**BARTLETT CITY SCHOOLS**
**EMPLOYEE BENEFIT PLAN**

**REVISED EFFECTIVE JULY 1, 2020**

**THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE DISTRICT AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.**

## NON-DISCRIMINATION NOTICE

Bartlett City Schools complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Bartlett City Schools does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Bartlett City Schools provides:

A. free aids and services to people with disabilities to communicate effectively with us;

B. qualified sign language interpreters;

C. written information in other formats (large print, audio, accessible electronic formats, other formats); and

D. free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact James Aldinger, Bartlett City Schools' Civil Rights Coordinator. If you believe that Bartlett City Schools has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with James Aldinger or Gina Bennett. Gina Bennet can be reached by calling 901-202-0855 ext. 2230, sending a fax to 901-202-0854, or by e-mailing her at gbennett@bartlettschools.org. James Aldinger can be reached by emailing him at jaldinger@bartlettschools.org.

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, Bartlett City Schools' Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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**ພາສາລາວ (Lao)**: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 901-202-0855 (TTY: 901-202-0855).

**አማርኛ (Amharic)**: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 901-202-0855 (መስማት ለተሳናቸው: 901-202-0855).

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**हिंदी (Hindi)**: ध्यान द□: य□द आप □हदी बोलते ह □तो आपके िलए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 901-202-0855 (TTY: 901-202-0855) पर कॉल कर□।

**Русский (Russian)**: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 901-202-0855 (телетайп: 901-202-0855).

**Persian فارسی (Farsi)**:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

فراهم می باشد. با (TTY: 901-202-0855) 901-202-0855 تماس بگیرید.

## MEDICAL BENEFITS ADMINISTRATORS, INC.

Established in 1989, Medical Benefits Administrators, Inc. (MBA) is a subsidiary of Medical Benefits Mutual Life Insurance Co., one of the oldest health insurance firms in the United States. In 1938, the Company entered the insurance business operating under the name Hospital Services Association. Later, it became known as HSA of Ohio.

The name, Medical Benefits Mutual, was adopted in 1987, signaling the Company's establishment as a full-fledged mutual life insurance company. Medical Benefits Administrators, Inc. builds on this great service tradition and commitment to the future by delivering the services the marketplace demands.

MBA is pleased to have been chosen as your Benefit Manager. MBA is committed to the fundamental criteria that distinguish us from the crowd. The first is a commitment to excellent claims administration. The second is a commitment to long term relationships with the people we serve.

We will appreciate your comments and strive to make any dealings with us as simple as possible. If you have any questions about a claim, we invite you to call us at (800) 423-3151, e-mail us at medben@medben.com or to drop in at our offices at 1975 Tamarack Road, Newark, Ohio 43055.

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# ARTICLE I

# PLAN INFORMATION

## NAME OF PLAN

The name of the Plan is the Bartlett City Schools Employee Benefit Plan.

## PURPOSE OF THE PLAN

Bartlett City Schools executes this document, including any amendments, to establish a health benefit plan for the exclusive benefit of its participating employees and Retirees, and the eligible Dependents of these, and to grant them legally enforceable rights under this Plan. While Bartlett City Schools has every intention of continuing this Plan indefinitely, it reserves the right to amend or terminate the Plan, and the benefits provided hereunder, at any time.

The Plan Administrator has issued a Summary Plan Description to each Participant that summarizes the benefits to which that person is entitled, to whom benefits are payable, and the provisions of this Plan principally affecting the Participant and his or her covered Dependents.

## PLAN EFFECTIVE DATE

The Plan Effective Date of this revision of the Plan is July 1, 2020. This Plan was originally effective on July 1, 2014.

## AMENDMENT OR TERMINATION

Bartlett City Schools may amend or terminate the Plan at any time by means of a writing signed by a person authorized by Bartlett City Schools to do so. Any such amendment or termination shall become effective upon its execution or on such date as may be specified in that writing. Such amendment, modification or termination may result in the termination of Participant and Dependent Coverage under the Plan. Expenses Incurred prior to any Plan termination will be paid as provided under the terms of the Plan prior to such termination. Any termination of the Plan will be communicated by Bartlett City Schools to the Participants.

Upon Plan termination, any Plan assets remaining in the Plan's account(s) will be distributed by the Plan Administrator to the Plan Sponsor and/or Participants, in accordance with method(s) set forth in any applicable law or regulation. The Plan Administrator shall pay all eligible Plan benefits and expenses before any distribution is made.

The terms of the Plan cannot be amended or modified by oral statement(s). Only the Plan Administrator can interpret the terms of the Plan.

Bartlett City Schools reserves the right, at any time and from time to time, to modify or amend, in whole or in part, any or all of the provisions of the Plan.

## PLAN ADMINISTRATOR TAX ID NUMBER (EIN)

46-4546457

## PLAN ADMINISTRATOR

Bartlett City Schools
5705 Stage Road
Bartlett, TN 38134
(901) 202-0855

## GROUP NUMBER

10488

## PLAN YEAR

The Plan Year is a time period defined for fiscal purposes and used for certain Plan reporting and disclosure requirements. The Plan Year will begin on September 1st and end on August 31st of the following year.

**CALENDAR YEAR**
The Calendar Year is the period beginning January 1st and ending December 31st that is used in the application of Out-of-Pocket and benefit maximum amounts.

**TYPE OF ADMINISTRATION**
Contract Administration.

**DESCRIPTION OF PLAN**
The Plan is an employee health and welfare benefit plan providing medical and prescription Drug benefits. A copy of the Plan documents and insurance contracts, if any, are on file at the Plan Administrator's office and may be read by any Covered Person at any reasonable time. In the event of any discrepancy between any summary of this Plan and the actual provisions of the Plan document, the Plan document shall govern.

This Plan is self-funded by the District and administered in accordance with applicable provisions of Tennessee law. The state insurance laws of Tennessee only apply to the extent that such laws specifically include self-funded Tennessee non-federal governmental plans.

The Plan shall not be deemed to constitute a contract between the District and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the District or to interfere with the right of the District to discharge any employee at any time.

**NAMED FIDUCIARY**
Bartlett City Schools
5705 Stage Road
Bartlett, TN 38134
(901) 202-0855

**AGENT FOR SERVICE OF LEGAL PROCESS**
Bartlett City Schools
5705 Stage Road
Bartlett, TN 38134
(901) 202-0855

In addition, service of legal process may be made upon the Plan Administrator or a Plan Trustee, if a Trustee has been appointed.

**FUNDING**
The Plan is funded by the Employer. Funds for payment of claims considered under the Plan are forwarded to account(s) from which claims are to be paid. Additionally, funds for payment of premiums, expenses and fees associated with the Plan will be forwarded from such account.

**ASSIGNMENT**
A Covered Person's benefits may not be assigned, except by consent of the District, other than to Providers of Plan benefits.

**SOURCE OF CONTRIBUTIONS**
The Plan is funded by contributions made by the Employer, employees, and Retires who are participating under the Plan. Participant Contributions are currently required for both Participant and Dependent Coverage.

The District shall, from time to time, evaluate the funding method of the Plan benefits and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by the Participants for each type of coverage.

**BENEFIT MANAGER**
Medical Benefits Administrators, Inc.
1975 Tamarack Road
P. O. Box 1099
Newark, Ohio 43058-1099
(740) 522-8425
(800) 423-3151
www.medben.com

**UTILIZATION REVIEW SERVICE**
Inter-Facility Air Ambulance Services
Sentinel Air Medical Alliance, LLC
(877) 542-8828

Other
Hines and Associates
(800) 735-1200

**GRANDFATHERED STATUS UNDER PPACA**
This Plan is currently considered to be non-grandfathered for the purposes of the Patient Protection and Affordable Care Act.

# ARTICLE II

# SCHEDULE OF BENEFITS

## 2.1 SCHEDULE OF MEDICAL BENEFITS

**This Schedule of Medical Benefits is intended to provide only a general description of a Covered Person's medical benefits. This Plan contains limitations and restrictions that are described later in this booklet and could affect any benefits that may be payable.**

## 2.2 OUT-OF-POCKET LIMITS

**Initial Calendar Year Out-of-Pocket Limits**
*(includes medical Copayments only)*

| | |
|---|---|
| **Per Individual** | $2,000.00 |
| **Per Employee Plus One (1) Dependent** | $3,750.00 |
| **Per Family** | $5,500.00 |

**Overall Calendar Year Out-of-Pocket Limits**
*(includes medical and Prescription Drug Copayments)*

| | |
|---|---|
| **Through August 31, 2020** | |
| Per Individual | $7,350.00 |
| Per Employee Plus One (1) Dependent | $14,700.00 |
| Per Family | $14,700.00 |
| **Effective September 1, 2020** | |
| Per Individual | $8,150.00 |
| Per Employee Plus One (1) Dependent | $16,300.00 |
| Per Family | $16,300.00 |

Charges related to services and supplies that are not Covered Expenses under this Plan, in excess of any Reasonable and Allowable Amount, or other Plan limitations, or attributable to any Plan penalty will not apply to the Out-of-Pocket limits listed above.

## 2.3 MEDICAL COPAYMENT AMOUNTS

*Copayments will be applied on a per visit or per service basis and reflect amounts to be paid by the Covered Person. Covered Expenses that exceed the Copayments will be paid in full by the Plan, unless a limitation listed in Section 2.4 applies, or the charges are attributable to any penalty amount listed in this Plan. If more than one (1) Copayment would apply during the same visit, total Copayments will be limited to the highest Copayment that would otherwise apply. Copayments will no longer apply in any Calendar Year once the applicable Out-of-Pocket limits are satisfied for that year.*

**Certain services and supplies require pre-certification. If pre-certification is not obtained a penalty may apply. A list of these services and supplies can be found in Article VI of this Plan. Pre-certification can be obtained by calling the Utilization Review Service at the number printed on the Covered Person's ID card.**

**COPAYMENTS**

**Elective Sterilizations**
All Females ........ None
All Males *(per date of service)* ........ $45.00
**Contraceptives and Contraception Related Medical Services** ........ None
**Tobacco Cessation Counseling**① ........ None

**Hearing Exams**①
Included in Recommended Wellness Services .................. None
Other Exams *(per date of service)* .................. $45.00
**Other Covered Preventive/Wellness Services**① *(including Recommended Wellness Services)* .................. None
**Office Visits not Specified Elsewhere** *(including telehealth services during State of Emergency only; per date of service)*
Primary Care Physician (PCP) .................. $30.00
Specialist .................. $45.00
**Other Office Based Services**① *(per date of service)*
Allergy Injections and their Administration .................. $5.00
Other Injections and their Administration & Surgical Procedures
*Primary Care Physician (PCP)* .................. $30.00
*Specialist* .................. $45.00
Allergy Testing .................. $45.00
Other Services, including Allergy Serum/Venom, Medical Supplies and Diagnostic/Laboratory Services .................. None
**COVID-19 Testing and Related Office Visit, Urgent Care or Emergency Room Visit** *(through 1/23/21 or later if required by law)* .................. None
**Hearing Aids**① *(per date of service)* .................. $50.00
**Prosthetic Bras following Mastectomy** .................. None
**Durable Medical Equipment**
Device *(per device)* .................. $50.00
Related Medical Supply *(per date of service)* .................. $50.00
**Outpatient Non-Office Based Medical Supplies, Prosthetics not Otherwise Mentioned, and Orthotics** *(per device/supply)* .................. $50.00
**Routine Foot Care** *(per date of service)* .................. $45.00
**Diabetic Self-Management Training** *(per date of service)* .................. $45.00
**Glaucoma/Cataract Lenses/Glasses Following Surgery**① .................. $50.00
**Dental Procedure Due to Injury** *(per date of service)* .................. $45.00
**Other Covered Oral Surgery** *(per date of service)* .................. $250.00
**Chiropractic Services**① *(per date of service)* .................. $45.00
**Cognitive, Speech, Occupational and Physical Therapy**① *(per date of service)* .................. $45.00
**Cardiac and Pulmonary Rehabilitation**① *(per date of service)* .................. $45.00
**Dialysis**
Outpatient Facility/Office-Based *(per treatment)* .................. $50.00
Inpatient Facility .................. None
**Chemotherapy and Radiation Services**
Provided at Baptist Health Services Group of the Mid-South
*Through August 31, 2020 (per date of service)* .................. $50.00
*Effective September 1, 2020* .................. None
Other Providers *(per date of service)* .................. $50.00
**Outpatient Hospital/Facility Charges not Listed Elsewhere**
Cat Scans *(per date of service)* .................. $150.00
MRI, MRA, PET Scans and Nuclear Medicine *(per date of service)* .................. $250.00
Surgical Procedures *(per date of service)* .................. $250.00
Other Services .................. None

**Ambulance, Including Air** *(per date of service)* ....................$50.00
**Emergency Room**
Facility Charges *(per visit; if not admitted on the same date to the same Facility)*........$250.00
Physician's Charges and Other Services/Supplies during Visit.................None
**Urgent Care Facility** *(per visit)* ....................$50.00
**Hospital Room & Board, Intensive Care Units, and all Other Inpatient Hospital Expenses**② *(per admission)* ....................$500.00
**Maternity Services** *(per date of service)*
Initial Office Visit ....................$30.00
Office Based Surgery/Injections, including Administration through Specialist..............$30.00
Other Covered Services ....................Paid Same as Other Conditions
**Organ & Tissue Transplants**
Through Special Transplant Network/Center of Excellence Facility ....................None
Through Other Facility ....................Paid Same as other Conditions
**Treatment of Mental/Nervous Disorders, Alcohol and Other Drug Abuse**
Office Visits & Individual or Group Counseling *(per date of service)*....................$30.00
Intensive Outpatient Treatment *(per date of service)*....................$250.00
Other Covered Services ....................Paid Same as Other Conditions
**Skilled Nursing/Extended Care Facility**①*(per admission)* ....................$100.00
**Radiology Services Through EvoCare Program**
**Diagnostic Imaging Center** ....................None
**Other Covered Services & Supplies**① ....................None

**EXPLANATION**

① Please see additional limitations in Section 2.4, Medical Plan Benefit Maximums.

② Covered Expenses for Hospital Room & Board will be determined based on the Hospital's daily Semi-Private room rate. Charges for Intensive Care Units will be considered at the Reasonable and Allowable Amount for such a unit.

## 2.4 MEDICAL PLAN BENEFIT MAXIMUMS

**The medical Plan benefit maximums and limitations are shown below.**

| | |
|---|---|
| **Wellness Services** | |
| Visual Acuity Screenings | Through age twenty-one (21) |
| Hearing Examinations | |
| *Included in Recommended Wellness Services* | Through age twenty-one (21) |
| *Other* | One (1) per Calendar Year |
| Cologuard Testing | One (1) test every three (3) years |
| Lifesigns Wellness Examinations/Testing | See page 65 for information on this program |
| **Spinal Manipulation, Pulmonary Rehabilitation, Post-Cochlear Implant Aural Therapy, and Cognitive, Physical, Occupational & Speech Therapy** | Sixty (60) visits per Calendar Year, combined |
| **Cardiac Rehabilitation** | Thirty-six (36) visits per Calendar Year |
| **Tobacco Cessation Counseling** | Two (2) attempts to quit tobacco use per Calendar Year with up to four (4) sessions per attempt |

| | |
|---|---|
| **Surgical Procedures related to Gender Dysphoria** | One (1) per Lifetime |
| **Surgical Treatment of Morbid Obesity** | One (1) Surgery per Lifetime |
| **Skilled Nursing Facility/Extended Care Facility** | Sixty (60) visits per Calendar Year, combined |
| **Home Health Care** | Sixty (60) visits per Calendar Year |
| **Hearing Aids** | Up to age eighteen (18)<br>One (1) pair every three (3) Calendar Years |
| **Spinal Pain Injections** | Three (3) per site, per rolling twelve (12) months. Additional injections require prior authorization |
| **Lenses/Glasses Following Glaucoma/Cataract Surgery** | One (1) set per Surgery |

## 2.5 SCHEDULE OF PRESCRIPTION DRUG PROGRAMS

The Plan has a retail prescription Drug program that covers prescriptions dispensed through a participating retail pharmacy and a mail order prescription program. The Plan Administrator will provide a listing of the pharmacies that are participating in these programs and the Drugs that are considered formulary/preferred. The Plan will cover up to a maximum of a ninety (90) day supply per prescription through either the retail program or the mail order program. Certain exclusions and limitations apply to the prescription Drug programs. These are described in Section 9.4 of the Plan. Some prescriptions require prior authorization to be completed.

**Prescriptions obtained from Walgreen's Pharmacy are subject to higher Copayments as described below.**

*If a Brand Name Drug is dispensed when a generic Drug is available, the Covered Person will be responsible for the difference in cost between the generic and the Brand Name Drug in addition to the Copayment listed below, unless the prescribing Physician has indicated to "dispense as written (DAW)."*

**COPAYMENTS**

*(other than Walgreen's Pharmacy)*

| | **30 Day Supply** *(retail)* | **60 Day Supply** *(retail)* | **90 Day Supply** *(retail/mail order)* |
|---|---|---|---|
| **Certain FDA Approved Contraceptives for Females and Tobacco Cessation Products, Breast Cancer Prevention Medications, Bowel Preparation Kits used with Colonoscopies and Other Products included in the Recommended Wellness Services** | None | None | None |
| **Over-the-Counter Non-Sedating Antihistamines** | None | None | None |
| **Other Low Cost Generic Equivalent Prescription Drugs** | $10.00 | $20.00 | $30.00 |
| **Other High Cost Generic and Brand Name Preferred Prescription Drugs** | 20% of the cost of the Drug up to $200.00 | 20% of the cost of the Drug up to $400.00 | 20% of the cost of the Drug up to $600.00 |

| | **30 Day Supply** *(retail)* | **60 Day Supply** *(retail)* | **90 Day Supply** *(retail/mail order)* |
|---|---|---|---|
| **Other Brand Name Non-Preferred Prescription Drugs** | 20% of the cost of the Drug, plus $50.00, up to $200.00 | 20% of the cost of the Drug, plus $100.00, up to $400.00 | 20% of the cost of the Drug, plus $150.00, up to $600.00 |

**COPAYMENTS - WALGREENS PHARMACY**

| | **30 Day Supply** *(retail)* | **60 Day Supply** *(retail)* | **90 Day Supply** *(retail)* |
|---|---|---|---|
| **Certain FDA Approved Contraceptives for Females and Tobacco Cessation Products, Breast Cancer Prevention Medications, Bowel Preparation Kits used with Colonoscopies and Other Products included in the Recommended Wellness Services** | None | None | None |
| **Over-the-Counter Non-Sedating Antihistamines** | None | None | None |
| **Other Low Cost Generic Equivalent Prescription Drugs** | $25.00 | $50.00 | $75.00 |
| **Other High Cost Generic and Brand Name Preferred Prescription Drugs** | 30% of the cost of the Drug up to $400.00 | 30% of the cost of the Drug up to $800.00 | 30% of the cost of the Drug up to $1,200.00 |
| **Other Brand Name Non-Preferred Prescription Drugs** | 30% of the cost of the Drug, plus $50.00, up to $450.00 | 30% of the cost of the Drug, plus $100.00, up to $900.00 | 30% of the cost of the Drug, plus $150.00, up to $1,350.00 |

# ARTICLE III

# DEFINITIONS

*All terms that are defined in this Article III are capitalized wherever they appear in this Plan.*

## 3.1 GENERAL AND MEDICAL PLAN DEFINITIONS

### ACCIDENT

The term "Accident" means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

### ACCIDENTAL BODILY INJURY or ACCIDENTAL INJURY

The terms "Accidental Bodily Injury" or "Accidental Injury" mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

### ACTIVELY AT WORK or ACTIVE WORK

The terms "Actively at Work" or "Active Work" mean the active expenditure of time and energy in the service of the District. A Participant shall be deemed Actively at Work while working the full number of hours shown in Section 5.2 and while in a relationship with the Employer within the meaning of "employee" for federal tax withholding purposes. In addition, individuals acting as independent contractors; leased employees; consultants; a member of the Board of Directors; temporary, free-lance, incidental, seasonal or occasional employees; individuals on retainers; or retirees are not considered Actively at Work unless each meets the requirements specified in Section 5.2. This term shall not apply to any provision of this Plan to the extent that such application would be deemed to violate the requirements of HIPAA.

### ADA

The term "ADA" means the American Dental Association.

### ADVERSE BENEFIT DETERMINATION

The term "Adverse Benefit Determination" means any of the following:

A. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan;

B. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate;

C. a reduction or termination by the Plan Administrator of a previously approved course of treatment, other than by Plan termination or amendment; or

D. any retroactive rescission of coverage (other than due to the failure to make Participant Contributions, fraud or intentional misrepresentation of a material fact), whether or not there is an adverse effect on any particular benefit at that time.

### AHA

The term "AHA" means the American Hospital Association.

### ALCOHOLISM

The term "Alcoholism" means the taking of alcohol at dosages that place a Covered Person's welfare at risk, cause the Covered Person to endanger the public welfare and that constitute alcohol dependence.

In making the determination as to whether the Covered Person's condition meets the definition of Alcoholism under this Plan, the Plan Administrator shall use recognized authorities, including designations contained in the most current editions of the *International Classification of Diseases*

(ICD) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

**ALTERNATE RECIPIENT**
The term "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

**AMA**
The term "AMA" means the American Medical Association.

**AMBULATORY SURGICAL CENTER**
The term "Ambulatory Surgical Center" means any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the Facility, and which does not provide services or other accommodations for patients to stay overnight.

