not transferred to a PPO Limited facility once the medical condition allows.

(I) Out-of-State Retirees, Employees, Spouses, Dependent Children and COBRA Participants. Retirees and their dependents, COBRA participants, and spouses and dependent children who permanently reside out of state should utilize the out of area program as established by the claims administrator. This program allows covered persons of the plan to utilize participating network physicians, facilities and agencies that participate in the network established by the claims administrator within each state. Plan participants who choose a network participating provider will receive benefits as outlined in Attachment A. Employees and their dependents who are stationed outside of Tennessee on a job assignment and continue to be paid as an employee should also utilize the out of area program to obtain maximum benefits under this plan. Employees and dependents who reside out of state and work in Tennessee will receive benefits as indicated in Attachment A for PPO Limited and non-PPO Limited expenses.

(J) Out-of-Country Benefits. In the event that expenses are incurred for medically necessary services rendered while a covered person is out of the country, benefits shall be paid as indicated in Attachment A. Should charges be incurred in a non-English speaking country, claims should be translated to standard English at the covered person's expense before being submitted to the claims administrator. The current exchange rate should also be provided.

(K) Pharmacy Program. In the event that expenses are incurred for prescription drugs, the applicable copayment shall be paid by the employee or dependent as indicated in Attachment A.

(L) Geographic Areas Where the Committee Has Determined the PPO Limited Network to Be Insufficient. The committee retains the right to determine if the covered persons in a specific geographic area do not have adequate access to PPO Limited providers (either in total or specific specialties). If this determination is made at any time, the committee will direct the claims administrator to provide benefits in these areas, at a reimbursement level as determined by the committee even when non-PPO Limited providers are utilized.

11.04 Emergency Room Visit Copayment.

The covered person is responsible for payment of a copayment equal to the dollar amount shown in Attachment A for each visit to a hospital emergency room. This amount is waived if the visit results in an admission (of more than twenty-three [23] hours) to the hospital with a bed assignment, a walk-in clinic is used, or the visit to the emergency room is subsequent to an initial visit to an emergency room for the same episode of an injury or illness within forty-eight (48) hours. The deductible amount shown in Attachment A applies whether the covered person is admitted to the hospital or not. The copayment applies to the stop loss provision, but not to the deductible.

11.05 Stop Loss Provision.

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

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

(C) Limitation on Stop-Loss Coverage. Notwithstanding the foregoing, for purposes of subsections (A) and (B) of this section, covered expenses shall not include expenses (inpatient or outpatient) for treatment of mental health disorders and/or substance abuse, after the applicable deductible has been met, prescription drug copayments, or expenses incurred for any services not in compliance with the guidelines of the utilization management program.

11.06 Maximum Benefits.

There is no dollar amount lifetime maximum benefit applied to the Preferred Provider Organization Limited plan.

11.07 Utilization Management Program(s).

The utilization management programs shall include requirements governing pre-admission certification, post-certification of emergency admissions, weekend admissions, optional second surgical opinions, mandatory outpatient procedures, home health, case management, private duty nursing, durable medical equipment and pharmacy program. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. In order to assure the necessity, appropriateness and quality of the hospital care a covered person receives, the committee shall retain a utilization review organization to review all general hospital admissions to certify medical necessity and length of stay.

Non-emergency hospital admissions are to be reviewed prior to being admitted to the hospital in accordance with the procedures found in this document.

Emergency admissions must be reviewed within twenty-four (24) hours or one (1) working day after admission. However, even if an emergency admission procedure is not followed, the hospital pre-admission certification procedure shall be deemed to have been followed if the utilization review organization later determines that the hospital admission was medically necessary as determined by the claims administrator.

In order to satisfy the guidelines of the utilization management program, the utilization review organization shall require elective admissions to begin on a weekday unless there is sufficient justification that the admission be made on a weekend.

Tests and other procedures that can be safely and effectively performed on an outpatient basis will be required to be administered in an outpatient setting to satisfy the guidelines of the utilization management program.

If the review decision differs from those of the covered person's attending physician and the differences are not resolved through the appeals process described in Section 6.05, the covered person and his/her attending physician shall be notified that the plan shall not provide benefits for the length of stay which exceeds the limits set forth by the utilization review organization. These charges will normally be the responsibility of the covered person; however, if part of the contracted PPO Limited network, such providers have, by separate contract with the claims administrator, agreed not to bill the covered person if the claims administrator determines that service(s) were not medically necessary, or if the PPO

Limited provider has not followed applicable utilization management guidelines, such as obtaining pre-admission certification. PPO Limited providers have agreed to accept the maximum allowable amount as payment in full for such services and hold the covered person harmless (from any balance of charges), except with respect to deductibles, coinsurance and non-covered expenses of the covered person's coverage.

The ultimate choice of a provider is solely up to each covered person.

The claims administrator does not furnish covered services directly but rather pays benefits according to the plan. The claims administrator, the committee, the employer and the plan shall not be responsible for any claims, injuries or damages whatsoever caused by or which arise from the acts or failure to act of any provider. None of the entities listed above shall be liable for a provider's refusal or failure to render services on behalf of a covered person.

Whether a provider is a PPO Limited or non-PPO Limited provider shall not be taken as a recommendation or endorsement with respect to a particular provider's qualifications, skills, or competence.

(B) Optional Second Surgical Opinion. The covered person may receive a second surgical opinion from a qualified surgeon, if the suggested procedure is listed in Attachment C. The second opinion must be obtained from a surgeon qualified to perform the surgical procedure but who is not in the same medical group as the physician who originally recommended surgery. The charges for the second opinion and any tests performed in obtaining the second opinion shall be paid in full by the plan regardless of whether or not the covered person's deductible has been met.

(C) Mandatory Outpatient Procedures. In order to satisfy the guidelines of the utilization management program, the plan shall require certain procedures be performed on an outpatient basis. The pre-admission certification process will determine which procedures should be performed in the outpatient setting. These procedures should be performed in the outpatient department of a hospital or in an ambulatory surgical center unless deemed to be medically necessary as determined by the claims administrator, and as approved by the utilization review organization, to be performed on an inpatient basis.

(D) Home Health. Covered persons may receive home health benefits if prior approval is received from the claims administrator. These benefits should be obtained based upon a referral from the covered person's physician and should be obtained from a provider participating in the network of home health agencies established by the claims administrator.

