Metropolitan Nashville and Davidson County
Employee Benefit Board

BLUECROSS BLUESHIELD PPO MEDICAL PLAN

Group Number: 80616

Effective January 1, 2021

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ABOUT THIS DOCUMENT

This document is the official Plan document of the Metropolitan Government of Nashville & Davidson County BlueCross BlueShield Medical PPO Plan (the "Plan"). If there is a difference between this Plan and other documents that describe the Plan, this document will govern.

References in this Plan to the "Administrator" mean BlueCross BlueShield of Tennessee, Inc., or BCBST. The pronouns "we," "us," and "our" used throughout this Plan refer to BCBST. The Metropolitan Government of Nashville & Davidson County ("Metro") through the Employee Benefit Board (the "Board") has entered into an Administrative Services Agreement (ASA) with BCBST for it to administer the claims payments under the terms of the Plan, and to provide other services. BCBST is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary. Metro and the Board are the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. Other federal laws may also affect your coverage. To the extent applicable, the Plan complies with federal requirements.

This Plan describes the terms and conditions of your Coverage through the Plan. It replaces and supersedes any Certificate or other description of benefits you have previously received from the Plan.

Please read this Plan carefully. It describes your rights and duties as a Member. It is important to read the entire Plan. Certain services are not covered by the plan. Other Covered Services are or may be limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a health care provider recommends or orders that non-covered benefit.

While the Board has delegated discretionary authority to make any benefit or eligibility determinations to the Administrator, the Board retains the authority to make any final determination. The Board, as the Plan Administrator, also has the authority to construe the terms of your coverage.

Any grievance related to your Coverage under this Plan shall be resolved in accordance with the "Grievance Procedure" Section VII of this Plan.

In order to make it easier to read and understand this Plan, defined words are capitalized. Those words are defined in the "DEFINITIONS OF TERMS" section of this Plan or are defined in other sections of the Plan.

Please contact one of the Administrator's Customer Service Representatives, at the number listed on your ID card, if you have any questions when reading this Plan. The Customer Service Representatives are also available to discuss any other matters related to your Coverage through the Plan.

Metro Nashville Government believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other

plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits. Annual and lifetime limits continue to apply to custom built shoes, and travel expenses for organ transplants.

Questions regarding which protections apply and which protections do not apply to a grandfathered plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Metro Human Resources (615) 862-6640. You may also contact the U.S. Department of Health and Human Services at *www.healthreform.gov*.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BCBST is an independent corporation operating under a license from the BlueCross BlueShield Association (the "Association"). That license permits BCBST to use the Association's service marks within its assigned geographical location. BCBST is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

RELATIONSHIP WITH NETWORK PROVIDERS

Independent Contractors

Network Providers are not Employees, agents or representatives of the Administrator. Such Providers contract with the Administrator, which has agreed to pay them for rendering Covered Services to Members. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Administrator does not make medical treatment decisions under any circumstances.

While the Administrator has the authority to make benefit and eligibility determinations and interpret the terms of your Coverage, the Board, as the Plan Administrator has the discretionary authority to make the final determination regarding the terms of your Coverage ("Coverage Decisions"). Both the Administrator and the Board make Coverage Decisions based on the terms of this Plan, the ASA, the Administrator's Participation Agreements with Network Providers, and applicable State or Federal laws.

The Administrator's Participation Agreements permit Network Providers to dispute Coverage Decisions if they disagree with those Decisions. If your Network Provider does not dispute a Coverage Decision, you may request reconsideration of that Decision as explained in the Grievance Procedure section of this Plan. The Participation Agreement requires Network Providers to explain fully and fairly Coverage Decisions to you, upon request, if you decide to request that the Administrator reconsider a Coverage Decision.

The Administrator has established various incentive arrangements to encourage Network Providers to provide Covered Services to you in an appropriate and cost effective manner. You may request information about your Provider's Payment arrangement by contacting the Administrator's Customer Service Department.

Termination of Providers' Participation
The Administrator or a Network Provider may end their relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients during the term of this Agreement. The Administrator does not promise that any specific Network Provider will be available to render services while you are covered.

OTHER METRO MEDICAL BENEFITS
Metro offers additional medical options other than the benefits described in this Plan. Specifically, Metro also offers the CIGNA Choice Fund Plan as an option. Other medical coverage options are not discussed in this Plan.

SECTION I – SCHEDULE OF BENEFITS

BENEFITS AVAILABLE

A Member is entitled to benefits for Covered Services as specified in this Schedule of Benefits. Benefits shall be determined according to the ASA terms in effect when a service is received. Benefits may be amended at any time in accordance with applicable provisions of the ASA. Under no circumstance does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefit.

CALCULATION OF CO-INSURANCE

As part of the efforts to contain health care costs, BCBST has negotiated agreements with Hospitals under which BCBST receives a discount on Hospital bills. In addition to such discounts, BCBST also has some agreements with Hospitals under which payment is based upon other methods of payment (such as flat rates, capitation or per diem amounts).

Your Co-insurance will be based upon the same dollar amount of payment that BCBST uses to calculate its portion of the claims payment to the Hospital, regardless of whether our payment is based upon a discount or an alternative method of payment.

MEMBER'S RESPONSIBILITY

Prior Authorization may be required for certain services. Please have your Physician contact BCBST at the telephone number shown on your identification card before services are provided. Otherwise, your benefits may be reduced or denied.

The Dependent Child Limiting Age will be to age 26. When a Dependent's coverage terminates for reasons other than the Limiting Age, the Subscriber will be responsible for notifying BCBST to obtain a letter of Creditable Coverage.

DEDUCTIBLE

Deductible To Be Applied To:	Network provider	Non-network provider
All Covered Services (unless otherwise specified)	None	$200
Family Deductible Maximum	None	$600

The Deductible will be waived for accidental injuries and emergencies.

If a Member has Covered Charges during the last three months of a Calendar Year which are applied to that year's Deductible, these charges will also be applied toward the Deductible for the next year, known as a Calendar Year deductible Carryover. Family deductible applies to those enrolled in Family or Employee + Child(ren) coverage.

CO-INSURANCE

Co-insurance percentages will be applied to the lesser of the negotiated fee or other basis for our reimbursement for Covered Services**.**

Benefits available for Covered Services received from a Non-Network Provider will be significantly less than benefits available for services received from a Network Provider. For services received from a Non-Network Provider, the Member must pay the applicable Co-insurance, as well as the difference between the Non-Network Provider's Billed Charges and the Maximum Allowable Charge.

Co-insurance To Be Applied To:	Network Provider	Non-Network Provider
All Covered Services after Deductible has been satisfied (unless otherwise specified)	80%	60%
Well Care / Preventive Services	100% up to $750, then 80%	60%
Co-insurance percentages will be applied to the lesser of the negotiated fee or other basis for our reimbursement of Covered Services**.**		

CO-PAYMENTS

Service	Network Provider	Non-Network Provider
Emergency Room Visit[1]	80% after $100 Co-payment	60% after $100 Co-payment
Office Visit[2]	80% after $20 Co-payment	60% after $20 Co-payment
Specialist Office Visit[2]	80% after $30 Co-payment	60% after $30 Co-payment
Office visit co-payments apply to office visit charge only		

OUT-OF-POCKET MAXIMUM

Maximum to be applied to:	Network Provider	Non-Network Provider
Individual	$1,000	$5,000
Family[3]	$2,000	$10,000

[1] The Member is responsible for payment of this Co-payment for each visit to a Hospital Emergency Room. This Co-payment is waived if the visit results in an admission (of more than twenty-three (23) hours) to the Hospital with a bed assignment or if the visit is due to an accident. Benefits are available for treatment in conjunction with an accidental injury or emergency treatment at the Network level of benefits whether services are provided by a Network or Non-Network Hospital. For Network level of benefits to continue to be paid after the initial visit of the accident or emergency, Network providers must be used.

[2] The Member is responsible for payment of this Co-payment for each office visit (for example, to the office of a Physician, Specialist or walk-in clinic). This Co-payment is waived for the office visit if it is for an allergy shot without physician consultation, treatment of TMJ, acupuncture, and chiropractic services.

[3] Members only have to meet the individual limit with Family or Employee + Child(ren) coverage; the Out-of-Pocket maximum for any one Member may be less.

PSYCHIATRIC CARE AND SUBSTANCE ABUSE CARE

Psychiatric Care	Network Provider	Non-Network Provider
Inpatient (Admissions must be pre-authorized)	80%	60%
Outpatient	80% after $20 Co-payment	60% after $20 Co-payment

Substance Abuse Care	Network Provider	Non-Network Provider
Inpatient (Admissions must be pre-authorized)	80%	60%
Outpatient	80% after $20 Co-payment	60% after $20 Co-payment

Psychiatric Care and Substance Abuse Care claims incurred on and after January 1, 2010, are treated the same as any other illness. If treating Psychiatric Care and Substance abuse care increases the total cost of the Plan by 2% in 2010 and/or 1% or more in subsequent years, the limitations on reimbursement for such care which existed under the Plan prior to January 1, 2010, the Board may reinstate such limitation effective for the plan year which follows the year in which such cost increases occur.

ORGAN TRANSPLANT SERVICES

Transplant Type	Blue Distinction Centers for Transplants (BDCT)	Network Providers Not in Blue Distinction Centers for Transplants (BDCT)	Non-Network Providers
Organ Transplant Services	100% after Network deductible, Network Out-of-pocket Maximum applies	80% after Network Deductible, Network Out-of-pocket Maximum applies	60% after Non-Network Deductible, Non-Network Out-of- Pocket Maximum applies

[1]Network Providers not in our Blue Distinction Centers for Transplants Network include Network Providers in Tennessee and Blue Card PPO Providers outside Tennessee.

WELL-CARE / PREVENTIVE SERVICES

Care	Network Provider	Non-Network Provider
Immunizations age 6 or under[1]	80%	60%
Immunizations age 7 or over	80%	60%
Routine exams age 6 or under[2]	80%	60%
Routine exams age 7 or over[3, 4]	100% up to $750, then 80%	60%

[1] Immunizations are covered if required by Tennessee public school guidelines.
[2] See Section IV for details on child health supervision services.
[3]A 100% benefit up to $750 per year applies for each covered Member.

[4]Benefits **INCLUDED** are:
- Annual Health Assessment
- Childhood immunizations
- Blood pressure screening
- Flu shot
- Tetanus-diptheria(Td) booster
- pneumoccocal immunization
- Other recommended adult immunizations and immunizations not completed in childhood
- Other prescribed x-ray and lab screenings associated with preventive care
- Vision and hearing screenings performed by the physician during the preventive health exam
- Prostate exam
- Immunizations for travel to foreign countries

The following benefits are **EXCLUDED** from the Well Care/Preventive Benefit as they are paid at the normal benefit level of 80% in-network and 60% out-of-network:
- Prostate screening test (These tests are covered under the regular benefits)
- Pap smears – that are routine screenings (These are covered under the regular benefits)
- Wellwoman exam screenings (These are covered under the regular benefits)
- Mammograms that are routine (These are covered under the regular benefits)
- Colorectal cancer screenings (These are covered under the regular benefits)
- Diagnosis of physical that is for employment, insurance, school, camp, travel, or marriage or legal proceedings will not be covered by the wellcare benefit or by the Plan.
- Routine foot care will continue not to be covered unless related to a diagnosis of diabetes.

SPECIAL RULES FOR OTHER COVERED SERVICES

Acupuncture
For both Network and Non-Network providers, 50% of maximum allowable charges with an Annual Maximum of $1,000.

Chiropractic Services
For both Network and Non-Network providers, limited to 20 visits per year covered at 50% of maximum allowable charges.

Immunizations

Immunizations	Network Provider	Non-Network Provider
Age 6 or under Covered if required by public school guidelines	80%	60%
Age 7 or older (covered under Well Care benefit)	80%	60%

Refractive Eye Surgery

Refractive Eye Surgery	Network Provider	Non-Network Provider
Lasik	Not Covered	Not Covered
Other Refractive Eye Surgery	Not Covered	Not Covered

Skilled Nursing Facility

Skilled Nursing Facility	Network Provider	Non-Network Provider
Skilled Nursing Facility	80%	80%

Coverage is limited to 100 days per person, per year and must immediately follow a hospital stay of at least 3 days.

Temporomandibular Joint Syndrome (TMJ)

TMJ	Network Provider	Non-Network Provider
Surgical	80%	60%
Non-surgical	50%	50%

Lifetime Maximum
Certain covered services (such as custom built shoes and transplant travel expenses) do have Lifetime Maximums as noted within this document.

ADDITIONAL BENEFITS
Blood or blood plasma, including components and derivatives, will be an eligible expense when provided by a Hospital. This is not an eligible expense if blood is donated or replaced.

Benefits are available for incontinence supplies when the individual is totally incontinent and the incontinence is the result of an injury to the spinal cord or brain trauma. "Totally incontinent" is defined as being incapable of controlling any of the excretory functions.

Benefits are available for "custom built shoes" subject to a lifetime maximum of $1,500 which includes repair and maintenance. The shoes must be custom made for the Member by an eligible provider and must be Medically Necessary due to the patient's medical condition.

Benefits are available for diabetic pens when prescribed by a Physician for known diabetics.

Benefits are available for talking glucose monitors for known diabetics who are visually impaired or mentally handicapped. A Physician must submit documentation to us outlining the medical need for the equipment.

Benefits are available for a well woman exam and other appropriate screenings (i.e. cervical screenings) and related diagnostics every Calendar Year.

Benefits are available after age 50 for colorectal cancer examinations and laboratory tests for colorectal cancer screening of asymptomatic Members every five (5) years.

Benefits are available for hearing aids for children ages 17 and under and coverage is limited to one ear every three years and includes ear molds and services to select, fit and adjust hearing aids.

Benefits are available for the rental of breast feeding equipment and supplies as ordered or prescribed by a physician under the durable medical equipment provisions of this plan.

PRESCRIPTION DRUG PROGRAM
Definitions

- **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
- **Brand Name Drug** – A Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
- **Compound Drug** – An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as an outpatient Prescription Drug.
- **Covered Drug Expenses** – Covered Drug Expenses will be the lesser of: (a) the Maximum Allowable Charge (MAC) plus any dispensing fees and applicable sales tax; or (b) the Average Wholesale Price less any negotiated discounts plus any applicable dispensing fees and applicable sales tax.
- **Drug Co-payment** – The amount of the Covered Drug Expense of a Prescription Drug, which is the obligation of the Member. The drug co-payment is paid directly to the Network Pharmacy at the time the covered Prescription Drug is dispensed. The drug co-payment is determined by the type of drug purchased, and must be paid for each Prescription Drug.
- **Drug Formulary** – A list designating which Prescription Drugs and drug products are approved for reimbursement. This list is subject to periodic review and modificationby BCBST.
- **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: Caution – limited by federal law to Investigational use.
- **Generic Drug** – A Prescription Drug included in the Approved Manufacturers List of the Tennessee Department of Health and Environment and which can be legally substituted for a trade or Brand Name Drug prescribed under applicable law. Generic Drugs must be AB rated by the FDA.
- **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, "Caution: Federal law prohibits dispensing without a Prescription."
- **Maintenance Drug** – Prescription Drugs most commonly used for selected disease states that are considered long term, chronic, and stable. BCBST maintains a list of Maintenance Drugs, which is reviewed periodically by BCBST. In keeping with accepted standards of medical practice, not all-therapeutic classes are included on the Maintenance Drug Prescription list.
- **Managed Dosage Limitation –** Quantity limitations applied to certain Prescription Drug products as determined by BCBST.
- **Maximum Allowable Charge** – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider or the amount payable based on the Plan's fee schedule for the Covered Services rendered by Non-Network Providers.

- **Network Pharmacy** – A Pharmacy, which has entered into a Network Pharmacy Agreement with BCBST or its agent to provide Prescription Drug benefits to Members.
- **Non-Network Pharmacy** – A Pharmacy, which has not entered into a service agreement with BCBST or its agent to provide benefits at specified rates to Members.
- **Pharmacy** – A state or federally licensed establishment which is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription to the general public by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.
- **Prescription** – A written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure to a pharmacist for a drug, or drug product to be dispensed.
- **Prescription Drug** – A medication containing at least one Legend Drug which may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
- **Prior Authorization Drugs** – Prescription Drugs which are only eligible for reimbursement after prior approval from BCBST.

Covered Services
Prescription Drugs prescribed to a Member who is not confined in a hospital or other facility. Prescription Drugs must be:

- Prescribed on or after the Member's coverage begins;
- Approved for use by the Food and Drug Administration (FDA);
- Dispensed by a licensed pharmacist;
- Listed on the Drug Formulary; and
- Not available for purchase without a Prescription

Treatment of Phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.

Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.