**APPROVED CLINICAL TRIAL**
The term "Approved Clinical Trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Condition and is one (1) of the following:

A. a federally funded trial that is approved or funded, including in-kind contributions, by one (1) or more of the following entities:
   1. the Centers for Disease Control and Prevention;
   2. the Agency for Health Care Research and Quality;
   3. the Centers for Medicare & Medicaid Services;
   4. the National Institutes of Health;
   5. a cooperative group or center of any of the above entities or the United States Department of Defense or the United States Department of Veterans' Affairs;
   6. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
   7. any of the following if the clinical trial has been approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
      a. the United States Department of Energy;
      b. the United States Department of Veterans' Affairs; and
      c. the United States Department of Defense;

B. a clinical trial conducted under an FDA investigational new Drug application reviewed by the FDA; or

C. a Drug trial that is exempt from the requirement of an FDA investigation new Drug application.

**ASSIGNMENT OF BENEFITS**
The term "Assignment of Benefits" shall mean an arrangement whereby the Covered Person assigns their right to seek and receive payment from the Plan for eligible Covered Expenses to a Provider, in strict accordance with the conditions and limitations of such rights provided under the terms of this Plan document.

Conditions and Limitations of an Assignment of Benefits:

A. the validity of an Assignment of Benefits by a Covered Person to a Provider is limited by the terms of this Plan document. An Assignment of Benefits is considered valid on the condition that Provider accepts the payment received from the Plan as consideration, in full, for Covered Expenses for services, supplies and/or treatment rendered. This amount does not include any cost sharing amounts (i.e. Copayments, deductibles, or coinsurance), or charges for non-covered services; the Provider may bill the Covered Person directly for these amounts.
B. an Assignment of Benefits cannot be inferred, implied or transferred. An Assignment of Benefits must be made by the Covered Person to the Provider directly through a valid written instrument that is signed and dated by the Covered Person.
C. unless specifically prohibited by a Covered Person, a Provider with a valid Assignment of Benefits may exhaust, on behalf of the Covered Person, any administrative remedies available under the terms of the Plan document, including initiating an internal or external appeal of an Adverse Benefit Determination in accordance with the terms of the Plan document. Notwithstanding the foregoing, the Covered Person does not, under any circumstances, have the right to assign to any Provider (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Covered Person them self may be afforded under applicable law. The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.
D. an Assignment of Benefits does not grant the Provider any rights other than those specifically set forth herein.
E. the Plan Administrator may disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole recipient of the benefits available under the terms of the Plan.
F. an Assignment of Benefits by a Covered Person or Provider will not constitute the appointment of an Authorized Representative.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Plan document. The Provider further agrees to the payments received constitute an ‘accord and satisfaction’ and consideration, in full, for the Covered Expenses for services, supplies and/or treatment rendered. The Provider agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the patient not be balance billed for any amount beyond applicable cost sharing amounts (i.e. Copayments, deductibles, or coinsurance), or charges for non-covered services; the Provider may bill the Covered Person directly for these amounts.

If a Provider refuses to accept an Assignment of Benefits under the conditions and limitations as set forth herein, any Covered Expenses payable under the terms of the Plan document will be payable directly to the Covered Person, and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expense.

**AUTISM SPECTRUM DISORDER**
The term “Autism Spectrum Disorder” means a group of disorders characterized by impairment of development in multiple areas, including the acquisition of reciprocal social interaction, verbal and non-verbal communication skills, imaginative activity and by stereotyped interests and behaviors. It includes but is not limited to Autistic Disorder, Rett Syndrome, Childhood Disintegrative Disorder and Asperger Syndrome.

**BENEFIT MANAGER**
The term “Benefit Manager” means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the management, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written agreement. If no Benefit Manager is appointed or retained (as a result of the termination or expiration of such agreement or other reason) or if the term is used in connection with a duty not

expressly assigned to and assumed by the Benefit Manager in writing, the term will mean the Plan Administrator. The Benefit Manager is not the Plan fiduciary and does not have final discretion under any Plan provisions, including claims determinations.

As of the Plan Effective Date of this revision of the Plan, the Benefit Manager of the Plan is Medical Benefits Administrators, Inc.

**BIRTHING CENTER**

The term "Birthing Center" means a Facility that meets professionally recognized standards and all of the following requirements:

A. it mainly provides an Outpatient setting for childbirth following a normal, uncomplicated Pregnancy, in a home-like atmosphere;

B. it has the following:

   1. at least two (2) delivery rooms;
   2. all medical equipment needed to support the services furnished by the Facility;
   3. laboratory and diagnostic facilities; and
   4. Emergency equipment, trays, and supplies for use in life-threatening situations;

C. it has medical staff that is supervised by a Physician on a full-time basis, and includes a Registered Nurse at all times when Covered Persons are at the Facility;

D. if it is not part of a Hospital, it has a written agreement with a local Hospital and a local ambulance company for the immediate transfer of Covered Persons who develop complications or who require either pre or post-natal care;

E. it admits only Covered Persons who have undergone an educational program to prepare them for the birth, and have medical records of adequate prenatal care;

F. it schedules confinements of not more than twenty-four (24) hours for a birth;

G. it maintains medical records for each Covered Person;

H. it complies with all licensing and other legal requirements that apply; and

I. it is not the office or clinic of one (1) or more Physicians or a specialized Facility other than a Birthing Center.

**BRAND NAME DRUG**

The term "Brand Name Drug" means Drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

**CALENDAR YEAR**

The term "Calendar Year" means the period of time from January 1st, at 12:00 A.M. midnight, through the next December 31st.

**CARDIAC CARE UNIT**

The term "Cardiac Care Unit" means a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

A. it is solely for the treatment of patients who require special medical attention because of their critical condition;

B. it provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;

C. it provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;

D. it contains at least two (2) beds for the accommodation of critically ill patients; and

E. it provides at least one (1) professional registered nurse, who continuously and constantly attends the patient confined in such area on a twenty-four (24) hour-a-day basis.

**CARDIAC REHABILITATION**

The term "Cardiac Rehabilitation" means a comprehensive exercise, education, and behavioral modification program designed to improve the physical and emotional condition of patients after heart Surgery, frequently beginning in a Hospital setting and continuing on an Outpatient basis after the patient is discharged over a period of six (6) to twelve (12) months, divided into the following three (3) phases:

A. Phase 1 begins during a patient's Hospital stay and consists of education and highly controlled exercises;
B. Phase 2 is a twelve (12) week Outpatient program consisting of forty (40) minutes of aerobic exercise, three (3) times a week; and
C. Phase 3 is a non-monitored but supervised exercise program.

**CENTERS OF EXCELLENCE**

The term "Centers of Excellence" means medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator, in its discretion, shall determine what facilities are considered to be Centers of Excellence and which Centers of Excellence are to be used.

Any Covered Person in need of an organ transplant may contact the Benefit Manager or Utilization Review Service to initiate the pre-certification process resulting in a referral to a Center of Excellence.

If a Covered Person chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to Covered Persons and updated as requested.

**CHIP**

The term "CHIP" means the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

**CHIROPRACTIC CARE**

The term "Chiropractic Care" means office visits, x-rays, manipulations, supplies, heat treatment, and cold treatment.

**CLEAN CLAIM**

The term "Clean Claim" means a claim for a Covered Expense that:

A. is timely received by the administrator;
B. when submitted via paper has all of the elements of the UB 04 or CMS 1500 (or successor standard) forms or when submitted via an electronic transaction, uses only permitted transaction code sets (e.g. CPT4, ICD9, ICD10, HCPCS) and has all the elements of the standard electronic formats required by applicable Federal authority;
C. is a claim for which the Plan is the primary payor or the Plan's responsibility as a secondary payor has been established;
D. contains no defect, error or other shortcoming resulting in the need for additional information to adjudicate the claim; and
E. that does not lack necessary substantiating documentation to completely adjudicate the claim.

A Clean Claim does not include a claim that is being reviewed for the Reasonable and Allowable Amount payable under the terms of the Plan.

**CLOSE RELATIVE or IMMEDIATE FAMILY MEMBER**
The terms "Close Relative" or "Immediate Family Member" mean the Covered Person or his or her spouse, child, brother, sister, parent or in-law.

**COBRA**
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**COPAYMENT**
The term "Copayment" means a specific dollar amount (or percentage) of the Covered Expenses that the Covered Person must pay before the Plan pays benefits for a particular service or supply.

**COSMETIC SURGERY**
The term "Cosmetic Surgery" means any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal, but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

**COVERED EXPENSE**
The term "Covered Expense" means those Medically Necessary services, supplies and/or treatment that are covered under this Plan. The term Covered Expenses does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a Provider. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's medical error are not considered Covered Expenses. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Allowed or not a Covered Expense.

**COVERED PERSON**
The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

**CUSTODIAL CARE**
The term "Custodial Care" means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

**DENTIST**
The term "Dentist" means an individual holding a D.D.S. or D.M.D. degree, licensed to practice Dentistry in the jurisdiction where such services are provided.

**DEPENDENT**
The term "Dependent" means:

A. the Participant's legal spouse who:
    1. has met all requirements of a valid marriage contract in the state in which such parties were married; and
    2. is not eligible for health coverage through his or her own employer, unless such spouse qualifies for a hardship exception because his or her employer contributes less than fifty percent (50%) of the cheapest individual medical coverage. Documentation must be provided and verified in order for the hardship exception to apply; or

B. the Participant's child who meets all of the following conditions:

1. is the Participant's natural child, adopted child, stepchild, a child for whom the Participant has Legal Guardianship or Legal Custody pursuant to a valid court order, or is a child Placed For Adoption with the Participant; and
2. is less than twenty-six (26) years of age. The age requirement above is waived for any unmarried mentally or physically handicapped child who is incapable of self-sustaining employment and is chiefly dependent upon the Participant for support and maintenance, provided the child suffered such incapacity prior to attaining twenty-six (26) years of age. Proof of incapacity must be furnished to the Plan Administrator, or its designee, within thirty-one (31) days of the date the child's coverage would have ended due to age.

The Plan Administrator has the right to obtain sufficient proof of Dependent status from any Participant under the Plan who is requesting coverage of his or her Dependents.

This definition and all provisions of this Plan are intended to comply with state and federal law as both regard "Qualified Medical Child Support Orders" and "Medical Child Support Orders," as those terms are defined in the law. The Plan Administrator has established procedures governing "Qualified Medical Child Support Orders". Covered Persons under this Plan can receive upon request, free of charge, a copy of such procedures from the Plan Administrator.

The term "Dependent" excludes these situations:

A. a spouse who is Legally Separated or divorced from the Participant. Such separation/ divorce must have met all the requirements of a valid Legal Separation or divorce in the state granting it;
B. any person on active military duty;
C. any person who is a resident of a country outside of the United States; or
D. any person who is covered under this Plan as an individual Participant or as the Dependent of another Participant.

**DEPENDENT COVERAGE**

The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent.

**DIAGNOSIS**

The term "Diagnosis" means the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

**DIAGNOSTIC SERVICE**

The term "Diagnostic Service" means a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

**DISEASE**

The term "Disease" means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker's compensation law, occupational Disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

**DISTRICT**

The term "District" means Bartlett City Schools, the Plan sponsor.

**DRUG**

The term “Drug” means insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a State restricted Drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

**DURABLE MEDICAL EQUIPMENT**

The term “Durable Medical Equipment” means equipment which:

A. can withstand repeated use;
B. is primarily and customarily used to serve a medical purpose;
C. generally, is not useful to a person in the absence of an Illness or Injury; and
D. is appropriate for use in the home.

**EMERGENCY**

The term “Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
B. serious impairment to bodily functions; or
C. serious dysfunction of any bodily organ or part.

**EMERGENCY SERVICES**

The term “Emergency Services” means, with respect to an Emergency medical condition:

A. a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and
B. such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

**EMPLOYER**

The term “Employer” means the District and any entity that is affiliated with the District, as defined by any applicable state or federal statute, that adopts this Plan for the benefit of its employees, whose participation in the Plan is approved by the President (or any duly authorized officer) of the District. An Employer may withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

**ESSENTIAL HEALTH BENEFITS**

The term “Essential Health Benefits” means, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories:

A. ambulatory patient services;
B. Emergency care;
C. Hospitalization;
D. maternity and Newborn care;
E. Mental/Nervous Disorders, Alcoholism and Substance Abuse disorder services, including behavioral health treatment;

F. prescription Drugs;
G. rehabilitative and habilitative services and devices;
H. laboratory services;
I. preventive and wellness services and chronic Disease management; and
J. pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Tennessee as permitted by the Departments of Labor, Treasury, and Health and Human Services.

**EXCESS CHARGES**

The term “Excess Charges” means the part of an expense for services, supplies and/or treatment of an Injury or Sickness that is in excess of the Reasonable and Allowable Amount.

**EXPERIMENTAL or INVESTIGATIVE**

The terms “Experimental” or “Investigative” mean any treatment, procedure, Drug, device, equipment and/or supplies (referred to as “service(s)” hereafter in this definition) to which any of the following applies:

A. it cannot be lawfully marketed without approval from the federal Food and Drug Administration (FDA) or other governmental agency and did not have approval at the time of its use for the purpose or manner in which it was used;
B. it is provided pursuant to a written protocol with objectives of determinations of safety, toxicity, effectiveness or effectiveness in comparison to conventional alternatives;
C. the predominant opinion of independent experts is that the service is Experimental or Investigative or not a generally accepted medical procedure; or
D. was not recognized by authoritative medical literature or studies to be non-Experimental and safe and effective for treating or diagnosing the condition for which it is used or proposed. Authoritative medical literature or studies include:
    1. at least two (2) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
    2. the following standard reference compendia, including:
        a. the *American Hospital Formulary Service-Drug Information*,
        b. the *American Medical Association Drug Evaluations*,
        c. the American Dental Association *Accepted Dental Therapeutics*, and
        d. the *United States Pharmacopoeia* Drug information; or
    3. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the:
        a. Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services;
        b. National Institutes of Health;
        c. National Cancer Institute;
        d. National Academy of Sciences;
        e. Center for Medicare and Medicaid Services; and
        f. any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

This does not exclude coverage for Routine Patient Costs provided as part of an Approved Clinical Trial for the treatment of cancer or another Life Threatening Condition or Disease for a Qualified

Individual. Additionally, this does not exclude off-label Drug use when determined to be Medically Necessary, subject to the criteria listed in the definition of Medical Necessity.

The Plan Administrator, in its sole discretion, shall determine whether or not a treatment, procedure, Drug, device, equipment and/or supply is Experimental or Investigative under the Plan.

**FACILITY or INSTITUTION**
The terms "Facility" or "Institution" mean a Facility operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, Rehabilitation Hospital, community mental health center, dialysis center, residential treatment Facility, psychiatric treatment Facility, substance abuse treatment Center, Birthing Center, Home Health Care Center, or any other such Facility that the Plan approves.

**FAMILY**
The term "Family" means a covered Participant and his or her covered Dependents.

**FDA**
The term "FDA" means the United States Food and Drug Administration, an agency of the United States Department of Health and Human Services that is charged with the responsibility for regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical Drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), cosmetics, animal foods & feed and veterinary products within the United States.

**FINAL ADVERSE BENEFIT DETERMINATION**
The term "Final Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Plan Administrator, in whole or in part, at the end of the internal appeals process described in Section 4.4.

**FMLA**
The term "FMLA" means the Family and Medical Leave Act of 1993, as amended.

**FULL-TIME EMPLOYEE**
The term "Full-Time Employee" means any employee who, on the date of hire, is reasonably expected to work, on average, at least thirty (30) hours per week (or one hundred thirty (130) hours per month) on an annual basis. Such an employee shall start his or her waiting period, if any, on the date of hire.

**GENETIC TESTING**
The term "Genetic Testing" means medical tests used to identify changes in chromosomes, genes or proteins.

**GINA**
The term "GINA" means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

**HEALTH CARE REFORM, PPACA, AFFORDABLE CARE ACT or ACA**
The terms "Health Care Reform," "PPACA," "Affordable Care Act" or "ACA" mean the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and as otherwise amended, including all current final regulations that are issued regarding such acts.

**HEALTH INFORMATION**
The term "Health Information" means any information, whether oral or recorded in any form or medium that:

A. is created or received by this Plan, or a Plan designee; and
B. relates to any of the following:

1. the past, present or future physical or mental health or condition of an individual;
2. the provision of health care to an individual; or
3. the past, present or future payment for the provision of health care to an individual.

**HIPAA**

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

**HOME HEALTH CARE**

The term "Home Health Care" means the continual care and treatment of an individual if:

A. the Institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
B. the treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
C. the Home Health Care is the result of an Illness or Injury.

**HOME HEALTH CARE AGENCY**

The term "Home Health Care Agency" means an agency or organization which provides a program of Home Health Care and which:

A. is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
B. meets all of the following requirements:
   1. it is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
   2. it has a full-time administrator;
   3. it maintains written records of services provided to the patient;
   4. its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
   5. its employees are bonded, and it provides malpractice insurance.

**HOSPITAL**

The term "Hospital" means an Institution that meets all of the following requirements:

A. it provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
B. it is under the supervision of a staff of Physicians;
C. it provides twenty-four (24) hour-a-day nursing service by registered nurses;
D. it is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax- supported Institution;
E. it is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
F. it is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a Facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The term "Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of Ambulatory Surgical Center.

**ILLNESS**
The term "Illness" shall have the meaning set forth in the definition of Disease.

**IMPREGNATION AND INFERTILITY TREATMENT**
The term "Impregnation and Infertility Treatment" means artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

**INCURRED**
The term "Incurred" means that a Covered Expense is considered "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

**INJURY**
The term "Injury" means an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

**INPATIENT**
The term "Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, Skilled Nursing Facility or other covered Facility for treatment and charges are made for Room and Board to the Covered Person as a result of such admission.

**INTENSIVE CARE UNIT**
The term "Intensive Care Unit" shall have the same meaning set forth in the definition of Cardiac Care Unit.

**JOINT COMMISSION**
The term "Joint Commission" means an independent commission that accredits and certifies health care organizations and programs in the United States, including Hospitals, Skilled Nursing Facilities, ambulatory facilities, behavioral health facilities, laboratories, Home Health Care agencies and pharmacies. To receive and maintain accreditation from the Joint Commission, an organization must undergo an on-site survey by a Joint Commission survey team at least every three (3) years. (Laboratories must be surveyed every two (2) years.) Information about the accreditation status of an organization can be found on the Joint Commission website (www.qualitycheck.org/consumer/searchQCR.aspx).

The Joint Commission was formerly known as the Joint Commission on Accreditation of Healthcare Organizations.

**LEAVE OF ABSENCE**
The term "Leave of Absence" means a leave of absence of an employee that has been approved by the Employer, as provided for in the Employer's rules, policies, procedures and practices.

**LEGAL GUARDIAN or LEGAL GUARDIANSHIP**
The terms "Legal Guardian" or "Legal Guardianship" mean a person, or the status of a person and his or her ward, who has been appointed by a state court with specific jurisdiction over guardianships and estates, to have the care and management of a minor child. The Legal Guardian must have guardianship of the person of the minor child, and not merely the estate of such child. An order granting a person legal custody of a minor child, without the appointment of the person as the child's Legal Guardian, does not create a Legal Guardianship.

**LEGALLY SEPARATED**
The term "Legally Separated" means an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

**LIFE THREATENING CONDITION**
The term "Life Threatening Condition" means any Disease or condition from which the likelihood of death is probable, unless the course of the Disease or condition is interrupted.

**LIFETIME**
The term "Lifetime" is a word used in the Plan in reference to benefit maximums and limitations. The term "Lifetime" means the total time period of a Covered Person's coverage under this Plan, regardless of the number of breaks in that coverage. Under no circumstances does the term "Lifetime" mean the duration of a Covered Person's life.

**MASTECTOMY**
The term "Mastectomy" means the surgical removal of all or part of a breast.

**MEASUREMENT PERIOD**
The term "Measurement Period" means the look back period of time, as determined by the Plan Administrator, for use in determining whether Variable Hour Employees (and On-Going Employees who are not eligible under the provisions of Section 5.2 A) are employed for an average of at least thirty (30) hours per week and are therefore eligible for coverage under the Plan during the next applicable Stability Period. The Employer sponsoring this Plan uses a twelve (12) month Measurement Period, starting on the date of hire for new employees (and ending one (1) year later), or on July 1st and ending June 30th of the next Calendar Year for other employees.

If an employee experiences a break in service during a Measurement Period, the existing Measurement Period will resume once he or she returns to active employment with the Employer if the break in service is less than the period of active employment prior to the break, and less than twenty-six (26) weeks in length. If the break in service is more than either the employee's total employment before the break, or twenty-six (26) weeks, a new initial Measurement Period will commence once he or she resumes employment. Any such break in service that is attributable to FMLA, Service in the Uniformed Services, jury duty, or any other statutory continuation will be disregarded for the purposes of determining what the average number of hours of employment were during the entire Measurement Period.

The Employer will notify all new Variable Hour Employees who become eligible for coverage under this Plan within two (2) months following the end of the initial Measurement Period, and prior to the beginning of the initial Stability Period. On-Going Employees will be notified within the months of July and August each year as to their eligibility during the next applicable Stability Period.

**MEDICAL CARE**
The term "Medical Care" means professional services given by a Physician or other Provider to treat an Injury, ailment, condition, Disease, disorder or Illness, including medical advice, treatment, medical Diagnosis and the taking of prescription Drugs.

**MEDICAL CHILD SUPPORT ORDER**
The term "Medical Child Support Order" means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

A. provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
B. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

**MEDICALLY NECESSARY or MEDICAL NECESSITY**

The terms "Medically Necessary" or "Medical Necessity" mean health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, Diagnosis or treatment of that Covered Person's Sickness or Injury. Such services, in order to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Covered Person's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, in order to be considered Medically Necessary, must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Covered Person's Sickness or Injury without adversely affecting the Covered Person's medical condition. In order to be considered Medically Necessary:

A. the service must not be maintenance therapy or maintenance treatment;
B. the purpose of such service must be to restore health;
C. the service must not be primarily custodial in nature;

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or a Covered Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting.