(E) Case Management. Notwithstanding any contract provision, rider or endorsement to the contrary, the utilization review organization will consider alternative treatment plans proposed by the covered person or provider, committee or employer on behalf of a covered person and may elect to offer alternative benefits for services not otherwise specified as covered expenses hereunder.

The claims administrator and/or utilization review organization will identify potential cases, evaluate proposed alternative treatment plans, and will otherwise coordinate the delivery of alternative benefits when the committee, or its representative, upon consultation with the utilization review organization, determines that alternative treatment is medically necessary and cost effective. Such benefits will be offered only in accordance with a plan of alternative treatment with which the covered person (or the covered person's legal guardian) and the attending physician concur. Alternative benefits will be made available on a case-by-case basis to individuals. Under no circumstances does a covered person acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer of, or confirmation of, alternative benefits in one instance shall not obligate the plan to provide the same or similar benefits for any other covered person in another instance. In addition, nothing herein shall be deemed a waiver of the right of the plan to enforce this plan in strict accordance with its express terms and conditions. No benefits of any type will be payable, however, beyond the date the contract or covered person's coverage terminates.

If medically appropriate, the claims administrator and/or utilization review organization may exceed the established plan limitations on outpatient therapy for covered persons under the plan, who, because of their injury or illness, require additional speech, occupational and/or physical therapy beyond the plan limitations. Covered persons of the plan requiring outpatient therapy beyond plan limitations must be under active case management.

(F) Private Duty Nursing. The claims administrator, based upon available medical information, may determine that a covered person needs the services of private duty nursing. The claims administrator will review medical charts documenting services provided by the nursing staff and will determine the duration for which reimbursement will be provided for this service.

(G) Durable Medical Equipment. In the event that it is determined that a covered person requires the use of durable medical equipment, such equipment should be obtained through a provider in the network established by the claims administrator. The covered person

should have a written prescription from a PPO Limited provider for such durable medical equipment. The level of reimbursement is in Attachment A.

(H) Pharmacy Program. In order to receive maximum benefits of the pharmacy program available, covered persons should utilize the prescription home delivery program. Covered persons may also utilize a pharmacy in the network established by the claims administrator. If the prescription is filled through the home delivery program or at a participating retail pharmacy, a copayment is required as outlined in Attachment A. A covered person should present their insurance identification card at the time of purchase, along with the applicable copayment as outlined in Attachment A. When a participating pharmacy is utilized, the charges for the prescription will be electronically filed with the claims administrator. If a participating or non-participating pharmacy is utilized and the claim is filed by the covered person, amounts exceeding the maximum allowable charge are the responsibility of the covered person. Prescriptions are generally limited to a thirty-four (34) day supply at the retail pharmacy level with some having additional limitations and pre-authorization requirements. Certain medications can be purchased through the home delivery program for up to a one hundred and two (102) day supply with one copayment from the covered person. Refer to Attachment A for pharmacy program stop-loss benefit limitations.

(I) Procedures. The utilization review organization shall establish procedures for administering the utilization management program and the committee shall communicate such procedures to all covered employees and qualified beneficiaries. If benefits are reduced due to non-compliance with the procedures established for administering the utilization management program, and the covered person wishes to dispute such reduction, such covered person may request that his/her claim be reconsidered pursuant to Section 6.05.

The reconsideration shall ensure that covered persons who, in good faith, attempt to comply with the utilization management program procedures are provided benefits at the same level as if those procedures had been followed.

A covered person has the responsibility to notify his/her physician and hospital that he is a covered person under the PPO Limited and of the plan's certification requirements for hospital admissions. This notification by the covered person can be by presentation of the plan identification card by the covered person or if the covered person verbally informs the provider.

If the covered person notifies the PPO Limited provider that he/she is a covered person under the PPO Limited before the admission, it will be the provider's responsibility to contact the utilization review organization for certification. If certification is not obtained,

the plan and the covered person shall be held harmless from the reduction resulting from not satisfying the utilization management program by the provider.

On an elective admission, if a covered person does not notify the PPO Limited provider that he/she is a covered person under the PPO Limited, or does not give the PPO Limited provider correct information or the covered person will not admit to being covered by the plan when asked by the PPO Limited provider, the plan will be held harmless if certification is not obtained. The covered person will be responsible for the full payment.

On an emergency admission, if a covered person does not inform the hospital of his/her participation in the PPO Limited or of the utilization management program guidelines, the provision under subsection 11.07(A) shall apply and determine what benefits will be provided by the plan when certification is not obtained. If it is determined by the claims administrator that the admission was not an emergency, the plan shall be held harmless. The covered person will be responsible for the full payment.

During a stay at a PPO Limited facility, if the hospital utilizes the services of a non-PPO Limited hospital-based provider for the care of the covered person; the plan will provide benefits at the PPO Limited level (see Attachment A). The covered person is only responsible for the PPO Limited level of coinsurance (see Attachment A) and any charges above the maximum allowable charge, and the plan is held harmless.

A provider may obtain certification by writing to the utilization review organization (no more than thirty [30] days in advance) or by calling the appropriate utilization review organization on the pre-certification toll-free line during normal business hours. If the provider contacts the utilization review organization when the office is closed, the caller will get a recorded message asking the caller to call again during office hours. It is the responsibility of the provider to call back to obtain certification or extension of days, unless the admission is an emergency.

When the call is received during office hours, the utilization review organization will approve or deny the certification at that time, unless additional information is needed before the certification is determined. Once all of the information is received by the utilization review organization, certification will be denied or approved within one (1) working day.

When the certification is approved or denied, the utilization review organization will send a letter to the covered person (or his/her guardian), physician and hospital advising them of the approval or denial of the certification. This letter will be sent no later than one (1) working day after the certification is denied or approved.

When determining certification for elective or emergency admissions, medical personnel under the direction of a physician will review the timing and setting of the medical care. The utilization review organization will not question the medical necessity of the care. The utilization review organization will not verify eligibility under the plan or if the benefits are eligible expenses under the plan.

When certification is approved, the utilization review organization will notify the provider of the number of days that are being certified for the inpatient stay. If the hospitalization is in a PPO Limited facility, it will be the facility's responsibility to contact the appropriate utilization review organization if the physician wants to request additional days. If the benefits for additional inpatient days are denied, the utilization review organization will notify the patient, the physician and hospital on what date inpatient benefits will cease.

If the admission is in a non-PPO Limited facility, the utilization review organization will contact the hospital the day following the last day of certification to confirm the patient has been discharged from the facility. If the physician requests additional days and the extension of inpatient benefits is denied, the utilization review organization will notify the patient, the physician and hospital of what date inpatient benefits will cease.