Benefit Payment
Benefit payment for Covered Services will be determined as follows:

Network Pharmacy
- Generic Drug: 100% after a $10 Drug Co-payment
- Non-Generic Drug (Brand Name): 100% after a $30 Drug Co-payment
- Maintenance Drug: 100% after two Drug Co-payments ($20 for Generic and $60 for Non-Generic) for up to a 102 day supply

Non-Network Pharmacy

- Generic Drug: We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Drug Co-payment of $10, and pay the difference up to the Maximum Allowable Charge.
- Non-Generic Drug (Brand Name): We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Drug Co-payment of $30, and pay the difference up to the Maximum Allowable Charge.
- Maintenance Drug: We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the two Drug Co-payments ($20 for Generic and $60 for Non-Generic), and pay the difference up to the Maximum Allowable Charge.

Benefits will be provided for up to a 34-calendar day supply of Prescription Drugs or up to a 102-day for Maintenance Drugs: Benefits through home delivery will be provided for up to a 102-calendar day supply of Prescription Drugs. Coverage for Maintenance Drugs and Prescription Drugs obtained through home delivery dispensed in quantities greater than a 34-day calendar supply is subject to a Co-payment equal to two times the Drug Co-payment. Some products may be subject to additional quantity limitations as adopted by the Administrator.

If a Member has a Prescription filled at a Non-Network Pharmacy, the Member must pay all expenses and file a claim for reimbursement with BCBST. The Member will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Deductible and/or Drug Co-payment amount.

If a Member's claim for benefits under the Prescription Drug Program is denied, a member may file an appeal with BCBST under the Grievance Procedure in the Plan.

LIMITATIONS

- Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
- Drugs for the treatment of onychomycosis (e.g., nail fungus) are not Covered, except for:
    - Diabetics; or
    - or immuno-comprimised drugs
- Growth hormones are not Covered, except for:
    - Treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; and
    - Patients with "Turner" syndrome, including the drugs: Genotropin; Humatrope; Norditropin; Nutropin; Saizen; Serostim; Somatropin; and Protropin (Somatrem)Any Prescription and non-Prescription medical supplies, devices and appliances, other than syringes used in conjunction with injectable medications or other supplies used

in the treatment of diabetes and/or asthma; provided that certain supplies for the treatment of diabetes are covered under "Diabetes Treatment" as described on page 40;

- Immunizations or immunological agents, including but not limited to:
    - Biological sera,
    - Blood,
    - Blood plasma; or
    - Other blood products except as required by hemophiliacs; and,
    - Injectable drugs, except when: (a) intended for self-administration; or (b) defined by the Plan
- Compound Drugs must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug
- All Compound Drugs are processed as a Non-Generic drug

Exclusions
In addition to the limitations and exclusions specified in the Plan, benefits are not available for the following:

- Drugs which are prescribed, dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or similar facility, are not covered under the Prescription Drug part of the plan but are covered under "Inpatient Services" described on page 34 and 35;
- Any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law are excluded except as otherwise Covered in the Plan;
- Any quantity of Prescription Drugs which exceed that specified by BCBST;
- Any Prescription Drug purchased outside the United States, except in emergency or urgent care situations and when authorized by BCBST;
- Non-medical supplies or substances, including support garments, regardless of intended use;
- Artificial appliances;
- Any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs a Member is entitled to receive without charge in accordance with any state or federal program;
- Replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- Drugs dispensed by a Provider other than a Pharmacy;
- Administration or injection of any drugs; (though not specifically enumerated as a covered

charge under "Physician and Other Provider Services beginning on page 37, such services are covered under that part of the plan as a physician service if medically necessary and appropriate);

- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- Anorectics (any drug or medicine for the purpose of weight loss and appetite suppression) except for Meridia (per the FDA, Meridia is no longer available as a prescription in the United States as of October 2010) ;
- All newly FDA approved drugs prior to review by BCBST Compounded Drugs not containing at least one ingredient requiring a Prescription or refill; Provider-administered Specialty Drugs, as indicated on Our Specialty Drug List;
- Prescription Drugs used for cosmetic purposes including, but not limited to:
    - Drugs used to reduce wrinkles (e.g. Renova);
    - Drugs to promote hair-growth;
    - Drugs used to control perspiration;
    - Drugs to remove hair (e.g. Vaniqa); and
    - Fade cream products;
- Drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs; and
- Prescription Drugs or refills dispensed:
    - In quantities in excess of amounts specified in the Benefit payment section;
    - Without our Prior Authorization when required; or
    - Which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in the Plan.

SECTION II — ELIGIBILITY

COVERAGE FOR YOU

This Plan describes the benefits you may receive under the PPO Medical Plan.

COVERAGE FOR YOUR DEPENDENTS

If this program covers you, you may enroll your Dependents. Your covered Dependents are also called Members. The names of Dependents for whom application for coverage is made must be listed on the application on file in our records**.** Subsequent applications for Dependents must be submitted to Metro Human Resources in writing.

Dependents shall be limited to include only the following:

- Legally recognized spouse in accordance with the laws of the State of Tennessee, while not divorced or legally separated from the Subscriber;
- Domestic partner and his or her children as outlined in the Domestic Partnership Benefits Policy approved by the Board and where a Declaration of Domestic Partnership has been completed and acknowledged by Metro Human Resources;
- Natural and adopted children of the Subscriber who may or may not reside in the home of the Subscriber the majority of the time on an annual basis;
- "Foster child" means a child placed with an eligible Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- A child of Subscriber or Subscriber's spouse/domestic partner for whom a Qualified Medical Child Support Order has been issued;
- Step-children of the Subscriber; or Children, other than those listed above, who are in the Subscriber's legal custody by court order

Dependent children, as defined above, will be covered from birth until the last day of the month of their twenty-sixth (26th) birthday, married or unmarried.

If on the child's twenty-sixth (26th) birthday, he is Incapacitated, which is defined as incapable of self-sustaining employment by reason of intellectual or physical disability, the child shall continue to be deemed a Dependent after said birthday, during the continuation of said incapacity and while he is otherwise included as a Dependent under the above definition, subject to the other terms and conditions of this Plan and to the right of the Administrator to require proof of incapacity when claim is first made for benefits after said birthday, and proof once each year thereafter of the continuation of said incapacity. Dependents that will **not** be eligible for coverage under this Plan shall include the following:

- Dependents that are not defined in the definitions in this Section;

- Foster children that are not described in the section above headed "Dependents shall be limited to include only the following:";
- Ex-spouses/domestic partners;
- Parents of the Subscriber or spouse/domestic partner; and
- Incapacitated children who the Administrator determines are no longer incapacitated.

A Dependent can be covered only once under this Plan.

TYPES OF COVERAGE AVAILABLE FOR EMPLOYEES

- Individual – Covers the Employee only;
- Family – Covers the Employee, Spouse/Domestic Partner and any other Eligible Dependent;
- Employee + Child(ren) – Covers the Employee and one or more eligible Dependent Child(ren);
- No Coverage – If you have other non-Medicare medical insurance, you may opt out of Metro's health benefits program in accordance with the Opt Out/Opt In policies adopted by the Board. To opt out, the Employee must provide Metro with proof of other coverage.

TYPES OF COVERAGE AVAILABLE FOR PENSIONERS

If you are a Pensioner, your coverage is affected by whether (1) you or a Dependent is Medicare eligible and (2) if Dependents, including your spouse/domestic partner, are covered. The following levels of coverage are available (for the purpose of this section, "Medicare" means coverage under Medicare Parts A **and** B and eligible domestic partners qualify for the spouse coverage level below):

- Pensioner Only (Individual) – Covers the Pensioner, if the Pensioner does not have Medicare;
- Pensioner with Medicare – Covers the Pensioner, if the Pensioner has Medicare;
- Pensioner and Dependent(s) (Family) – Covers the Pensioner and at least one Dependent none of whom have Medicare;
- Pensioner and Spouse both with Medicare – covers the Pensioner and Pensioner's spouse/domestic partner if both have Medicare or the Pensioner and one Child if both have Medicare;
- Pensioner without Medicare, Spouse with Medicare – covers the Pensioner, if the Pensioner does not have Medicare, and Pensioner's spouse/domestic partner, who has Medicare;
- Pensioner with Medicare, Spouse without Medicare – covers the Pensioner, who has Medicare, and Pensioner's spouse/domestic partner without Medicare;
- Pensioner, Spouse and Child(ren) all with Medicare – covers the Pensioner, Pensioner's spouse/domestic partner and child (ren), when all three have Medicare;

- Pensioner with Medicare and Child (ren) with or without Medicare – covers Pensioner with Medicare and a dependent child (ren) with or without Medicare;
- Three Family Members Covered with Two of them having Medicare Parts A and B.

ELIGIBLE EMPLOYEES AND PENSIONERS

To be eligible for coverage as an Employee, you must (1) be Regularly Employed; (2) satisfy the Two Quarter Rule; (3) be an official of Metro who is elected by popular vote and is Regularly Employed; (4) be a classified employee of the Metro Nashville Public Schools or be a classified Employee of a Public Charter school operating within the geographic area served by the Metro Nashville Public School system who is not certified as a teacher and is Regularly Employed (This will generally include "non-certified" employees who work in the lunch room and in custodian, maintenance, transportation, and clerical positions); (5) be an Employee of the Metropolitan Nashville Hospital Authority; or (6) be an Employee of the Convention Center Authority. Provided however, that otherwise Eligible Employees of Public Charter Schools and the Convention Center Authority shall become Eligible Employees effective as provided by the laws of the State of Tennessee, the Metropolitan Code of Laws or applicable inter-governmental agreements. Solely for purposes of this Plan, the term Employee includes a member of the Metropolitan Council ("Council Member") who is eligible to elect coverage under the plan in accordance with Section 3.24.010(C)(1) of the Metropolitan Code. A Council Member may elect coverage under this Plan by (i) electing to participate and make pre-tax contributions under the Metro Government cafeteria plan, or (ii) making a separate election to make after-tax contributions on a form provided by Human Resources, which election shall be in accordance with, and subject to, rules adopted by the Board.

In the event that each spouse/domestic partner is an Employee, each spouse/domestic partner is a Pensioner, or one spouse/domestic partner is an Employee and the other spouse/domestic partner is a Pensioner, one spouse/domestic partner may opt out of coverage as an Employer or Pensioner and elect to be covered as a Dependent of the Employee or Pensioner. A spouse/domestic partner who is an Employee or Pensioner who elects to be covered as a Dependent as described in the preceding sentence may subsequently elect during any Annual Enrollment, or at such other times that election changes are permitted under the Plan, to again be covered as an Employee or Pensioner. An Employee who is covered as the spouse/domestic partner of another Employee who wishes to change the coverage status to that of an Employee during an Annual Enrollment may make such change in accordance with the rules for election changes generally applicable during Annual Enrollment. An Employee who is covered as the spouse/domestic partner of another Employee who experiences a Change in Family Status who wishes to change the coverage status to that of an Employee must (1) contact Metro Human Resources, and (2) apply for any needed change within sixty (60) calendar days of the Change in Family Status.

"**Regularly employed**" means working a minimum of 20 hours per week, including: (a) nine (9) month employees who are scheduled to work 780 hours or more during a calendar year; (b) ten (10) month employees who are scheduled to work 860 hours or more during a calendar year; and (c) twelve (12) month employees who are scheduled to work 1040 hours or more during a calendar year.

The "**Two Quarter Rule**" states that an Employee who is not Regularly Employed, but averages 20 hours or more per week in each of two consecutive quarters, becomes eligible for coverage during the following quarter. If an Employee does not average 20 or more hours per week in each of two consecutive quarters, the Employee becomes ineligible for coverage in the following quarter.

To be eligible for coverage as a Pensioner, you must satisfy the guidelines to continue coverage as a Pensioner under the Continuation of Coverage provisions in Section IX.

In addition, if you are a Regular Pensioner, you may elect to continue medical coverage at the time you go on pension. If you do not elect to be covered at the time you go on pension, you are ineligible to enroll at a later date. However, if you have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013, you may opt back into coverage in accordance with the Opt Out/Opt In policies approved by the Board. If you elect not to continue medical benefits when going on pension and you have not opted out of coverage in accordance with the Opt Out/Opt In policies adopted by the Board, your Dependents, including your spouse/domestic partner, will not be eligible for coverage under the Plan in the event of your death**.** If you opted out of coverage and provided proof of other non-Medicare coverage for yourself and each of your eligible Dependents, your spouse/domestic partner will be eligible at your death to opt back into coverage at the time the survivor's pension benefits are being processed or within 60 days of an eligible change in status. If you elect not to cover your spouse/domestic partner at the time of your retirement, your spouse/domestic partner must sign an acknowledgement form stating they understand they will not be covered and that the Pensioner may not subsequently elect to provide coverage under the Plan for such spouse/domestic partner, except (i) if the spouse/domestic partner experiences a Special Enrollment Event (as described on page 27) or (ii) an eligible change in status. A surviving spouse/domestic partner and/or surviving eligible dependent children of Pensioners, who are entitled to a pension payment by Metro, shall be eligible for the same medical benefits provided for Pensioners as long as they are entitled to a pension payment and were covered by the medical Plan, by the Pensioner, prior to the Pensioner's death or had opted out of coverage in accordance with the Opt Out/Opt In policies adopted by the Board under circumstances that preserved the option of subsequently electing coverage as described in this paragraph.

If you are a Disability Pensioner, you must elect to continue medical coverage for yourself at the time you go on a disability pension unless you have other non-Medicare coverage and elect to opt-out of coverage. If you elect to opt-out of coverage, you may re-enroll at Annual Enrollment, at the time of conversion to a service pension, or if you have a Special Enrollment Event (as defined in the Enrolling in Coverage for Employees and Their Dependents section). If you elect not to cover your spouse/domestic partner at the time of your disability, your spouse/domestic partner must sign an acknowledgement form stating they understand they will not be covered and that the Disability Pensioner may not subsequently elect to provide coverage under the Plan for such spouse/domestic partner, except (i) if the spouse/domestic partner experiences a Special Enrollment Event (as described on page 27), (ii) an eligible change in status, or (iii) at the time the Disability Pensioner converts to a service pension. A surviving spouse/domestic partner and/or surviving eligible dependent children of Pensioners, who are

entitled to a pension payment by Metro, shall be eligible for the same medical benefits provided for Pensioners as long as they are entitled to a pension payment and were covered in the medical Plan, by the Pensioner, prior to the Pensioner's death, or if the Pensioner had opted out of coverage in accordance with the preceding paragraph, the surviving spouse/domestic partner and/or surviving eligible dependent children of Pensioners may opt back in, in accordance with the Opt Out/Opt In policies adopted by the Board.

A Pensioner's insurance coverage may be terminated for failure to make premium payments in accordance with the Direct Payment of Insurance Premium Policy approved by the Board.

INELIGIBLE SUBSCRIBERS (EMPLOYEES AND PENSIONERS)
Subscribers who are **not** eligible for benefits shall include:

- Certified or licensed employees whose employment is with the Metropolitan Board of Public Education;
- Employees of the Metropolitan Transit Authority or employees working for the Metropolitan Transit Authority under contract;
- Employees of the Electric Power Board of The Metropolitan Government of Nashville and Davidson County;
- Employees of The Metropolitan Development and Housing Agency;
- Employees who are not regularly employed as defined in this Section.
- Employees (i) hired on or after January 1, 2013 or (ii) rehired on or after January 1, 2013 who had not earned a vested right to a pension in accordance with the Metropolitan Code of Laws prior to the date of rehire, are only eligible for medical care benefits as a Regular Pensioner if:

  The Employee is eligible to begin receiving an early or normal service pension at the time of their termination of employment – even if they decide to defer their pension to their unreduced retirement date as outlined in the Metropolitan Code.

  Employees described in items (i) or (ii) in the immediately preceding bulleted paragraph are not eligible for medical care benefits as a Regular Pensioner unless they are eligible to retire immediately with either an early or normal pension as outlined in the Metropolitan Code even if they elect to defer their pension until their unreduced retirement date.

Those Employees covered by the Plan, prior to August 1, 1990, that do not meet the eligibility criteria of the Plan on August 1, 1990, shall have their coverage "grand-fathered", even if other Employees in the same classification are not covered.

Each person who is regularly employed, as defined in this Section, except Metro Council members, is mandated by Section 13.07 of the Metropolitan Charter and Section 3.08.010 of the Metropolitan Code to be a member of the "System".

"System," as defined in Section 3.08.010 of the Metropolitan Code, shall mean the metropolitan employee benefit system, comprising of the following six (6) Plans: Plan for life insurance

benefits, Plan for medical care benefits, Plan for disability benefits, Plan for pension benefits for credited employee service, Plan for pension benefits for credited fire and police service, and Plan for hazardous duty death benefit.

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR EMPLOYEES

All persons who meet the definition of an Employee shall become eligible for coverage, and if elected, their coverage will become effective under the Plan on the appropriate date below:

- The first of the month following thirty (30) days after the Employee becomes eligible for benefits;
- With respect to an elected official, the date the elected official takes office; or
- With respect to a Metro Council member, the date the Metro Council member, after being elected and taking office, notifies Human Resources he or she wishes to join the Plan.