The fact that certain services are excluded from coverage under this Plan because they are not Medically Necessary does not mean that any other services are deemed to be Medically Necessary.

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care or services does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

A. the Drug is approved by the FDA;
B. the prescribed Drug use is supported by one of the following standard reference sources:
   1. DRUGDEX;
   2. The American Hospital Formulary Service Drug Information;
   3. Medicare approved Compendia; or
   4. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and
C. the Drug is Medically Necessary to treat the specific condition, including Life Threatening Conditions or chronic and seriously debilitating conditions.

The Plan reserves the right to make the final determination of Medical Necessity on the basis of final Diagnosis and supporting medical data. This determination will be based on, and consistent with, standards approved by the Plan's medical review consultants.

**MEDICARE**

The term "Medicare" means the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," and that includes parts A, B, C and D of Subchapter XVIII of the Social Security Act, as amended from time to time.

**MENTAL/NERVOUS DISORDER**
The term “Mental/Nervous Disorder” means any Disease or condition, regardless if the cause is organic in nature, that is classified as a mental disorder in the current edition of the *International Classification of Diseases*, published by the World Health Organization, or is listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, with the exception of disorders related to Alcoholism or Substance Abuse. Mental/Nervous Disorders include, but are not limited to:

A. psychotic disorders;
B. bipolar disorders; or
C. psychoneurotic disorders.

**MULTIPLE SURGICAL PROCEDURES**
The term “Multiple Surgical Procedures” means separate Surgical Procedures performed by a Physician on the same patient during the same operative session or during the same day. This term does not include procedures that are components of, or incidental to, a primary procedure, an intraoperative service or an incidental Surgery.

For the purposes of determining Covered Expenses under this Plan, Multiple Surgical Procedures will be considered, as follows:

A. the Plan will consider as Covered Expenses up to one hundred percent (100%) of the Reasonable and Allowable Amount for the primary or highest valued procedure;
B. the Plan will consider as Covered Expenses up to fifty percent (50%) of the Reasonable and Allowable Amount for each additional procedure, for the second procedure through the fifth procedure; and
C. if more than five (5) procedures are performed in the same operative session/day, coverage of any additional procedures will be subject to the review and approval of the Plan Administrator, in its discretion. In order for any additional payment to be considered by the Plan under the provision, the operating Physician must submit the applicable operative notes.

Other restrictions and limitations may be applied to the payment of Multiple Surgical Procedures. Such restrictions and limitations will be consistent with the rules applied under the Medicare program, as listed in the most recent Medicare payment manuals.

**NAMED FIDUCIARY**
The term “Named Fiduciary” means the individual or entity that has the ultimate authority to control and manage the overall operation of the Plan.

**NATIONAL MEDICAL SUPPORT NOTICE (NMSN)**
The term “National Medical Support Notice (NMSN)” means a notice that contains the following information:

A. name of an issuing State agency;
B. name and mailing address (if any) of an employee who is a Participant under the Plan;
C. name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
D. identity of an underlying child support order.

**NEWBORN**
The term “Newborn” means an infant from the date of birth until the earlier of the initial Hospital discharge or the last day of the mother’s covered admission for a vaginal or cesarean delivery.

**NO OBLIGATION TO PAY**
The term “No Obligation to Pay” means charges Incurred for which the Plan has no legal obligation to pay.

**ON-GOING EMPLOYEE**
The term "On-Going Employee" means any employee of the Employer who has been employed for at least one (1) full standard Measurement Period.

**OUT-OF-POCKET**
The term "Out-of-Pocket" means the amount of Covered Expenses that are the responsibility of the Covered Person and that accumulate towards the Plan's Out-of-Pocket maximum, not including amounts:

A. for expenses that are not covered under this Plan;
B. in excess of the Reasonable and Allowable Amount for a service or supply;
C. in excess of any maximum benefit listed in the Plan; or
D. attributable to any penalty.

**OUTPATIENT**
The term "Outpatient" refers to the classification of a Covered Person when that Covered Person receives Medical Care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital, if not a registered bed patient at that Hospital or other covered Facility.

**PARTICIPANT**
The term "Participant" means a person who meets the eligibility requirements listed in Section 5.2 and who is properly enrolled in the Plan.

**PARTICIPANT CONTRIBUTION**
The term "Participant Contribution" means that amount that is due from an eligible employee in order for that employee to obtain Participant and/or Dependent Coverage(s) under the Plan. The District shall determine the amount of the Participant Contribution that may vary depending upon the type of coverage an eligible employee desires to obtain. Eligible Participants will be advised of any required Participant Contributions at the time each applies for Participant and/or Dependent Coverage. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required Participant Contribution amount. Participants in the Plan that are not required to make Participant Contributions at the time of enrollment will be notified by the Plan Administrator prior to the date a Participant Contribution requirement is made effective.

**PHYSICIAN**
The term "Physician" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

**PLACED FOR ADOPTION or PLACEMENT FOR ADOPTION**
The terms "Placed For Adoption" or "Placement For Adoption" mean the assumption and retention by such Participant hereunder of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such Participant terminates upon the termination of such legal obligation.

**PLAN**
The term "Plan" means the Sickness and accident plan, as described in and administered by the Bartlett City Schools Employee Benefit Plan.

**PLAN ADMINISTRATOR**
The term "Plan Administrator" means the entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services. Bartlett City Schools is the Plan Administrator as of the Plan Effective Date of this revision of the Plan.

**PLAN EFFECTIVE DATE**
The Plan Effective Date of this revision of the Plan is July 1, 2020. This Plan was originally effective on July 1, 2014.

**PLAN SPONSOR**
The term "Plan Sponsor" means the entity that sponsors this Plan for the benefit of its own employees and their eligible Dependents, and the employees/Dependents of related Employers, if any. As of the Plan Effective Date, the Plan Sponsor is Bartlett City Schools.

**PLAN YEAR**
The term "Plan Year" means a period of time used for certain reporting and disclosure requirements of the Plan. The Plan Year will begin on September 1st and end on August 31st of the following year.

**PREGNANCY**
The term "Pregnancy" means that physical state that results in childbirth, abortion or miscarriage, and any medical complications arising out of, or resulting from, such state.

**PRIMARY CARE PHYSICIAN or PCP**
The terms "Primary Care Physician" or "PCP" mean a Physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or Diagnosis. Primary Care Physicians include those trained and actively practicing in family practice, general practice, pediatrics, internal medicine or gynecology.

**PROTECTED HEALTH INFORMATION**
The term "Protected Health Information" means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and that is one (1) of the following:

A. transmitted by electronic media, including:
    1. the internet;
    2. an extranet;
    3. leased lines;
    4. dial-up lines;
    5. private networks; and
    6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
B. maintained in any electronic media; or
C. transmitted or maintained in any other form or medium.

**PROVIDER**
The term "Provider" means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or Facility defined or listed herein, or approved by the Plan Administrator.

**PSYCHIATRIC HOSPITAL**
The term "Psychiatric Hospital" means an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

A. it is primarily engaged in providing psychiatric services for the Diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
B. it maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
C. it is licensed as a Psychiatric Hospital;
D. it requires that every patient be under the care of a Physician; and
E. it provides twenty-four (24) hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

**QUALIFIED INDIVIDUAL**

The term "Qualified Individual" means an individual who is properly enrolled in the Plan and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another Life Threatening Condition or Disease. To be a Qualified Individual, there is an additional requirement that a determination be made that the individual's participation in the Approved Clinical Trial is appropriate to treat the Disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual.

**QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

The term "Qualified Medical Child Support Order (QMCSO)" means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan.

**REASONABLE AND ALLOWED AMOUNT/REASONABLE AND ALLOWABLE AMOUNT**

The terms "Reasonable and Allowed Amount" or "Reasonable and Allowable Amount" mean the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Expense. The Reasonable and Allowable Amount is the lesser of:

A. the charge made by the Provider that furnished the care, service, or supply;
B. the negotiated amount established by a discounting or negotiated arrangement;
C. the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a Provider of like service or similar training and experienced as further described below; or
D. an amount equivalent to the following:
    1. for Inpatient or Outpatient Hospital claims, an amount equivalent to one hundred forty percent (140%) of the Medicare equivalent allowable amount;
    2. for Outpatient laboratory and Physicians claims, and amount equivalent to one hundred twenty percent (120%) of the Medicare allowable amount;
    3. for Drugs, including Specialty Drugs, that are covered under the medical provisions of the Plan, the amount equivalent to one hundred forty percent (140%) of the Medicare equivalent allowable amount. This does not include Drugs and products obtained through the Plan's prescription Drug programs (pharmacy programs).

The term 'reasonable and customary charge' shall mean an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and utilized by the Plan from time to time.

If there is insufficient information submitted for a given procedure, the Plan will determine the Reasonable and Allowed Amount based upon charges made for similar services. Determination of the reasonable and customary charge will take into consideration the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The term 'geographic area' shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge was made. For Covered Expenses rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law may dictate the maximum amount that can be billed by the rendering Provider, the Reasonable and Allowed Amount shall mean the lesser of amount established by applicable law for that Covered Expense or the amount determined as set forth above.

The Plan Administrator or its designee has the *ultimate discretionary authority* to determine the Reasonable and Allowable amount, including establishing the negotiated terms of a Provider arrangement as the Reasonable and Allowable Amount even if such negotiated terms do not satisfy the lesser of test described above.

**RECOMMENDED WELLNESS SERVICE**

The term "Recommended Wellness Service" means a service or supply that is not intended to treat an existing medical condition, but rather is intended to detect or prevent potential future problems or assist the Covered Person in maintaining his or her health. They are recommended by recognized medical bodies and are required to be covered without cost sharing by non-grandfathered health plans under the Affordable Care Act. These recommendations include the following:

A. evidence-based preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (www.uspreventiveservicestaskforce.org);

B. immunizations recommended by the Advisory Committee on Immunization Practices, as updated annually (www.cdc.gov/vaccines); and

C. guidelines supported by the Health Resources and Services Administration that are applicable to children and women, including:

   1. services provided to children under the Bright Futures recommendations of the American Academy of Pediatrics (brightfutures.aap.org) and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) national recommendations on Newborn screening - See (www.hrsa.gov /advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html); and

   2. women's health services recommendations developed by the Institute of Medicine (www.hrsa.gov/womens-guidelines).

Any changes to the above recommendations will take effect for this Plan at the beginning of the first Plan Year beginning one (1) year after the issuance of such new recommendation or a change in the existing recommendations by the above entities, unless the change was prompted by safety or other concerns that make it inadvisable to continue to cover the service or supply.

**REHABILITATION HOSPITAL**

The term "Rehabilitation Hospital" means an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

A. it carries out its stated purpose under all relevant Federal, State and local laws; or

B. it is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities.

**RETIREE**

The term "Retiree" means a former employee of the Employer who meets the Employer's criteria for Retiree status. Retiree eligibility requirements are provided in the policy manual of the school District. Please refer to this document for all Retiree eligibility information or contact the Plan Administrator.

**ROOM and BOARD**

The term "Room and Board" refers to all charges, by whatever name called, that are made by a Hospital, Hospice or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

**ROUTINE PATIENT COSTS**

The term "Routine Patient Costs" means all items and services consistent with the coverage provided under the Plan that is typically covered for a Qualified Individual for treatment of cancer or another Life Threatening Condition or Disease who is not enrolled in a clinical trial. However, costs associated with the following are excluded from that definition, and the Plan is not required under federal law to pay for the following:

A. the cost of the investigational item, device or service;
B. the cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and
C. the cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.

**SEMI-PRIVATE**
The term "Semi-Private" refers to a class of accommodations in a Hospital or other covered Facility in which at least two (2) patient beds are available per room.

**SERVICE IN THE UNIFORMED SERVICES**
The term "Service in the Uniformed Services" means performance of duty in the Armed Forces or Uniformed Services for a period of five (5) years or less, on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty in the Armed Forces, the Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States in time of war or emergency. Service in the Uniformed Services also includes a period for which an individual is absent from a position of employment for the purpose of an examination to determine the fitness of the person for duty in the Armed Forces or the commissioned corps of the Public Health Service.

**SICKNESS**
The term "Sickness" shall have the meaning set forth in the definition of Disease.

**SPECIALIST**
The term "Specialist" means a Physician who primarily practices in any medical specialty, such as neurology, cardiology, or pulmonology, and who is not a Primary Care Physician.

**SPECIALTY DRUG**
The term "Specialty Drug" means a scientifically or "bioengineered" oral or injectable medicine that targets and treats a specific or "niche" condition, and includes one (1) or more of the following features:

A. it is usually a complex compound;
B. it is offered by the manufacturer at a premium price that is generally significantly higher than those for traditional medications;
C. it is primarily prescribed and administered by a Specialist, such as an oncologist or pulmonologist;
D. it often requires special or unique storage and handling; and
E. it requires Disease management services, such as patient education and monitoring.

The Plan Administrator, in its discretion and in consultation with pharmaceutical experts, will determine if a Drug is considered to be a Specialty Drug under this Plan.

**STABILITY PERIOD**
The term "Stability Period" means the period of time, as determined by the Plan Administrator, for which new Variable Hour Employees and On-Going Employees are eligible for coverage under the Plan, as determined during the latest prior Measurement Period. The Employer sponsoring this Plan uses a twelve (12) month Stability Period, starting fifteen (15) months from the date of hire for new Variable Hour Employees (and ending one (1) year later), or on September 1st and ending August 31st of the next Calendar Year for other employees. If a Variable Hour Employee is determined to work an average of at least thirty (30) hours per week during his or her initial Measurement Period following his or her date of hire, he or she will continue to be eligible for coverage during the current ongoing Stability Period from the end of such employees initial Measurement Period to the end of the current Stability Period (provided he or she is still employed by the Employer during such Stability Period), even if determined to be ineligible during a subsequent overlapping Measurement Period.

If an employee becomes ineligible for coverage due to a break in service that occurs during a Stability Period for which coverage is being provided under this Plan, but returns to active employment with the Employer within twenty-six (26) weeks and prior to the end of the same Stability Period, he or she will once again become eligible for coverage from the date he or she resumes active employment until the end of such Stability Period.

**SUBSTANCE ABUSE**

The term "Substance Abuse" means the taking of Drugs (except those taken under the direction of a Physician or through a valid prescription) at dosages that place a Covered Person's welfare at risk, cause the Covered Person to endanger the public welfare and that constitute Drug dependence.

In making the determination as to whether the Covered Person's condition meets the definition of Substance Abuse under this Plan, the Plan Administrator shall use recognized authorities, including designations contained in the most current editions of the *International Classification of Diseases* (ICD) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

**SUBSTANCE ABUSE TREATMENT CENTER**

The term "Substance Abuse Treatment Center" means an Institution which provides a program for the treatment of Substance Abuse by means of a treatment plan approved and monitored by a Physician. This Institution must be:

A. affiliated with a Hospital under a contractual agreement with an established system for patient referral;
B. accredited as such a Facility by the Joint Commission on Accreditation of Hospitals; or
C. licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

**SUMMARY HEALTH INFORMATION**

The term "Summary Health Information" means information that may be individually identifiable Health Information that:

A. summarizes the claims history, claims expenses or type of claims experienced by Covered Persons under this Plan; and
B. from which the following information has been removed:
    1. names;
    2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
    3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
    4. telephone numbers;
    5. fax numbers;
    6. electronic mail addresses;
    7. social security numbers;
    8. medical record numbers;
    9. Plan identification numbers; or
    10. other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

**SURGERY OR SURGICAL PROCEDURE**

The term "Surgery" means any of the following:

A. the incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
B. the manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

C. the removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
D. the induction of artificial pneumothorax and the injection of sclerosing solutions;
E. arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
F. obstetrical delivery and dilatation and curettage; or
G. biopsy.

**TOTAL DISABILITY or TOTAL DISABLED**

The terms "Total Disability" or "Total Disability" mean that an individual has been determined, for Social Security purposes, as being disabled and has provided evidence to that affect if required by the Plan Administrator, in its sole discretion.

**UNIFORMED SERVICES**

The term "Uniformed Services" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

**USERRA**

The term "USERRA" means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

**VARIABLE HOUR EMPLOYEE**

The term "Variable Hour Employee" means any employee who, as of his or her date of hire:

A. is expected to work less than thirty (30) hours a week as of their date of hire, on average; or
B. for whom, on the date of hire, it cannot reasonably be determined whether or not the employee will work at least thirty (30) hours per week (or one hundred thirty (130) hours per month) as his or her hours vary from week to week for an indefinite period of time.

Variable Hour Employees include employees whose hours routinely vary from week to week, or employees whose hours vary depending on the season or time of year.

# ARTICLE IV

# CLAIM AND APPEAL PROCEDURES

## 4.1 INITIAL FILING OF CLAIMS

A Clean Claim for benefits should be filed within ninety (90) days after the occurrence or commencement of any loss covered by this Plan. Failure to give such notice and proof within the time required will neither invalidate nor reduce any claim if it is shown that written notice and proof are given no later than twelve (12) months after the claim is Incurred, unless the Covered Person is legally incapacitated.

Upon termination of the Plan, final claims must be received within ninety (90) days of termination. In any of the events described above, notice and proof of claim will be determined at the discretion of the Plan Administrator, subject to the requirements listed below.

Claims should be submitted to the appropriate address listed on the Covered Person's identification card and can be submitted either by the Provider or the Covered Person. Such claim should be on any of the following appropriate forms (or their successor forms):

A. CMS 1500;

B. UB-92;

C. UB-04 or CMS 1450;

D. NCPDP Form 1983; or

E. J512 claim forms.

A Clean Claim can be submitted by the Provider in electronic format if the Provider submits it in accordance with the electronic transaction requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent laws.

In order to be considered a Clean Claim, such claim must use the most current CPT code in effect as published by the American Medical Association, the *International Statistical Classification of Diseases and Related Health Problems* ("ICD") codes, including ICD-9 and ICD-10, published by the World Health Organization, the most current dental code in effect as published by the American Dental Association in the *Code for Dental Procedures or Nomenclature* or the most current HCPCS code in effect, as published by U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

If the Plan is not the primary carrier for a Covered Person who has, or had at the time the claim was Incurred, more than one health plan that would provide benefits for the services or supplies for which the claim is being made, including, but not limited to Medicare, copies of the explanations of benefit payment from all carriers who would pay benefits before the Plan should be submitted with the claim. For more information regarding which plan pays first, see Section 11.1, or contact the Benefit Manager.

## 4.2 REQUESTS FOR ADDITIONAL INFORMATION

If the claim is not submitted in accordance with the procedures listed in Section 4.1, the claim will not be considered to be a Clean Claim, and the Participant or Covered Person will be notified of the claim deficiencies and requested to refile it in the proper format.

If the Plan Administrator or the Benefit Manager needs more information to process the claim, a letter will be sent to the Participant, the Covered Person, the Provider or other parties requesting additional information. In some situations, information is needed on a periodic basis, including:

A. information regarding other coverage. This may include providing copies of medical child support orders for children of divorced parents; and

B. verification of handicapped status for overage Dependent children.

Other information may be requested on a case-by-case basis, including information pertaining to Accident details or potential third-party liability.

The requested information must be provided within forty-five (45) days of the date the Participant or Covered Person receives notice of the required additional information. If the information is not received within this time period, the claim will be denied for failure to provide the needed information.

### 4.3 APPEALS OF ADVERSE BENEFIT DETERMINATIONS

The Covered Person can appeal an Adverse Benefit Determination by the Plan, including that coverage for a service or supply is denied or reduced under the Plan, or any rescission of coverage for an individual or pre-service coverage denials, provided such appeal is made in writing within one hundred eighty (180) days of the Covered Person or Participant's receipt of the explanation of benefit payment or the pre-certification letter reflecting the denial or reduction or any other notification made by the Plan of an adverse decision involving the individual. Any individual other than the Covered Person who wishes to submit an appeal on the Covered Person's behalf (other than a parent or Legal Guardian filing an appeal for a minor child) must be designated by the Covered Person, in a writing signed by the Covered Person, as his or her authorized representative specifically for the purpose of the appeal. An Assignment of Benefits is not sufficient to designate another person as an "authorized representative" for the purpose of an appeal. These appeal procedures shall not apply to any contractual dispute between a Provider and the Plan as to amounts due the Provider, rather than the Covered Person, under the terms of any agreement between the Provider and the Plan that does not affect the amount payable by the Covered Person (i.e. balance billing issues in a Provider contract).

A request for review in which the Covered Person is requesting an expedited appeal of a pre-service claim as an "urgent care" case, as described in Section 6.1, can be submitted either orally or in writing and can be submitted by a Provider with knowledge of the Covered Person's condition without prior designation by the Covered Person. If a course of treatment has been previously approved by the Plan to be provided over a period of time or for a number of treatments, no reduction or termination of coverage for such treatment (other than termination of the individual's coverage under this Plan) will be made without allowing the Covered Person sufficient advance notification and the opportunity to appeal this termination or reduction.

The appeal request should be addressed as follows (unless the Adverse Benefit Determination notification indicates otherwise):

Interlocal Health Benefits Committee
Bartlett City Schools Employee Benefit Plan
c/o Benefit Manager
Medical Benefits Administrators, Inc.
P.O. Box 1099
Newark, Ohio 43058-1099

The writing should clearly be identified as an appeal, and include the name of the Plan, the Covered Person whose claims are the subject of the appeal, the Participant's identification number, and the identity of the specific treatment, service or supply for which coverage was denied or limited under the Plan.

The Covered Person should submit with the appeal written comments, documents, records and other information relating to the claim for benefits, even if such information was not submitted as part of the initial claim or request for preauthorization or pre-certification. The Covered Person will also have the right to present testimony as part of the appeal.

The Covered Person has the right to request information from the Plan Administrator as part of the appeals process, as described in Section 4.4.

Appeals submitted under this Plan will be adjudicated in a manner designed to ensure the independence and impartiality of the person making the decision. The Interlocal Health Benefits Committee has the sole authority for the final decision on appeals.