When determining if additional inpatient days should be certified, the utilization review organization will review the health care services delivered during the confinement to make sure they meet community standards of quality and are consistent with the patient's needs. If the utilization review organization determines that, after reviewing the hospital records, the health care is not medically necessary, benefits for the additional inpatient days will be denied.

If a covered person is transferred from one facility to another, certification at the second facility must be obtained under the certification guidelines in subsection 11.07(A).

ARTICLE XII
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS
(PPO LIMITED)

Each reference to an attachment in this article shall mean one of the applicable PPO Limited attachments. Each reference to a specific section shall mean the applicable section within this PPO Limited article unless otherwise specified.

For the purpose of interpreting these provisions, the following definitions will apply:
"Eligible Providers" shall mean those providers considered eligible to provide mental health/substance abuse services or employee assistance services. For mental health/substance abuse services, eligible professional providers include psychiatrists, psychologists, licensed professional counselors, registered nurse clinical specialists and licensed clinical social workers, as defined herein. For employee assistance program (EAP) services, eligible providers are those considered eligible by the claims administrator for those services.

"Provider-Referral" shall mean a referral made by the claims administrator for a covered person for treatment of mental health/substance abuse, which is determined to be medically necessary and/or clinically necessary. Such referral is made based upon a request by the covered person and made to a provider chosen by the claims administrator.

"Self-Referral" shall mean a referral requested by a covered person for treatment of mental health/substance abuse, which is determined to be medically necessary and/or clinically necessary. Such referral is based upon the covered person seeking treatment from an eligible provider that has not been recommended by the claims administrator.

12.01 Amount of Benefits.

The amount of benefits provided by the plan is outlined in Attachment B, "Schedule of Mental Health/Substance Abuse Benefits," which is attached to and made a part of the plan. Upon receipt of proof of loss, the plan shall pay (unless otherwise specified herein) a percent, pursuant to Section 12.03, of covered expenses incurred within each plan year and which are in excess of the deductible requirement, as described in Section 12.02.

12.02 Deductible Amount.

For purposes of determining the amount of benefits under Section 12.01, a covered person must first satisfy the deductible requirement outlined in Attachment B. This deductible is separate and distinct from the medical deductible under Section 11.02.

12.03 Coinsurance.

The plan will pay a percentage of covered expenses incurred within each plan year, and which are in excess of the deductible requirement of Section 12.02. Out-of-pocket and coinsurance costs incurred for mental health and substance abuse benefits are not applicable to the out-of-pocket medical plan limits. Mental health and substance abuse benefits are not payable at the one hundred (100) percent level.

(A) Inpatient Benefits. The plan will pay the following benefits for mental health and substance abuse treatment received in an inpatient setting.

(1) Referred. In the event of covered expenses for those inpatient services received from and payable to a provider affiliated with **and** specifically referred by the mental health and substance abuse utilization review organization the coinsurance percentage is indicated in Attachment B, provided the deductible has been met.

(2) Non-Referred - Authorized. In the event of covered expenses for those inpatient services received from and payable to a provider authorized by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, the coinsurance percentage is indicated in Attachment B, provided the deductible has been met.

(3) Non-Referred - Non-Authorized. In the event of covered expenses for those inpatient services received without authorization by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, the coinsurance percentage is indicated in Attachment B, provided the deductible has been met.

(4) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those inpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

(B) Outpatient. The plan will pay the following benefits for mental health and substance abuse treatment received in an outpatient setting:

(1) Referred. In the event of covered expenses for those outpatient services received from and payable to a provider referred by the mental health and substance abuse utilization review organization, benefits are payable once the deductible has been met.

(2) Non-Referred - Authorized. In the event of covered expenses for those outpatient services received from and payable to a provider authorized by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, benefits are payable once the deductible has been met.

(3) Non-Referred - Non-Authorized. In the event of covered expenses for those outpatient services received without authorization by the mental health and substance abuse utilization review organization based upon the employee's self-referral for those services, benefits are payable once the deductible has been met.

(4) Services Which Are Determined Not to Be Medically Necessary and/or Clinically Necessary. In the event of expenses for those outpatient services received, which are determined by the mental health and substance abuse utilization review organization not to be medically necessary and/or clinically necessary, the plan will make no benefit payments.

12.04 Benefits for Detoxification.

In the event of covered expenses for a detoxification program, benefits will be paid at the level indicated in Attachment B. The limitations on the number of days and length of stay allowed will be as outlined in Attachment B.

12.05 Stop Loss.

For the purposes of mental health and substance abuse benefits, the plan does not contain a stop loss provision. There is no maximum amount of out-of-pocket expenses that a covered person may incur for treatment of mental health and substance abuse.

12.06 Maximum Benefits.

(A) Lifetime Maximum. There are no lifetime dollar maximums under the plan for mental health/substance abuse.

(B) Annual Maximum. Inpatient care for mental health treatment is limited to forty-five (45) days per year. Outpatient care for mental health treatment is limited to forty-five (45) visits per year.

12.07 Utilization Management.

The utilization management programs described in this Section 12.07 shall include requirements governing pre-admission certification, outpatient referrals, case management and EAP benefits. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship, and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

(A) Hospital Pre-Admission Certification. A utilization management function that occurs at or prior to admission to determine whether or not the admission is both medically necessary and appropriate for the individual patient. The result is a recommendation for treatment.

(B) Outpatient Referrals. The process in which a patient is introduced to a health provider for treatment.

(C) Case Management. A process that evaluates the medical necessity and appropriateness of treatment.

(D) EAP Benefits. Employee assistance program (EAP) services are available at no cost to all full-time employees and covered dependents, retirees and COBRA participants enrolled in a state-sponsored health plan. Services consist of short-term counseling (up to six [6] sessions per episode) for problems such as marital or family, emotional, substance abuse, stress, job and financial loss. Legal consultation via telephone is also available. If an employee or dependent is determined to need greater assistance, they will be referred to other resources. All EAP services must be pre-authorized.

(E) Procedures. In order to receive maximum benefits, all inpatient and outpatient mental health, substance abuse and EAP services must be pre-authorized by the utilization review organization.

ARTICLE XIII
COVERED EXPENSES
(PPO LIMITED)

Each reference to an attachment in this article shall mean one of the applicable PPO Limited attachments. Each reference to a specific section shall mean the applicable section within this PPO Limited article unless otherwise specified.