Provided the Employee (including an elected official) is "Actively at Work" on the date coverage is to take effect, otherwise on the first date thereafter on which the Employee or elected official is actively at work.

The effective date of coverage may be a Saturday or Sunday; however, if the Employee (including an elected official) is not scheduled to work on his effective date of coverage, to satisfy this requirement, he must have been "actively at work" the last scheduled work day before the effective date of coverage.

"Actively at Work" means the performance of all of an Employee's regular duties for Metro on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively at Work on a non-scheduled work day (which would include a regularly scheduled vacation day) only if he or she was Actively at Work on the last regularly scheduled workday. An Employee who is not at work due to a health-related factor shall be treated as Actively at Work for purposes of determining eligibility. If it is determined, the Employee was not Actively at Work on the date coverage should have begun, the Effective Date of Coverage will be delayed until the date the Employee meets the definition of Actively at Work.

Effective Date after Leave of Absence

An Employee that is on a leave of absence and did not obtain COBRA coverage while on the leave of absence, whether such leave be approved or unapproved, will be automatically re-enrolled with the same health care Plan when he returns to work, with the same level of coverage that the Employee had before the leave of absence. Under these circumstances, coverage will be effective the first of the month following thirty (30) days from the date he or she returns from the leave of absence.

However, if the Employee is on a leave of absence, whether such leave be approved or unapproved, for less than thirty (30) calendar days, his coverage will be automatically reinstated with no break in coverage and the Employee must therefore pay any contributions that are owed

to continue coverage during the leave of absence.

Disciplinary Action Reinstatement
Any Employee whose employment is terminated due to disciplinary charges and subsequently his employment is reinstated by a court or other authority with jurisdiction over the employment status of the Employee, will, except as provided under Reinstatement Pursuant to Court Order below, have his insurance coverage reinstated on either:

1. The date the Employee returns to work; or
2. The first of the month following thirty (30) days after the Employee returns to work, whichever the Employee elects.

If the Employee elects option (1) above, the Employee must pay any contributions for past months so that coverage will be continuous.

If the Employee is enrolled in Family or Employee + Child(ren) coverage, the Dependents will have the same effective date as the Employee. Coverage for the Covered Person will not take effect on the date outlined above if the Covered Person is hospitalized on the date coverage is reinstated. The effective date will then be delayed to the date as outlined in this section for an Employee and to the date outlined below for Dependents.

Reinstatement Pursuant to Court Order

(a) If an Employee whose employment is terminated for disciplinary reasons shall be reinstated to employment by an order of a court or other authority with jurisdiction over the employment status of an Employee, such Employee shall have the insurance coverage reinstated. If the effective date of such reinstatement of coverage shall be prior to the date the Employee returns to work, such Employee must pay any contributions required for such coverage which otherwise would have been due between the date his or her coverage ceased because of such disciplinary termination and the date such employee returns to work. The effective date of such coverage reinstatement shall be the applicable date described below:

(i) The date specified in such order; or

(ii) If no date is specified in such order, the date such employee returns to work; or

(iii) If the reinstatement is determined under subparagraph (a) above, and such date is prior to the date such Employee returns to work, such Employee may elect to have his or her coverage reinstated effective as of the date he or she returns to work. Such election shall be made in accordance with Section 3.2 of the Metropolitan Government of Nashville & Davidson

County Amended and Restated Cafeteria plan with Flexible Spending Arrangement (the "Cafeteria Plan").

(b) In the event an Employee, and/or his or her Dependents, whose coverage is retroactively reinstated and who did not make the election described in subsection (a)(iii) immediately above shall have claims which claims would have been subject to pre-authorization requirements which are incurred at any time between the effective date of the retroactive reinstatement of coverage and the date the Employee returns to work, the following special rules shall apply:

(i) Such claim shall not be denied or reimbursement therefore shall not be reduced simply because the Employee or Dependent did not comply with such pre-authorization requirements at the time the claim was incurred.

(ii) The pre-authorization process shall be applied to such claim at the time it is submitted based on the standards used by the Administrator to approve or deny such pre-authorization which were in effect at the time the claim was incurred.

(iii) The Administrator and the Plan Administrator may take into account such facts not related to the Employee's medical condition that exist at the time a decision or appeal of a decision on pre-authorization is made; provided however, that the Administrator or Plan Administrator shall not consider any facts respecting the Employee's or Dependent's medical condition which are or could be material to the pre-authorization determination that were first discovered at or after the time the Employee or Dependent first received the treatment for which the pre-authorization was required.

Effective Date after Termination

If an Employee terminates employment and returns to work for Metro within thirty (30) days of the date of termination, coverage will automatically be reinstated retroactively to the date coverage would have terminated. The Employee will be responsible for paying any contributions that are due so that there will not be a break in coverage. The appropriate contribution will be deducted from the Employee's paycheck.

If the Employee's date to return to work at Metro is more than thirty (30) days from the date of termination, the Employee will be treated as a newly eligible Employee.

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR PENSIONERS

All persons who meet the definition of a Pensioner shall become eligible for coverage in the Plan and have coverage effective on the date the pension benefit becomes effective. Regular Pensioners who do not elect to continue coverage at the first time they become eligible, may not elect coverage at a later time, unless the Pensioner made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject

to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013. Pensioners have the option of electing Family coverage or adding dependents at the time their pension becomes effective. Pensioners electing Individual coverage at the time of pension or electing Family Coverage but not declaring certain dependents will not be permitted to change to Family Coverage or to add those dependents during an Annual Enrollment period. The only permitted changes are those that qualify as a "Special Enrollment Event" as described in the Enrolling in Coverage for Pensioners and Dependents below.

DECLARING DEPENDENTS

Subscribers must list, on the appropriate enrollment application, all Dependents covered under the Plan. If the dependent is not listed on the appropriate enrollment application, benefits will not be provided under the Plan. Human Resources have the right to require documentation at any time to prove eligibility of dependents enrolled in the Plan.

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR EMPLOYEE'S DEPENDENTS

Your Dependents become eligible for benefits on the latest to occur of the date that you become eligible under this Plan or the date that the Dependent meets the definition of Dependent under the Coverage for Dependents section above. Coverage for Dependents becomes effective on the same date as your effective date of coverage if you have elected coverage for your Dependents.

Effective Date when Adding a Dependent

If you are enrolled in the Before–Tax Premium Savings Plan, restrictions are placed on adding Dependents to this Plan. If you want to add a Dependent and you are enrolled in the Before–Tax Premium Savings Plan, the effective date of coverage for the Dependent(s) will be the date specified in this Section:

- When an Employee has Individual coverage and the Employee elects to add a Dependent(s) within sixty (60) calendar days of a Change in Family Status, the effective date of coverage for the Dependent(s) and the change to Family or Employee + Child(ren) coverage will be the date of the Change in Family Status. The Employee must complete the appropriate enrollment form through Human Resources within sixty (60) calendar days of the Change in Family Status. The Employee will be required to pay any additional contribution.
- When an Employee has Individual coverage and the Employee elects to add a Dependent(s) after sixty (60) calendar days of a Change in Family Status, the effective date of coverage for the Dependent(s) and the change to Family or Employee + Child(ren) coverage will be effective at the next Annual Enrollment period by completing the appropriate Annual Enrollment forms through Human Resources.
- When an Employee has Family or Employee + Child(ren) coverage and the Employee elects to add a Dependent(s) within sixty (60) calendar days of a Change in Family Status, the effective date of coverage for the Dependent(s) will be the latest of:
    - The date of the Change in Family Status;
    - The date the Employee acquired the Dependent; or,

- The date the Employee enrolled in Family or Employee + Child(ren) coverage.

- The Employee must complete the appropriate enrollment form through Human Resources to add the Dependent(s).
- When an Employee has Family coverage, Dependents may be added even if there is no Change in Family Status, or when an Employee has Employee + Child(ren) coverage, Dependent Children may be added even if there is no Change in Family Status. The effective date of the added Dependents coverage will be the latest of:

  - The date of the Change in Family Status;
  - The date the Employee enrolled in Family or Employee + Child(ren) coverage; or,
  - The first of the current month if the Dependent is being added after sixty (60) calendar days.

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR PENSIONER'S DEPENDENTS

Your Dependents become eligible for benefits on the latest to occur of the date that you become eligible under this Plan or the date that the Dependent meets the definition of Dependent under the Coverage for Dependents section above. Coverage for Dependents becomes effective on the same date as your effective date of coverage if you have elected coverage for your Dependents.

Effective Date when Adding a Dependent

If you want to add a Dependent, you must add the Dependent within sixty (60) calendar days of a Special Enrollment Event (as defined in Enrolling in Coverage for Pensioners and their Dependents Section) or the dependent may not be added at a later time. When a Pensioner has Individual coverage and the Pensioner elects to add a Dependent(s) within sixty (60) calendar days of a Special Enrollment Event, the effective date of coverage for the Dependent(s) and the change to Family coverage will be the date of the Special Enrollment Event. The Pensioner must complete the appropriate enrollment form through Human Resources within sixty (60) calendar days of the Special Enrollment Event. The Pensioner will be required to pay any additional contribution.

ENROLLING IN COVERAGE FOR EMPLOYEES AND THEIR DEPENDENTS

After meeting the eligibility requirements, you may apply for one of the types of coverage shown above. You have thirty (30) days from your date of eligibility, as defined above, to choose coverage for your Dependents or to choose an alternative health care plan such as the CIGNA Choice Fund Plan. To enroll in coverage, you must complete the proper benefit enrollment forms through Human Resources. If you fail to enroll during the thirty (30) day enrollment period, you will automatically be enrolled by Human Resources with individual coverage under the medical Plan outlined in this document.

If You Did Not Enroll On Time

If you wait more than thirty (30) days from the date you are first eligible to apply or add a Dependent, the Dependent will be considered a Late Enrollee and will not be eligible for benefits

until the next Annual Enrollment period or unless you have a special enrollment right under the Health Information Portability and Accountability Act of 1986 (HIPAA).

HIPAA gives you certain Special Enrollment rights. If you decline coverage for yourself or Dependents, you and/or your Dependents may enroll under certain circumstances, provided you request enrollment by completing and submitting enrollment materials otherwise required for coverage to become effective within sixty (60) calendar days of certain Special Enrollment Events. These events, and the rights they confer, follow.

Employee Loses Coverage: If you were eligible but did not enroll in the Plan, and explained in writing as required under the Plan that you had other coverage, even if it were COBRA continuation coverage, and that other coverage has now expired, you are entitled to special enrollment. However, to be entitled to special enrollment, the other coverage must have been lost because of loss of eligibility, loss of an employer contribution or exhaustion of COBRA continuation coverage.

If the above conditions are satisfied, you and/or your Dependents may enroll effective the first day after your other coverage terminates. Your request for enrollment must be received within sixty (60) calendar days of the loss of coverage.

Dependent Loses Coverage: If your Dependent was eligible but not enrolled in the Plan, and the Dependent had other coverage, even if it were COBRA continuation coverage, which has expired because of loss of eligibility, loss of an employer contribution or exhaustion of COBRA continuation coverage, your Dependent is entitled to special enrollment.

If the above conditions are satisfied, your Dependent may enroll effective the first day after your other coverage terminates. Your request to enroll your Dependent must be received within sixty (60) calendar days of the loss of coverage.

Acquisition of Dependent: If you and/or your Dependents were eligible but not enrolled in the Plan, and you gained a Dependent through marriage, birth, adoption or placement for adoption, you and/or your Dependents are entitled to special enrollment.

Enrollment for you and/or the Dependent (including spouse/domestic partner) will be effective on the date of birth, adoption or placement for adoption. In the case of marriage, enrollment will be effective the date of the marriage. Your request to enroll your Dependent must be received within sixty (60) calendar days of the event.

For purposes of special enrollments, loss of eligibility for other coverage includes loss due to legal separation, divorce, death, termination of employment or reduction in work hours. Such loss of eligibility does not apply when loss of coverage is due to failure to pay contributions on a timely basis, or for cause, such as making fraudulent claims or intentional misrepresentations of material facts in connection with the Plan.

ENROLLING IN COVERAGE FOR PENSIONERS AND THEIR DEPENDENTS

At the time of Service pension eligibility, if you meet the definition of Regular Pensioner, you may enroll yourself and your Dependents. If you meet the definition of Disability Pensioner,

you are required to maintain coverage for yourself through the Plan, unless proof of other non-Medicare coverage is provided and an opt-out election is made. As a Disability Pensioner, you may also enroll your Dependents at the time of pension eligibility. You may apply for one of the types of coverage shown above. You have the option of electing Family coverage and adding dependents at the time that your pension becomes effective.

If You Did Not Enroll at Pension Eligibility

If you did not enroll at the time you were initially eligible for a service pension, you and your dependents may not enroll in the plan at a later time, unless you and your eligible Dependents have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013.

If you are a Disability Pensioner and you opted out of coverage, you will be considered a Late Enrollee and will not be eligible to enroll in benefits until the next Annual Enrollment period, unless you have special enrollment rights under the Plan or HIPAA. To exercise these special enrollment rights, you must request enrollment by completing and submitting enrollment materials otherwise required for coverage to become effective within sixty (60) calendar days of certain Special Enrollment Events. Failure to request special enrollment within sixty (60) calendar days of the event means that you will not ever be able to enroll that Dependent. These events, and the rights they confer, follow:

> **Disability Pensioner Loses Coverage:** If you were eligible but did not enroll in the Plan, and explained in writing as required under the Plan that you had other coverage, even if it were COBRA continuation coverage, and that other coverage has now expired, you are entitled to special enrollment. However, to be entitled to special enrollment, the other coverage must have been lost because of loss of eligibility, loss of an employer contribution or exhaustion of COBRA continuation coverage.
>
> If the above conditions are satisfied, you and/or your Dependents may enroll effective the first day after your other coverage terminates. Your request for enrollment must be received within sixty (60) calendar days of the loss of coverage.
>
> **Special Enrollment of Dependents**: Other than an enrollment of a Dependent that is covered by the loss of your coverage above, your Dependents special enrollment rights are governed by the following subsection entitled "If you Did Not Enroll your Dependents on Time."

For purposes of special enrollments, loss of eligibility for other coverage includes loss due to legal separation, divorce, death, and termination of employment or reduction in work hours. Such loss of eligibility does not apply when loss of coverage is due to failure to pay contributions on a timely basis, or for cause, such as making fraudulent claims or intentional misrepresentations of material facts in connection with the Plan.

If You Did Not Enroll Your Dependents On Time

If you did not enroll a Dependent who was eligible at the time of pension eligibility, you may not enroll that Dependent unless that Dependent has a special enrollment right under HIPAA. To exercise these special enrollment rights, you must request enrollment by completing and

submitting enrollment materials otherwise required for coverage to become effective within sixty (60) calendar days of certain Special Enrollment Events. Failure to request special enrollment within sixty (60) calendar days of the event means that you will not ever be able to enroll that Dependent. These events, and the rights they confer, follow.

Special Enrollment of a Spouse/Domestic Partner: If you are enrolled in the Plan, your spouse/domestic partner is entitled to special enrollment if (a) you marry (and the marriage is legally recognized by the State of Tennessee (b) you acquire another Dependent through birth, adoption, or placement for adoption; or (c) your spouse/domestic partner had other coverage that has now expired. However, for your spouse/domestic partner to be entitled to special enrollment because of loss of the spouse's/domestic partner's other coverage, the other coverage must have been lost as a result of: 1) loss of eligibility 2) loss of an employer contribution, 3) exhaustion of COBRA continuation coverage; or 4) exceeding the lifetime maximum benefit under such other coverage.

Special Enrollment of a Dependent Other than a Spouse/Domestic Partner: If you are enrolled in the Plan, and you acquire a Dependent other than a spouse/domestic partner by (a) marriage as legally recognized by the State of Tennessee (such as a step-child), birth, adoption, or placement for adoption or (b) your Dependent other than a spouse/domestic partner had other coverage and that other coverage has now expired, the newly acquired Dependent or Dependents are entitled to special enrollment. However, for your Dependent(s) to be entitled to special enrollment because of loss of the Dependent's other coverage, the other coverage must have been lost as a result of: 1) loss of eligibility 2) loss of an employer contribution, or 3) exhaustion of COBRA continuation coverage; or 4) exceeding the lifetime maximum benefit under such other coverage. Your request to enroll your Dependent must be received within sixty (60) calendar days of the event.

What this Means to You:
If you did not enroll your spouse/domestic partner or dependent children at the time you went on pension, you may only enroll your dependents within 60 days of a special enrollment right. A special enrollment is considered to be:

a) the birth of your dependent child at which time you may also add your spouse/domestic partner;
b) the date of your dependent child's adoption or placement for adoption (the period of time immediately preceding the final adoption) at which time you may also add your spouse/domestic partner;
c) the date of your marriage as legally recognized by the State of Tennessee at which time you may also add any dependent step-children; or
d) when your spouse/domestic partner or dependent child loses coverage due to:
    1) loss of eligibility
    2) loss of an employer contribution
    3) or when their COBRA coverage has expired.