## 4.4 ACCESS TO DOCUMENTS, RECORDS OR OTHER INFORMATION

A Covered Person is entitled to examine the claim file, and present testimony as part of the internal claims and review process. He or she will also receive, free of charge, copies of documents, records and other information generated by the Plan Administrator that is relevant to his or her claim for benefits, including any new or additional information received during the appeals process, and the rationale behind the Plan's adverse decision. Such information will be provided within sufficient time to respond prior to the final decision of the appeal by the Plan Administrator. Such information is considered to be relevant if it:

A. was relied upon by the Plan Administrator in making the benefit determination;
B. was submitted, considered or generated in the course of making the benefit determination;
C. demonstrates compliance with the administrative processes required by ERISA;
D. constitutes a statement of policy or guidance with respect to the Plan concerning the denial of a treatment option or benefit; or
E. involves the identity of medical or vocational experts whose advice was obtained in connection with the claim.

In addition, if an Adverse Benefit Determination is based upon the Medical Necessity or Experimental nature of the service or supply, the Covered Person can request an explanation of the scientific or clinical judgment of the determination, free of charge.

## 4.5 EXTERNAL REVIEW RIGHTS AND PROCEDURES

If, after the appeal process described in Section 4.3 is completed, the Covered Person is still not satisfied with the resolution of the claim or precertification, he or she may be entitled to an external review of the decision by an outside external review entity. This would apply to any determination made based on Medical Necessity, appropriateness, the healthcare setting or level of care or effectiveness, or that the service or supply is Experimental. Such a request may be filed by the Provider, the Covered Person or the Covered Person's authorized representative. An external review can also be requested in such situations if an appeal or grievance has been previously filed, and no response has been made within thirty (30) days on a pre-service request, or sixty (60) days on a post-service claim. Except as specified below, a request for external review should be made, in writing, to the Plan Administrator at the address listed in Article I within six (6) months of the notification of the determination on appeal. As part of this request for external review, the Covered Person will be required to authorize the release of any of his or her medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The Plan Administrator must decide within ten (10) days of receipt as to whether the request meets the criteria for an external review; this determination can be appealed to the Tennessee Department of Commerce and Insurance, Insurance Division by telephoning the such Division at (800) 342-4029 or (615) 741-2218 or by mail at Consumer Insurance Services, 500 James Robertson Parkway, 4th Floor, Nashville, TN 37243-0574. If conducting such an external review within the timeframe of a standard review would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function, or if the final initial adverse decision concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received Emergency Services but has not been discharged, an urgent care review can be requested orally or in writing. A decision as to whether this meets the criteria for external review, and for an urgent review, will be made by the Plan Administrator immediately upon receipt, and, if so determined, will be forwarded to the elected external review organization, which will render an opinion within seventy-two (72) hours of their receipt of the necessary information to conduct the review. In either situation, the opinion of the external review organization will be binding on the Plan.

## 4.6 ADDITIONAL APPEAL RIGHTS

No action at law or in equity shall be brought to recover benefits under the Plan prior to the exhaustion of all claims and appeals procedures described in this Article, nor shall such action be

brought at all unless brought within three (3) years from the expiration of the time within which proof is required by the Plan.

### 4.7 EXAMINATION

The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and as often as it may reasonably require during the pending claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where it is not forbidden by law.

### 4.8 PLAN ADMINISTRATOR DISCRETION

Nothing in this Plan precludes the Plan Administrator from exercising full discretionary authority and responsibility with respect to all aspects of Plan administration and interpretation. The Plan Administrator shall have all powers necessary to carry out the purposes of the Plan, including supplying any omissions in accordance with the intent of the Plan and deciding all questions concerning eligibility for participation in the Plan and concerning the amount of benefits payable to a Covered Person.

# ARTICLE V

# COVERAGE AND ELIGIBILITY

## 5.1 COVERAGE UNDER THIS PLAN

Coverage provided under the Plan for a Participant shall be in accordance with the Participant Eligibility, Participant Effective Date and Participant Termination provisions included herein.

## 5.2 PARTICIPANT ELIGIBILITY

Only individuals who meet all of the conditions of one (1) of the following categories shall be deemed eligible for coverage as a Participant under the Plan:

A. an employee of the Employer who:

1. is expected by the Employer as of the date of his or her hire to be a Full-Time Employee; and
2. has satisfied a thirty (30) day waiting period, commencing with his or her date of hire. If an employee is employed by all or part of this thirty (30) day waiting period and is absent from work due to any health factor (such as being absent from work on sick leave) the employee will be considered Actively At Work for the period of his or her absence upon his return to work. This waiting period may be waived, in whole or in part, if:
   a. during the first twelve (12) months of his or her employment, coverage is terminated because he or she is no longer a Full-Time Employee, coverage will be reinstated on the first of any month in which the employee is once again employed for at least one hundred thirty (130) hours, provided that a period of more than thirteen (13) weeks has not expired during which the employee was credited with no hours of employment with the Employer; or
   b. the employee is employed by the Employer for any or all of this thirty (30) day waiting period prior to his or her entry into Service in the Uniformed Services, this period of previous employment shall be credited towards the partial or full satisfaction of any waiting period imposed under this Plan if the employee is re-employed by the Employer at the expiration of the term of Service in the Uniformed Services, provided such employee applies for reemployment within the applicable time frame listed in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as described in Section 5.13.

B. if not eligible under the provisions of A above, is a Variable Hour Employee or an On-Going Employee of the Employer, who has worked an average of at least thirty (30) hours per week during the most recent applicable Measurement Period. Coverage for such employee will become effective (or be continued) as of the first day of the next applicable Stability Period, as long as such employee is still employed on that date.

   A new Variable Hour Employee, or an On-Going Employee who was not previously eligible who has a Change in Employment Status during a Measurement Period, will be treated as a Full-Time Employee as of the earlier of:

1. thirty (30) days following the Change in Employment Status; or
2. the first day of the next Stability Period applicable to such person (provided the employee averaged more than thirty (30) hours of service per week during the prior applicable Measurement Period).

   For purposes of this Plan, Change in Employment Status means a material change in the employee's position of employment or other employment status that, had the employee begun employment in the new position or status, the employee would have reasonably been expected to work thirty (30) or more hours of service per week; or

C. a Retiree, as defined in Section 3.1.

It is the intention of the Plan Administrator to comply with the hours of service and break in service rules of the Affordable Care Act, as applicable. When determining eligibility for coverage under this Plan, any hours for which the Participant is off from work, but utilizing any paid time off made available by the employer including, but not limited to, vacation time and sick time, as applicable, will be considered hours worked by such Participant. Participants must agree to any applicable Participant Contribution for such coverage.

Additionally, Participants have access to the Employer's sick bank/shared paid time off program. This program allows employees to utilize donated paid time off, subject to any program requirements, as determined by the Employer. While utilizing this program, the Participant will be considered Actively at Work.

## 5.3 DEPENDENT COVERAGES

A Participant eligible to elect Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent, set forth in Article III of the Plan. A Participant must make written request for Dependent Coverage and agree to any applicable Participant Contribution for such coverage. Each Participant will become eligible to elect Dependent Coverage on the latest of the following:

A. the date he or she becomes eligible for Participant coverage; or

B. the date on which he or she first acquires a Dependent.

If two (2) spouses are employed by the District, and both are eligible to elect Dependent Coverage, one (1) spouse or the other, but not both, may elect Dependent Coverage for the eligible Dependents. In addition, no person can be covered under this Plan as both a Participant and a Dependent, or the Dependent of more than one (1) Participant.

## 5.4 PARTICIPANT EFFECTIVE DATE

Each eligible employee who makes written request for Participant coverage hereunder, on a form approved by the Plan Administrator, subject to the provisions of this section and who agrees to the applicable Participant Contribution for such coverage, shall become effective on the first of the month following the date he or she becomes eligible, provided the written application for such coverage is made within thirty (30) days of the date he or she becomes eligible for Participant Coverage.

Any eligible person who wishes to make an application for Participant coverage other than as described above, or as described in Section 5.6, shall be required to wait until the next Plan open enrollment period, as described in Section 5.7 before such application can be submitted.

## 5.5 DEPENDENT EFFECTIVE DATE

Each Participant who makes written request for Dependent Coverage hereunder within the thirty (30) day period immediately following the first day on which he or she is eligible for Dependent Coverage or when a special enrollment, as described in Section 5.6, applies to such Dependent, on a form approved by the Plan Administrator, subject to the provisions of this section and who agrees to the applicable Participant Contribution for such coverage, shall become eligible for Dependent Coverage on the later of the date specified in the special enrollment period or the date the Participant becomes covered, as applicable.

Any Participant who wishes to make an application for Dependent Coverage other than as described above, or as described in Section 5.6, shall be required to wait until the next Plan open enrollment period, as described in Section 5.7 before such application can be submitted.

## 5.6 SPECIAL ENROLLMENT PERIODS

An eligible person for whom written application for coverage is submitted under any of the circumstances listed below will be eligible for coverage on the date specified below:

A. within thirty (30) days of the date of a Dependent child's birth. The eligible employee, the Newborn, the Dependent spouse, and any other eligible Dependent children are eligible to

enroll during this special enrollment period. Coverage shall become effective on the date of the Dependent child's birth;

B. within thirty (30) days after the adoption of a Dependent child, or the Placement for Adoption with the employee of such a child. The eligible employee, the newly acquired Dependent child, the Dependent spouse, and any other eligible Dependent children are eligible to enroll during this special enrollment period. Coverage shall become effective on the date of the adoption or Placement for Adoption;

C. within thirty (30) days of the date of the eligible employee's marriage. The eligible employee, the new Dependent spouse, and any other eligible Dependent children are eligible to enroll during this special enrollment period. Coverage shall become effective on the first of the month following the date the application is approved by the Plan Administrator;

D. within thirty (30) days of the entry of an order requiring the employee to provide medical coverage for a Dependent child. The eligible employee, the Dependent child or children who are the subject of the court order, the Dependent spouse, and any other eligible Dependent children are eligible to enroll during this special enrollment period. Coverage shall become effective on the first of the month following the date the application is approved by the Plan Administrator;

E. within thirty (30) days of the date a Dependent child otherwise first becomes eligible, or re-eligible for coverage after a period of ineligibility. The employee, the newly acquired Dependent child, the Dependent spouse, and any other eligible Dependent children shall be eligible to enroll during this special enrollment period. Coverage shall become effective on the first of the month following the date the application is approved by the Plan Administrator;

F. within thirty (30) days of the date the employee experiences a "change in family status" under the Employer's Section 125/cafeteria plan. Only the family members who are affected by the "change in family status" are eligible to enroll during this special enrollment period. Coverage shall become effective on the date the change becomes effective under the Section 125/cafeteria plan;

G. within sixty (60) days of the date an eligible employee and/or his or her Dependent(s) first become eligible for coverage under a state Medicaid or Children's Health Insurance Program (CHIP), or, if covered, becomes ineligible for coverage through such programs. The eligible employee, any eligible Family member who becomes eligible or loses eligibility through such programs, the Dependent spouse, and any other eligible Dependent children are eligible to enroll during this special enrollment period. Coverage shall become effective on the first of the month following the date the application is approved by the Plan Administrator; or

H. within thirty (30) days of the date coverage under another group health plan or health insurance coverage was lost, if:

   1. the reason the eligible employee and/or Dependent did not enroll for coverage under this Plan when initially eligible was the existence of the other coverage; and
   2. the eligible employee/Participant stated in writing, at the time the person was initially eligible for coverage under this Plan, that the reason the person was not enrolled in this Plan was the existence of the other coverage; and
   3. the person lost coverage under the other plan due to one (1) of the following:
      a. if covered under a COBRA continuation provision, the exhaustion of COBRA continuation coverage under the other plan;
      b. the loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in hours of employment or other involuntary loss of eligibility (with the exception of terminations due to fraud or failure to pay premiums);

c. the overall lifetime maximum benefit under the other coverage has been exhausted so that no further expenses will be payable under such coverage; or

d. the termination of employer contributions towards such other coverage.

Coverage for which a person is eligible under this provision shall become effective on the first of the month following the date the application is approved by the Plan Administrator.

In no event shall any person become covered under this Plan prior to the date the Participant becomes a Covered Person, or prior to the end of the waiting period listed in Section 5.2.

### 5.7 OPEN ENROLLMENT

The Plan will have an annual open enrollment period during which otherwise eligible persons, not including Retirees or their dependents, who were not enrolled when initially eligible (or who previously terminated coverage) and do not qualify for one of the special enrollment periods described in Section 5.6 can be enrolled in the Plan. Applications submitted pursuant to this open enrollment provision must be submitted sometime during the second quarter of each year. The specific dates of the open enrollment period will be announced in advance, by the Plan Administrator to all eligible parties. Coverage for any person for whom application for coverage under this Plan was submitted pursuant to this provision shall be effective the following September 1st.

### 5.8 PARTICIPANT TERMINATION

Participant coverage terminates immediately only upon the earliest of the following dates:

A. if covered under the provisions of Section 5.2 A above (as a regular, Full-Time Employee), the last day of the period for which a Participant Contribution was made following the date such Participant is no longer paid for working the number of hours required for Full-Time Employee status, or otherwise fails to meet the eligibility requirements listed in Section 5.2;

B. if covered under the provisions of Section 5.2 B as a Variable Hour Employee or an On-Going Employee, the earlier of the last day of the last Stability Period during which the employee was eligible if the employee failed to average thirty (30) hours per week during the latest Measurement Period that applies to such employee, or the last day of the period for which a Participant Contribution was made following the date such employee's employment with the Employer is terminated. This will be considered to be a reduction in hours Qualifying Event for the purposes of this Plan's COBRA continuation provisions;

C. if covered under the provisions of Section 5.2 C as a Retiree, the last day of the period for which a Participant Contribution was made following the date such Participant no longer meets the criteria set forth in the definition of Retiree, as described in Section 3.1;

D. if voluntarily terminating coverage during the Plan's open enrollment period, the following August 31st;

E. the date specified in the notification from the Plan Administrator that coverage is terminated due to fraud or a material fraudulent act committed or contributed to by the Participant, including, but not limited to, intentionally submitting false claims to the Plan, or knowingly allowing the use of a Plan identification card to obtain Plan benefits by a person who is not authorized to do so;

F. the last day of the period for which a Participant Contribution was made following the date the Participant fails to make any required Participant Contribution for coverage; or

G. the date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of any such benefit.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the Family and Medical Leave provisions as described in Section 5.12, and COBRA continuation coverage as described in Article VII. This Plan will also

comply with the continuation provisions contained in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as they apply to Participants entering Service in the Uniformed Services, as described in Section 5.13.

### 5.9 DEPENDENT TERMINATION

Dependent Coverage terminates immediately only upon the earliest of the following dates:

A. the date the Participant's coverage ceases under this Plan;
B. the last day of the month in which the Dependent otherwise ceases to be a Dependent, as defined in the Plan.;
C. if voluntarily terminating coverage during the Plan's open enrollment period, the following August 31st;
D. the date specified in the notification from the Plan Administrator that coverage is terminated due to fraud or a material fraudulent act committed or contributed to by the Dependent, including, but not limited to, intentionally submitting false claims to the Plan, or knowingly allowing the use of a Plan identification card to obtain Plan benefits by a person who is not authorized to do so;
E. the last day of the period for which a Participant Contribution for Dependent Coverage was made following the date the Participant fails to make any required Participant Contribution for Dependent Coverage; or
F. the date of cancellation of Dependent benefits under this Plan.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the COBRA continuation coverage as described in Article VII.

### 5.10 CONTINUATION OF COVERAGE

Coverage for a Participant and his or her eligible Dependents under this Plan may be continued if the Participant is no longer eligible for coverage because he or she is laid off by the Employer, on an Employer approved leave of absence, or due to Total Disability until the earliest of the following dates:

A. the date the Participant is required to return to Active Work by the Employer, and he or she fails to do so;
B. the date the Participant fails to make any required Participant Contribution for this coverage;
C. the date the Participant elects to drop this coverage, or, in regard to any Dependent, the date such Dependent becomes ineligible or coverage is voluntarily terminated for such Dependent (once such coverage is terminated, it cannot be reinstated);
D. if continuation of coverage is due to lay off, the date that this twelve (12) months from the date of lay off;
E. if continuation of coverage is due to an employer approved leave of absence, the date that is twelve (12) months from the date the Participant was no longer Actively at Work, including any period covered under the Family any Medical Leave Act of 1993 (FMLA);
F. if continuation of coverage is due to Total Disability, the date that is twelve (12) months from the date the Participant was no longer Actively at Work, including any period covered under the Family any Medical Leave Act of 1993 (FMLA);
G. the date the Participant becomes eligible for coverage as an employee under any other similar health plan sponsored by another employer; or
H. the date that this Plan is terminated.

Continuation as described above is limited to the Participant and any covered Family members who were covered as of the date the Participant became eligible for continuation. Any continuation

rights that the Participant may be entitled to under the provisions of COBRA, as described in Article VII, shall begin after the period of continuation described above.

### 5.11 CONTINUATION OF COVERAGE FOR DEPENDENTS OF EMPLOYEES OR RETIREES ENROLLED IN MEDICARE

Coverage for eligible Dependents under this Plan may be continued if the Participant is enrolled under the Employer's Medicare Advantage Plan, until the earliest of the following dates:

A. the date the Dependent spouse reaches sixty-five (65) years of age;

B. the date a Dependent, other than a spouse, reaches twenty-six (26) years of age;

C. the date the Dependent or Participant fails to make any required premium contribution for this coverage;

D. the date the Dependent elects to drop this coverage, or, the date such Dependent becomes ineligible or coverage is voluntarily terminated for such Dependent (once such coverage is terminated, it cannot be reinstated);

E. the date the Dependent becomes eligible for coverage as an employee under any other similar health plan sponsored by another employer; or

F. the date that this Plan is terminated.

Continuation as described above is limited to Dependents who were covered under this Plan as of the date the employee or Retiree became enrolled in the Employer's Medicare Advantage Plan. Any continuation rights that the Participant may be entitled to under the provisions of COBRA, as described in Article VII, shall begin after the period of continuation described above.

### 5.12 FAMILY AND MEDICAL LEAVE PROVISIONS

This Plan intends to comply with the Family and Medical Leave Act of 1993 (FMLA) regarding the maintenance of health benefits during any period that an eligible employee takes a Leave of Absence in accordance with the Employer's FMLA policy, if the Employer is subject to such law. In applicable situations, FMLA allows an eligible employee to maintain group health plan coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave. Employee eligibility requirements, the obligations of the Employer and employees concerning conditions of leave, and notification and reporting requirements are specified in the Employer's FMLA policy. If the Employer is subject to FMLA, any Plan provision that conflicts with FMLA is superseded by FMLA to the extent such provision conflicts with FMLA. Questions regarding rights and/or obligations under FMLA should be directed to an Employer representative or the Plan Administrator.

### 5.13 USERRA RIGHTS

A Participant under this Plan who is no longer Actively At Work due to his or her Service in the Uniformed Services can elect, under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to continue Participant and Dependent Coverage under this Plan for up to twenty-four (24) months after such coverage would otherwise have terminated. This period of continued coverage shall run concurrently with any continuation for which any Covered Person would have been entitled to under the provisions of COBRA due to the Participant's termination or reduction in hours of employment. If the Service in the Uniformed Services is for thirty-one (31) days or more, the Participant Contribution for such coverage will be one hundred two percent (102%) of the full cost of the coverage, without any Employer contribution. If the Service in the Uniformed Services is less than thirty-one (31) days, the Participant Contribution shall be the same as would have applied if the Participant were still an active employee.

If coverage is not continued as described above, or the Service in the Uniformed Services exceeds the time limit listed above, upon release from his or her Service in the Uniformed Services, coverage will be reinstated in the Plan effective the date the employee is reemployed by the

Employer, provided the employees reapplies for employment or reports back to work within the following applicable time:

A. if the period of service was less than thirty-one (31) days, the beginning of the next regularly scheduled work period on the first full day after release from Service in the Uniformed Services, taking into account safe travel home plus an eight (8) hour rest period;
B. if the period of service was more than thirty (30) days, but less than one hundred eighty-one (181) days, within fourteen (14) days of release from Service in the Uniformed Services; and
C. if the period of service was more than one hundred eighty (180) days, but less than five (5) years, within ninety (90) days of the release from Service in the Uniformed Services.

This period may be extended for up to two (2) years from the date the Service in the Uniformed Services ended, under the provisions of USERRA, if the person is unable to return to active employment due to a disability Incurred while performing Service in the Uniformed Services.

The Plan Administrator reserves the right to request verification of any Service in the Uniformed Services, including copies of military orders or the applicable Form DD 214.

# ARTICLE VI

# COST MANAGEMENT SERVICES

## 6.1 UTILIZATION REVIEW

The Plan has a utilization pre-certification provision. Pre-admission certification must be obtained for every Inpatient admission to a covered Facility, including, but not limited to Hospitals, Skilled Nursing Facilities, Hospices, psychiatric treatment facilities and Alcoholism and Substance Abuse treatment facilities, except Emergency admissions, Urgent Care admissions, and minimum stays following childbirth. ("Emergency" and "Urgent Care" admissions are defined below). A "minimum stay following childbirth" is either:

A. a stay following a normal vaginal delivery that is forty-eight (48) hours or less; or

B. a stay following a cesarean section that is ninety-six (96) hours or less.

If a Hospital stay following childbirth will exceed the limitations listed above, the Pre-Certification Center must be notified as soon as the Covered Person and/or her Provider have determined that the Hospitalization will exceed such limitations, but not later than the end of the applicable period listed above.