13.01 Conditions.

All medical services, medical treatment and medical expenses will be considered covered expenses pursuant to this plan if:

(A) They are listed in Sections 13.02 or 13.03;

(B) They are not excluded under the exclusions from coverage under Section 13.04;

(C) They are determined to be medically necessary and/or clinically necessary by the claims administrator;

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

(E) Are consistent with plan policies and guidelines.

The committee, or its representative, shall make determinations regarding whether expenses will be considered covered expenses pursuant to (A) and (B) above. Medical specialists shall be consulted to determine whether a medical service, treatment or expense is medically necessary and/or clinically necessary. All medical claims from a hospital, physician or other provider shall be examined to determine whether the services, treatment and expenses were medically necessary and/or clinically necessary. If the medical specialist determines the treatment was not medically necessary and/or clinically necessary, the physician of the covered person for whom the claim is submitted can choose to provide additional information. If after examining the additional information it is determined that the service, treatment or expense was not medically necessary and/or clinically necessary, the claim shall not be considered as a covered expense by the plan, and the covered person may be responsible for payment of all of the bills associated with that claim, subject to the appeal process as described in Section 6.05.

13.02 Covered Expenses - Generally.

The charges for the following services and supplies are eligible covered expenses under the PPO Limited plan:

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

(B) Services and supplies furnished to the eligible covered persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an injury or illness, including consultations with a physician requested by the covered person's physician.

(C) Charges for "surgical procedures." Surgical procedures shall mean the generally accepted operative and cutting procedures rendered by a physician for the necessary diagnosis and treatment of an injury or illness, including treatment of fractures or dislocations, maternity care, any diagnosis of burns and abrasions and any endoscopic procedure (i.e. sigmoidoscopy, cystoscopy, etc.). During one (1) operation, a physician may perform two (2) or more surgical procedures through the same incision. In this situation, payment is equal to the full benefit amount for the most expensive procedure plus one-half of the benefit amount for the other procedure.

(D) Office visits to a physician that are due to an injury or illness.

(E) Private-duty or special nursing charges (including intensive nursing care) for medically necessary and/or clinically necessary treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative, if prescribed by the attending physician.

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

(G) Charges for diagnostic laboratory and x-ray services including, but not limited to: laboratory examinations, metabolism tests, cardiographic examinations and encephalographic examinations.

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

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

(J) Charges for speech therapy by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. There is no limitation on speech therapy benefits for covered persons under the PPO Limited plan, providing said therapy is deemed to be medically necessary.

(K) Charges for treatment received by a licensed doctor of podiatric medicine provided treatment was within the scope of his/her license.

(L) Charges for chemotherapy and radiation therapy when medically necessary as determined by the claims administrator.

(M) Charges for hemodialysis.

(N) Charges for the taking or the reading of an x-ray, CAT scan, MRI (upon approval of the claims administrator) or laboratory procedure, including physician charges and hospital charges. Positron emission tomography (PET) is a covered expense when determined to be medically necessary by the claims administrator. PET scan technology is currently considered experimental and investigative in many applications. Covered persons or their provider should verify medical necessity and benefit eligibility prior to incurring charges for use of this technology.

(O) Charges for laser procedures, other than those specifically excluded in Section 13.04.

(P) Charges for lithotripter treatment.

(Q) Charges for transfusion services for autologous blood and blood components.

(R) Lab charges and associated office visits for pap smears (annually).

(S) Cryosurgical ablation of the prostate is covered only when approved by the claims administrator.

(T) Charges for esophageal PH monitoring for the diagnosis of gastroesophageal reflux when the patient meets specific criteria as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator for these services.

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

(1) Knee replacement surgery; and

(2) Anterior cruciate ligament repair.

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

(V) Percutaneous lumbar discectomy (PLD) is a covered outpatient procedure only when the patient meets specific criteria, as determined by the claims administrator. Covered persons should obtain prior authorization from the claims administrator.

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

(1) Single Pharmacy Limitation.

If the claims administrator or administrative services organization (ASO) has the reasonable belief that a covered person is receiving covered services in an excessive, dangerous, or medically inadvisable amount, and this belief is based upon the professional opinion of a medical doctor and a pharmacist, the claims administrator may impose a limitation on services providing that the covered person may only receive services from one specific pharmacy. The covered person must receive advance written notification of any such restriction stating the reasons for this restriction. The restriction must provide an exception for emergency services. The covered person has the right to request removal or modification of such restriction. The claims administrator will respond in writing to any written request for removal or modification. The covered person also has the right to appeal such restriction pursuant to Section 6.05.

(2) Drugs and medicines (unless excluded under Section 13.04) requiring written prescription of a physician, approved for use by the Food and Drug Administration

and dispensed by a licensed pharmacist or physician. This includes over-the-counter drugs that require pharmacist preparation prior to patient use. Investigational new drugs (FDA designation), if published peer review literature indicates beneficial and effective patient care;

(3) "Off-label" (FDA approved but not for treatment of the condition for which it is prescribed) prescription drugs;

(4) Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:

(a) Prescription must be written by a licensed physician;

(b) Prescriptions are for a ninety (90) day period only; and

(c) Benefit is allowable once per year, with a maximum lifetime benefit of two (2) ninety (90) day periods.

(5) Surgical supplies including bandages and dressings;

(6) Insulin, the related syringes (including needle-free syringes when medically necessary as determined by the claims administrator based on the patient's age, weight, skin and medical condition and/or the frequency of injections), home blood glucose monitors and related supplies for the treatment of diabetes as approved by a physician;

(7) Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to $250 per calendar year. Coverage for additional training and education is available when a significant change occurs in the patient's symptoms or condition which necessitates a change in the patient's self-management or when a physician determines that re-education or refresher training is needed and determined to be medically necessary;

(8) Blood plasma or whole blood;

(9A) Artificial eyes - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness;

(9B) Artificial limbs - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age eighteen (18), or as a result of injury or illness, with the following exceptions:

(a) One (1) additional limb prosthesis past age eighteen (18) if additional surgery has altered the size or shape of the stump; or

(b) Replacement of the original limb prosthesis if a severe medical condition to the stump could result from improper fitting of the initial prosthesis as determined by a physician. Replacement must be within twelve (12) months of the initial purchase of the limb prosthesis and proof of medical severity must be furnished to the claims administrator. The claims administrator must furnish written approval to the covered person prior to the replacement purchase.