CHANGING COVERAGE FOR EMPLOYEES – CHANGES IN FAMILY STATUS

If your marital status changes (marriage or divorce), your relationship with your domestic partner ends, your spouse/domestic partner experiences a loss of coverage, or if there is a change in the number of your children (e.g., birth, adoption), you may want to change your coverage to one of the other options available. You should contact Metro Human Resources to discuss how these changes impact your benefits. (See "Types of Coverage Available for Employees" section on page 17.)

When you need to make a change, you should (1) contact Metro Human Resources, and (2) apply for any needed change within sixty (60) calendar days of the Change in Family Status, of the date the new Dependent is acquired, etc. If your domestic partnership has ended, you must notify Metro Human Resources and complete a Termination of Domestic Partnership form within thirty (30) days of the partnership termination.

A newborn child of the Employee or Employee's legally recognized spouse in accordance with the laws of the State of Tennessee is a Covered Dependent from the moment of birth. The Employee must enroll that child within sixty (60) calendar days of the date of birth. If the Employee fails to do so, the Plan will not provide Coverage for that child after sixty (60) calendar days from the child's date of birth until the child is added as a Dependent during the next annual enrollment (or unless the Employee already has Family or Employee + Child(ren) coverage, where no additional payment is required to cover the child, and the Employee contacts Human Resources and completes appropriate paperwork to add the child).

Coverage for new Dependents added begins on the date the Dependent is acquired if the application is received within sixty (60) calendar days after that date.

CHANGING COVERAGE FOR PENSIONERS – CHANGES IN FAMILY STATUS

The types of changes that you are permitted to make as a Pensioner to you and your Dependents medical coverage depends upon whether you are a Regular Pensioner or a Disability Pensioner.

If you are a Regular Pensioner who has not elected a Survivor Option under the Metro Pension Plan, you may drop coverage for you or your dependents at any time. Please note that once you drop coverage for you or your dependents, you will not be able to re-enroll yourself or the Dependents that you drop from coverage to the Plan unless you and your eligible Dependents have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013. As a Regular Pensioner, you are not eligible to enroll a Dependent in coverage unless that Dependent has a Special Enrollment Event as described in the "Enrolling in Coverage for Pensioners and their Dependents" section above.

If you are a Regular Pensioner who has elected a Survivor Option under the Metro Pension Plan, you may drop coverage for your dependents who are not your spouse/domestic partner at any time. You may not, however, drop coverage for your spouse/domestic partner or yourself and your spouse/domestic partner, without the written acknowledgement of your spouse/domestic partner. Please note that once you drop coverage for you or your Dependents, you will not be

able to re-enroll yourself or the Dependents that you drop from coverage to the Plan, unless you and your eligible Dependents have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013 . As a Regular Pensioner, you are not eligible to enroll a Dependent in coverage unless that Dependent has a Special Enrollment Event as described in the Enrolling in Coverage for Pensioners and their Dependents section above.

If you are a Disability Pensioner, you are not permitted to drop coverage for yourself unless you have other non-Medicare coverage and an opt-out election is made. The opt-out election may be made only at Annual Enrollment or within 60 days of obtaining other coverage. You are permitted to drop coverage for your Dependents at any time. Please note that once you drop coverage for your Dependents, you may not re-enroll those dependents at any time unless you have dropped those Dependents in connection with the dropping of your coverage through an opt-out election or in connection with an eligible change in status. The ability to add other Dependents is governed by the "Special Enrollment Events of the Enrolling in Coverage for Pensioners and their Dependents" section above. In addition, you may elect to cover your Dependents at the time your disability pension converts to a service pension.

SECTION III — BLUECARD PPO PROGRAM

BLUECARD PPO PROGRAM

When you are in an area where the BCBST Network Providers are not available and you need health care services or information about a BlueCross BlueShield PPO physician or hospital, just call the BlueCard PPO Participating Doctor and Hospital Information Line at 1-800-810-BLUE (2583.) They will help you locate the nearest BlueCard PPO Participating Provider.

If you call 1-800-810-BLUE (2583), **and** go to a BlueCard PPO Participating Physician or Hospital, your benefits will be Covered as Network benefits, and your out-of-pocket expenses will be less than if you go to a non-BlueCard PPO Participating Provider or Hospital. In the BlueCard PPO Program, the term "Host Plan" means the BlueCross BlueShield Plan that provides access to service in the location where you need health care services. Show your membership ID card (that has the "PPO in a suitcase" logo) to any BlueCard PPO Participating Provider. The BlueCard PPO Participating Provider can verify your membership, eligibility and Coverage with your BlueCross BlueShield Plan. When you visit a BlueCard PPO Participating Provider, you should not have claim forms to file. After you receive services, your claim is electronically routed to BCBST, which processes it and sends you a detailed explanation of benefits. You are responsible for any applicable Co-payments or your Deductible and Co-insurance payments (if any.)

The calculation of your liability for claims incurred outside the BCBST service area which are processed through the BlueCard PPO Program will typically be at the lower of the provider's Billed Charges or the negotiated price BCBST pays the Host Plan. The negotiated price BCBST pays to the Host Plan for health care services provided through the BlueCard PPO Program may represent either: (a) the actual price paid by the Host Plan on such claims; (b) an estimated price that factors into the actual price expected settlements, or withholds any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the Host Plan's expected average savings for all of its Providers or for a specified group of Providers. The discount that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price. In addition, laws in certain states may require BlueCross and/or BlueShield Plans to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if you receive Covered Services in these states, your liability for Covered Services will be calculated using these states' statutory methods.

Remember: You are responsible for receiving prior authorization from us. If prior authorization is not received, your benefits may be reduced or denied. Call the 1-800 numbers on your membership ID card for prior authorization. In case of an emergency, you should seek immediate care from the closest health care provider.

If you don't have BLUECARD PPO (your membership card doesn't have the "PPO in a suitcase" logo), you can go to any BlueCard Participating Provider, and receive the same level of benefits.

BLUECARD Worldwide

Through the BlueCard Worldwide Program, you also have access to a participating hospital network and referrals to doctors in major travel destinations throughout the world. When you need to locate a hospital or doctor, you can call the BlueCard Worldwide Service Center at 1-800-810-BLUE, or call collect at 1.804.673.1177, 24 hours a day, 7 days a week. You can also visit the web site ***http://www.bcbs.com/healthtravel/worldwide.html*****,** or you can call BCBST. When you need inpatient medical care, call the BlueCard Worldwide Service Center, who will refer you to a participating hospital. You will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-covered expenses, deductible, co-payment and/or co-insurance). In an emergency, you should go to the nearest hospital and call the BlueCard Worldwide Service Center if you are admitted. You still have the choice of using non-BlueCard Worldwide hospitals; however, you may have to pay the hospital directly and then file a claim for reimbursement. Your out-of-pocket expenses may be significantly higher. The BlueCard Worldwide Service Center will also provide referrals to doctors, but you will have to pay the provider and then file the claim for reimbursement.

SECTION IV — COST CONTAINMENT FEATURES: WHAT THEY ARE AND HOW TO USE THEM

WHAT YOU CAN DO TO CONTAIN COSTS

In order to take advantage of the cost-saving features of this program, it's important that you follow some basic procedures.

Before you receive health care services, you should be sure that your health care provider is a Network Provider. Although you have received a directory listing the Network Providers in your area, there may have been changes since printing.

MEDICAL MANAGEMENT

The BCBST Medical Management department handles various areas that affect your health care. For example, the Medical Management drafts the Medical Policies, which determine which medical procedures that BCBST considers Medically Appropriate and Necessary. Medical Management also operates the Case Management Program, which helps Members obtain access to alternative treatments, as described below. It also handles Prior Authorizations, which are necessary for certain medical procedures.

MEDICAL POLICY

Medical Policy looks at the value of new and current medical science. Its goal is to make sure that Covered Services have proven medical value. These services must be able to improve the health of the Members.

BCBST often evaluates medical technologies; these evaluations are based on information from:

- External organizations;
- Providers;
- Medical Societies; and
- Searches of medical literature.

BCBST uses their Technology Evaluation Center to assist in interpreting this information. A technology may be proven to be Medically Necessary for Members with appropriate Coverage in their Medical Plan Documents; however, that does not mean that it is appropriate for specific individuals. As technologies change and improve, and as Members' needs change, BCBST may reevaluate and change Medical Policies. It is their right to change or modify these without notice to Members.

CASE MANAGEMENT

Under the Case Management Program, the Administrator will identify Members with potentially

complicated medical needs, chronic illness and/or catastrophic illnesses or injuries that may be suited for alternative treatment plans. After evaluation of the Member's condition, the Plan may, at its sole discretion, determine that alternative treatment is Medically Necessary and Appropriate.

In that event, notwithstanding any provision of this Medical Plan Document to the contrary, the Plan, through the Administrator, may elect to offer alternative benefits for services not otherwise specified as Covered Services in Attachment A. Such benefits shall not exceed any Lifetime Maximum specified or the total amount of benefits under this Medical Plan Document, and will only be offered in accordance with a written Case Management or alternative treatment plan agreed to by the Member, the Member's attending physician and the Plan, through the Administrator.

Case Management services and alternative treatment plans will be offered to eligible Members on a case-by-case basis to address their unique needs. Under no circumstances does a Member acquire a vested interest in continued receipt of a particular level of benefits. Offer or confirmation of Case Management services or an alternative treatment plans to address a Member's unique needs in one instance shall not obligate the Plan to provide the same or similar benefits for any other Member. In addition, nothing herein shall be deemed a waiver of the Plan's right to enforce this Medical Plan Document in strict accordance with its express terms and conditions.

PRIOR AUTHORIZATION

Select Covered Services must be approved by the Administrator **in advance** in order to be paid at the Maximum Allowable Charge without penalty. The Administrator may also approve some services for a limited time. The Administrator must review any request for additional days or services. Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced or not covered.

Network Providers in Tennessee are required to comply with all Administrator medical management programs. Penalties for failure to comply with medical management programs are the responsibility of the Network Provider and the Member is held harmless.

If you use a Non-Network Provider or an out-of-state Provider, you are responsible for ensuring that the Provider obtains the appropriate Prior Authorization prior to treatment. Failure to obtain the necessary Authorization will result in additional Member payments and reduced Plan Payment.

Remember: If you receive services from a Bluecard/Bluecard PPO network provider, and that provider does not comply with medical management programs, you may not be held harmless. Please make sure that the Bluecard/Bluecard PPO provider you use follows the BCBST medical management program procedures to receive the maximum benefit from your health plan. The "PPO in a suitcase" logo on the membership ID card will indicate that you are in the Bluecard PPO program.

HEALTHY FOCUS PROGRAM
Healthy Focus is a disease management program available through the Employer and managed by Health Dialogue. Through this program, you can receive extra resources and personalized attention to help manage chronic health conditions and help you take better care of yourself. Participation in the program is voluntary.

CONCURRENT UTILIZATION REVIEW
The goal of Concurrent Utilization Review is to encourage the appropriate use of hospitalization. BCBST monitors each case of hospitalization until the Physician discharges the patient. If a Physician determines that a patient needs to remain in the Hospital, additional certification should be requested.

If the review process determines Hospital care is no longer Medically Necessary, BCBST will notify your Physician and the Hospital of the date on which benefits will end.

DURABLE MEDICAL EQUIPMENT
When Durable Medical Equipment is rented and the rental will extend beyond the period for which it was originally prescribed, a Physician must re-certify that the equipment is Medically Necessary for continued treatment. If a request for re-certification is not submitted, benefits will cease on the date through which use of the equipment was previously prescribed.

SECTION V — YOUR BENEFITS

Your Network coverage provides benefits for most medical service and supplies you receive ["you" means Subscriber and/or Dependent]. However, not all medical expenses are covered. It is important for you to understand which services are covered by this program. And, you also need to remember how the Cost Containment Features can affect your benefits.

Most health care coverage contains limitations and exclusions. These limitations and exclusions that apply to this program are outlined in this Plan.

Benefits will be provided under your coverage only for services or supplies which are Medically Necessary and Appropriate and performed and billed by an Eligible Provider. **All services or supplies must be provided in accordance with the Administrator's administrative procedures (See Medical Management Section).** Services must be related to the diagnosis and/or treatment of a Member's illness, injury, or pregnancy. The portion of any charge for a service or supply which is more than the Maximum Allowable Charge amount will not be considered covered.

Your benefits for each expense will normally be a percentage of the Maximum Allowable Charge as stated in the Schedule of Benefits. You should refer to the Schedule of Benefits to see what benefit maximums apply. An advantage of using PPO Network Providers is these Providers have agreed to accept the Maximum Allowable Charge set by the Plan for Covered Services. Network Providers have also agreed not to bill you for amounts above these amounts. However, Non-Network Providers do not have a contract with the Plan. This means they may be able to charge you more than the allowable amount set by the Plan in its contracts. With Non-Network Providers, you will be responsible for any difference between what the Plan pays and what you are charged.

Obtaining services not listed in this Plan document or not in accordance with the Administrator's Medical Management Policies and Procedures may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services.

HOSPITAL AND OTHER FACILITY PROVIDER SERVICES

Inpatient Services

- Room, board, and general nursing care in a:
  - Semi-private room;
  - Private room (limited to most common semi-private room rate, unless approved by BCBST);
  - Special Care Unit as approved by BCBST;
- Use of operating, delivery and treatment rooms;

- Drugs and medicines;
- Sterile dressings, casts, splints and crutches;
- Anesthetics;
- Diagnostic services (x-ray and laboratory and certain other tests); and
- Certain therapy services

Room, board and general nursing care will not be covered on the day of discharge unless admission and discharge occur on the same date, except this does not include a 23-hour observation room.

Outpatient Services
- Treatment of accidental injuries;
- Treatment of a sudden and serious illness;
- Removal of sutures, anesthetics and their administration, and other surgical services provided by a Hospital employee other than the surgeon or assisting surgeon;
- Dialysis;
- Drugs, crutches, and medical supplies; and
- Pre-admission testing.

Emergency Services
Benefits will be provided as specified in the Schedule of Benefits for Emergency Services received in a Hospital Emergency department when symptoms have been recorded by the attending Physician that an Emergency Medical Condition could exist.

Prior Authorization for Emergency Services will not be required. However, once the Member's medical condition has stabilized, Prior Authorization will be required for continuing Inpatient care or transfer to another facility. Benefits will be reduced or denied if such Prior Authorization is not obtained.

An "Emergency" or "Emergency Medical Condition" means the sudden onset of a medical condition of sufficient severity that, in the absence of immediate medical attention, could reasonably be expected to result in:

- Serious impairments to body functions;
- Serious dysfunction of a bodily organ or part; or
- Placing the Member's health in serious jeopardy.

An "Emergency" does not include treatment of a chronic condition in which sub-acute symptoms have existed over a period of time and would not be considered an Emergency unless symptoms suddenly became severe enough to require immediate medical assistance.

"Emergency Services" means health care services and supplies furnished in a Hospital which are required to determine, evaluate and/or treat an Emergency Medical Condition until such Condition is stabilized, as directed or ordered by a Physician or Hospital protocol.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES

Surgery
Operative and Cutting procedures.

Multiple or Bilateral Surgical Procedures
When two or more covered surgical procedures are performed at the same time, or in one surgical setting, benefits will be based on:

- The amount of benefits for the procedure for which the highest dollar amount would be billed (if charges for the surgical procedures are different); and
- Up to one-half of the benefits which are available with respect to the other covered surgical procedure(s), whether performed through the same or separate incisions.

Assistant Surgeon
Services of an assistant surgeon, who actively assists the operating surgeon in performing a covered surgical procedure, when:

- No intern, resident, or other staff doctor is available, and
- In our opinion, the surgical procedure requires the services of an assistant.

Anesthesia
Anesthesia administered by a Registered Nurse Anesthetist (RNA) or a Physician (MD other than the operating surgeon) provided the Surgery is covered.

Physicians' Services
- A second and/or third surgical opinion received before Surgery;
- Services of an attending Physician for Inpatient or Outpatient services, or consultation services when requested by the attending Physician;
- Services of a Physician for treatment by x-ray, radium, or other radioactive substances; and
- Counseling services of a Physician, Licensed Psychologist designated, by law, as a health service provider, or Licensed Independent Practitioner of Social Work including treatment for drug addiction or alcoholism.

Diagnostic Services
When ordered by a covered Provider to determine a specific condition or disease:

- Diagnostic Services, including X-ray and other radiology services;

- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope test;
- Prostate specific Antigen (PSA) test;
- Transrectal ultrasound for prostate cancer;
- Group B Streptococcus testing on pregnant or newborn Members as recommended by the American College of Obstetricians and Gynecologists and the Center for Disease Control; and
- One annual cervical cancer screening.