Pre-admission certification may be made through the Utilization Review Service. The telephone number for the Utilization Review Service is listed in Article I, Plan Information, and on the medical identification card. A Covered Person may inform his or her health care Provider that he or she participates in a program that has pre-admission certification provisions. In order to obtain pre-admission certification:

A. contact the Utilization Review Service and report the upcoming Hospital or other Facility stay no later than forty-eight (48) hours prior to the admission;

B. notice can be given by:
   1. the Hospital or other covered Facility;
   2. the Covered Person's admitting Physician;
   3. the Covered Person;
   4. a family member of the Covered Person; or
   5. a representative of the Employer; and

C. the Utilization Review Service must be provided with information necessary to make a decision as to the Medical Necessity of the admission.

The Utilization Review Service may request additional information that is necessary to make the determination from the Covered Person or a Provider. In the case of an urgent care request, such information must be provided within forty-eight (48) hours of the request. If the request does not involve urgent care, the information must be provided within forty-five (45) days of such request. An "urgent care" request is one that, if a determination is not made on an expedited basis, the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function, could be seriously jeopardized, or, in the opinion of the attending Physician, the Covered Person would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

When pre-admission certification is provided to the Covered Person, a certain number of Inpatient days for the stay will be assigned. If the Utilization Review Service is not informed of the Covered Person's admission within the required timeframe, there will be a penalty. Covered Expenses for Hospital or other Facility services the Utilization Review Service, as the entity designated by the Plan Administrator to handle utilization review, would have approved for payment under the Pre-Admission Certification program will be reduced by two hundred fifty dollars ($250.00). (This reduction is the penalty.) The penalty is not considered an eligible expense. Charges for Inpatient days that are determined by the Utilization Review Service to not be Medically Necessary are not covered under this Plan.

The Plan Administrator shall have full discretionary authority and responsibility with respect to all aspects of Plan administration, including utilization review. If a Utilization Review Service is designated by the Plan Administrator, the Utilization Review Service agrees to recognize the ultimate authority of the Plan Administrator.

## 6.2 CONTINUED STAY REVIEW

During a Covered Person's Inpatient stay, a Continued Stay Review will be conducted. This review applies to all Hospital or other Facility admissions. The purpose of Continued Stay Review is to:

A. provide the Utilization Review Service with an update as to the Covered Person's condition and/or progress; and

B. if necessary, enable the Utilization Review Service to re-evaluate the Medical Necessity of a continued Inpatient stay.

The Utilization Review Service has the right to initiate a Continued Stay Review for any Inpatient admission. The Utilization Review Service will always confirm the outcome of the Continued Stay Review by telephone or in writing. This notification will go to the Covered Person and/or the Covered Person's Physician. The notification always includes any newly authorized length of stay.

If a stay is longer than the specified number of Inpatient days that the Utilization Review Service considers to be Medically Necessary, Covered Expenses will be denied for any charges Incurred for the days not Medically Necessary. This will occur if the Utilization Review Service is informed that the confinement is no longer Medically Necessary, and the Covered Person knowingly chooses to remain in the Hospital or other Facility.

If the Covered Person's Physician and the Covered Person disagree with the findings of the Utilization Review Service, the Covered Person may file an appeal, in accordance with the procedures described in Article IV, with the Plan Administrator. The Plan Administrator has final authority over any such decisions.

## 6.3 WEEKEND ADMISSION REVIEW

All weekend (Friday, Saturday, and Sunday) Hospital admissions will be reviewed. Coverage is limited to Medically Necessary admissions.

## 6.4 EMERGENCY AND URGENT CARE REVIEW

If a Covered Person is admitted to a Hospital or other covered Facility for an Emergency or Urgent Care admission, notice of the admission may be provided to the Utilization Review Service no later than forty-eight (48) hours after the admission or as soon as reasonably possible. Notice may be given to the Utilization Review Service by:

A. the Hospital or other Facility;

B. the Covered Person's admitting Physician;

C. the Covered Person;

D. a family member of the Covered Person; or

E. a representative of the Employer.

The Utilization Review Service will review the case with the Covered Person's Physician to determine if a continued Inpatient stay is Medically Necessary. If the Utilization Review Service is not informed of the Covered Person's admission, there will be a penalty. Covered Expenses for Hospital or other Facility services the Utilization Review Service, as the entity designated by the Plan Administrator to handle utilization review, would have approved for payment under the Pre-Admission Certification program will be reduced by two hundred fifty dollars ($250.00). (This reduction is the penalty.) The penalty is not considered an eligible expense. Charges for Inpatient days that are determined by the Utilization Review Service to not be Medically Necessary are not covered under this Plan.

An Emergency admission is an admission to a Hospital through the emergency room of that Facility for treatment of a life threatening Illness or Injury. An Urgent Care admission is an unplanned

admission, or an admission scheduled less than forty-eight (48) hours prior, for a condition requiring prompt medical attention. An Urgent Care admission is not an admission through the emergency room.

In the case of Emergency or Urgent Care Outpatient Surgical Procedures, it is recommended that notification be provided to the Utilization Review Service no later than forty-eight (48) hours after the Surgical Procedure or as soon as reasonably possible. The penalty described above will not apply for failure to make such notification.

### 6.5 DISCHARGE PLANNING

Review for Discharge Planning occurs during Hospitalization review. The purpose is to:

A. identify patients requiring extended care following discharge; and

B. determine the most appropriate setting for continued care.

### 6.6 PRE-CERTIFICATION OF OTHER SERVICES

The Plan requires that the following services be pre-approved by the Utilization Review Service prior to the commencement of any such services:

A. non-office based Outpatient Surgery;

B. deviated septum nasal surgery;

C. Durable Medical Equipment for which the cost exceeds one thousand five hundred dollars ($1,500.00);

D. electron beam tomography;

E. endoscopic procedures;

F. home Health Services;

G. magnetic resonance imaging (MRI), Cat Scan (CT), and positron emission tomography (PET). The pre-certification requirement does not include bone density scans;

H. radiation; and

I. varicose vein ligation.

As soon as possible after a Covered Person’s Physician has determined that one of the services listed above is necessary, but not later than forty-eight (48) hours prior to the service, the Covered Person’s Physician, the Covered Person or the Hospital or Facility where the procedure is to be performed must notify the Utilization Review Service and submit any documentation required by such service. The Covered Person is ultimately responsible for making sure this notification is made. The Utilization Review Service reserves the right to request additional records or information from the Covered Person, the Covered Person’s Physician, Hospital or other Facility or Provider that is related to the service.

If prior approval is not obtained for any of these services, charges for such service will be subject to a penalty. Expenses for services or supplies that would have been approved for payment by the Utilization Review Service, as the entity designated by the Plan Administrator to handle utilization review, will be reduced by two hundred fifty dollars ($250.00). This penalty will not be considered as a Covered Expense under any other Plan provision, and shall not apply towards any Out-of-Pocket limit, or maximum benefit limit. In addition to this penalty, any services and supplies that would not have been approved for payment will not be covered under this Plan.

**Pre-certification is not required for any imaging services that are performed through the EvoCare program, or for Outpatient services rendered at Baptist Health Service Group of Mid-South, Inc. or St. Francis/Tenet.**

### 6.7 ADDITIONAL PRE-CERTIFICATION REQUIREMENTS

All services requiring pre-certification, as noted in the Plan, are to be certified in advance by the Utilization Review Department, except for emergencies. The Covered Person or their Representative is required to call the phone number for pre-certification located on the back of their ID card for the services specified above at least seven (7) business days prior to services being

rendered. The Covered Person or their representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for pre-certification determinations and service pre-pricing.

Utilization review is the process of evaluating if services, supplies or treatment are Medically Necessary, appropriate and priced at the prevailing rates to help ensure cost-effective care. Utilization review can eliminate unnecessary services, Hospitalizations, and shorten confinements while improving quality of care and reducing costs to the Covered Person and the Plan.

Pre-certification establishes the Medical Necessity of certain care and services covered under the Plan. It ensures that the pre-certified care and services will not be denied on the basis of Medical Necessity (as defined by this Plan). The Pre-certification process will also establish the reference prices for requested services. However, pre-certification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as Plan limitations, exclusions, and eligibility at the time care and services are provided.

## 6.8 INDIVIDUAL BENEFITS MANAGEMENT

Individual benefits management is designed to inform Covered Persons of more cost effective settings for treatment. On an exception basis and subject to approval, the Plan may provide benefits for settings not expressly provided for under this Plan, but which are not prohibited by law, rule or federal policy.

Services and Supplies provided in connection with individual benefits management must be:

A. for an acute level of care;
B. Medically Necessary; and
C. provided in a more cost effective setting.

Under individual benefits management, the Plan Administrator may waive the Copayment amount for certain services.

The Plan Administrator has the right to deny an extension of benefits under individual benefits management. The Plan Administrator also has the right to administer benefits pursuant to the terms of the Plan, exclusive of this provision. If benefits are provided to a Covered Person, under this provision for individual benefits management, that are outside of the conditions, limitations and/or exclusions of this Plan, the Covered Person has no right to expect that the same or similar benefits (provided outside of the conditions, limitations and/or exclusions of this Plan) will be provided to that Covered Person in the future.

The Plan Administrator shall have full discretionary authority and responsibility with respect to all aspects of Plan administration, including utilization review. If a Utilization Review Service is designated by the Plan Administrator, the Utilization Review Service agrees to recognize the ultimate authority of the Plan Administrator.

## 6.9 SECOND SURGICAL OPINION

The Plan will provide benefits for a second surgical opinion, including necessary testing, prior to any elective Surgery at the level described in Article II.

The Physician providing the second surgical opinion must be qualified to render such an opinion, through experience or training, in the field related to the Surgical Procedure, and must not be financially associated with the Physician who recommended and/or will perform the Surgery.

The Plan Administrator and the Utilization Review Service reserve the right to direct the Covered Person to a Physician of their choosing for a second surgical opinion.

# ARTICLE VII

# CONTINUATION COVERAGE UNDER COBRA

## 7.1 RIGHT TO ELECT CONTINUATION COVERAGE

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he or she may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the District. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:

A. the date of the Qualifying Event; or

B. the date the Qualified Beneficiary was notified of his or her right to continue coverage.

If a Covered Employee has been determined to be an Eligible TAA Recipient or an Eligible Alternative TAA Recipient, as those terms are defined in the Trade Act of 2002, such Covered Employee and his or her Dependents who lost coverage under the Plan due to a job loss that qualified such employee for TAA assistance shall be entitled to a second sixty (60) day election period (if continuation coverage was not elected during the period described above) beginning on the first day of the month in which the Covered Employee is determined to be TAA eligible, provided such election is made within six (6) months of the original loss of coverage. If elected under this provision, coverage shall begin on the first day of the month in which the Covered Employee is determined to be TAA eligible.

## 7.2 NOTIFICATION OF QUALIFYING EVENT

If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the District, in writing addressed to the Plan Administrator, of the Qualifying Event within sixty (60) days of the event, or sixty (60) days of the date the Qualified Beneficiary would lose coverage because of the event, in order for coverage to continue. Appropriate documentation of the Qualifying Event must be submitted, including, as appropriate, final divorce and legal separation decrees issued and properly signed by the court. In addition, a Totally Disabled Qualified Beneficiary must notify the District in accordance with the section below entitled "Total Disability" in order for coverage to continue.

## 7.3 LENGTH OF CONTINUATION COVERAGE

A Qualified Beneficiary who loses coverage may continue coverage under the Group Health Plan for:

A. a Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee:

   1. for up to eighteen (18) months from the date of the Qualifying Event; or
   2. if a Qualified Beneficiary is Totally Disabled at any time during the first sixty (60) days of Continuation Coverage, he or she may continue coverage for up to twenty-nine (29) months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the District of the determination of his or her Total Disability under the Social Security Act:

      a. before the end of the original eighteen (18) month continuation period; and

      b. within sixty (60) days following the date of such determination; or

B. a Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, or Medicare eligibility and Dependent children who have become ineligible for coverage may continue under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event.

## 7.4 TERMINATION OF CONTINUATION OF COVERAGE

Continuation Coverage will automatically end earlier than the applicable eighteen (18) or thirty-six (36) month period for a Qualified Beneficiary if:

A. the required monthly contribution for coverage is not received by the District within thirty (30) days following the date it is due;
B. the Qualified Beneficiary becomes covered under any other Group Health Plan containing an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the pre-existing condition applies to the Qualified Beneficiary;
C. for Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled;
D. the Qualified Beneficiary becomes entitled to Medicare benefits; or
E. the District ceases to offer any Group Health Plans.

## 7.5 MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) months, and a second Qualifying Event occurs during the eighteen (18) month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the first Qualifying Event.

## 7.6 TOTAL DISABILITY

In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled at the time of a Qualifying Event or at any time during the first sixty (60) days of the Qualified Beneficiary's Continuation Coverage (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer, in writing addressed to the Plan Administrator:

A. prior to the end of eighteen (18) months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and
B. within sixty (60) days of the determination of Total Disability under the Act.

A copy of the determination letter from Social Security must be submitted with the notification.

The Employer will charge the Qualified Beneficiary an increased contribution for Continuation Coverage extended beyond eighteen (18) months pursuant to this Section.

If during the period of extended coverage for Total Disability (Continuation Coverage months nineteen (19) through twenty-nine (29)) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

A. the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and
B. Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

## 7.7 CARRYOVER OF PLAN MAXIMUMS

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Copayment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

## 7.8 PAYMENTS OF PREMIUM

The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, that will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred two percent (102%) of the applicable premium for that period.

For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred fifty percent (150%) of the applicable premium for continuation coverage months nineteen (19) through twenty-nine (29).

Contributions for coverage may, at the election of the payer, be paid in monthly installments.

If Continuation Coverage is elected, the first monthly contribution for coverage must be made within forty-five (45) days of the date of election.

Without further notice from the District, the Qualified Beneficiary must pay the monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the District within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage," Subsection A.

No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

## 7.9 DEFINITIONS

For purposes of this Article VII, unless specifically stated otherwise, the following definitions apply:

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

B. "Code" means the Internal Revenue Code of 1986, as amended.

C. "District" means the Employer, as defined in Article III.

D. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

E. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.

F. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.

G. "Qualified Beneficiary" means:

   1. a Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering the Covered Employee ineligible for coverage under the Plan; and
   2. a covered spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below. Qualified Beneficiary also includes any child who is born to or Placed for Adoption with the Covered Employee during the period of Continuation Coverage.

H. "Qualifying Event" means the following events that, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

   1. termination of a Covered Employee's employment (other than gross misconduct) or reduction in the Covered Employee's hours of employment;
   2. the death of the Covered Employee;
   3. the divorce or legal separation of the Covered Employee from his or her spouse;

4. the Covered Employee becoming entitled to Medicare coverage; or
5. a child ceasing to be eligible as a Dependent child under the terms of the Group Health Plan.

I. "Totally Disabled" or "Total Disability" means totally disabled as determined under Title II or Title XVI of the Social Security Act.

## 7.10 COBRA BANKRUPTCY PROVISIONS UNDER TITLE XI

For purposes of this subsection only:

A. "Qualified Beneficiary" means:
   1. a Covered Employee who retired on or before the date of the Qualifying Event and who was covered as a Retiree under the Group Health Plan;
   2. an individual who was covered under the Group Health Plan as a surviving spouse of a deceased Retiree on the day before the date of the Qualifying Event; and
   3. a Dependent of either of the above described individuals who was covered under the Group Health Plan on the day before the date of the Qualifying Event.

B. "Qualifying Event" means the substantial elimination of coverage under the Group Health Plan within one (1) year before or after the City files a petition in bankruptcy under Title XI of the United States Code.

If a Qualified Beneficiary experiences a Qualifying Event, as defined in this provision, he or she may elect to continue coverage under the Group Health Plan if he or she pays the monthly contribution specified from time to time by the City and makes his or her election in accordance with the provision above entitled "Right to Elect Continuation Coverage."

Continuation Coverage for a Qualified Beneficiary who is a Retiree and his or her Dependents who are Qualified Beneficiaries will continue for the life of the Retiree. When the Retiree dies, his or her Qualified Beneficiaries may elect to continue coverage for up to thirty-six (36) additional months.

If a surviving spouse and Dependent children are covered as beneficiaries of a deceased Retiree when the loss of coverage due to bankruptcy occurs, they may elect to continue coverage until the death of the surviving spouse. Upon the death of the surviving spouse, the Continuation Coverage terminates.

Continuation Coverage elected under this provision will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the City ceases to offer any Group Health Plans.

# ARTICLE VIII

# DESCRIPTION OF BENEFITS

## 8.1 MEDICAL BENEFITS – COVERED EXPENSES

In order to be eligible for benefits under this section of the Plan, charges actually Incurred by a Covered Person must be for services or supplies administered or ordered by a Physician, be provided by a properly licensed or certified health care professional or entity, and be Medically Necessary for the Diagnosis and treatment of an Illness or Injury unless otherwise specifically covered. In addition, such charges will only be covered to the extent that they do not exceed the Reasonable and Allowable Amount for the service or supply in question.

**Certain services and supplies require pre-certification. If pre-certification is not obtained a penalty may apply. A list of these services and supplies can be found in Article VI of this Plan. Pre-certification can be obtained by calling the Utilization Review Service at the number printed on the Covered Person's ID card.**

Covered charges include the following:

A. Charges for **abortion** performed because the life of the mother would be endangered by carrying the fetus to term.

B. Charges for the treatment of **Alcoholism, Substance Abuse and Mental/Nervous Disorders** when recommended by or under the clinical supervision of a licensed Physician or a licensed Psychologist. Such treatment must be recognized as appropriate in accordance with broadly accepted standards of medical practice. Coverage includes treatment in a Psychiatric Hospital and Substance Abuse Treatment Center and the following:

   1. Inpatient care, subject to the pre-certification requirements described in Article VI, including:
      a. Room and Board, subject to the provisions in Section 2.3;
      b. miscellaneous charges made by the Hospital; and
      c. medical services;
   2. intensive Outpatient psychotherapy; and
   3. Outpatient care, including but not limited to:
      a. individual and group psychotherapy; and
      b. psychological testing.

C. Charges for **allergy services** and treatment, including testing, serum/venom and injections.

D. Charges for **ambulance** services. Coverage includes transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights):

   1. to the nearest Hospital equipped to treat the specific Illness or Injury in an Emergency situation;
   2. from a Hospital to the nearest Facility having the capability to treat the condition, when the first Hospital lacks the services/facilities required to treat the Covered Person;
   3. to and from a Hospital during a period of Hospital confinement to another Facility for special services which are not available at the Hospital; and
   4. from a Hospital to the Covered Person's home or to a Skilled Nursing Facility, Rehabilitation Facility, or other type of convalescent Facility nearest to the Covered Person's home, when the Medical Necessity of ambulance transport is

documented.

Professional ground or air ambulance charges for convenience are not covered. Air ambulance is covered only when terrain, distance, or condition warrants.

Covered Expenses include charges for ground ambulance transportation by professional ambulance, including approved available train transportation, to a local Hospital or transfer to the nearest Facility having the capability to treat the condition, if the transportation is connected with an Inpatient Confinement.

For a Covered Person who is in a Hospital or other health care Facility under the care or supervision of a licensed health care Provider, it is strongly encouraged that a prior authorization be obtained before transport of the Covered Person via air transport, or any form of flight, to another Hospital or Facility. Prior authorization can be obtained by contacting the designated inter-Facility air ambulance review service, as described in Article I.

The designated inter-Facility air ambulance review service may discuss with the Physician and/or Hospital/Facility the Diagnosis and the need for inter-Facility patient transport versus alternatives.

E. Charges for the care, services and supplies provided by an **Ambulatory Surgical Center or other free-standing Facility,** subject to any applicable precertification requirements described in Article VI.

F. Charges for **anesthesia**, including, anesthesia supplies, and administration of anesthesia.

G. Charges for the Diagnosis and treatment of **Autism Spectrum Disorders**, including speech, occupational and physical therapy, subject to any applicable limitations listed in Section 2.4.

H. Charges for the services of a **Birthing Center** for Medically Necessary care provided within the scope of its license.

I. Charges for **B-12 or iron injections** when a Covered Person has a medical Diagnosis beyond vitamin deficiency.

J. Charges for **blood and plasma**. Covered Expenses include blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

K. Charges for **Cardiac Rehabilitation** services, subject to the limitation listed in Section 2.4.

L. Charges for **chemotherapy** and radiation services.

M. Charges for **Chiropractic Care**. Covered Expenses include evaluation, spinal adjustment and manipulation, x-rays for manipulation and adjustment, and other modalities performed by a Physician or other licensed practitioner, subject to the limitations listed in Section 2.4.

N. Charges for **cognitive therapy** when rehabilitative in nature, subject to the limitations in Section 2.4.

O. Charges for FDA approved **contraceptives**. Covered Expenses include contraceptive methods prescribed for females, as included in the Recommended Wellness Services, including birth control pills, implantable contraceptives, diaphragm or cervical cap, Depo Provera injections, insertion and surgical removal of IUDs, IUD equipment, and other medical services related to contraception.

P. Charges for certain **dental services**. Covered Expenses include the following:

1. repair due to Accidental Injury to sound natural teeth, if the repair is made within six (6) months from the date of the Injury (unless otherwise required by applicable law);
2. excision of lesions, bony growths of jaw, or hard palate;
3. excision of tumors and cysts of jaw, cheeks, lips, tongue, and roof and floor of mouth;
4. excision and drainage of cellulitis;
5. incision of accessory sinus, mouth, salivary glands, or ducts, not including surgical removal of impacted teeth; and
6. general anesthesia and Hospital expenses for eligible dental services that must be performed in a Hospital to monitor the patient due to a serious underlying medical condition, or due to Accidental Injury to sound natural teeth.

Outpatient Surgery is subject to any applicable precertification requirements described in Article VI.

Q. Charges for **diabetic self-management training**.

R. Charges for **Diagnostic Services**, tests and examinations. Covered Expenses include x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures, such as MRI, MRA, cat scans, and nuclear medicine. Laboratory tests which are included in an office visit charge must be rendered at the same time and the same place of service as the office visit.