(9C) Replacement prosthesis - As determined by the claims administrator, benefits are available for the purchase, fitting, necessary adjustment, repairs and replacement of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding artificial heart and dental appliances). Replacement costs will be covered only if the prosthetic appliance was used by the employee or dependent of the employee in the manner and for the purpose for which such appliance was intended and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. Benefits are not available for prosthetic appliances to replace those which are lost, damaged, stolen or prescribed as a result of improvements in technology.

(10) Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, surgical collars, lumbosacral supports, corsets-back and special surgical, trusses, and rigid back or leg braces. Orthopedic shoes for the correction of a deformity or abnormality of the musculoskeletal system are only considered for coverage when attached to a brace;

(11) Foot orthotics, devices or rigid construction used to maintain the foot (and its superstructure) in a more efficient functional state in both standing (stance) and ambulating (gait) positions, including shoes for diabetic conditions, when prescribed by a physician and are medically necessary as determined by the claims administrator. Examples of items **not** considered to be a foot orthotic are:

(a) Inner soles (foam rubber, leather, flexible, etc.);

(b) Corn plasters (pads, etc.); and

(c) Foot padding (adhesive moleskin, etc.);

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

(13) X-ray, radium and other radioactive substances;

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

(15) Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus;

(16) If elected by the covered person following a mastectomy, coverage shall include:

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

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

(c) Prostheses, pursuant to Section 13.02(W)(9C), and physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year;

(17) The purchase or rental (not to exceed the total maximum allowable charge for purchase) of durable medical equipment as outlined in the applicable section and attachment;

(18) Immunizations, including hepatitis B immunizations, unless the employer is mandated to pay for the immunization;

(19) Transrectal prostatic ultrasound, when a physical examination of the prostate indicates the presence of nodules;

(20) Family planning and infertility services including history, physical examination, laboratory tests, advice and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing and treatment for organic impotence. If fertility services are initiated (including, but not limited to artificial insemination or in-vitro fertilization) benefits will cease;

(21) Bone density scans when medically necessary.

(X) Charges for treatment by a licensed doctor of chiropractic provided treatment was within the scope of his/her license under the PPO Limited plan.

(Y) Ketogenic diet counseling (must be enrolled in case management).

13.03 Other Covered Expenses.

(A) Convalescent Care. Upon receipt of proof that a covered person has incurred medically necessary expenses related to convalescent care, the plan shall pay for charges for convalescent facility room, board and general nursing care, provided:

(1) A physician recommends confinement for convalescence;

(2) The covered person is under the continuous care of a physician during the entire period of confinement;

(3) The confinement is required for other than custodial care; and

(4) Services were pre-authorized by the claims administrator.

Eligible charges for convalescent facility room, board and general nursing care shall only include:

(1) Charges not to exceed the charge for its greatest number of semi-private rooms; and

(2) Charges up to and including the one-hundredth (100th) day of confinement during any plan year.

(B) Maternity Benefits. The plan provides coverage for pregnancy, childbirth or related medical conditions on the same basis as any other illness, unless the covered person is acting as a surrogate mother (carrying a fetus to term for another woman) in which case no benefits will be payable. Hospital admissions for maternity coverage and childbirth will be available for a minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a caesarean delivery. No additional approval or authorization is needed for lengths of stay that fall within these timeframes. A covered person is not required to stay in the hospital for a fixed period of time following the birth of her child. New benefits will apply if transferring to another health plan prior to delivery.

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

(2) Newborn Care. Coverage for a newborn child shall be provided to covered employees who have elected family coverage or coverage pursuant to Section 2.05(A). The pre-existing condition requirements of the PPO Limited plan shall not apply to newborn children who are covered under the PPO Limited plan at birth, or legally adopted children or children placed for adoption.

Covered expenses of a newborn child shall include:

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

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

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

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

(3) Babies First Program. This is a voluntary prenatal education program for PPO Limited plan pregnant employees and eligible dependents. Once registered, covered persons will receive information on how to care for themselves during pregnancy to increase the chances of delivering a healthy baby. Pregnant patients must register with babies first by calling the Division of Insurance Administration before the end of their first trimester. Under the PPO Limited plan, once registered, the patient will receive a $50 credit toward their deductible for the applicable plan year, or if their deductible has already been satisfied, they will receive a check in the amount of $50.

(C) Mammogram Screening. The plan provides coverage for mammogram screenings within the following guidelines:

(1) Once as a baseline mammogram for ages 35-39;

(2) Once every year for ages 40 and over; or

(3) When prescribed by a physician.

(D) Cochlear Implantation. The plan provides coverage for cochlear implantation using FDA-approved cochlear implants provided **all** of the following criteria are met:

Adults (Age 18+).

(1) Diagnosis of post-lingual profound deafness;

(2) Patient has achieved little or no benefit from a hearing aid;

(3) Patient is free from middle ear infection, has an accessible cochlear lumen that is structurally suited to implantation and is free from lesions in the auditory nerve and acoustic areas of the central nervous system;

(4) Patient has the cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and

(5) Patient has no contraindications to surgery.

Children (Age 2-17).

(1) Diagnosis of bilateral profound sensorineural deafness; and

(2) Patient has achieved little or no benefit from a hearing or vibrotactile aid, as demonstrated by the inability to improve on an age-appropriate closed-set word identification task.

An electrophysiological assessment should be performed to corroborate behavioral evaluation in very young children who cannot be adequately evaluated by standard audiometry tests. This assessment may consist of an auditory brain stem evoked response or similar test which would be covered when medically necessary as determined by the claims administrator.

A minimum six (6) month trial with appropriate amplification (hearing aid or vibrotactile aid) and rehabilitation should be performed for children to ascertain the potential for aided benefit.

(E) Hospice Care Program. When approved by the claims administrator, the plan shall provide hospice care, as provided in the applicable section, designed to provide covered persons who are terminally ill (a person whose life expectancy is six [6] months or less) with dignified, comfortable and less costly care the few months or weeks prior to death. This program shall be administered through an approved hospice. Care provided shall include physical, psychological, social and spiritual for dying persons and their families, rendered by a medically supervised interdisciplinary team of professionals and volunteers on a twenty-four (24) hour on-call basis.

(F) Home Health Care. The plan shall provide benefits for the services of part-time or intermittent home nursing care, given or supervised by a registered nurse (R.N.), but only if the services are certified as medically necessary and pre-authorized by the claims administrator. Home health aide care is also a covered service with the following limitations:

(1) No more than thirty (30) visits per plan year;

(2) A visit shall be four (4) or fewer hours;

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

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

(5) The home health aide service is in conjunction with medically necessary skilled care.