Maternity Services
Pregnancy and childbirth are covered on the same basis as an illness. Unless the mother and attending health care provider agree on an earlier date of discharge, benefits will be available for Hospital stays of not less than 48 hours following a conventional delivery or 96 hours following a cesarean delivery.

Acupuncture
Acupuncture is covered if the services are provided by an eligible provider and otherwise meet the guidelines for payment under this Plan.

Chiropractic Services
Benefits are available for charges of a licensed chiropractor when charges are for maintenance or treatment of an injury, illness or disease. Massage therapy is not covered. Benefits are available only for care that is expected to result in significant physical improvement in your condition.

OTHER SERVICES

BEHAVIORAL HEALTH PROGRAM
The Plan provides a program of Coverage for inpatient and outpatient services for Medically Necessary and Appropriate care and treatment of behavioral health disorders. All inpatient levels of care, which include Acute care, residential care, partial hospital care, electro-convulsive therapy (ECT) and intensive outpatient programs must receive Prior Authorization from the Plan. Call the toll-free number indicated on the back of the membership ID card if you have questions about your Behavioral Health Services benefit.

Covered Services
Inpatient and outpatient benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances is the dominant features.

Exclusions
- Non-emergency behavioral health Acute care, residential care, partial hospitalization, intensive outpatient programs stays or treatment in halfway houses or group homes and

electroconvulsive treatments that are not Prior Authorized during the Member's treatment in a facility or program, whether the facility or program is an Network Provider or a Non-Network Provider. Emergency Care Services require a notification within 24 hours to receive Prior Authorization;

- Pastoral counseling;
- Marriage and family counseling without a behavioral health diagnosis;
- Vocational and educational training and/or services;
- Custodial or domiciliary care;
- Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs;
- Sleep disorders;
- Services related to mental retardation or developmental disabilities;
- Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained;
- Behavioral problems such as anti-social personality disorders, sexual deviation or dysfunction or social maladjustment;
- Any care in lieu of legal involvement or incarceration;
- Pain management;
- Hypnosis or regressive hypnotic techniques;
- Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.

AMBULANCE

Benefits are available for an Ambulance to treat and transport the Member:

- From a Member's home or the scene of an accident or medical Emergency to the nearest Hospital where appropriate medical or surgical services are available;
- Between a Hospital and a Skilled Nursing Facility;

  Transportation to: (i) the Member's or Dependent's home and (ii) another treatment or diagnostic facility other than a hospital shall be covered where it is determined to be Medically Necessary and Medically Appropriate.

Benefits are available for medically necessary and appropriate treatment at the scene (paramedic services) without ambulance transportation.

Benefits are available for air and water Ambulance only when ground Ambulance is not available or when justified by the patient's medical condition, as determined by BCBST. Benefits are available for ground transportation providing intensive care for Members less than

two (2) years of age ("angel vans").

AUTISM SPECTRUM DISORDERS
The Plan provides benefits and coverages for the treatment of autism spectrum disorders for any person in compliance with the relevant provisions of 2006 Public Acts, Chapter 894, of the Tennessee Code Annotated Section 56-7-2367.

These benefits are subject to deductibles, coinsurance and co-payment requirements and benefit limits which are equal to those established for the treatment of other neurological disorders.

DENTAL CARE
Benefits are provided only for removal of impacted wisdom teeth or for dental work needed as a result of an Accidental Injury to the jaw, natural teeth, mouth, or face.

An injury caused by chewing or biting, or received in the course of other dental procedures, will not be considered an Accidental Injury. In coordinating any eligible dental expenses under this Plan with any dental plan available to Subscriber's or their dependents, this Plan will be considered secondary and the dental plans will be considered primary.

Anesthesia for Dental Services
Benefits will be available for anesthesia, as well as Inpatient or Outpatient Hospital expenses, in connection with a dental procedure if such procedure involves:

- Complex oral surgical procedures which have a high probability of complications due to the nature of the Surgery;
- Concomitant systemic disease for which the patient is under current medical management and which increases the probability of complications;
- Mental illness or behavioral condition which precludes dental Surgery in an office setting;
- Use of general anesthesia, and the Member's medical condition requires such procedure be performed in a Hospital; or
- Dental Surgery performed on a Member eight (8) years of age or younger, where such procedure cannot safely be provided in a dental office setting.

DIABETES TREATMENT
Benefits are available for treatment, medical equipment, supplies and Outpatient self-management training and education, including nutritional counseling, for the treatment of diabetes. In order to be covered, such services must be:

- Prescribed and certified by a Physician as Medically Necessary; and
- Provided by a Network Physician, Registered Nurse, Dietitian, or Pharmacist who has completed a diabetes patient management program recognized by the American Council on

Pharmaceutical Education and the Tennessee Board of Pharmacy.

Services and supplies included under this provision shall include:

- Blood glucose monitors, including monitors for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading and urine test strips;
- Injection aids (including diabetic pens);
- Syringes and lancets;
- Insulin pumps, infusion devices, and Medically Necessary accessories;
- Podiatric appliances for prevention of complications associated with diabetes; and
- Glucagon Emergency kits.

(Benefits for insulin and oral hypoglycemic agents will also be available).

DURABLE MEDICAL EQUIPMENT AND SUPPLIES
Benefits are available for Medically Necessary and Appropriate medical equipment or items which, in the absence of illness or injury;

- Are of no medical or other value to you;
- Can withstand repeated use in an ambulatory or home setting;
- Require the prescription of a Practitioner for purchase;
- Are approved by the FDA for the illness or injury for which it is prescribed; and
- Are not for your convenience.

Benefits are available for the rental and, where deemed Medically Necessary and Appropriate, the purchase of Durable Medical Equipment.

Benefits are also available to fit, adjust, repair, or replace Durable Medical Equipment, provided the need for this arises from normal wear or the Member's physical development — and not as a result of improved technology or loss, theft, or damage. (See information about Cost Containment Features that apply to Durable Medical Equipment.)

EYEGLASSES OR CONTACT LENSES
One set following cataract Surgery.

HOME HEALTH CARE
Benefits are available for the following services when prescribed by the Member's Physician and

performed and billed by a Home Health Care Agency: part-time or intermittent nursing care by a visiting RN or LPN (not to include private duty nursing); physical therapy and respiratory therapy by persons licensed to perform such services; oxygen and its administration; diagnostic services; and Home Infusion Therapy.

HOSPICE CARE
Hospice care is an alternative to lengthy Inpatient treatment for terminally ill patients. Benefits are available where life expectancy is 6 months or less.

- The patient's Physician must establish a Plan of treatment;
- An Approved Hospice must provide the services.

In-home services are available, such as:

- Prescription drugs;
- Medical supplies;
- Durable Medical Equipment

and other essential medical services. Prior Authorization is necessary to receive Hospice care. In-patient benefits at a Network Hospice Provider may be available when Prior Authorization is obtained from Case Management.

MAMMOGRAPHY SCREENING
Benefits are available for female Members in accordance with the following schedule:

- Benefits will be provided for one baseline mammogram for each Member between 35 and 40 years of age, and one mammogram every year for Members 40 years of age and older.

ORGAN TRANSPLANTS
As soon as your Provider tells you that you might need a transplant, you or your Provider needs to contact Transplant Case Management.

Medically Necessary and Appropriate services and supplies provided to you, when you are the recipient of the following organ transplant procedures: heart; heart/lung; bone marrow; lung; liver; pancreas; pancreas/kidney; kidney; small bowel; and small bowel/liver.

Benefits may be available for other organ transplant procedures which, in our sole discretion, are not experimental or Investigational and which are Medically Necessary and Medically Appropriate.

You have access to three levels of benefits: In-Transplant Network, Network, and Non-Network. If you go to an In-Transplant Network Provider, you will have the highest level of benefits.

Transplant Services or supplies that have not received Prior Authorization will not be Covered. "Prior Authorization" is the pre-treatment Authorization which must be obtained from BCBST before any pre-transplant evaluation or any Covered Procedure is performed. (See Prior Authorization Procedures below.)

Prior Authorization Procedures
To obtain Prior Authorization, you or your Practitioner must contact Transplant Case Management before pre-transplant evaluation or transplant services are received. Approval should be obtained as soon as possible after you have been identified as a possible candidate for transplant services.

Transplant Case Management is a mandatory program for those Members seeking transplant services. Call the 800 number on the front of your ID card for customer service, and they can transfer you to Transplant Case Management. BCBST must be notified of the need for a transplant in order for it to be a Covered Service.

Covered Services
The following Medically Necessary and Appropriate transplant services and supplies which have received Prior Authorization and are provided in connection with a Covered Procedure:

- Medically Necessary and Appropriate services and supplies, otherwise Covered under this Plan.
- Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant. Not all Network Providers are in our Transplant Network. Please check with Transplant Case Management to see which Hospitals are in our Transplant network.
- Travel expenses for your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes your and a companion's travel expenses. The companion must be your Spouse/domestic partner, family member or your guardian.
- Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel for travel more than thirty (30) miles away from your home to and from a facility in the Transplant Network.
- Lodging expenses are Covered if you or your companion travels more than thirty (30) miles each way. Lodging expenses are limited to $50 per night, per person for up to two people (maximum of $100 per night), including the transplant recipient. Any amount over that is the individual's responsibility.
- The aggregate limit for travel expenses is $10,000 per Covered Procedure and is included in your Lifetime Maximum.
- Travel Expenses are Covered only if you go to a Contracted Transplant Institution;
- Travel expenses for the designated live donor for a Covered recipient are covered subject to the same conditions noted above. Donor lodging is limited to $50 per night and any amount over that is the donor's responsibility. Charges for the expense of a donor companion are not

covered. Donor Organ Procurement: If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself:

- testing for the donor's compatibility;
- removal of the organ from donor's body;
- preservation of the organ; and
- transportation of the organ to the site of transplant.

Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of your Organ Transplant and is included in the Lifetime Maximum.

Conditions/Limitations

The following limitations and/or conditions apply to services, supplies or Charges:

- You or your Physician must notify Transplant Case Management prior to your receiving any transplant service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;
- Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with BCBST in coordination of these services;
- Failure to notify BCBST of proposed transplant services, or to coordinate all transplant related services with BCBST, will result in the reduction or exclusion of payment for those services;
- You must go through Transplant Case Management and receive Prior Authorization for your transplant to be Covered;
- Once you have notified Transplant Case Management and received Prior Authorization, you may decide to have the transplant performed outside the Transplant Network. **However, your benefits will be greatly limited, as described below. Only the Transplant Maximum Allowable Charge for the Service provided will be Covered.**

    - **In-Transplant Network transplants.** You have the transplant performed at an In-Transplant Network Provider. You receive the highest level of reimbursement for Covered Services. The Plan will reimburse the In-Transplant Network Provider at the benefit level listed in the Schedule of Benefits, at the Transplant Maximum Allowable Charge. The In-Transplant Network Provider cannot bill you for any amount over the Transplant Maximum Allowable Charge for the transplant, which limits your liability;
    - **Network transplants.** You have the transplant performed outside the Transplant Network, but still at a facility that is a Network Provider or a Blue Card PPO Participating Provider. The Plan will reimburse the Network or Blue Card PPO

Participating Provider at the benefit levels listed in the Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to your liability. The Provider also has the right to bill you for any amount not Covered by the Plan – this amount may be substantial;

- **Non-Network transplants.** You have the transplant performed by a Non-Network Provider (i.e., outside the Transplant Network, and not at a facility that is a Network Provider or a Blue Card PPO Participating Provider). The Plan will reimburse the Non-Network Provider only at the benefit level listed in the Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to your liability. **The Non-Network Provider also has the right to bill you for any amount not Covered by the Plan - this amount may be substantial.**

You can find out what the Transplant Maximum Allowable Charge is for your transplant by contacting Transplant Case Management. Remember, the Transplant Maximum Allowable Charge can and does change from time to time.

If you go through Transplant Case Management for your transplant, follow its procedures, cooperate fully with them, and have your transplant performed at a Contracted Transplant Institution, the transplant expenses specified in the Schedule of Benefits are Covered, up to your Lifetime Maximum.

Exclusions
The following services, supplies and Charges are not Covered under this section:

- If you do not receive Prior Authorization, the transplant and related services will not be Covered;
- Any service specifically excluded from Coverage, except as otherwise provided in this section;
- Services or supplies not specified as Covered Services under this section;
- If you receive Prior Authorization through Transplant Case Management, but do not obtain services through the Transplant Network, you will have to pay the Provider any additional charges not Covered by the Plan;
- Any attempted Covered Procedure that was not performed, except where such failure is beyond your control;
- Non-Covered Services;
- Services which are covered under any private or public research fund, regardless of whether you applied for or received amounts from such fund;
- Any non-human, artificial or mechanical organ;
- Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;

- Donor services including screening and assessment procedures which have not received Prior Authorization from Us;
- Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;
- Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled within three (3) months of harvest;
- Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

OUTPATIENT PRIVATE DUTY NURSING
Benefits are available for private duty nursing when such care is given by a practicing Registered Nurse (RN) or a Licensed Practical Nurse (LPN), provided their professional skills are Medically Necessary to provide the appropriate level of care and such services are ordered by a Physician.

PRESCRIPTION DRUGS
Benefits are available for prescription drugs for use by a Member outside of a Hospital. In order to be considered covered, such drug must be:

- Prescribed in writing by a licensed Physician on or after the Member's coverage begins;
- Approved for use by the Food and Drug Administration (FDA) for the prescribed indication. (However, benefits will be available for a drug which is prescribed to treat a recognized indication which has not been approved by the FDA for such indication, provided such drug is (a) otherwise approved by the FDA and, (b) approved by BCBST);
- Listed on the Drug Formulary;
- Dispensed by a licensed Pharmacist, and
- Not be available for purchase without a prescription.

Over-the-counter drugs (not requiring a prescription), prescription devices, vitamins not by law requiring a prescription; and/or prescription drugs dispensed in a doctor's office are excluded except as otherwise specified. However, benefits will be available for:

- Drugs or formula required to treat Phenylketornuria; and
- Injectable insulin, oral hypoglycemic agents, and syringes.

PREVENTIVE SERVICES
Benefits are available for the following services as outlined in the Schedule of Benefits:

Child Health Supervision Services
Benefits include history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunization and laboratory tests, in keeping with prevailing medical standards.

PROSTHETIC APPLIANCES
Benefits are available for orthopedic braces (except corrective shoes and arch supports), crutches, and prosthetic appliances such as artificial limbs and eyes. Replacement, repair, or adjustment of the appliances is also covered if the need for this arises from normal wear or the Member's physical development and not as a result of improved technology, loss, theft, or damage to the appliance or device.

SERVICES OR SUPPLIES TO CORRECT REFRACTIVE ERRORS OF THE EYES
Benefits are available only for surgery for removal of cataracts (including surgical implant of a prosthetic lens following cataract extraction). Benefits are not available for any other type of refractive eye surgery including LASIK or PRK.

TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)
The Plan shall provide for the treatment or diagnostic services for TMJ or the muscles of chewing. The following are considered eligible expenses for TMJ:

- History exams and office visits;
- X-rays of the joint;
- Diagnostic study cases;
- Appliances removable or fixed (which are designated primarily to stabilize the jaw joint and muscles and not to permanently alter the teeth);
- Physical medical procedures;
- Medications.

The following are not considered eligible expenses for TMJ under the Plan:

- Orthodontic treatment (braces);
- Prosthodontic treatments (dentures, bridges);
- Restorative treatment (fillings, crowns);
- Full mouth rehabilitation (restorations, extractions);
- Equilibrations (shaving, shaping, reshaping teeth).

THERAPEUTIC/REHABILITATIVE SERVICES

Benefits are available for Medically Necessary and Appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as the result of illness or injury. Outpatient, home health or office therapeutic and rehabilitative services which are expected to result in significant and measurable improvement in the Member's condition resulting from an Acute disease or injury are covered expenses. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner.

- Chemotherapy — Treatment of malignant disease by chemical or biological agents ;
- Cardiac rehabilitation — A comprehensive program to improved health outcomes for patients with cardiovascular disease;
- Occupational therapy — Treatment which involves the use of activities designed to restore, develop and/or maintain a person's ability to accomplish those daily living tasks necessary to a particular occupational role;
- Physical therapy — Treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part;
- Pulmonary rehabilitation — A multidisciplinary approach to the rehabilitation of individuals who are diagnosed with a chronic pulmonary disease;
- Radiation therapy — Treatment of disease by x-ray, radium, or radioactive isotopes;
- Respiratory therapy — Introduction of dry or moist gases into the lungs;
- Speech therapy — Treatment for disorders of articulation and swallowing, following an Acute illness.

SECTION VI — LIMITATIONS/EXCLUSIONS

The services and supplies described in this Plan are subject to Medical Necessity and Appropriateness, coverage provisions and the following limitations and exclusions. When a service or supply is limited or excluded all expenses related to and in connection with the service and/or supply will also be limited or excluded. Read this section carefully before submitting a claim.