S. Charges for **dialysis services**, diagnostic testing, laboratory tests, equipment and supplies are a Covered Expense under the Plan only to the extent they are Medically Necessary and only insofar as their cost does not exceed the Reasonable and Allowable Amount, subject to the provisions set forth in Section 2.3, specific to dialysis services.

Dialysis services, diagnostic testing, laboratory tests, equipment and supplies are those services and items used in the dialysis treatment. This also includes injectable and intravenous medication including, but not limited to, Heparin, Epogen, Procrit, and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an Inpatient or Outpatient basis.

T. Charges for **Durable Medical Equipment**, subject to any applicable pre-certification requirements described in Article VI. Covered Expenses include the rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-dependent diabetics. At its option, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan covers repair if not caused by misuse and covers replacement if necessary due to the Covered Person's growth/development and if the equipment was initially provided five (5) or more years prior. Coverage also includes the rental, or purchase if less, of breast feeding equipment. The Plan does not cover rental or purchase of items that do not fully meet the definition of Durable Medical Equipment.

U. Charges for **enteral feedings/TPN** when a Covered Person has a covered Diagnosis and is dependent on enteral/parenteral feedings for their sole source of nutrition or if the Covered Person has a Disease of the small bowel that necessitates such feedings to maintain weight and strength.

V. Charges for **foot disorders**. Covered Expenses include surgical treatment of foot disorders and associated services, performed by a licensed podiatrist (excluding routine foot care and palliative services), including:

1. capsular or bone Surgery for treatment of bunions;
2. complete or partial removal of the nail matrix affected by Disease, infection, or fungus;
3. Surgical Procedures or injections involving the bones, nerves, muscles, or tendons of the foot or ankle; and
4. cutting or removal of corns, calluses, or toenails, if done in connection with an underlying medical condition such as diabetes or peripheral vascular Disease.

Routine foot care is covered only when the Covered Person has an underlying medical condition such as diabetes or peripheral vascular Disease.

W. Charges for **gender dysphoria and gender reassignment Surgery**, subject to any applicable precertification requirements described in Article VI and the limitations listed in Section 2.4. Covered Expenses include Medically Necessary services and treatments for Covered Persons diagnosed with gender dysphoria, including but not limited to mental health care as otherwise provided herein, prescription Drug therapy, including related hormone therapy and gender reassignment Surgery.

1. the following procedure eligibility requirements apply:
   a. Mastectomy for female-to-male Covered Persons:
      i. a Referral Letter from a Qualified Mental Health Professional, as defined below;
      ii. a persistent, well-documented Diagnosis of gender dysphoria;
      iii. the Covered Person must be at least eighteen (18) years old and have the capacity to make a fully informed decisions and consent to treatment; and
      iv. if the Covered Person suffers from significant medical or mental health concerns, they must be reasonably well controlled.

      A trial of hormone therapy is not a pre-requisite to approval for a Mastectomy;
   b. gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to female Covered Persons):
      i. two (2) Referral Letters from Qualified Mental Health Professionals, as defined below, one in a purely evaluative role;
      ii. a persistent, well-documented Diagnosis of gender dysphoria;
      iii. the Covered Person must be at least eighteen (18) years old and have the capacity to make a fully informed decisions and consent to treatment;
      iv. if the Covered Person suffers from significant medical or mental health concerns, they must be reasonably well controlled; and
      v. twelve (12) months of continuous hormone therapy as appropriate to the Covered Person's gender goals (unless he or she has a medical contraindication or is otherwise unable or unwilling to take hormones). If testosterone is used for hormone therapy, the Covered Person is required to have an adequate trial and treatment failure with injectable testosterone cypionate prior to the use of topical testosterone products;
   c. genital reconstructive Surgery (i.e. vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male Covered Person; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female Covered Persons):
      i. two (2) Referral Letters from Qualified Mental Health Professionals, as defined below, one in a purely evaluative role;
      ii. a persistent, well-documented Diagnosis of gender dysphoria;

iii. the Covered Person must be at least eighteen (18) years old and have the capacity to make a fully informed decisions and consent to treatment;

iv. if the Covered Person suffers from significant medical or mental health concerns, they must be reasonably well controlled;

v. twelve (12) months of continuous hormone therapy as appropriate to the Covered Person's gender goals (unless the he or she has a medical contraindication or is otherwise unable or unwilling to take hormones). If testosterone is used for hormone therapy, the Covered Person is required to have an adequate trial and treatment failure with injectable testosterone cypionate prior to the use of topical testosterone products; and

vi. twelve (12) months of living in a gender role that is congruent with the Covered Person's gender identity (real life experience);

2. the following limitations and exclusions apply:

   a. gender reassignment Surgery is limited to one (1) procedure per Covered Person per lifetime;

   b. certain procedures and surgeries performed as a component of gender reassignment Surgery may be determined by the Plan Administrator in its discretion to be Cosmetic Surgery and will not be covered. Examples of Cosmetic Surgeries and procedures, include, but are not limited to body contouring (including breast augmentation and liposuction), hair removal, hair transplants, voice modification Surgery or lessons, skin resurfacing, facial implants and reconstruction;

   c. the Plan's prescription formulary status will apply to any pharmacologic treatments for gender dysphoria;

3. the following definitions apply:

   a. the term "Referral Letter" as used herein, shall mean a letter from a Qualified Mental Health Professional and shall contain the Covered Person's general identifying characteristics, results of the Covered Person's psychosocial assessment, including any diagnoses, and the duration of the Mental Health Professional's relationship with the Covered Person, including the type of evaluation and therapy or counseling to date, a statement about the fact that informed consent has been obtained from the Covered Person, and a statement that the Mental Health Professional is available for coordination of care and welcomes a phone call to establish this;

   b. the term "Qualified Mental Health Professional" as used herein, shall mean an individual with a Master's degree or equivalent in a clinical behavioral science field granted by an Institution accredited by the appropriate national accrediting board, competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes, ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria, knowledge about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria, and continuing education in the assessment and treatment of gender dysphoria.

X. Charges for **Genetic Testing**. Covered Expenses include Medically Necessary diagnostic Genetic Testing and related counseling, when:

1. the Covered Person has symptoms or signs of a genetically-linked inheritable Disease; and

2. the Covered Person is at risk for carrier status for a genetically-linked inheritable Disease, as supported by existing peer-reviewed, evidence-based, scientific literature, and the results will impact clinical outcome; or
3. the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

It is recommended that pre-certification be obtained, prior to any Genetic Testing that is not included in the Recommended Wellness Services.

Y. Charges for **glaucoma**. Covered Expenses include the treatment of glaucoma, cataract Surgery and one (1) set of lenses (contacts or frame-type). Outpatient Surgery is subject to any applicable pre-certification requirements described in Article VI.

Z. Charges for **Gleevec**. Gleevec, for treatment of any of the following conditions:

1. CML myeloid blast crisis;
2. CML accelerated phase; or
3. CML in chronic phase after failure of interferon treatment.

Prior authorization is required. In order to obtain such authorization, information from the Covered Person's Physician indicating the condition being treated must be submitted to the Plan.

AA. Charges for **hearing services**, including hearing exams and Hearing Aids, subject to the limitations listed in Section 2.4. Implants and devices used to improve or restore hearing, such as cochlear implants or bone anchored hearing aids (BAHA) are not covered; however, the Plan will cover cochlear implant programming and post-cochlear implant aural therapy, subject to the limitations listed in Section 2.4.

AB. Charges for **Home Health Care** provided by a Home Health Care Agency, subject to any applicable pre-certification requirements described in Article VI and the limitations listed in Section 2.4. Covered Expenses include the following:

1. Registered Nurses or Licensed Practical Nurses;
2. certified home health aides under the direct supervision of a Registered Nurse;
3. registered therapists performing physical, occupational or speech therapy;
4. Physician calls in the office, home, clinic or Outpatient department;
5. services, Drugs and medical supplies which are Medically Necessary for the treatment of the Covered Person that would have been provided in the Hospital, but not including Custodial Care; and
6. rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

The Plan also covers services by a Medical Social Worker. Transportation services are not covered under this benefit.

AC. Charges for **hospice care** provided the Covered Person has a life expectancy of six (6) months or less. Covered hospice expenses are limited to:

1. Room and Board for confinement in a hospice;
2. ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
3. medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;

4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
5. home health aide services;
6. home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
7. medical social services by licensed or trained social workers, Psychologists or counselors;
8. nutrition services provided by a licensed dietitian; and
9. bereavement counseling, which is a supportive service provided by the Hospice team to Covered Persons in the deceased's Family after the death of the terminally ill person, to assist the Covered Person in adjusting to the death. Benefits will be limited to the immediate family of the Covered Person.

The Hospice Care Program must be renewed in writing by the attending Physician every thirty (30) days. Hospice Care ceases if the terminal Illness enters remission.

AD. Charges for **Hospital** services. Covered Expenses include the following:

1. Inpatient treatment, subject to the pre-certification requirements described in Article VI:
   a. daily Semi-Private Room and Board charges, as described in Section 2.3;
   b. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges, as described in Section 2.3;
   c. general nursing services; and
   d. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board; and
2. Outpatient treatment, including but not limited to:
   a. emergency room services;
   b. treatment for chronic conditions;
   c. physical therapy treatments; and
   d. x-rays, Diagnostic Services and laboratory services, and linear therapy.

AE. Charges for services and supplies related to the initial Diagnosis of **infertility**.

AF. Charges for **Mastectomy**. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

Covered Expenses include the following:

1. reconstruction of the breast on which the Mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. physical complications from all stages of Mastectomy, including lymphedemas.

Such reconstruction must be performed in a manner determined in consultation with the attending Physician. Outpatient Surgery is subject to any applicable pre-certification requirements described in Article VI.

AG. Charges for **medical supplies**. Covered Expenses include dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of

dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.

AH. Charges for **Newborn care**. Covered Expenses include Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan. Benefits will be provided under the mother's coverage. Covered Expenses include the following:

1. Hospital routine care for a Newborn during the child's initial Hospital confinement at birth; and
2. the following Physician services for well-baby care during the Newborn's initial Hospital confinement at birth:
   a. the initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
   b. circumcision.

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

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan.

AI. Charges for the **nursing services** of a Registered Nurse or Licensed Practical Nurse.

AJ. Charges for **obesity** Surgery for morbidly obese Covered Persons, subject to any applicable pre-certification requirements described in Article VI and the limitations listed in Section 2.4, including complications arising therefrom, if all of the following conditions are met:

1. the Covered Person has either a body mass index (BMI) of forty (40) or greater, or a BMI of thirty-five (35) or greater in conjunction with a severe co-morbidity such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction;
2. the Covered Person has at least a twenty-four (24) month history of morbid obesity as documented in his or her medical records;
3. the Covered Person does not have an underlying diagnosed medical condition that would cause morbid obesity (e.g., an endocrine disorder) that can be corrected by means other than surgical treatment;
4. the Covered Person has completed full growth which means he or she is at least eighteen (18) years old or the Physician has submitted supporting documentation of complete bone growth;
5. the Covered Person has failed to achieve and maintain significant weight loss and has participated in a Physician supervised nutrition and exercise program for at least six (6) months within the twenty-four (24) month period prior to the proposed surgical treatment, and such participation is documented in his or her medical records; and

6. a licensed professional counselor, psychologist, or psychiatrist evaluates the Covered Person within twelve (12) months prior to the proposed surgical treatment and documents:
   a. that there is no significant psychological problem that would limit the ability of the Covered Person to understand the procedure and comply with any medical/surgical recommendations;
   b. any psychological co-morbidities that may be contributing to the Covered Person's inability to lose weight or a diagnosed eating disorder, and
   c. the Covered Person's willingness to comply with the pre- and post-operative treatment plans.

Covered Surgical Procedures include Lap Band placement, replacement, removal, and adjustment and Gastric Bypass, and gastric sleeves. Loop Gastric Bypass, Mini Gastric Bypass, Abdominoplasty, and Gastroplasty ("stomach stapling") are not covered under the Plan.

Additionally, Covered Expenses include charges for office visits and laboratory services related to weight loss, obesity, or morbid obesity.

AK. Charges for **Occupational Therapy** rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a Facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient Facility. Services are subject to the limitations listed in Section 2.4.

AL. Charges for **oral Surgery**. Covered Expenses include oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth, subject to any applicable pre-certification requirements described in Article VI. The extraction of impacted teeth is not covered.

AM. Charges for **orthopedic shoes and foot orthotics**. Covered Expenses include the initial purchase, fitting, and repair of orthopedic shoes and foot orthotics when determined to be Medically Necessary by the attending Physician when:

1. a person has impaired peripheral sensation and/or altered peripheral circulation (e.g.., diabetic neuropathy or peripheral vascular Disease);
2. the foot orthosis is a replacement or substitute for missing parts of the foot and is necessary for the alleviation or correction of Injury, Sickness, or congenital defect; or
3. a person has neurologic or neuromuscular conditions producing spasticity, malalignment, or pathological positioning of the foot (e.g., cerebral palsy, hemiplegia, or spinal bifida), where there is reasonable expectation of improvement.

The Plan covers the replacement of any eligible orthopedic shoe or orthotic which is Medically Necessary and not resulting from loss, theft, or damage. The Plan does not cover corrective/orthopedic shoes not attached to a brace, or palliative treatment (e.g., heel lifts, arch supports, and foot pads).

AN. Charges for **osseous Surgery**, subject to any applicable pre-certification requirements described in Article VI.

AO. Charges for **pathology services**.

AP. Charges for **physical therapy**. Covered Expenses include treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a Facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy Facility. Services are subject to the limitations listed in Section 2.4.

AQ. Charges for **Physician services**. Covered Expenses include the services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

AR. Charges for **Pregnancy expenses** for any female Covered Person. Covered Expenses include, pre-natal care, delivery services, the charges of a midwife, ultrasounds amniocentesis, and post-natal care. Under the Newborns' and Mothers' Health Protection Act of 1996, Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

AS. Charges for **preventive care**. Covered Expenses include the following, subject to the limitations listed in Section 2.4:

1. routine hearing examinations;
2. visual acuity screenings;
3. immunizations and their administration;
4. bone density testing;
5. colonoscopy, sigmoidoscopy, and colorectal screenings,
6. mammography, including interpretation;
7. pap smear;
8. PSA testing;
9. any services and supplies included in the Recommended Wellness Services as defined in Section 3.1; and
10. Lifesigns wellness examinations through Lifesigns Physical Exam Clinic, including:
    a. one (1) physical examination per Calendar Year (age 16 and older);
    b. one (1) mammogram per Calendar Year (age 35 and older);
    c. one (1) pap smear test per Calendar Year (age 21 and older);
    d. one (1) pelvic/breast exam per Calendar Year (age 21 and older);
    e. one (1) prostate-specific antigen (PSA) test per Calendar Year (age 40 and older);
    f. *through August 31, 2020*, one (1) stress test per Calendar Year (age 40 and older). Female Covered Persons age fifty (50) and older may elect to have one (1) bone density test per Calendar Year instead of a stress test; and
    g. *effective September 1, 2020*, coverage for both of the following is available:
        i. one (1) stress test per Calendar Year (age 40 and older); and
        ii. one (1) bone density test per Calendar Year (age 50 and older).

AT. Charges for **prosthetics, orthotics, supplies and surgical dressings**. Coverage includes:

1. prosthetic devices to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, excluding dental prosthesis and penile prosthesis due to sexual dysfunction or impotency (unless related to organic Disease). Coverage includes prosthetic bras following

Mastectomy. Includes repair, and replacement if necessary due to Covered Person's growth/development and if items were initially provided five (5) or more years prior;

2. Orthotic devices other than those for the feet. Includes repair, and replacement if necessary due to Covered Person's growth/development and if items were initially provided five (5) or more years prior;
3. medical supplies;
4. surgical dressings; and
5. compression stockings.

AU. Charges for **respiration therapy** and pulmonary rehabilitation services, when rendered in accordance with a Physician's written treatment plan, subject to the limitations listed in Section 2.4.

AV. Charges for **Routine Patient Costs** for a Qualified Individual in an Approved Clinical Trial for treatment of cancer or other Life-Threatening Condition or Disease. Coverage is not provided for charges not otherwise covered under the Plan and does not include charges for the Drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

AW. Charges for **second surgical opinions**.

AX. Charges for care in a **Skilled Nursing Facility**. Covered Expenses include the services provided by a Skilled Nursing Facility, extended care Facility or a Convalescent Care Facility, subject to the limitations listed in Section 2.4 and the pre-certification requirements described in Article VI, in connection with convalescence from an Illness or Injury (excluding Drug addiction, chronic brain syndrome, Alcoholism, senility, mental retardation or other Mental/Nervous Disorders) for which the Covered Person is confined.

AY. Charges for **sleep disorders**. Covered Expenses include the treatment of sleep disorders, including sleep studies in Physician's office, oral appliances to reduce airway obstruction, Continuous Positive Airway Pressure (CPAP), and Bilevel Positive Airway Pressure (BiPAP, DPAP, VPAP, AutoPAP).

AZ. Charges for **speech therapy**. Covered Expenses include speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to Surgery performed as the result of a Sickness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders. Services are subject to the limitations listed in Section 2.4.

BA. Charges for **spinal pain injections**, subject to the limitations listed in Section 2.4.

BB. Charges for **sterilization**. Covered Expenses include charges related to FDA approved elective sterilization procedures. The reversal of a prior sterilization procedure is not covered under this Plan. Outpatient Surgery is subject to any applicable pre-certification requirements described in Article VI.

BC. Charges for **Surgery**. Covered Expenses include surgical operations and procedures, unless otherwise specifically excluded under the Plan, subject to any applicable pre-certification requirements described in Article VI. Multiple Surgical Procedures are subject to the limitations set forth in the definition of Multiple Surgical Procedures in Article III. Charges made for services rendered by an assistant surgeon will be allowed at twenty-five percent (25%) of the Usual, and Customary fee value for the type of Surgery performed. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative

session. Covered Expenses, including both Physician and Facility expenses, for robotic Surgical Procedures and related expenses will be limited to the Reasonable and Allowable Amount for the same Surgical Procedure performed under standard methods.

BD. Charges for **surgical treatment of jaw**. Covered Expenses include the surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist, subject to any applicable pre-certification requirements described in Article VI.

BE. Charges for **telehealth services**, but only during a State of Emergency declared by the federal government or by the state of Tennessee. Covered Expenses include consultations, visits with primary care Providers, Specialists, psychotherapists, covered consultants, and certain other medical or health services that are provided by an eligible health care Provider and covered under the Plan. Services can include diagnostic evaluation and the prescribing of medication. Telehealth visits can be performed from offices, Hospitals, and other locations such as nursing homes and assisted living facilities. Copayments, coinsurance, and deductibles shall be applied based on the tier, type of health care Provider and location where the telehealth services are being performed. Any exclusion in the Plan contrary to the foregoing shall be void based on the inclusion of telehealth services described herein.

BF. Charges for **Temporomandibular Joint Disorder ("TMJ")**. Covered Expenses include the Diagnosis and treatment of, or in connection with, Temporomandibular Joint Disorders, myofascial pain dysfunction, or orthognathic treatment. The Plan will also cover surgical and non-surgical treatment of conditions of the structures linking the jawbone and skull and complex muscles, nerves, and other tissues related to the Temporomandibular Joint. Treatment includes but is not limited to orthodontics, physical therapy, splint therapy, and any other appliance attached to or resting on the teeth. Outpatient Surgery is subject to any applicable pre-certification requirements described in Article VI.

BG. Charges for **testosterone** when administered to treat a medical condition and when determined to be Medically Necessary. "Low-T" (low testosterone) due to aging is not considered Medically Necessary.

BH. Charges for **tobacco cessation counseling**, subject to the limitations listed in Section 2.4.

BI. Charges for Medically Necessary human to human organ and tissue **Transplants** when not Experimental or Investigational in nature, subject to any applicable pre-certification requirements described in Article VI. Covered transplants include, but are not limited to, the following:

1. bone marrow;
2. heart;
3. lung;
4. heart and lung;
5. liver;
6. pancreas;
7. kidney; and
8. cornea.

Covered Expenses include:

1. organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
2. services and supplies furnished by a Provider; and
3. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage, and other costs directly related to the procurement of an organ or tissue used in a transplant described herein will also be covered.

The following are not covered:

1. meals, travel, and lodging;
2. the purchase of an organ or tissue;
3. donor charges when the transplant recipient is not a Covered Person.

The Plan has access to special transplant networks "Centers of Excellence" that can provide transplant related services and supplies at a cost that is less, for the most part, than that charged to other patients of the Facility. **If a Covered Person chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.** For more information about utilizing these networks, contact the Benefit Manager or the Utilization Review Service.

BJ. Charges for the services of an **urgent care** center.

# ARTICLE IX

# OTHER BENEFITS

## 9.1 RETAIL PRESCRIPTION DRUG PROGRAM

The Plan has a retail prescription Drug card program that covers prescriptions dispensed through a participating pharmacy. There is a Copayment for most prescriptions, as described in Section 2.5, that must be paid for each such prescription obtained until the Out-of-Pocket limit is satisfied. Any Copayment paid under the retail prescription Drug program shall not be a Covered Expense under any other provision of this Plan.

## 9.2 MAIL ORDER PRESCRIPTION PROGRAM

The Plan provides a mail order prescription Drug program. The Plan covers both Brand Name Drug and generic equivalents in accordance with the Copayment amounts shown in Section 2.5 of the Plan. The Plan covers up to a ninety (90) day supply of the medication with a single Copayment. Any Copayment paid under the mail order prescription program shall not be a Covered Expense under any other provision of this Plan.