Intravenous (I.V.) therapy administered in the home during these visits is a covered service, provided the medication is approved for use by the Federal Drug Administration. Case management services will be requested by the physician, patient or employer for home health cases requiring extensive care.

(G) Rehabilitation Therapy. The plan shall provide pre-authorized inpatient and/or outpatient physical therapy benefits for services for conditions resulting from illness or injury, or prescribed immediately following surgery related to the condition. Outpatient benefits under the plans are limited to a maximum of forty-five (45) visits, per condition, per plan year according to a prescription from a physician concerning the nature, frequency and duration of treatment. Therapy shall include functional, physical and occupational therapy to the extent such therapy is performed to regain use of the upper or lower extremities, or if the covered person is a child, as long as improvement in the covered person's condition continues (subject to the limitations contained in this Section 13.03). Occupational therapy shall not include vocational therapy or vocational rehabilitation, nor educational or recreational therapy on an outpatient basis.

Phase I and Phase II (as defined below) cardiac rehabilitation services will be a covered expense provided they meet the following criteria:

(1) Phase I includes inpatient rehabilitation services that begin during hospitalization and extended until discharge; and

(2) Phase II includes supervised ambulatory services that follow discharge and extend until the patient becomes sufficiently independent to perform prescribed exercise and carry out any recommended long-term lifestyle changes. Phase II services are limited to three (3) sessions per week for a maximum of twelve (12) weeks.

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

(H) Sitter. A sitter who is not a relative (i.e. spouse, parent, child, brother or sister by blood, marriage or adoption or member of the household) of the covered person may be used in those situations where the covered person is confined to a hospital as a bed patient and

certification is made by a physician that an R.N. or L.P.N. is needed and neither (R.N. or L.P.N.) is available.

(I) Covered Dental Expenses.

(1) Charges for orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function of a covered person. Covered persons in the PPO Limited plan must meet the pre-existing condition clause or qualify for a waiver of the pre-existing condition clause.

(2) Charges for extraction of impacted wisdom teeth, excision of solid based oral tumors, treatment of accidental injury (other than by eating or chewing) to sound natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary as determined by the claims administrator) providing the accident occurred while the individual was covered under a state-sponsored plan and has remained continuously covered.

(3) Charges for the facility and related medical services when hospitalization for dental services is determined medically necessary by the claims administrator.

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

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

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

(c) Mental illness or handicap precludes dental/surgical management in an office setting;

(d) When general anesthesia is used or;

(e) For children eight (8) years and younger benefits will be provided for anesthesia (inpatient or outpatient) and any expenses associated with a dental procedure that cannot be safely provided in the office. Benefits will be available for anesthesia regardless of whether or not the base procedure is covered by the insurance program.

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

(a) History, exams and office visits;

(b) X-rays of the joint;

(c) Diagnostic study casts;

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

(e) Medications; and

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

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

(a) Prosthodontic treatments (dentures, bridges);

(b) Restorative treatment (fillings, crowns);

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

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

(J) Organ Transplants. Organ transplant benefits will be paid for covered medical expenses related to transplants of the: heart, heart/lung, lung, liver, kidney, pancreas, pancreas/kidney, cornea, small bowel, small bowel/kidney and certain bone marrow transplants. Transplant services or supplies require pre-authorization before any pre-transplant evaluation or any covered service is performed. Coverage will include expenses incurred for donor search and organ procurement by the transplant center or hospital facility and all inpatient and outpatient hospital/medical expenses for the transplant procedure and related pre- and post-operative care, including immunosuppressive drug therapy. Should a transplant request fall outside those addressed and covered by the *Plan Document*, the claims administrator will review the information provided and render a decision based on acceptable medical practices on behalf of the state insurance program. The claims administrator will notify the Division of Insurance Administration of its decision prior to approving such services. If the service(s) or procedure(s) does not meet the claims administrator's accepted medical standards, the covered person will be notified of their option to appeal the decision as described in Section 6.05. If a network facility is utilized for the transplant, travel and living expenses will be covered from the initial evaluation to one (1) year after the transplant (for medically necessary visits only as determined by the claims administrator). Air transportation, if necessary, will be paid at commercial coach fare. Ground travel will be paid at the State of Tennessee approved mileage rate. Additionally, hotel and meal expenses will be paid up to $150 per diem. The transplant recipient and one (1) other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.

If the donor is not a covered person and the recipient is covered under the plan, the donor will be considered eligible for coverage for expenses which are incurred during hospitalization for the transplant procedure and which are not covered by another group health plan. Covered services include those services and supplies directly related to the transplant service itself such as removal of the organ from the donor's body, preservation of the organ and transportation of the organ to the site of transplant. The aggregate limit for organ procurement is $10,000 per covered procedure. No benefits are payable for donor services for recipients who are not covered under the plan. These services are ineligible even when the recipient does not provide reimbursement for the donor's expenses. Bone marrow transplantation will fall into one (1) of three (3) categories: syngeneic, allogeneic or autologous.

Expenses eligible for coverage include the charge to harvest bone marrow for covered persons diagnosed with any covered malignant condition or any conditions approved for coverage by the claims administrator. Coverage for harvesting, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow will be covered when re-infusion is scheduled within three (3) months or less. Autologous bone marrow transplantation is considered investigational in the treatment of other malignancies, including primary intrinsic tumors of the brain.

(K) Well-Baby, Well-Child Care. Physician office visits for routine check-ups and immunizations are covered expenses for children through age five (5) under the PPO Limited plan, and a total of twelve (12) routine visits are covered.

(L) Prostate Screening. The plan will cover PSA (prostate specific antigen) and transrectal ultrasound for the following conditions:

(1) Annually in men who have been treated for prostate cancer with radiation therapy, surgery or chemotherapy;

(2) Annually in men over the age of forty-five (45) who have enlarged prostates as determined by rectal examination; and

(3) Annually in men of any age with prostate nodules or other irregularity noted on rectal exam.

The plan will cover PSA for the primary screening of men over the age of fifty (50) and will cover transrectal ultrasound in these individuals with an elevated PSA.

(M) Biofeedback Therapy. The plan shall provide benefits for biofeedback therapy, which is determined to be medically necessary with a maximum benefit of five (5) sessions per calendar year for each of the following conditions:

(1) Chronic pain;

(2) Incontinence;

(3) Migraine headaches; and

(4) Incapacitating stress.