EXCLUSIONS

This Plan does not provide benefits for the following services, supplies or charges:

- Services or supplies not prescribed or performed by a Physician or Professional Other Provider, as defined in the Basic Terms Section;
- Services or supplies which are determined not to be Medically Necessary and Appropriate, or have not been authorized by the Plan;
- Services provided before the Member's coverage begins;
- A drug, device, or medical treatment or procedure which is experimental or Investigational (see Section X, Definition of Terms);
- Services or supplies furnished without cost under the laws of any government except Medicaid (TennCare[SM]) coverage provided by the State of Tennessee;
- Illness or injury resulting from war and covered by: (1) veteran's benefit; or (2) other coverage for which you are legally entitled and which occurred before your Coverage began under this Medical Plan Document;
- Services for which the patient is not required or legally obligated to pay;
- Services or supplies received in a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust, or similar group;
- Services, supplies or prosthetics primarily to improve appearance or which are provided in order to correct or repair the results of a prior surgical procedure the primary purpose of which was to improve appearance. However, reconstructive breast Surgery as a result of a mastectomy (other than a lumpectomy), and Surgery on the non-diseased breast needed to establish symmetry between the two (2) breasts is covered. Benefits will also be available for surgery needed to restore an impaired bodily function if the condition and results from disease, birth defect or accidental injury;
- Self-treatment or services provided by any person related to the Member by blood or marriage, including the Member's spouse, parent, child, legal guardian, aunt, uncle, stepchild, or any person who resides in the Member's immediate household (e.g., domestic partner);
- Services rendered by other than a Hospital, Physician or Other Provider(s) specified in this Plan;
- Services paid under any other group, blanket or franchise insurance coverage; any other Blue

Cross or Blue Shield group ASA, other health insurance Plan, union welfare Plan, or labor-management trust Plan;

- Personal hygiene and convenience items (such as air conditioners, humidifiers, or physical fitness equipment);
- Telephone consultations, charges incurred due to failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records;
- Hospital admissions which are primarily for diagnostic studies;
- Inpatient stays primarily for therapy (such as physical or occupational therapy);
- Whole blood, blood components, and blood derivatives which are not officially classified as drugs;
- Custodial Care;
- Routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails, fallen arches, weak feet, and chronic foot strain, except for those services specifically covered for diabetics;
- Routine physical examinations, immunizations, and screening examinations including x-rays made without film, except as otherwise specified;
- Physician's charges for well-baby care, except as otherwise specified;
- Services or supplies for dental care, except as specified;
- Eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses, except as otherwise specified;
- Hearing aids and examinations for and the fitting of hearing aids for members age 18 and older, unless the hearing aid is necessitated by damage to the ear as a result of an injury; Hearing aids shall include a conventional device to restore or enhance the patient's ability to hear. **However, benefits for certain surgical procedures to restore hearing may be available if approved by BCBST as Medically Necessary;**
- Surgery to change sex;
- Procedures, drugs or biologicals for, or in connection with, artificial insemination, in vitro fertilization, or any other service or supply intended to create a pregnancy. However, a service or supply may be covered if it is provided to treat an illness or underlying medical condition resulting in infertility. Services which may be covered under this provision include: treatment to correct a previous tubal pregnancy, and treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods;
- Services covered under Medicare, except as required by applicable state or federal law;
- Non-medical self-care or self-help training and any related diagnostic testing or medical social services;
- Any services or supplies designed to correct refractive errors of the eyes except as otherwise stated in this Plan;
- An artificial heart or any other artificial organ, or any associated expense;

- Services or supplies for the reversal of sterilization;
- Services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary;
- Charges in excess of the Maximum Allowable Charge for Covered Services or any charges that exceed any Lifetime or Annual Maximum or any other Plan limitation;
- Services rendered for or in connection with physical therapy which consist primarily in the application, supervision, or direction in the use of exercise or physical fitness equipment — whether or not such services are rendered by an Eligible Provider;
- Any balance of charges, Deductibles, or Co-insurance resulting from a Member's failure to comply with applicable requirements of any other individual or group contract, including: Prior Authorization, second surgical opinion consultation, Outpatient Surgery, or concurrent care review programs;
- Services or supplies for Inpatient treatment of bulimia, anorexia, or other eating disorders which consist primarily of behavior modification, diet and weight monitoring, and educational services;
- Services or supplies in connection with treatment of obesity including weight loss programs, except for surgical or other treatment of morbid obesity. However gastric bypasses are a covered benefit if determined to be Medically Necessary for the treatment of morbid obesity by the Administrator;
- Services required as a result of the commission of a felony by the Member, or the attempt to commit a felony (if a claim is denied under these circumstances, the Administrator will report to the Board only the name of the individual and that the services were rendered as a result of the alleged commission of a felony. The nature of the injury or illness or the service provided will not be disclosed.);
- Services or supplies rendered prior to the Effective Date or after a Member's coverage is terminated, except as otherwise specified;
- Room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day;
- A second or third surgical opinion rendered by a Physician in the same medical group or practice as (a) the Physician who initially recommended the Surgery, or (b) the Physician who rendered either the second or third surgical opinion;
- Staff consultations required by Hospital rules;
- Prosthetic appliances or items of Durable Medical Equipment to replace those which were lost, damaged, or stolen or prescribed as a result of improved technology;
- Exercise or athletic equipment, saunas, whirlpools, air conditioners, water purifiers, humidifiers, home modifications or improvements, motorized vehicles (except electric wheelchairs), swimming pools, tanning beds, and recreational equipment;
- Dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function unless

otherwise specified under this Plan;

- Inpatient private duty nursing in an acute care Hospital;
- Over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; prescription devices, vitamins, except those which by law require a prescription; and/or prescription drugs dispensed in a doctor's office;
- Replacement of implanted cataract lenses;
- For any wig or hair replacement;
- For court-ordered treatment of a Subscriber unless benefits are otherwise payable;
- Medical treatment for which the Member has been reimbursed under a mass tort or class action lawsuit, settlement or judgment;
- Inpatient hospital services that could be provided in a less intensive setting;
- Ambulance charges for the convenience of the Member or when transportation is not to a Hospital or Skilled Nursing Facility, provided however that transportation to: (i) the Member's or Dependent's home and (ii) another treatment or diagnostic facility other than a hospital shall be covered where it is determined to be Medically Necessary and Medically Appropriate;
- Motorized scooters, exercise equipment, hot tubs, pools, saunas "deluxe" or "enhanced" equipment. In all instances, the most basic equipment needed to provide the needed medical care will determine the benefit;
- Office visits and physical exams for: (1) school; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings; and (7) related immunizations and tests;
- Therapeutic or rehabilitative services: (1) where treatment is beyond what can reasonably be expected to significantly improve health; (2) which utilize modalities that do not require the attendance or supervision of a licensed therapist; (3) which were not pre-authorized when it is required; or (4) which duplicate therapy;
- Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions; or Expenses arising from any work related injury or illness which is compensable under the provisions of any state worker's compensation law shall not be covered; provided, that if such work related injury or illness arises from employment with Metro then this exclusion will not apply.

SECTION VII — CLAIMS AND PAYMENT

When you receive Covered Services, either you or the Provider must submit a claim form to BCBST. BCBST will review the claim and let you or the Provider know if more information is required, before they pay or deny the claim.

CLAIMS

Due to federal regulation, there are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

- A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part;
- A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to the Member. Only post-service claims can be billed to the Plan, or you;
- Urgent Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment. A claim for denied Urgent Care is always a pre-service claim.

CLAIMS BILLING

You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member payments. The Network Provider will submit the claim directly to BCBST. You may be charged or billed by a Non-Network Provider for Covered Services rendered by that Provider. If you use a Non-Network Provider, you are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of the Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).

- If you are charged, or receive a bill, you must submit a claim to BCBST.
- To be reimbursed, you must submit the claim within two (2) years from the date a Covered Service was received. If you do not submit a claim, within the 2-year time period, it will not be paid.

Not all Covered Services are available from Network Providers. There may be some Provider types that BCBST does not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled in the same manner as described above for Non-Network Providers. You also have the same responsibilities as described above.

You may request a claim form from the BCBST customer service department. They will send you a claim form within 15 days. You must submit proof of payment acceptable to BCBST with the claim form. BCBST may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

A Network Provider or a Non-Network Provider may refuse to render, or reduce or terminate a service that has been rendered, or require you to pay for what you believe should be a Covered Service. If this occurs:

- You may submit a claim to BCBST to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide you with a prescribed medication; or (2) requires you to pay for that prescription, you may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.
- You may request a claim form from the BCBST customer service department. BCBST will send you a claim form within 15 days. BCBST may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

PAYMENT

If you received Covered Services from a Network Provider, BCBST will pay the Network Provider directly. These payments are made according to their agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.

If you received Covered Services from a Non-Network Provider, you must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, BCBST will reimburse you. If you have not paid the Provider, BCBST may make payment for Covered Services to either the Provider or to you, at their discretion. The BCBST payment fully discharges their obligation related to that claim.

- Non-Contracted Providers may or may not file your claims for you. Either way, the Network Benefit level shown in the Schedule of Benefits, will apply to claims for Covered Services received from Non-Contracted Providers. However, you will be responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. The BCBST payment fully discharges their obligation related to that claim.
- If the ASA is terminated, all claims for Covered Services rendered prior to the termination date must be submitted to the Plan within one (1) year from the date the Covered Services was received.
- BCBST will pay benefits within 30 days after they receive a claim form that is complete. Claims are processed in accordance with current industry standards and based on BCBST's information at the time they receive the claim form. BCBST is not responsible for over or under payment of claims if their information is not complete or inaccurate. BCBST will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.

Payment for Covered Services is more fully described in the Schedule of Benefits.

"Information Please"
Whenever you need to file a claim, BCBST can process it for you more efficiently if you complete a claim form. This will ensure that you provide all the information needed. Most providers will have claim forms, or you can request them directly by calling your nearest BCBST office:

Toll Free Number	**800-367-7790**
Chattanooga	423-755-5917
Jackson	901-664-4100
Nashville	615-386-8500
Johnson City	423-854-6000
Knoxville	865-588-4600
Middle Tennessee	931-386-8500

Mail all claim forms to:
BlueCross BlueShield of Tennessee
Attention: Corporate Operations Service, 1NA
P.O. Box 180150
Chattanooga, TN 37401-7150

In addition to using a claim form, there are two other ways you can help to ensure timely response to your claim:

- Keep BCBST informed if you have other health insurance. In processing a claim where two or more group health programs are involved, benefits are coordinated between the two programs. This coordination allows the patient, whenever possible, to meet his health care expenses — and yet not collect more than the actual costs. To avoid delays that may occur when BCBST has to ask about your coverage under another Plan, be sure to let them know if you become covered under another group health program.
- Let Metro know if you move. Notify Metro of your new address to make sure you receive claim payments and Explanations of Benefits (EOB) paid on your behalf. BCBST cannot change your address.

Benefit Administration Error
If the Administrator makes an error in administering the benefits under this Plan, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this Plan.

SECTION VIII — GRIEVANCE

GRIEVANCE PROCEDURE

The BCBST Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause you to be dissatisfied with any aspect of your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action you may have against the Plan. Please contact the customer service department, at the number listed on your membership ID card:

- To file a Claim;
- If you have any questions about this Plan or other documents that you receive from BCBST (e.g. an explanation of benefits); or
- To initiate a Grievance concerning a Dispute.

This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance, arbitration, or litigation action, pursuant to the terms of the ASA and this Plan. Any decision to award damages must be based upon the terms of the ASA and this Plan.

The Procedure can only resolve Disputes that are subject to BCBST's control. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan; however, to complain about any matter related to the quality or availability of services or any other aspect of your relationship with Providers.

This Procedure incorporates the definitions of: adverse benefit determination; urgent care; and pre-service and post-service claims ("claims").

An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what you believe should be a Covered Service.

- If a Provider does not render, or reduces or terminates a service that has been rendered, or requires you to pay for what you believe should be a Covered Service, you may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide you with a prescribed medication or requires you to pay for that prescription, you may submit a Claim to the Plan to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold you harmless for the cost of services in some circumstances.
- Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
- A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is

required to hold you harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.

You may request a form from the Plan to authorize another person to act on your behalf concerning a Dispute.

The Plan and you may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.

Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA and this Plan.

DESCRIPTION OF THE REVIEW PROCEDURES

Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a customer service representative if you have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (your "Grievance"). You must begin the Dispute process within 180 days from the date BCBST issues notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing you to be dissatisfied with the Plan. If you do not initiate a Grievance within 180 days of when BCBST issues an Adverse Benefit Determination, you may give up the right to take any action related to that Dispute.

Contact the customer service department at the number listed on your membership ID card for assistance in preparing and submitting your Grievance. They can provide you with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure. The Plan will assign a Grievance coordinator to assist you throughout the Grievance process. That Grievance coordinator will not make determinations concerning your Dispute.

Grievance Hearing

After the Plan has received and reviewed your Grievance, the BCBST first level Grievance committee will meet to consider your Grievance and any additional information that you or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim

determinations. Determinations by the First Level Grievance Committee, BCBST and such other reviewers shall be subject to the review standards adopted by the Plan Administrator, as described in Appendix 1.

Written Decision
The committee or reviewers will consider the information presented, and the chairperson will send you a written decision concerning your Grievance as follows:

- For a pre-service claim, within thirty (30) days of receipt of your request for review;
- For a post-service claim, within sixty (60) days of receipt of your request for review; and
- For a pre-service, urgent care claim, within seventy-two (72) hours of receipt of your request for review.
- The decision of the Committee will be sent to you in writing and will contain:
    - A statement the committee understands your Grievance;
    - The basis of the committee's decision; and
    - Reference to the documentation or information upon which the committee based its decision. The Plan will send you a copy of such documentation or information, without charge, upon written request.

Next-Level Grievance Procedure
If you disagree with the decision of the first level Grievance committee, you may appeal the decision to the Metro Employee Benefit Board.

SECTION IX — RIGHTS OF RECOVERY AND REIMBURSEMENT

RIGHT OF RECOVERY

If another party is legally responsible for causing a Member's illness or injury, BCBST has the right on behalf of Metro to recover any amounts paid for any services required to treat such illness or injuries from: that party; his or her insurer; or any other source that is legally obligated to pay for such services, including uninsured or underinsured motorist coverage (collectively "Responsible Parties"), whether or not the Member has been made whole by such Responsible Parties pursuant to the ASA.

A Member shall be deemed to have granted such right of recovery to BCBST individually and on behalf of his or her representatives, heirs, successors, or assigns as a condition of receiving Covered Services from BCBST.

SUBROGATION

In addition to the Right of Recovery above, if another party is legally responsible for causing a Member's illness or injury, that Member shall be deemed to assign, transfer and subrogate all of his or her rights of action against any Responsible Parties to Metro and to BCBST, to the full extent benefit payments were made for Covered Services provided to treat such illness or injury, plus the costs of recovering such amounts from those Responsible Parties, whether or not the Member has been made whole by such Parties. Such actions may be based in tort, contract or other cause of action, to the fullest extent permitted by law.

LIEN

Metro and BCBST shall have a lien against any payment judgment or settlement of any kind that a Member receives from or on behalf of Responsible Parties for the cost of providing services to that Member and any costs of recovering such amounts from Responsible Parties, whether or not the Member is made whole by that recovery. Metro or BCBST may notify other parties of its lien without notice to, or the consent of, that Member.

The recovery and subrogation rights stated in this provision shall be considered to be a first priority claim against the proceeds of any judgment against, settlement with, or payment from Responsible Parties; to be paid before any other claims are paid, whether or not the Member has recovered the total amount of his or her damages. In the event the Member settles any claim or action against any third party, Metro or BCBST shall be entitled to immediately collect the present value of its claims pursuant to this section as the first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of Metro.

NOTICE AND COOPERATION

Members must promptly notify the Claims Administrator if they are injured or become ill as a result of the act or omission of other parties, to enable the Plan to protect its rights pursuant to

this section. Members must cooperate with the Plan and agree to execute any documents that Metro Government or Claims Administrator deems necessary to protect the rights of the Metro Government under this section. The Member is solely responsible for paying all costs of litigation, including any attorney fees and expenses, regarding any proceeds obtained from any judgment against, settlement with, or payment from Responsible Parties. The Plan will not pay the attorney fees for the Member's attorney.

SECTION X— TERMINATION, REINSTATEMENT AND CONTINUATION OF COVERAGE

TERMINATION OF COVERAGE

A Subscriber loses eligibility when one of the following occurs:

- The Subscriber no longer meets the definition of an eligible Subscriber as defined, including when an Employee has worked less than an average of twenty (20) hours per week in two (2) consecutive quarters;
- The Employee terminates his or her employment;
- The Subscriber fails to make the required contribution to Metro by either (a) payroll deduction or (b) direct payment for his or her participation under this Plan, unless otherwise stated;
- The Plan is amended to terminate the coverage of a class of Subscribers of which the Subscriber is a Member; or
- The Plan terminates.