## 9.3 COVERED EXPENSES UNDER THE RETAIL PRESCRIPTION DRUG AND MAIL ORDER PRESCRIPTION PROGRAMS

Prescriptions covered under the retail prescription Drug and the mail order prescription programs include the following:

A. federal legend Drugs not specifically excluded below. A prescription legend Drug is any medicinal substance that is required to bear the label, “Caution: Federal law prohibits dispensing without a prescription” or “Rx only;”

B. Drugs that are part of the Recommended Wellness Services, subject to any provisions or limitations included therein, including:
   1. low dose aspirin products (up to 325 mg);
   2. sodium fluoride products, not including combinations;
   3. folic acid products, not including combinations;
   4. flu shots and shingles and pneumonia vaccines;
   5. iron suspension, ferrous sulfate;
   6. Vitamin D supplements;
   7. bowel preparatory kits;
   8. breast cancer risk reduction products;
   9. certain statins; and
   10. effective September 1, 2020, HIV pre-exposure prophylactics (PrEP). Specialty Drugs require prior authorization;

C. FDA approved contraceptives prescribed for females, including but not limited to oral, emergency, transdermal, injectable and over-the-counter contraceptives with a Physician’s prescription;

D. FDA approved tobacco cessation medications and products, including over-the-counter with a Physician’s prescription up to two (2) attempts to quit tobacco use per year with up to a ninety (90) day supply, per attempt;

E. oral medications for the treatment of infertility;

F. injectable insulin and insulin syringes with or without needles. Only one (1) Copayment will apply when insulin and syringes are obtained together;

G. certain diabetic supplies, including lancets, blood and urine test strips, blood glucose testing monitors, control solutions and glucagon emergency kits. Continuous glucose monitor/transmitter/sensors are covered with prior authorization;

H. medications to treat attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD);
I. Drugs for the treatment of impotency, including injectables and oral medications with prior authorization. Quantity limitations apply;
J. cosmetic agents, such as topical vitamin A derivatives, acne medications, Retin-A, Altinac or Avita;
K. legend prenatal vitamins;
L. folic acid and vitamin D preparations;
M. emergency allergic kits;
N. androgens and anabolic steroids, with prior authorization;
O. hemophilia factors, with prior authorization;
P. Drugs for treatment of migraine. Quantity limitations apply;
Q. standard self-injectable medications;
R. Specialty Drugs, with prior authorization;
S. anti-influenza agents, limited to two (2) therapies, per year;
T. pre-packaged products greater than a thirty (30) day supply;
U. Drugs for the treatment of Alcoholism or Substance Abuse;
V. compounded medications. Dollar limitations may apply;
W. growth hormones, with prior authorization;
X. Praluent and Repatha, with prior authorization;
Y. Accutane;
Z. Progesterone;
AA. chemotherapy Drugs with prior authorization;
AB. immunosuppressants;
AC. other injectable medications;
AD. certain combination medications; and
AE. over-the-counter non-sedating antihistamines, such as Zyrtec and Claritin.

## 9.4 LIMITATIONS UNDER THE RETAIL PRESCRIPTION DRUG AND MAIL ORDER PRESCRIPTION PROGRAMS

The following items are excluded from the retail prescription Drug card and mail order prescription programs:

A. Drugs dispensed in excess of any age or other limitation listed above;
B. Drugs listed above as requiring prior authorization if such authorization is not obtained;
C. fertility medications not listed above as covered, such as vaginal injectable medications;
D. diabetic supplies other than those specifically listed as covered above, including lancet devices, alcohol swabs, acetone test strips, over-the-counter hypoglycemic products, and insulin pumps and supplies;
E. contraceptives not specifically listed above as covered, including male contraceptives, contraceptives not approved by the FDA, implantable contraceptives and intrauterine devices;
F. over-the-counter products not specifically listed as covered above;
G. Addyi;
H. anorexiants, anti-obesity Drugs or appetite suppressants;
I. hair growth stimulants and products indicated on for cosmetic use;
J. Vitamin B12 injections;

K. vitamin hematinics;
L. nutritional supplements, including those to treat specific medication conditions, PKU and infant formulas;
M. allergy serums;
N. Auvi-Q;
O. non-specialty implantable medications;
P. blood, blood plasma and biological sera;
Q. inhaler assisting devices;
R. ostomy supplies;
S. topical fluoride products;
T. repackaged medications;
U. shampoos and soaps;
V. certain combination Drugs; and
W. discretionary Drugs. Certain categories of Brand Name Drugs are designated by the Plan to be discretionary Drugs and are not covered under the Plan. Generic forms of these Drugs are covered as described in Article II. A list of these discretionary Drugs will be provided to Covered Persons by the Plan Administrator and are also available upon request. The discretionary Drug list may be updated periodically at the discretion of the Plan Administrator. If there is a discrepancy in coverage terms between other language in this Plan document and the most current discretionary Drug list approved by the Plan Administrator, the discretionary Drug list will govern over any other contradictory Plan language. Examples of discretionary Drug categories include, but are not limited to, tetracycline antibiotics, and androgens.

# ARTICLE X

# EXCLUSIONS AND LIMITATIONS

## 10.1 GENERAL AND MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses Incurred by all Covered Persons and to all benefits provided by this Plan. Any exclusion listed below shall not apply to the extent that coverage for the service or supply is specifically provided for under this Plan, or that the exclusion is prohibited under any applicable law. The exclusions listed below will not apply to the extent that they relate to an Injury the source of which is directly caused by an act of domestic violence committed on a Covered Person. In addition, such exclusions will not apply to an underlying medical condition (including both physical and mental health conditions) triggered by an act of domestic violence. Additional exclusions that apply to the prescription programs are listed in Article IX.

A. Charges Incurred directly or indirectly as the result of an **abortion**, except where the life of the mother would be threatened if the fetus were carried to term.

B. Charges relating directly or indirectly to **acupuncture**.

C. Charges for inter-Facility **air transport services** that are not Medically Necessary. The Plan Administrator retains discretionary authority in determining Medical Necessity in this regard and will consider assessment by the designated inter-Facility air ambulance review service in determining Medical Necessity of inter-Facility patient air transport.

D. Charges for **applied behavioral analysis**.

E. Charges for **aquatic therapy** or hydrotherapy.

F. Charges for **biofeedback therapy**.

G. Charges for **chelation therapy**, unless related to heavy metal poisoning.

H. Charges for **complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan, unless specifically listed as a Covered Expense.

I. Charges for telehealth **consultations**, except as specifically listed as a Covered Expense during a State of Emergency, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

J. Charges for **Cosmetic Surgery**, unless specifically listed as a Covered Expense.

K. Charges for **cranial banding**.

L. Charges for **Custodial Care**, domiciliary care or rest cures, or Home Health Care except as specifically provided herein.

M. Charges for **Deductible.** Charges that are not payable due to the application of any specified Deductible provisions contained herein.

N. Charges for the treatment of **developmental delay**.

O. Charges for services performed by a Physician or other Provider enrolled in an **education or training program** when such services are related to the education or training program, except as specifically provided herein.

P. Charges for **Excess Charges**, as defined in Section 3.1, or those otherwise not payable under the Plan.

Q. Charges for **Experimental or Investigational** services, including expenses for treatment, procedures, devices, Drugs, or medicines which are determined to be Experimental and/or

Investigational, except for Off-Label Drug Use or when such expenses are considered Routine Patient Costs in connection with an Approved Clinical Trial.

R. Charges for **eye** refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury, or as otherwise listed as a Covered Expense). Additionally, Surgery to correct refractive errors of the eye, such as radial keratotomy or Lasik, are not covered.

S. Charges for **habilitative** services and therapy. This exclusion does not apply to the treatment of Autism Spectrum Disorders, attention deficit disorder (ADD), or attention deficit hyperactive disorder (ADHD).

T. Charges for wigs, artificial **hair pieces**, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness.

U. Charges for expenses related to the use of **hypnosis**.

V. Charges related to **illegal occupation, felony, or other criminal acts.** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation, or commission of a felony or other criminal act, are not covered. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

W. Charges provided by an **Immediate Family Member** or Close Relative. This exclusion also applies to services or supplies provided by a person residing in the same household as the Covered Person.

X. Charges for **Impregnation and Infertility Treatments**, including but not limited to, the following:
   1. artificial insemination;
   2. fertility Drugs;
   3. G.I.F.T. (Gamete Intrafallopian Transfer);
   4. impotency Drugs such as Viagra™;
   5. in-vitro fertilization;
   6. the correction of defects preventing Pregnancy;
   7. surrogate mother charges, when the pregnant person is not covered under the Plan; and
   8. donor eggs.

Y. Charges for **Incurred by other persons**. Charges for expenses actually Incurred by persons other than a Covered Person are not covered.

Z. Charges for **liability waived.** Charges in connection with a claim where the Covered Person does not meet his or her cost-sharing responsibility (i.e. copay, Deductible or coinsurance) are not covered. This exclusion applies regardless of whether the Provider charges or attempts to collect the Covered Person's cost-sharing responsibility.

AA. Charges for **marital counseling**.

AB. Charges for **massage therapy**.

AC. Charges for **nicotine withdrawal/tobacco cessation programs**, facilities, Drugs or supplies, except as included in the Recommended Wellness Services or as otherwise specifically listed as a Covered Expense.

AD. Charges for **No Obligation to Pay.** Services that are provided to a Covered Person for which the Provider customarily makes no direct charge, or for which the Covered Person is not legally obligated to pay, or for which no charges would be made in the absence of

this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or this benefit plan, may be liable for necessitating the fees, care, supplies, or services are not covered.

AE. Charges that are **not acceptable**. Charges that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration are not covered.

AF. Charges for services that are **not actually rendered**.

AG. Charges for services and supplies that are **not specifically listed as covered** under this Plan.

AH. Charges for **nutritional supplements**, except as included in the Recommended Wellness Services.

AI. Charges related to **obesity**, except as specifically listed as a Covered Expense or as included in the Recommended Wellness Services.

AJ. Charges for, or related to, **oral Surgery** or dental treatment, except as specifically listed in the Plan.

AK. Charges for expenses related to donation of a human **organ** or tissue, except as specifically listed as covered.

AL. Charges for **personal convenience** items, including equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician.

AM. Charges for the following **prescription drug** related services:

1. pharmacy based prescription drug reimbursement under the medical provisions of the Plan;
2. take home office based prescriptions; or
3. certain Specialty Drugs beyond the first occurrence of treatment. A one-time treatment is permissible under the medical provisions of this Plan. However, after this one-time treatment, these drugs must be obtained through the pharmacy programs described in Article IX. This exclusion does not apply to cancer related Specialty Drugs obtained through the West Clinic or Baptist Hospital.

AN. Charges Incurred **prior to coverage**. This exclusion applies to any charge for which a service was received prior to, or after, the date the Covered Person was enrolled and covered under this Plan.

AO. Charges for **private duty nursing**.

AP. Charges for radial keratotomy or other **plastic surgeries** on the cornea in lieu of eyeglasses.

AQ. Charges for **routine or periodic physical examinations**, related x-ray and laboratory expenses, and nutritional supplements, except as listed as a Covered Expense or as included in the Recommended Wellness Services.

AR. Charges for services or supplies for intentionally **self-inflicted** Illness or Injury. This exclusion does not apply if the Injury resulted from being the victim of an act of domestic violence or resulted from a documented medical condition (including both physical and mental health conditions).

AS. Charges related to **travel** unless specifically listed as a Covered Expense.

AT. Charges submitted by a Provider for services which have been **unbundled** contrary to the Centers for Medicare and Medicaid Services (CMS) guidelines under the Medicare program, unless prohibited by network agreements.

AU. Charges for **vitamins**, unless specifically listed as a Covered Expense.

AV. Charges Incurred as a result of **war** or any act of war, whether declared or undeclared, or any act of aggression, when the Covered Person is a member of the armed forces of any Country, or during service by a Covered Person in the armed forces of any Country. This exclusion does not apply to any Covered Person who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

AW. Charges related to **weight loss**, except as specifically listed as a Covered Expense.

AX. Charges related to **worker's compensation.** Services for, or in connection with, any Injury, Illness, or complication thereof that:

1. arises out of or in the course of employment, including self-employment, or an activity for wage or profit; or
2. is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that the Covered Person received or is eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from workers' compensation. The Plan will exercise its right to recover against the Covered Person. The Plan reserves its right to exercise its rights under this section and Section 11.2, entitled Third Party Recovery, Subrogation and Reimbursement, even though:
    a. the workers' compensation benefits are in dispute or are made by means of settlement or compromise;
    b. no final determination is made that the Injury or Illness was sustained in the course of or resulted from the Covered Person's employment;
    c. the amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
    d. the health care expense is specifically excluded from the workers' compensation settlement or compromise.

The Covered Person is required to notify the Plan Administrator immediately when he or she files a claim for coverage under workers' compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and the Covered Person will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

# ARTICLE XI
# GENERAL INFORMATION

## 11.1 COORDINATION OF BENEFITS

Coordination of benefits (COB) is a feature that prevents duplicate payment under this Plan and other health insurance or prepayment plans, including Medicare or other types of insurance. A Covered Person may have coverage under this Plan, another health plan of coverage or another kind of insurance policy at the same time. Other health plans of coverage include a group Sickness and accident insurance policy or program, a group contract of a health maintenance organization, an individual Sickness and accident insurance policy or an individual contract of a health maintenance organization. Other kinds of insurance policies include your automobile insurance policy's medical payments and uninsured motorist's coverage. For example, a person may be covered by an employer's group insurance program and also by the group program provided by a spouse's employer. Or a person may be covered by an employer's group insurance and also have coverage under a parent's group plan.

If a Covered Person files a claim under this Plan for services or supplies that are also covered under another plan or insurance policy, for instance, one of the plans or policies listed in the first paragraph, payments will be "coordinated." This means that this Plan will adjust its benefit payments so that combined payments under this and any other health plan or insurance policy will be no more than the usual, Reasonable and Allowable Amount for fee payments.

Once a Covered Person has provided this Plan with information about other health benefit plans and/or health benefits through other insurance policies under which he or she has coverage, the Plan will handle the coordination. This will be done according to the "Order of Benefit Determination." The Order of Benefit Determination will be determined, as described below.

The plan that pays first is called the primary plan. Any other plan that covers the Covered Person is called the secondary plan.

A. A group or individual plan or policy that does not contain a COB feature is always primary.

B. A plan that covers a person as the certificate holder or the contract holder is primary. In the two examples given, the coverage the person has through his or her employer would be primary. The coverage through a spouse's or parent's employer would be secondary. The exception to this would be when the laws and regulations governing Medicare require that the plan covering the person as a Dependent pay its benefits as primary to Medicare, but such laws and regulations also provide that the plan covering them as the certificate holder/contract holder should pay its benefits as secondary to Medicare. In such a case, the plan that is required to pay as primary to Medicare shall also pay as primary to the other coverage.

C. If a person is covered as a Dependent child under more than one (1) plan:

   1. For a Dependent child whose parents are married or are living together, even if they have never been married, the plan of the parent whose birthday falls earlier in the Calendar Year has primary responsibility for paying the claim. The plan of the parent with the later birthday becomes the secondary plan. If both parents have the same birthday, the parent whose coverage has been in effect the longest is primary (such determination is described in Subsection F below). The ages of the respective parents are not relevant. This method of coordinating benefits is commonly referred to as the "birthday rule."

   2. For a Dependent child whose parents are divorced, separated or are not living together (whether or not they have ever been married):

      a. If a court decree states that one (1) of the parents is responsible for the Dependent child's healthcare coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's

spouse does, such spouse's plan is the primary plan. This item shall not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

b. If a court decree states that both parents are responsible for the Dependent child's health care coverage, the birthday rule, as described in C1 above, shall apply.

c. If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care coverage of the Dependent child, the birthday rule, as described in C1 above, shall apply.

d. If there is no court decree allocating responsibility for the Dependent child's health care coverage, the order of benefits for the child are as follows:

   i) the plan of the custodial parent, if any, shall pay its benefits first;

   ii) the plan of the spouse of the custodial parent, if any, will pay next;

   iii) the plan of the non-custodial parent, if any, will pay after the prior listed plans; and

   iv) the plan of the spouse of the non-custodial parent, if any, shall pay it benefits last.

D. A plan that covers a person as an active employee or as a Dependent of an active employee is primary to a plan that covers a person as an inactive employee, such as a laid-off or retired employee or as a Dependent of a laid-off or retired employee. The exception to this rule is when the laws and regulations governing Medicare require that this Plan pay its benefits as primary to the plan covering the inactive employee.

E. If a person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree is primary to the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law. The exception to this rule is when the laws and regulations governing Medicare require that the plan covering the person pursuant to COBRA, or under a right of continuation pursuant to state or other federal law, pay its benefits as primary to the other plan.

F. There are some situations in which the above rules do not apply. Here the program that has been in effect longer is primary. To determine the length of time a person has been covered under a plan, two (2) successive plans through the same employer shall be treated as one (1) if the person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended. The person's length of time covered under a plan is measured from his or her first date of coverage under that plan. If that date is not readily available, the date the person first became a member of that group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force. Some examples of when coordination of benefits is based on coverage in effect longer are:

   1. when a person who works two (2) jobs has health coverage through both employers; or

   2. when a person is covered as the dependent of his or her spouse and a parent. If both coverages become effective on the same date, the birthday rule, as described in C1 above, will apply to this situation.

G. A plan or policy that covers a specific event may be primary to a plan that provides general coverage. For example, if a person is injured in an automobile accident with an uninsured motorist, his or her automobile policy's uninsured motorist's coverage would be primary to a group health plan if both policies had similar provisions regarding other insurance.

If coverage under this Plan is primary, benefits will be paid as if the Covered Person had no other coverage. But if this coverage is secondary, this Plan's payments will be calculated by subtracting

the primary plan's benefits for the services and supplies covered under this Plan from the benefits that would otherwise be payable under this Plan in the absence of the other coverage. If the benefits of the primary coverage are equal to or more than the benefits that would be payable under this Plan for the services or supplies in question, no benefit payment will be made by this Plan. By accepting coverage under this Plan, a Covered Person agrees to do two (2) things to enable the Plan to coordinate benefits. First, the Covered Person will supply the Plan with information about other coverage he or she has when asked. Second, if the Plan makes a payment and later finds out that the coverage under this Plan should not have been primary, the Covered Person will return the excess amount to the Plan. The Plan has the right to obtain information needed to coordinate benefits from others as well, i.e., insurance companies and other persons.

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage.

In the case of Medicare services that are furnished to End Stage Renal Disease ("ESRD") participants who are covered under this Plan:

A. if any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first thirty (30) months of Medicare entitlement with respect to charges Incurred on or after August 5, 1997, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law; and

B. in order to coordinate Covered Expenses under this Plan with Medicare coverage, the Covered Person is required to:

   1. notify the Plan Administrator and send a copy of his or her Medicare card when enrolled in Medicare; and

   2. notify the Plan Administrator if or when he or she begins to receive dialysis treatments.

If Medicare reimbursement rates are neither available nor applicable, rates will be set in accordance with all provisions of this Plan, including provisions within the definition of Reasonable and Allowable Amount provision.

## 11.2 THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

A Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one (1) party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one (1) or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;
D. workers' compensation or other liability insurance company; or
E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as

applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he or she is required to:

A. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
B. instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
C. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
D. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) Incurred prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;
D. workers' compensation or other liability insurance company; or
E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan to:

A. cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
B. provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
C. take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
D. do nothing to prejudice the Plan's rights of subrogation and reimbursement;

E. promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
F. notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
G. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
H. not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;
I. to instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
J. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
K. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section

shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

## 11.3 MEDICARE BENEFITS

This provision prevents duplication of benefits for Covered Expenses when Medical Care benefits are available from Medicare. Benefits under this Plan will be reduced to the extent that the Participant or his or her Dependents are reimbursed or entitled to reimbursement for those expenses by Medicare.

Under the Tax Equity and Fiscal Responsibility Act of 1982, as amended (TEFRA), active employees and/or their spouses who are sixty-five (65) or over may choose to have the District program as primary coverage, in which case Medicare may pay benefits on a secondary basis. Otherwise, an employee may elect to drop out of the District program and choose Medicare as primary coverage. Employees in this category who are enrolled under this Plan will remain so enrolled with this Plan as primary coverage unless an option form is on file indicating otherwise.

The Plan may also pay its benefits as primary to Medicare's in other situations, as prescribed by applicable laws and regulations.

The Plan intends to comply with the federal Social Security Act, as amended, and other applicable laws, as such apply to Medicare benefits.

## 11.4 ADDITIONAL RIGHTS OF RECOVERY

If payments are made under the Plan that should not have been made, the Plan may recover that incorrect payment. The Plan may recover this payment from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made to the Participant, the Plan may deduct it when making future payments directly to the Participant. Once the Plan Administrator determines that a previous benefit payment should be reimbursed, in whole or in part, either due to the provisions described in Section 11.2 or because such benefit payment should not have been made in accordance with the provisions of this Plan, the Participant and/or the applicable Provider will be notified of such overpayment, and a request will be made for such Participant/Provider to reimburse the Plan. If the reimbursement is not made as requested, such amount will constitute a lien against future claim payments that would otherwise be paid on the Participant or the Covered Person's behalf. The Plan Administrator retains the right to reduce or withhold such future claim payments until the lien is satisfied.

This Plan will comply with Sections 609(b)(1), (2) and (3) of the Employee Retirement Income Security Act with regard to Covered Persons eligible for Medicaid. An Employee's or Dependent's eligibility for, or participation in, Medicaid will not affect determination of whether or not payments should be made. Under state and federal law, should a Covered Person be entitled to payment of a claim under this Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the Covered Person's right to payment under this Plan to the extent of the amount paid by Medicaid, and reimbursement under this Plan will be made in that amount directly to the state.