(N) Bariatric Surgery (weight reduction). The plan will cover as outlined below, two (2) surgical procedures for treatment of morbid obesity:

(1) Vertical banded gastroplasty accompanied by gastric stapling

(2) Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum

The following criteria must be met before benefits are available for the two (2) surgical procedures listed above:

(1) Presence of morbid obesity that has persisted for at least five (5) years, defined as either:

(a) Body mass index (BMI) exceeding forty (40); or

(b) More than one hundred (100) pounds over one's ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or

(c) BMI greater than thirty-five (35) in conjunction with the following severe co-morbidities that are likely to reduce life expectancy:

1. Coronary artery disease; or

2. Type 2 diabetes mellitus; or

3. Obstructive sleep apnea; or

4. Three or more of the following cardiac risk factors:

a. Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)

b. Low high-density lipoprotein cholesterol (HDL less than 40mg/dL)

c. Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)

d. Current cigarette smoking

e. Impaired glucose tolerance (2-hour blood glucose>140 mg/dL on an oral glucose tolerance test)

f. Family history of early cardiovascular disease in first-degree relative (myocardial infarction at age under fifty

[50] in male relative or at age under sixty-five [65] for female relative)

g. Age greater than forty-five (45) years in men and fifty-five (55) years in women

(2) History of failure of medical/dietary therapies (including low calorie diet, increased physical activity, and behavioral reinforcement). This attempt at conservative management must be within two (2) years prior to surgery, and must be documented by an attending physician who does not perform bariatric surgery. (Failure of conservative therapy is defined as an inability to lose more than ten [10] percent of body weight over a six [6] month period and maintain weight loss.)

The claims administrator will determine if all the criteria have been met before approving surgery.

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

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

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

(3) Routine screenings among the elderly is considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

(P) Hearing Impairment Screening and Testing. The plan will cover, as determined by the claims administrator, medically necessary hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The claims administrator has determined eligibility of many of the tests/screenings to be specific to infants. Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.

(Q) Nutritional Treatment of Inborn Errors of Metabolism. The plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup urine disease, homocystinuria, methylmalonic

acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the claims administrator.

13.04 Exclusions and Limitations.

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

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

(2) Drugs and medicines which can be obtained without a written prescription (over-the-counter), except as covered pursuant to Section 13.02(W)(2);

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

(4) Services and supplies (notwithstanding organ donations) provided by an immediate family member of an eligible employee or covered dependent. Immediate family members include spouse, parent, child, brother or sister, by blood, marriage or adoption;

(5) Services rendered prior to the effective date of coverage;

(6) Services incurred after the covered person's coverage under this plan is terminated;

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

(8) Charges for the removal of corns or calluses, or trimming of toenails;

(9) Treatment of an injury or illness due to declared or undeclared war;

(10) Charges incurred outside the United States (including those for drugs and medicines subject to FDA approval and federal law) unless the charges are incurred while traveling on business or for pleasure by a covered person who is a resident of the United States and a medical emergency arises;

(11) Charges which the claims administrator determines to be in excess of the maximum allowable charge for that procedure or supply and for charges made which are not medically necessary as determined by the claims administrator;

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

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

(14) Expenses incurred for contact lenses, eyeglasses, sunglasses or for examinations for prescription or fitting of eyeglasses or contact lenses, except as may be allowed pursuant to Section 13.02;

(15) Expenses incurred for hearing aids or for examinations for prescription or fitting of hearing aids (except as previously defined in Section 13.02);

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

(a) The covered person experienced a traumatic injury or illness, while covered by a state-sponsored plan, which requires the cosmetic surgery;

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

(c) If elected by the covered person following a mastectomy:

(i) Reconstruction of the breast on which the mastectomy has been performed,

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) Prostheses, pursuant to Section 13.02(W)(9C) and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person. Benefits are also provided for six (6) mastectomy bras per plan year;

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

(17) Arch supports and other foot support devices, except for orthotic devices as defined in Section 13.02(W)(11);

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

(19) Garter belts;

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

(21) Hotel charges or travel expense incurred while receiving treatment as an inpatient or outpatient, (other than defined in Section 13.03J or Attachment A);

(22) Unapproved sitters;

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

(24) Non-surgical services, including prescription medication for weight control or reduction (obesity). Surgical services are also excluded unless specifically listed in Section 13.03;

(25) Experimental/investigational medical or surgical procedures and prescription drugs as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency;

(26) Organ transplants involving artificial implants and non-human organs, as well as any services or supplies in connection with experimental or investigational treatment, drugs or procedures;

(27) Reversal of sterilization procedures;

(28) Services or supplies for which there is no charge to the covered person, or for which the covered person would not have been charged if not covered by this plan;

(29) Surgery or treatment for, or related to, sex transformations or sexual dysfunctions or inadequacies, including penile prosthesis due to psychogenic impotence;

(30) Services or supplies in connection with artificial insemination, in vitro-fertilization or any procedure intended to create a pregnancy;

(31) Telephone consultations;

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

(33) Durable medical equipment not specified in Sections 13.02, 13.03 or Attachment C or Attachment D, as applicable;

(34) The purchase or rental of any device, mechanical aid or other contrivance which may be required for the transportation of an individual on a public conveyance; roadway or other means of transportation, with the exception of those items specifically included as an eligible medical expense;

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

(36) Custodial care (as defined in Section 1.11);

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

(38) Services of a private-duty nurse which would normally be provided by hospital nursing staff;

(39) Diapers (incontinent pads);

(40) Cranial prosthesis (wig);

(41) Nutritional supplements and vitamins (except injectable B-12 for the treatment of pernicious anemia). Nutritional treatment of inborn errors of metabolism is not excluded under this clause as noted in Section 13.03(Q);

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

(43) Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, collection and handling fees, or telephone consultations.

(B) Excluded Dental Expenses.

(1) Any dental care and treatment and oral surgery relating to the teeth and gums including but not limited to dental appliances; dental prostheses such as crowns, bridges or dentures; implants; orthodontic care except as provided in Section 13.03(I); operative restoration of teeth (fillings); dental extractions (except impacted wisdom teeth); endodontic care; treatment of dental carries, gingivitis or periodontal disease.

(2) Any other expenses incurred relating to the teeth and gums except those specifically provided as covered expenses pursuant to Section 13.03(I);

(C) On the Job Injuries and Illnesses. The plan will not be responsible for expenses for injuries or illnesses incurred on the job.

(D) Excluded Mental Health/Substance Abuse Expenses. In addition to relevant exclusions noted in Section 13.04(A), the following are specifically excluded under the mental health/substance abuse benefit:

(1) Court or employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the claims administrator.