When a Subscriber loses eligibility, the Subscriber's Coverage under this Plan will terminate on the earliest of the following dates:

- The end of the month following the last day for which the Employee is paid by Metro when the Employee's employment has terminated or when the Employee has been on a paid leave;
- The end of the month following the date the Subscriber no longer meets the definition of a Subscriber or fails to make the required contribution to Metro;
- The date the Plan is amended to terminate the coverage of a class of Subscribers of which the Subscriber is a Member;
- The date the Plan terminates; or
- The end of the month following the date the Subscriber opts out of coverage for a qualifying event as allowed under the Opt Out/Opt In Policies adopted by the Board.

A Dependent loses eligibility when one of the following occurs:

- The Subscriber's benefits under the Plan end;
- The Dependent no longer meets the definition of an eligible Dependent;
- The period for which the Subscriber last made the required contribution for participation of his or her Dependents under this Plan ends;
- The Dependent commences active duty in the armed forces of any country or state or international organization, or becomes a member of any civilian force auxiliary to any military force;

- The Subscriber's benefits under the plan end due to their opting out of coverage; or
- The Plan terminates.

When a Dependent loses eligibility, the Dependent's Coverage under this Plan will terminate on the earliest of the following dates:

- The end of the month following the date the Dependent no longer meets the definition of a Dependent or the Subscriber fails to make the required contribution to Metro for the Dependent's Coverage;
- The end of the month following the last day for which the Employee is paid by Metro when the Employee's employment has terminated or when the Employee has been on a paid leave;
- The end of the month following the date the Subscriber opts out of coverage for a qualifying event as allowed under the Opt Out/Opt In Policies adopted by the Board;
- The date the Plan is amended to terminate the coverage of a class of employees through which the Employee is Covered; or
- The date the Plan terminates.

When a Member's Coverage terminates, the Subscriber's contributions may be refunded back to the earlier of:

- The end of the month following the date Metro receives notice of the Member's loss of eligibility;
- The end of the month following the date the Member loses eligibility; or
- This refund will not exceed the Subscriber's contributions made for the ninety (90) day period before the end of the month during which Metro is notified of the loss of eligibility.

REINSTATEMENT OF COVERAGE

If an Employee terminates employment and returns to work for Metro within thirty (30) days of the date of termination, coverage will automatically be reinstated by Human Resources retroactively to the date coverage would have terminated. The Employee will be responsible for paying any contributions that are due so that there will not be a break in coverage. The appropriate contribution will be deducted from the Employee's paycheck.

If the Employee's date to return to work at Metro is more than thirty (30) days from the date of termination, the Employee will be treated as a newly eligible Employee.

TRANSFERRING COVERAGE FROM OTHER METRO PLANS

Human Resources will determine under what terms and conditions an Employee may transfer coverage from another health care plan, for which Metro contributes to the contribution on behalf of the Metro Employee, to this Plan. In general, Human Resources will reciprocate and therefore follow the same guidelines that the other Metro health care plan will follow when a

Metro Employee transfers from this Plan to their health care plan. These guidelines will include the effective date of coverage.

CONTINUATION COVERAGE

There are certain circumstances under which you or a Dependent may continue coverage with the Plan even though you are no longer on the active Metro payroll due to termination of employment, retirement or a leave of absence, or because you or a Dependent no longer meet the eligibility rules. These circumstances are discussed in the following paragraphs.

CONTINUATION COVERAGE UNDER COBRA

If the ASA remains in effect, but your Coverage under this Plan would otherwise terminate, Metro may offer you the right to continue Coverage. This right is referred to as "COBRA Continuation Coverage" and may occur for a limited time subject to the terms of this Section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA.)

Eligibility

If you have been Covered by the Plan on the day before a qualifying event, you and your Covered Dependents may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

- Subscribers. Loss of Coverage because of:
  - The termination of employment except for gross misconduct; or
  - A reduction in the number of hours worked by the Subscriber.
- Covered Dependents. Loss of Coverage because of:
  - The termination of the Subscriber's Coverage as explained in subsection (a), above;
  - The death of the Subscriber;
  - Divorce or legal separation from the Subscriber;
  - Termination of the domestic partnership;
  - The Subscriber becomes entitled to Medicare; or
  - A Covered Dependent reaches the limiting age or becomes eligible to enroll in his/her own employer-sponsored health plan.

Enrolling for COBRA Continuation Coverage

The COBRA administrator, acting on behalf of Metro, shall notify you of your rights to enroll for COBRA Continuation Coverage after:

- The Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or
- The Subscriber or Covered Dependent notifies Metro, in writing, within sixty (60) days after any other qualifying event set out above.

You have sixty (60) days from the later of the date of the qualifying event or the date that you receive notice of the right to COBRA Continuation Coverage to enroll for such Coverage. Metro or the COBRA administrator will send the forms that should be used to enroll for COBRA Continuation Coverage. If you do not send the Enrollment Form to Metro within that 60-day period, you will lose your right to COBRA Continuation Coverage under this Section. If you are qualified for COBRA Continuation Coverage and receive services that would be Covered Services before enrolling and submitting the Payment for such Coverage, you will be required to pay for those services. The Plan will reimburse you for Covered Services, less required Member payments, after you enroll and submit the Payment for Coverage, and submit a claim for those Covered Services as set forth in the Claim Procedure section of this Medical Plan Document.

Certain employees who have been displaced by import competition or shifts of production to foreign countries may receive a second 60-day election period during the six (6) months following the end of their group health coverage.

Payment

You must submit any Payment required for COBRA Continuation Coverage to the COBRA administrator at the address indicated on your Payment notice. The Payment due for the period between the date you first become eligible and the date you enroll for COBRA Continuation Coverage must be paid to Metro (or to the COBRA administrator, if so directed by Metro) within forty-five (45) days after the date you enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Payments are due and payable on a monthly basis as required by Metro. If the Payment is not received by the COBRA administrator on or before the due date, Coverage will be terminated, for cause, effective as of the last day for which Payment was received as explained in the Termination of Coverage Section. The COBRA administrator may use a third party vendor to collect the COBRA Payment.

Coverage Provided

If you enroll for COBRA Continuation Coverage you will continue to be Covered under the Plan and this Medical Plan Document. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this Medical Plan Document and the Plan. The Plan and Metro may agree to change the ASA and/or this Medical Plan Document. Metro may also decide to change COBRA administrators. If this happens after you enroll for COBRA Continuation Coverage, your Coverage will be subject to such changes.

Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

Eighteen (18) months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or

- Thirty-six (36) months for other qualifying events. If a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g., divorce), you may be eligible for thirty-six (36) months of COBRA Continuation Coverage from the date of the first qualifying event;
- As a limited exception to the above, if you become disabled, as defined by the COBRA law,

at the time of that qualifying event, and you notify the COBRA administrator or Metro of that fact during the 18-month COBRA Continuation Coverage period, you will be eligible for an additional eleven (11) months of COBRA Continuation Coverage (i.e., a total of twenty-nine (29) months of Coverage).

Termination of COBRA Continuation Coverage
After you have elected COBRA Continuation Coverage, that Coverage will terminate either at the end of the applicable 18, 29 or 36 month eligibility period or, before the end of that period, upon the date that:

- Payment for such Coverage is not submitted when due; or
- You become Covered as either a Subscriber or dependent by another group health care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or
- The ASA is terminated; or
- You become entitled to Medicare Coverage; or
- The date that you, otherwise eligible for twenty-nine (29) months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA law.

CONTINUED COVERAGE DURING A LEAVE OF ABSENCE
Federal law requires that Metro allow Subscribers to continue their Coverage during a leave of absence. Please check with the Human Resources Department to find out how long Subscribers may take a leave of absence.

Subscribers also have to meet these criteria to have continuous Coverage during a leave of absence:

- Metro continues to consider the Subscriber an Employee, and all other Employee benefits are continued;
- The leave is for a specific period of time established in advance; and
- The purpose of the leave is documented.

A Subscriber may apply for COBRA Continuation if the leave lasts longer than allowed by Metro.

LEAVE OF ABSENCE
A "leave of absence" will be defined for purposes of this document as any approved or non-approved leave whereby the Employee's employment has not been terminated but the Employee is no longer being paid on the Metro payroll, or is carried on the Metro payroll but is not receiving compensation. Special provisions apply to Employees on Family and Medical Leave ("FMLA"), short term disability ("STD") and military leave. These provisions are described in separate sections, below. The following provisions apply to people on other types of leave of

absence. A person will not be considered being on a leave of absence status if the Employee is receiving pay for vacation, compensatory time, sick leave, or such other type of pay including payment from a pension Plan administered by the Board. While on leave of absence, coverage will continue until the Employee has gone two consecutive pay periods without the full amount of the required employee contribution being withheld from his or her pay. Coverage under the plan will terminate on the date such second pay check would have been issued. However, an Employee, or Dependent(s) of an Employee who is on an approved or unapproved leave of absence, has the right to continue his coverage with the Plan. The guidelines under which the Covered Persons may continue coverage are those guidelines outlined for COBRA above. If a Covered Person wishes to continue coverage, they must follow the COBRA guidelines. COBRA coverage, if elected, will be effective as of the date the Employee's coverage under the plan terminates.

The Covered Person may elect not to continue coverage while on a leave of absence. If the Covered Person has not elected coverage through COBRA within the time frames outlined in the COBRA section, Human Resources will assume the Covered Person does not wish to continue medical coverage.

If the Covered Person does not elect to continue coverage while on a leave of absence, benefits will cease. When the Employee returns from the leave of absence, the Employee's coverage will automatically be reinstated by Human Resources (see Effective Date after Leave of Absence on page 21). Coverage will be reinstated for the Employee and Dependents with the same coverage and with the same health care Plan that the Employee had before the leave began, as long as the Employee and Dependents still meet the eligibility rules. However, the Employee will be allowed to transfer to another health care Plan when he returns from leave if the Employee was on leave during the Annual Enrollment period.

Coverage through the Plan while on a leave of absence may not exceed the amount of time allowed under the provisions of COBRA.

FAMILY MEDICAL LEAVE ACT COVERAGE

During a leave covered by the Family and Medical Leave Act, coverage under the Plan continues at the contribution rate that you would have paid had you remained active. Please contact your department's Human Resources Representative regarding how to pay for contributions while you are on leave.

If your FMLA will be unpaid (or a portion of it will be unpaid), you have the option of paying your contributions in one of the three (3) ways:

- pre-pay contributions prior to your FMLA or Short-Term Disability beginning;
- pay contributions directly to Metro on a month-by-month basis while on leave; or,
- have contributions held in arrears and when you return to work, contributions will be withheld from your paychecks.

If an election is not made and you are no longer in a paid status, your contributions will be held in arrears and will be collected when you return to work.

SHORT TERM DISABILITY

While you are receiving Short-Term Disability (STD) benefits, your medical benefits will be continued and you will pay the same rate that you paid when you were actively working. Contributions will be withheld from your Metro paycheck as long as you are in a paid status. If your STD leave or a portion of your leave will be unpaid, you have the option of paying your contributions in one of three (3) ways:

- Pre-pay contributions prior to your FMLA or STD beginning;
- Pay contributions directly to Metro on a month-by-month basis while on leave; or,
- Have contributions held in arrears and when you return to work, contributions will be withheld from your paychecks.

If an election is not made and you are no longer in a paid status, your contributions will held in arrears and will be collected when you return to work.

MILITARY LEAVE

While you are on military leave, your medical benefits may be continued for up to 24 months and you will pay the same rate that you paid when you were actively working. Contributions will be withheld from your Metro paycheck as long as you are in a paid status. If your military leave will be unpaid, you have the option of paying your contributions in one of three (3) ways:

- Pre-pay contributions prior to your leave beginning;
- Pay contributions directly to Metro on a month-by-month basis while on leave; or,
- Have contributions held in arrears and when you return to work, contributions will be withheld from your paychecks.

If an election is not made and you are no longer in a paid status, your contributions will be held in arrears and will be collected when you return to work.

ELECTED OFFICIALS

Elected officials who were participants in the Plan during the time they held office may elect to continue medical coverage provided they pay the full amount of the contribution without any subsidy from Metro. Elected officials may continue coverage also on their Dependents provided they were covered during the elected official's tenure in office. Dependents may continue to participate in the Plan upon the elected official's becomes deceased if they were covered by the Plan during the life of the elected official (see Metropolitan Code Section 3.24.010). Elected officials who continue coverage, or Dependents who continue coverage after the elected official becomes deceased, must elect coverage through Human Resources within sixty (60) calendar

days of when their coverage would otherwise terminate with the Plan.
Elected officials who retire from Metro and receive a pension check will pay the contribution established by the Board for Pensioners.

All elected officials who continue their coverage will follow the administrative guidelines established in this Plan document for Pensioners.

PENSIONERS

A Regular Pensioner may elect to continue coverage with the Plan upon service retirement. Disability Pensioners are required to maintain coverage through the Plan unless they opt out of the Plan with proof of other coverage. However, a Disability Pensioner may elect not to continue coverage when he or she converts to a service pension or at the time he or she is eligible to convert to a service pension. When a Regular Pensioner elects a survivor's option under the Metro Pension Plan and the Regular Pensioner elects not to have medical coverage or elects to opt out with proof of other non-Medicare coverage, the medical coverage will be discontinued only if the surviving spouse/domestic partner also agrees in writing with the election not to have medical coverage. The surviving spouse/domestic partner must agree only when the survivor is an eligible Dependent (spouse/domestic partner) under the Plan's guidelines.

Pensioners must be receiving a monthly pension check from Metro to be eligible to continue coverage with the Plan.

Retired members and surviving spouses of the Old Davidson County Board of Education Pension Plan are eligible to maintain the medical benefits (at the same rate paid by all other Pensioners) and provisions of this Medical Plan Document.

To continue coverage while on pension, the Pensioner must complete the appropriate forms in Human Resources at the time the Pensioner completes his pension application or prior to the effective date of the pension. The Pensioner, at that time, may add eligible Dependents to his coverage and change from Individual to Family coverage. The Pensioner will be allowed to add Dependents at a later date only under the very limited conditions specified in "Eligibility" section. The Pensioner must continue coverage with the same health care Plan when retiring but may change to other health care Plans, if available, during the Annual Enrollment period.

In the event of the death of a Pensioner, the covered Dependents may continue coverage if the Dependents as specified above in the "Eligibility" section meet the eligibility guidelines and completes the appropriate forms.

Upon retirement, if the Pensioner's spouse/domestic partner is an active Employee participating in the Plan, the Pensioner may elect to transfer his medical coverage to the active Employee's coverage and continue coverage as a Dependent.

Employees who have retired but will <u>not</u> be receiving a pension benefit check are not eligible to continue the Plan as a Pensioner, but may be eligible to continue coverage through other provisions of COBRA.

If a Pensioner who has continued coverage with the Plan returns to work with Metro and becomes eligible for coverage as an Employee, the Pensioner's status for insurance purposes will be transferred from a Pensioner to an Employee the day the Pensioner returns to work with Metro. If the Pensioner did not continue coverage as a Pensioner, the Pensioner will be treated for insurance purposes when he returns to work with Metro, as a newly eligible Employee.

If a Pensioner's pension ends for whatever reason, the Pensioner and his covered Dependents will not be allowed to continue coverage with the Plan as a Pensioner. The Pensioner and his Dependents may be allowed to continue coverage through COBRA depending on the amount of time that has expired as a Pensioner in comparison to the time limitations specified under COBRA.

PENSION BENEFICIARY

If an Employee dies before he or she goes on pension, the Employee's beneficiary on the Pension Plan **may** be eligible to be covered under this Plan. The term "**Beneficiary**" for the purposes of this Section will be defined as "the person that will receive survivor pension benefits from the Metro Pension Plan due to the death of a Metro Employee".

To qualify for coverage, the Beneficiary must meet the following criteria:

- At the time of death, the Employee must have been eligible for pension benefits due to years worked (service pension) or due to an in the-line-of-duty Injury or Illness;
- The Beneficiary must be receiving a monthly survivor's benefit check from the Metro Pension Plan; and,
- The Beneficiary must be a Dependent, as defined by this Plan, of the deceased Employee.

The Beneficiary did not have to be covered by the Plan as a Dependent when the Employee died to be eligible for coverage as the Beneficiary.

The Beneficiary must complete the appropriate insurance forms in Human Resources at the time the Beneficiary completes the pension forms to receive the survivor's benefit. At that time, the Beneficiary may add other eligible Dependents to the Beneficiary's coverage and be covered under family coverage as long as they are Dependents (as defined by the Plan) of the deceased Employee. The Beneficiary must add eligible Dependents at this time because Dependents may not be added to coverage at a later date under any circumstances.