## 11.5 FACILITY OF PAYMENT

Whenever a Covered Person or Provider to whom payments are directed to be made is mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Plan Administrator nor the Benefit Manager shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative, if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Benefit Manager or any fiduciary shall not be liable to any person as a result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

## 11.6 ADMINISTRATION OF THE PLAN

Except as otherwise specifically provided for in the Plan, the Plan Administrator shall have the exclusive authority to control and manage the operation and administration of the Plan and shall be Named Fiduciary of the Plan for purposes of any applicable law. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions thereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under any applicable law.

The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient; provided however, that both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Employer shall indemnify any employee to whom duties are delegated by the Plan Administrator pursuant to this section from and against any liability that such employee may incur in the administration of the Plan, except for liabilities arising from the recklessness or willful misconduct of such employee.

The Plan Administrator shall be responsible for controlling and managing the operation and administration of this Plan, including, but not limited to, the power:

A. to employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;
B. to construe and interpret this Plan;
C. to adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;
D. to decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;
E. to prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;
F. to authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;
G. to prepare and to distribute, in such manner as it deems appropriate, information explaining the Plan;
H. to apply consistently and uniformly to all Covered Persons in similar circumstances its rules, regulations, determinations and decisions;
I. to prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of any applicable laws, and all regulations promulgated thereunder; and
J. to retain counsel (who may, but need not, be counsel to the District), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of the Plan.

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan document, the decision of the Plan Administrator shall be final and binding on the Participants, Dependents, and all other persons. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious.

## 11.7 NON-ALIENATION AND ASSIGNMENT

The Plan Administrator may revoke an Assignment of Benefits at its discretion and treat the Covered Person as the sole beneficiary. Benefits for medical expenses covered under this plan may be assigned by a Covered Person to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider that accepts an Assignment of Benefits, in accordance with this Plan, does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

## 11.8 FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

## 11.9 FIDUCIARY RESPONSIBILITIES

No fiduciary of the Plan shall be liable for any acts or omission in carrying out his, her or its responsibilities under the Plan, except as may be provided under any applicable laws. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to such fiduciary under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in any applicable laws.

## 11.10 DISCLAIMER OF LIABILITY

The Plan is not responsible for the efficiency or integrity of any health care Provider delivering services or supplies utilized by the Participant. The Plan is not liable in any way for the effect of delivery of such services or supplies, the results of actions taken as a result of such services or supplies being limited or not covered by the Plan, nor any limitations imposed on the cost sharing responsibility of the Plan.

Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, Benefit Manager, or any Employer for the acts or omissions of any health care Provider from whom a Covered Person receives care, or for the acts or omission of any Physician from whom the Covered Person receives care under the Plan, or for any acts or omissions of any Provider of services or supplies under this Plan. Neither the Plan, nor the Plan Administrator, nor the Benefit Manager have any responsibility for or control over the actions of any networks offering services and/or supplies under the Plan.

## 11.11 ADMINISTRATIVE AND CLERICAL ERRORS

The benefits payable to or on behalf of a Participant or Dependent under this Plan will not be decreased nor increased due to administrative or clerical errors made by the Employer, the Plan Administrator, the Utilization Review Service or the Benefit Manager. If written application for coverage for an eligible employee or Dependent is submitted by the employee/Participant within the applicable time frame specified in Article V, any subsequent administrative or clerical error made by the Employer, the Plan Administrator or the Benefit Manager shall not act to delay the effective date of such person's coverage beyond the date such coverage would otherwise become effective if such application was processed in a timely manner. In addition, any such error made in claims processing, utilization review or other administrative functions shall not affect the benefits

payable to or on behalf of a Covered Person under this Plan. The Plan Administrator may require proof of an error described in this provision. The Plan Administrator shall have the sole responsibility to determine when an error is an "administrative or clerical" error and will be the sole judge of any proof required.

### 11.12 RESCISSION OF COVERAGE

A rescission of coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide an individual with coverage, just as if he or she never had coverage under the Plan. Such coverage can only be rescinded if the individual (or a person seeking coverage on an individual's behalf) perform an act, practice, or omission that constitutes fraud; or unless the individual (or a person seeking coverage on the individual's behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. Coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by an employer.

Such individual will be provided with thirty (30) calendar days' advance notice before coverage is rescinded. Such individual has the right to request an internal appeal of a rescission of his or her coverage. Once the internal appeal process is exhausted, such person has the additional right to request an independent external review.

### 11.13 PATIENT ADVOCACY CENTER

It is the Plan's position that the Provider should not balance bill the Covered Person for amounts in excess of the Reasonable and Allowable Amount. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant. However, balance billing for such amounts can occur for out of network claims and the Plan has no control over the actions of the Providers or their desire to pursue you for such amounts.

In the event you receive a balance-bill for an amount in excess of the Reasonable and Allowable Amount payable, please immediately email pac@hstechnology.com or call the Patient Advocacy Center toll free at (888) 837-2237.

Please Note: The Patient Advocacy Center provides assistance to Covered Persons with the understanding that:

A. the Patient Advocacy Center is not acting in a fiduciary capacity under this Plan;
B. that the Covered Person must make their own independent decision with respect to any course of action in connection with any balance-bill, including whether such course of action is appropriate or proper based on the Participant's specific circumstances and objectives; and
C. the Patient Advocacy Center does not provide legal or tax advice.

### 11.14 STATUTE OF LIMITATIONS: VENUE/FORUM

Before filing a lawsuit, the claimant must exhaust all available levels of review as described in this section and the Plan, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable. Further, any legal action brought against the Plan must be brought exclusively in the state of Tennessee. The Participant, or any Authorized Representative, submits to and accepts the exclusive jurisdiction of such courts for the purpose of such legal action. To the fullest extent permitted by law, Participant, and any Authorized Representative, irrevocably waive any objection which they may now or in the future have as to venue, as well as any claim that any legal action or proceeding brought in such court has been brought in an inconvenient forum.

### 11.15 DISCRIMINATION COMPLAINTS

It is the policy of Bartlett City Schools not to discriminate on the basis of race, color, national origin, sex, age or disability. The Plan Administrator has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at

45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Plan's Civil Rights Coordinator, who has been designated by the Plan Administrator to coordinate the efforts of Bartlett City Schools to comply with Section 1557:

James Aldinger
5705 Stage Road
Bartlett, Tennessee 38134
jaldinger@bartlettschools.org

Gina Bennet
5705 Stage Road
Bartlett, Tennessee 38134
(901) 202-0855 ext. 2230 (phone)
(901) 202-0854 (fax)
gbennett@bartlettschools.org

Any person who believes they or someone else has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Bartlett City Schools to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

The following procedures apply to complaints submitted under these procedures:

A. grievances must be submitted to the Civil Rights Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action;

B. a complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought;

C. the Civil Rights Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records of Bartlett City Schools Employee Benefit Plan. relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know;

D. the Civil Rights Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies; and

E. the person filing the grievance may appeal the decision of the Civil Rights Coordinator by writing to the Plan Administrator within fifteen (15) days of receiving the Civil Rights Coordinator's decision. The Plan Administrator shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure do not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F,

HHH Building
Washington, D.C. 20201

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within one hundred eighty (180) days of the date of the alleged discrimination. The Plan Administrator will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Civil Rights Coordinator will be responsible for such arrangements.

# ARTICLE XII

# PRIVACY

## 12.1 PRIVACY OF HEALTH INFORMATION

This provision is intended to bring this Plan into compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. Health Information transmitted or maintained by the Plan will be subject to the provisions described in this article.

## 12.2 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protected Health Information will only be disclosed or used by the Plan under one (1) of the following conditions:

A. with the specific consent of the individual who is the subject of the Protected Health Information, provided that the Plan obtains any required authorization;

B. for payment of claims submitted to the Plan, or for utilization review activities as described in Article VI, including, but not limited to, the review of any grievances or appeals involved in such activities that are generated by the Covered Person or his or her authorized representatives; or

C. for other reasonable purposes necessary to operate the Plan, to the extent that such Protected Health Information is required for such purposes, including:
   1. quality assessment and improvement activities;
   2. evaluation of Plan performance;
   3. underwriting and premium rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
   4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
   5. business planning and development of the Plan;
   6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service and the resolution of internal grievances; and
   7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of Protected Health Information is permitted by this Plan.

## 12.3 DISCLOSURES OF HEALTH INFORMATION TO THE DISTRICT

The Plan Administrator will disclose, or permit the disclosure of, Health Information to the District only as described below:

A. for any of the purposes and under the conditions described in Section 12.2;

B. as Summary Health Information, if requested by the District for the following purposes:
   1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
   2. modifying, amending or terminating the Plan; or

C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the District for the purpose of performing Plan administrative functions.

Prior to any disclosure of Health Information to the District, such entity must agree:

A. not to use or further disclose the information other than as permitted or required by this section, or as required by law;

B. that it will ensure that any agents, including subcontractors, employed by the District or Plan Administrator for Plan administration or other Plan purposes to whom it provides Protected Health Information, including, but not limited to, the Benefit Manager, any Utilization Review Service or pharmacy benefit manager, agree to the same restrictions and conditions that apply to the District with respect to such information;

C. not to use or disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the District;

D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware;

E. that it will make available Protected Health Information to the subject of such information, and allow amendment to such information as described in Section 12.4 and Section 12.5;

F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of Protected Health Information, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that section;

G. that it will make available its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;

H. that it will, if feasible, return or destroy all Protected Health Information received from the Plan that the District still maintains in any form, and that it will not retain any copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

I. that it will provide for adequate separation between the Plan and the Plan Sponsor by implementing the following procedures:

   1. access to Protected Health Information will only be provided to the:

      a. Benefits Clerk; and

      b. Benefits Supervisor;

   2. that access to and use by such employees or other persons as described above will be limited to the plan administration functions that the District performs for the Plan; and

   3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the District's established employee discipline and termination procedures.

## 12.4 ACCESS OF COVERED PERSONS TO PROTECTED HEALTH INFORMATION

A Covered Person or other individual has the right of access to inspect and obtain a copy of Protected Health Information about such person as long as such information is maintained by the Plan, except for:

A. psychotherapy notes;

B. information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or

C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator a writing signed by the Covered Person whose information is being requested. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

## 12.5 AMENDMENT RIGHTS

A Covered Person or other individual has the right to have the District amend Protected Health Information or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:

A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;

B. the information is not currently maintained in any record by the Plan;

C. the information would not be available for inspection under the reasons cited in Section 12.4; or

D. the information in the Plan's records is accurate and complete.

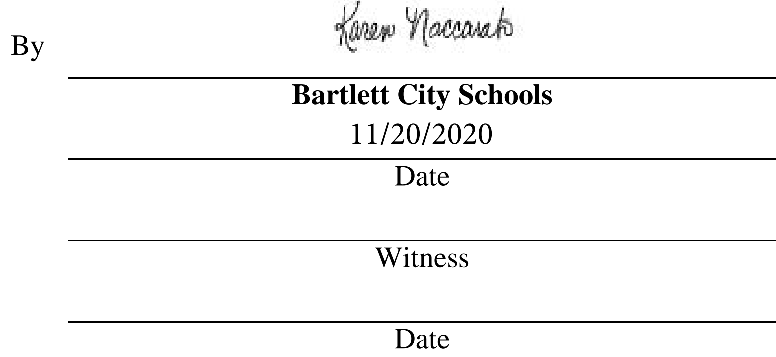
Any request for amendment of Protected Health Information must be provided in writing to the Plan Administrator and signed by the Covered Person or individual who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities that it has knowledge of such entity's receipt of any information that has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial that includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

## 12.6 SECURITY OF PROTECTED HEALTH INFORMATION

The District will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information (ePHI) that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the District and the Plan to support the requirements of Section 12.3. The District will further ensure that any agent, including a subcontractor, to whom it provides access to ePHI agrees to implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware to the Plan Administrator.

IN WITNESS WHEREOF, the revised Bartlett City Schools Employee Benefit Plan is adopted, by execution hereof, effective as of July 1, 2020.

By



**Bartlett City Schools**

11/20/2020

Date

Witness

Date

**BARTLETT CITY SCHOOLS**
**EMPLOYEE BENEFIT PLAN**
**SUMMARY PLAN DESCRIPTION**

**SUMMARY OF MATERIAL MODIFICATIONS NO. 1**

**This Summary of Material Modifications is a description of important changes which have been made to the Plan. You should read these changes carefully and keep this document with your copy of the Summary Plan Description. If you have any questions about these changes, you should contact the Plan Administrator for more information.**

Bartlett City Schools Employee Benefit Plan Summary Plan Description (hereinafter referred to as "SPD") is hereby amended and modified as set forth below. Such amendments are effective as of the dates listed below.

1) Effective July 1, 2021, Section 2.2, entitled, "**OUT-OF-POCKET LIMITS**," as set forth in Article II of the SPD, is amended in its entirety, as follows:

"**2.2 OUT-OF-POCKET LIMITS**

Initial Calendar Year Out-of-Pocket Limits
*(includes medical Copayments only)*

| | |
|---|---|
| **Per Individual** | $2,000.00 |
| **Per Employee Plus One (1) Dependent** | $3,750.00 |
| **Per Family** | $5,500.00 |

Overall Calendar Year Out-of-Pocket Limits
*(includes medical and Prescription Drug Copayments)*

| | |
|---|---|
| **Per Individual** | $8,550.00 |
| **Per Employee Plus One (1) Dependent** | $17,100.00 |
| **Per Family** | $17,100.00 |

Charges related to services and supplies that are not Covered Expenses under this Plan, in excess of any Reasonable and Allowable Amount, or other Plan limitations, or attributable to any Plan penalty will not apply to the Out-of-Pocket limits listed above."

2) Effective July 1, 2020, the item listed as "**Radiology Services Through EvoCare Program (West Clinic & Diagnostic Imaging Center)**," in Section 2.3, entitled, "**MEDICAL COPAYMENT AMOUNTS**," as set forth in Article II of the SPD, is hereby deleted in its entirety and replaced with the following:

"**Radiology Services Through EvoCare Program (Diagnostic Imaging Center)** ........... None"

3) Effective July 1, 2020, Number 10 of Subsection AS in Section 8.1, entitled, "**MEDICAL BENEFITS – COVERED EXPENSES**," as set forth in Article VIII of the SPD, is hereby amended in its entirety:

"10. Lifesigns wellness examinations through Lifesigns Physical Exam Clinic, including:
   a. one (1) physical examination per Calendar Year (age 16 and older);
   b. mammograms. One baseline mammogram (age 35 to 40) and one per Calendar Year (age 40 and older);
   c. one (1) pap smear test per Calendar Year (age 21 and older);
   d. one (1) pelvic/breast exam per Calendar Year (age 21 and older);
   e. one (1) prostate-specific antigen (PSA) test per Calendar Year (age 40 and older);

f. coverage for both of the following is available:
   i. one (1) stress test per Calendar Year (age 40 and older); and
   ii. one (1) bone density test per Calendar Year (age 50 and older)."

4) Effective February 23, 2021, Subsection G in Section 9.3, entitled, "**COVERED EXPENSES UNDER THE PRESCRIPTION DRUG AND MAIL ORDER PRESCRIPTION PROGRAMS**," as set forth in Article IX of the SPD, is amended in its entirety, as follows:

"G. certain diabetic supplies, including lancets, blood and urine test strips, blood glucose testing monitors, control solutions and glucagon emergency kits. Continuous glucose monitor/transmitter/sensors may require prior authorization;"

Bartlett City Schools hereby adopts the above amendments to the Bartlett City Schools Employee Benefit Plan Summary Plan Description effective as of the dates listed above.

**BARTLETT CITY SCHOOLS**
**EMPLOYEE BENEFIT PLAN**
**SUMMARY PLAN DESCRIPTION**

**SUMMARY OF MATERIAL MODIFICATIONS NO. 2**

**This Summary of Material Modifications is a description of important changes which have been made to the Plan. You should read these changes carefully and keep this document with your copy of the Summary Plan Description. If you have any questions about these changes, you should contact the Plan Administrator for more information.**

Bartlett City Schools Employee Benefit Plan Summary Plan Description (hereinafter referred to as "SPD") is hereby amended and modified as set forth below. Such amendments are effective as of July 1, 2021.

1) Section 2.2, entitled, "**OUT-OF-POCKET LIMITS**," as set forth in Article II of the SPD and as otherwise amended, is amended in its entirety, as follows:

"**2.2 OUT-OF-POCKET LIMITS**

Initial Calendar Year Out-of-Pocket Limits
*(includes medical Copayments only)*

| | |
|---|---|
| **Per Individual** | $2,000.00 |
| **Per Employee Plus One (1) Dependent** | $3,750.00 |
| **Per Family** | $5,500.00 |

Overall Calendar Year Out-of-Pocket Limits
*(includes medical and Prescription Drug Copayments)*

| | |
|---|---|
| **Per Individual** | |
| Through August 31, 2021 | $8,150.00 |
| Effective September 1, 2021 | $8,550.00 |
| **Per Employee Plus One (1) Dependent** | |
| Through August 31, 2021 | $16,300.00 |
| Effective September 1, 2021 | $17,100.00 |
| **Per Family** | |
| Through August 31, 2021 | $16,300.00 |
| Effective September 1, 2021 | $17,100.00 |

Charges related to services and supplies that are not Covered Expenses under this Plan, in excess of any Reasonable and Allowable Amount, or other Plan limitations, or attributable to any Plan penalty will not apply to the Out-of-Pocket limits listed above."

2) Subsection BE in Section 8.1, entitled, "**MEDICAL BENEFITS – COVERED EXPENSES**," as set forth in Article X of the SPD, is amended in its entirety as follows:

"BE. Charges for telehealth services. Covered Expenses include consultations, visits with primary care Providers, Specialists, psychotherapists, covered consultants, and certain other medical or health services that are provided by an eligible health care Provider and covered under the Plan. Services can include diagnostic evaluation and the prescribing of medication. Telehealth visits can be performed from offices, Hospitals, and other locations such as nursing homes and assisted living facilities. Copayments, coinsurance, and deductibles shall be applied based on the tier, type of health care Provider and location where the telehealth

services are being performed. Any exclusion in the Plan contrary to the foregoing shall be void based on the inclusion of telehealth services described herein."

3) Subsections I and AM in Section 10.1, entitled, "**GENERAL AND MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS**," as set forth in Article X of the Plan, is amended in its entirety as follows:

"I. Charges for failure to keep a scheduled visit or charges for completion of a claim form."

"AM. Charges for the following prescription drug related services:

1. pharmacy-based prescription drug reimbursement under the medical provisions of the Plan;
2. take home office-based prescriptions; or
3. certain Specialty Drugs beyond the first occurrence of treatment. A one-time treatment is permissible under the medical provisions of this Plan. However, after this one-time treatment, these drugs must be obtained through the pharmacy programs described in Article IX. This exclusion shall not apply if it is more cost effective for the Plan to continue such treatment under the medical provisions of the plan, as determined by the Plan Administrator in its discretion. Additionally, this exclusion does not apply to cancer related Specialty Drugs obtained through the West Clinic or Baptist Hospital."

4) Section 11.2, entitled, "**THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT**," as set forth in Article XI of the SPD, is amended in its entirety, as follows:

**"11.2 THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT**

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

A Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from

claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one (1) party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one (1) or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

<u>Subrogation</u>

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;
D. workers' compensation or other liability insurance company; or
E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

<u>Right of Reimbursement</u>

The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from

liability. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he or she is required to:

A. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
B. instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
C. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
D. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) Incurred prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the

case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;
D. workers' compensation or other liability insurance company; or
E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan to:

A. cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
B. provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
C. take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
D. do nothing to prejudice the Plan's rights of subrogation and reimbursement;
E. promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
F. notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
G. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

H. not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

I. to instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;

J. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

K. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Review By Counsel

It is recommended that a Covered Person seek the advice of an attorney regarding any of the rights of recovery of the Plan contained within this section.

Notices Under This Section

Any and all notices required by law pertaining to subrogation and reimbursement should be sent via mail to:

Bartlett City Schools Employee Benefit Plan
c/o Benefit Manager
Medical Benefits Administrators, Inc.

1975 Tamarack Road
Newark, OH 43056

The Request for Subrogation and Reimbursement Interest (RSRI) form can be found on the following page.

**"REQUEST FOR SUBROGATION AND REIMBURSEMENT INTEREST (RSRI FORM)**

**THIS FORM CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS AND RESPONSIBILITIES. PLEASE READ AND COMPLETE IT CAREFULLY.**

**PRIOR TO JUDGEMENT OR SETTLEMENT OF A THIRD-PARTY CLAIM, THE COVERED PERSON OR A DESIGNEE MUST RETURN THIS FORM TO THE PLAN.**

Pursuant to the Subrogation & Reimbursement provisions within the Plan, the health plan requires that the Covered Person notify the Plan in the event the patient (or authorized representative) has made a claim against and is seeking to recover money from any third party, such as a person or insurance company.

**Please fill out the following information:**

| | |
|---|---|
| Patient's full name: | |
| Date of Birth: | |
| SSN: | |
| Date of Accident: | |
| Person Requesting this information: | |
| Relationship to the Patient: | |
| Address where the Patient can receive certified mail: | |

This document is a request to the Plan to determine and make known to the patient, patient's attorney, or other party in interest the amount of the plan's subrogation or reimbursement interest.

**PRIOR TO JUDGEMENT OR SETTLEMENT OF A THIRD-PARTY CLAIM, THE COVERED PERSON OR A DESIGNEE MUST RETURN THIS FORM TO THE PLAN.**

Please complete and send this form certified mail with return receipt signature or electronic verification to the Plan at:

Bartlett City Schools Employee Benefit Plan
c/o Benefit Manager
Medical Benefits Administrators, Inc.
1975 Tamarack Road
Newark, OH 43056

____________________________________
Signature Date"

Bartlett City Schools hereby adopts the above amendments to the Bartlett City Schools Employee Benefit Plan Summay Plan Description effective as of July 1, 2021.