(2) Services for disorders not included in the *American Psychiatric Association Diagnostic & Statistical Manual*, 4th Edition, on Axis I or II.

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

(4) Conditions classified as developmental disorders such as mental retardation, learning disabilities, pervasive developmental disorders, including autism and Asberger's, and academic or motor skill disorders.

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

(6) Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.

(7) Ecological or environmental medicine, diagnosis and/or treatment.

(8) Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes, and related expenses for reports, including report presentation and preparation.

(9) Services given by a pastoral counselor.

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

ATTACHMENT A

SCHEDULE OF PPO LIMITED MEDICAL BENEFITS

	In-Network	Out-of-Network
DEDUCTIBLES		
Individual Maximum per Plan Year (See Section 11.02 A)	$500	
Family Maximum per Plan Year (See Section 11.02 B)	$1,500	
COINSURANCE (See Section 11.03)		
PPO Limited Expenses (See Section 11.03 A)	80% of MAC	
Non-PPO Limited Expenses (See Section 11.03 B)		60% of MAC
Non-PPO Limited Expenses Not Satisfying Utilization Management Program (See Section 11.03 D)		50% of MAC
Approved/Accredited Rehabilitation Facility		
Inpatient Rehabilitation Facility	80% of MAC	60% of MAC
Outpatient Rehabilitation Facility	80% of MAC	60% of MAC
Skilled Nursing Facility (Limited to 100 days per year following approved hospitalization. Prior authorization required.)	80% of MAC	60% of MAC
Home Health Care (See Section 13.03 F)	80% of MAC	60% of MAC
Non-Hospital & Non-Physician Services (See Section 11.03 E)		
Independently Practicing Physical Therapists, Speech Therapists, Occupational Therapists, Dialysis Clinics, Oral Surgeons, or Audiologists	80% of MAC (in-state)	60% of MAC
Non-Contracted Providers (Vary based on the network/services area outside of Tennessee)		
Sitters, Midwife Services (must be hospital based), Dentists (not oral surgeons)	80% of reasonable charges	
Transportation Charges if Approved for Unique Exception (See Section 13.02 H)	80% of reasonable charges	
Transportation Charges if Approved for Transplant (See Section 13.03 J)	100% subject to applicable limits	
Prescription Drugs (See Section 11.07 H)		
Generic	100% covered	
Preferred Brand	80% covered	
Non-Preferred Brand	60% covered	
Retail Pharmacy up to a 34-day supply and Home Delivery up to a 102-day supply for one copay		
Second Surgical Opinion (See Section 11.07 B)		
Regardless of whether of not the covered person's deductible has been met	100% of MAC if on Attachment C	

ATTACHMENT A (Continued)

SCHEDULE OF PPO LIMITED MEDICAL BENEFITS

	In-Network	Out-of-Network
Hospice (See Section 13.03 E)		
Regardless of whether of not the covered person's deductible has been met, preauthorization required	100% of MAC	100% of MAC
Emergency Services		
Out-of-State Emergency Requiring Hospitalization (See Section 11.03 G)	80% of MAC	
Certain In-State Emergencies (See Section 11.03 H)	80% of MAC	
Life Threatening Situations (as determined by the claims administrator utilizing non-PPO Limited providers in-state or out-of-state)	80% of reasonable charge	
Emergency Room Visit Copayment (See Section 11.04) - waived if admitted for more than 23 hours or if readmitted within 48 hours of the initial visit for the same episode of an illness or injury	$25 copayment per visit	
Out-of-Country Charges		
	80% of MAC	60% of MAC (unless life threatening
Ambulance Services		
Air Ambulance	80% of reasonable charge	
Ground and Other Ambulance Service	80% of reasonable charge	
Appliances & Equipment		
Durable Medical Equipment	80% of MAC	60% of MAC
Maximum Out-of-Pocket Expense (See Section 11.05)		
Individual	$5,500	$16,500
Family	$11,500	$33,000
Pharmacy	$0	

MAC = Maximum Allowable Charge

Covered persons will be responsible for payment of charges above the maximum allowable charge if non-PPO Limited providers are used.

If preauthorization is required but not obtained, benefits will be reduced to 50% of MAC for out-of-network providers. No benefits will be paid for network providers.

ATTACHMENT B

SCHEDULE OF PPO LIMITED MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

	Referred	Self-Referred
DEDUCTIBLES		
Individual Maximum per Plan Year	$150	
COINSURANCE (See Section 12.03)		
Inpatient - Preauthorized (the preauthorization process must be followed or benefits are reduced to 50% of the MAC of the 90/70% levels indicated)	80% of MAC	60% of MAC
Outpatient (copayments will not exceed actual session charge)	Sessions 1-15: $5 copay per visit Sessions 16-45: $25 copay per visit	Preauthorized Sessions 1-15: $20 copay per visit Sessions 16-45: $50 copay per visit Not-Preauthorized Sessions 1-15: $40 copay per visit Sessions 16-45: $100 copay per visit
Expenses determined not to be medically necessary by the utilization review organization	$0	

Intermediate Care
Halfway houses, residential treatment facilities, partial hospitalization – treated as one-half inpatient day subject to plan total of applicable days.

Substance Abuse Limitations (See Section 12.06)

- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay
- Lifetime maximum: Two stays for detoxification – maximum of 5 days per stay

Additional Mental Health Limitations (See Section 12.06)

- Inpatient care limit of 45 days per year (a daycare program is considered to be one-half day for purposes of this limitation).
- Outpatient care limit of 45 visits per year is for mental health/substance abuse combined.

Covered persons will be responsible for payment of charges above the maximum allowable charge if non-network providers are used.

ATTACHMENT C

PPO LIMITED OPTIONAL SECOND SURGICAL OPINION PROCEDURES

Inclusion on this list does not imply that a procedure is automatically approved for benefits.

Procedure

- Bone and Joint Surgery of the Foot
- Cataract Extraction with and without Implant
- Cholecystectomy
- Hysterectomy
- Knee Surgery
- Septoplasty/Sub-Mucous Resection
- Prostatectomy
- Spinal and Disc Surgery
- Tonsillectomy and Adenoidectomy
- Mastectomy
- Elective C-Section

ATTACHMENT D

LIST OF PPO LIMITED DURABLE MEDICAL EQUIPMENT

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

ATTACHMENT D (Continued)

LIST OF PPO LIMITED DURABLE MEDICAL EQUIPMENT

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

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

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

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