Once the Beneficiary meets the criteria outlined in this Section, the Beneficiary will follow the administrative guidelines established in this Plan document for Pensioners, unless otherwise specified.

The Beneficiary may continue coverage with the Plan as long as the Beneficiary qualifies for a survivor's benefit under the Metro Pension Plan. Once the Beneficiary becomes ineligible for the survivor's benefit, coverage under the Plan will terminate.

BENEFITS AFTER COVERAGE ENDS

Benefits for Hospital Services will be provided where a Member is hospitalized on the date this Plan is terminated, in which case benefits for Hospital Services only will be provided for up to 90 days or until the Member is discharged, whichever occurs first. The provisions of this Paragraph will not apply to a newborn child of a Subscriber for whom application for coverage was not received by the Plan within sixty (60) calendar days following such child's birth.

SECTION XI — DEFINITION OF TERMS

Accidental Injury – A traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to result in serious physical impairment or loss.

Acute – An illness or injury which is both severe and of short duration.

Administrative Services Agreement (ASA) – The agreement between BCBST and the Metro Government. It includes the ASA and any attached papers or riders (including the Letter of Intent, if any).

Allied Health Professional – A health care provider, other than a Physician, who has entered into a contract with BCBST to provide Covered Services to a Member under this Plan.

Ambulance – A specially designed and equipped vehicle used only to transport the sick and injured.

Ambulatory Surgical Facility – A health care facility which provides surgical services but usually does not have overnight accommodations; has an organized staff of Physicians and permanent facilities and equipment; and is not used primarily as an office or clinic for a Physician or other professional private practice. Such a facility must be licensed as an Ambulatory Surgical Facility by the state in which it is located or must be operated by a Hospital licensed by the state in which it is located.

Authorized Service - Any Covered Service which has been authorized by the Medical Director.

Benefit Period – A calendar year during which this Plan is in force during which benefits for Covered Services may be available. Charges for Covered Services are considered incurred on the date they are provided.

Billed Charges – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the Maximum Allowable Charge for services.

BlueCard Program – A program established by BlueCross and/or BlueShield organizations and the BlueCross BlueShield Association to process and pay claims for Covered Services received by a Member of a BlueCross and/or BlueShield organization from a provider outside the organization's Service Area with whom that organization does not have an agreement.

Blue Preferred Provider (Network Provider) – A Physician, Hospital, or other Provider that has contracted with BCBST to furnish services and to accept BCBST's payment, plus applicable Deductibles and Co-payments, as payment in full for Covered Services.

Case Management – A process directed at linking individual Members and families with the appropriate medical services and community resources necessary to manage the Member's total care to promote optimum quality and an optimum outcome. Case Management involves a systematic process of assessing, planning, service coordination and monitoring through which multiple health needs of patients are met.

Change in Family Status – A change in circumstances to an Employee that would permit the Employee to revoke an election under a cafeteria plan as defined in Section 125 of the Internal Revenue Code. A Change in Family Status includes (a) "Special Enrollment Events" as

described in the Enrolling in Coverage for Employees and their Dependents section above and the Enrolling in Coverage for Pensioners and their Dependents section above and (b) change in status events, including, change in legal marital status, number of dependents, employment status, dependent satisfying or ceasing to satisfy eligibility requirements, or residence.

Co-insurance – The amount stated as a percentage of the Maximum Allowable Charge for a Covered Service that is the responsibility of the Member during the Benefit Period after any Deductible has been satisfied.

The Member will be responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service if a Non-Network Provider's Billed Charges are more than the Maximum Allowable Charge for Services. In such case, the Member's total payment as a percentage of the Non-Network Provider's Billed Charges may exceed the Co-insurance Payment percentage set forth in the Schedule of Benefits.

Complications of Pregnancy – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarian section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Concurrent Review – Refers to the determination under BCBST's Utilization Management Program of whether continued Inpatient or Outpatient care, or a given level of service, is Medically Necessary.

This review can be performed by the Provider's Utilization Management staff, our Review Coordinator, or other person(s) designated by BCBST's Medical Director. If, under such review, it is determined that continued care is not Medically Necessary, the facility and Physician will be notified in writing of a specific date after which benefits will no longer be payable under this Plan. The Member or Physician can appeal the decision by contacting us. The case will be reviewed and both the Physician and the Member will be notified of the results.

Contracted Transplant Network Institution – One which has contracted with the Administrator (or with an entity on behalf of the Administrator) to provide facility Transplant Services for the organ and bone marrow transplant procedures Covered under this Plan. (A list of Contracted Transplant Institutions is available from BCBST upon request by Metro or the Member.)

Co-payment – The dollar amount (as specified in the Schedule of Benefits) for which a Member is responsible when a particular service or supply is received. Co-payments do not apply toward satisfying Deductibles, Out-of-Pocket, or any Lifetime or Annual Maximums.

Covered Charge – Amount of total charge that is eligible for consideration of payment.

Covered Service – A Medically Necessary service or supply (specified in this Plan) for which

benefits may be available.

Creditable Coverage – Individual or group health coverage of the Member prior to his or her Enrollment Date which may be applied to reduce a Member's Pre-existing Condition Waiting Period, if any, stated in this plan. Creditable Coverage also includes coverage under COBRA, a health maintenance organization, Medicare, Medicaid (including TennCare), the Federal Employee Health Benefit Plan, and/or a public, government, military or Indian Health Service benefit program.

Up to eighteen (18) months of Creditable Coverage may be applied to reduce the Member's applicable Pre-existing Condition Waiting Period. However, a period of coverage will not be counted for purposes of reducing a Member's Pre-existing Condition Waiting Period if there is a break in such coverage of sixty-three (63) days or more during which the Member was not covered under any Creditable Coverage.

Custodial Care – Any services or supplies provided to assist an individual in the activities of daily living, such as help in walking, getting in or out of bed, or any service that could be performed by a family member or non-professional personnel.

Deductible – The dollar amount of Covered Services specified in the Schedule of Benefits that must be incurred and paid by a Member before benefits are payable for all or part of the remaining Covered Services. Neither Co-payments nor any balance of charges (between Billed Charges and the Maximum Allowable Charge) required for services will be considered when determining if the Member has satisfied a Deductible. The Deductible will apply to the Out-of-Pocket and Family Out-of-Pocket Maximums.

Dependent – Dependents shall include only the following:

- Legally recognized spouse in accordance with the laws of the State of Tennessee, while not divorced or legally separated from the Subscriber;
- Domestic partner and his or her children as outlined in the Domestic Partnership Benefits Policy approved by the Board and where a Declaration of Domestic Partnership has been completed and acknowledged by Metro Human Resources;
- Natural and adopted children of the Subscriber who may or may not reside in the home of the Subscriber the majority of the time on an annual basis;
- Foster child" means a child placed with an eligible Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- A child of Subscriber or Subscriber's spouse/domestic partner for whom a Qualified Medical Child Support Order has been issued; or
- Step-children of the Subscriber and
- Children, other than those listed above, who are in the Subscriber's legal custody by court order.

Dependent children, as defined above, will be covered from birth until the last day of the month of their twenty-sixth (26th) birthday, married or unmarried.

If on the child's twenty-sixth (26th) birthday, he is Incapacitated, which is defined as

incapable of self-sustaining employment by reason of mental retardation or physical handicap, the child shall continue to be deemed a Dependent after said birthday, during the continuation of said incapacity and while he is otherwise included as a Dependent under the above definition, subject to the other terms and conditions of this Plan and to the right of the Administrator to require proof of incapacity when claim is first made for benefits after said birthday, and proof once each year thereafter of the continuation of said incapacity.

Disability Pensioner – A former Employee receiving disability benefits from Metro.

Drug Formulary – A list of prescription medications which designates products which are approved for coverage by BCBST and which will be dispensed through participating pharmacies to Members. This list is subject to periodic review and modification by BCBST.

Durable Medical Equipment – Equipment which:

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

Such equipment will not be considered a Covered Service, even if it is prescribed by a Physician or Other Provider, simply because its use has an incidental health benefit.

Effective Date - The date on which coverage of a Member begins under this Plan according to the Schedule of Eligibility.

Eligibility Waiting Period – The period that must pass before a person becomes eligible for coverage under this Plan.

Eligible Provider – The following are considered Eligible Providers, under this coverage:

Hospital – A licensed short-term, acute care general Hospital which:

- Provides Inpatient services and is compensated by or on behalf of its patients;
- Provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric Hospital will not be required to have surgical facilities;
- Has a staff of Physicians licensed to practice medicine; and
- Provides 24-hour nursing care by registered graduate nurses

A facility which serves, other than incidentally, as a nursing home, Custodial Care home, health resort, rest home, rehabilitation facility, or place for the aged is not considered a Hospital.

Other Facility Providers – Those providers listed below who are licensed to perform Covered Services in the state where the services are provided:

- Free-standing Dialysis Facility
- Ambulatory Surgical Facility
- Skilled Nursing Facility

- Substance Abuse Treatment Facility
- Residential Treatment Facility
- Licensed birthing center
- Other facilities approved by BCBST's Medical Director and licensed to provide Covered Services (such as a Freestanding Radiology Facility)

Physician – A licensed Physician legally entitled to practice medicine and perform Surgery. All Physicians must be licensed in Tennessee or in the state in which Covered Services are rendered.

Other Professional Providers – May provide services covered by this Plan. In order to be covered, all services rendered must fall within the provider's specialty and be those normally provided by a Provider within this specialty or degree. The Provider actually billing for them must render all services or supplies.

- The Provider must be licensed or certified by the state in which they are practicing;
- Services provided must be within the scope of his/her licensure; and
- Coverage of the provider must be required by state law of the state in which he/she is practicing; or
- Is a Provider (such as Physician Assistant) approved by BCBST.

Emergency or Emergency Medical Condition – Means the sudden onset of a medical condition of sufficient severity that, in the absence of immediate medical attention, could reasonably be expected to result in:

- Serious impairments to body functions;
- Serious dysfunction of a bodily organ or part; or
- Placing the Member's health in serious jeopardy.

An "Emergency" does not include treatment of a chronic condition in which sub-acute symptoms have existed over a period of time and would not be considered an Emergency unless symptoms suddenly became severe enough to require immediate medical assistance.

Emergency Admission – Admission as an Inpatient in connection with an Emergency.

Emergency Services means health care services and supplies furnished in a Hospital which are required to determine, evaluate and/or treat an Emergency Medical Condition until such Condition is stabilized, as directed or ordered by a Physician or Hospital protocol.

Employee – A person who meets the Eligibility requirements for coverage under this Plan.

Employer – The term Employer, in general, refers to the Metropolitan Government of Nashville and Davidson County and any other entity which, with the approval of the Metropolitan Government of Nashville and Davidson County, adopts the Plan. The Employer has delegated its authority to make decisions under the Plan to the Metropolitan Employee Benefit Board created in accordance with Section 13.02 of the Metropolitan Charter ("Metro").

Enrollment Date – The Effective Date of a Member's coverage or, if earlier, the first day of the applicable Eligibility Waiting Period.

Explanation of Benefits (EOB) – The form we send after a claim has been filed that tells you what services were covered and which, if any, were not.

Family Deductible – The maximum dollar amount of Covered Services stated in the Schedule of Benefits that must be incurred and paid by a Subscriber and his or her eligible Dependents before benefits are payable for all or part of the remaining Covered Services.

Family Out-of-Pocket Maximum – The dollar amount stated in the Schedule of Benefits for which a Subscriber and his or her covered eligible Dependents are responsible to pay for Covered Services during a Benefit Period. This Maximum can be satisfied by a combination of services provided by Network and non-Network Providers.

Freestanding Diagnostic Laboratory – An Other Provider that provides laboratory analysis for all Providers.

Freestanding Dialysis Facility – A facility Other Provider which provides kidney dialysis treatment, maintenance, and training to patients on an Outpatient or Home Health Care basis. To be eligible for payment under this coverage, Medicare must approve the facility.

Health Care Professional – A podiatrist, dentist, chiropractor, nurse midwife, registered nurse, optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which such provider practices.

Home Health Care Agency– An organization that provides health care services in a Member's home.

Home Infusion Therapy – Therapy in which fluid or medication is given intravenously. It includes total parenteal nutrition, enteral nutrition, hydration therapy, chemotherapy, aerosol therapy and intravenous drug administration.

Hospice– A public agency or private organization that provides services for a terminally ill patient. Approved Hospice refers to a Hospice which:

- Is licensed by and, if legally required, has been issued a Certificate of Need from the state in which it is operating;
- Is certified as a Home Health Care Agency under Title XVIII and Title XIX of the Social Security Act;
- Is eligible for accreditation by the Joint Commission on Accreditation of Healthcare Organizations as a Hospice; and
- Provides in-home health care services, which conform to the standards of a Hospice Program of Care as adopted by the Board of Directors of the National Hospice Organization.

Inpatient– An individual who is admitted as a registered bed patient in a Hospital or Skilled Nursing Facility and for whom a room and board charge is made. This term is also used to describe services provided in a Hospital or Skilled Nursing Facility setting.

In-Transplant Network – A network of Hospitals and facilities, each of which has agreed to perform specific organ transplants. For example, some Hospitals might contract to perform heart transplant, but not liver transplants.

Investigational Services – A drug, device, treatment, therapy, procedure, or other service or

supply that does not meet the definition of Medical Necessity or:

- Cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") when such approval has not been granted at that time of its use or proposed use; or
- Is the subject of a current Investigational new drug or new device application on file with the FDA; or
- Is being provided according to Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial); or
- Is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives; or
- Is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board ("IRB") as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS"); or
- The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is either experimental or investigational or that there is insufficient data to determine if it is clinically acceptable; or
- In the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings; or
- In the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives; or
- The service or supply is required to treat a complication of an experimental or Investigational Service.

The Medical Director has discretionary authority, in accordance with applicable ERISA standards even though Metro Government's Plan is not subject to ERISA, to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

- Your medical records; or
- The protocol(s) under which proposed service or supply is to be delivered; or
- Any consent document that you have executed or will be asked to execute, in order to receive the proposed service or supply; or
- The published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by you; or

- Regulations and other official publications issued by the FDA and HHS; or
- The opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational Services; or
- The findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

The Medical Director's decision may be appealed to the Metro Employee Benefit Board, which has final authority on any decision affecting the Plan.

Late Enrollee – An Employee or eligible Dependent who did not apply, or for whom application was not made, for coverage within 60 calendar days after such person first became eligible for coverage under this Plan.

Lifetime Maximum – The total dollar amount of benefits available under this Plan during the Member's lifetime, as stated in the Schedule of Benefits. The lifetime amount (as stated in the Schedule of Benefits) will be subject to (and reduced by) amounts paid in any and all contract years preceding the Effective Date of this coverage, provided the Member has had continuous coverage under group health contract(s) between BCBST and Metro Government during such years.

Limiting Age (or Dependent Child Limiting Age) – The age after which a child will no longer be considered an eligible Dependent.

Maximum Allowable Charge – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider or the amount payable based on the Administrator's fee schedule for the Covered Services.

Medical Director – The Physician designated by the Administrator, or that Physician's designee, who is responsible for the administration of the Plan's medical management programs, including its Authorization program.

Medically Appropriate – Services which have been determined by the Medical Director of the Plan to be of value in the care of a specific Member. To be Medically Appropriate a service must:

- Be Medically Necessary;
- Be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation;
- Be consistent with current standards of good medical practice for the Member's medical condition;
- Be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;
    - On an ongoing basis, have a reasonable probability of:
        - Correcting a significant congenital malformation or disfigurement caused by disease or injury;
        - Preventing significant malformation or disease;

- Substantially improving a life sustaining bodily function impaired by disease or injury.

- Not be provided solely to improve a Member's condition beyond normal variations in individual development and aging including:
  - Comfort measures in the absence of disease or injury;
  - Improving physical appearance that is within normal individual variation.
- Not be for the sole convenience of the Provider, Member or Member's family.

Medically Necessary or Medical Necessity – Services which have been determined by the Plan to be of proven value for use in the general population. To be Medically Necessary a service must:

- Have final approval from the appropriate government regulatory bodies.
- Have scientific evidence permitting conclusions concerning the effect of the service on health outcomes.
- Improve the net health outcome.
- Be as beneficial as any established alternative.
- Demonstrate the improvement outside the investigational setting.
- Not be an experimental or Investigational service.

Member, You, Your – Any person enrolled as a Subscriber or Covered Dependent under the Plan.

Mental Disorder – A condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances is the dominant feature. Mental Disorders include mental illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic chemical or non-chemical origin, and irrespective of cause, basis or inducement.

Network Hospitals – Hospitals with which BCBST has entered into a Network Hospital Agreement.

Network Pharmacy – A Pharmacy which has entered into a Network Pharmacy Agreement with the Plan or its agent to legally dispense Prescription Drugs to you, either in person or through home delivery.

Network Provider – An Institution, Physician, Outpatient mental health facility, Outpatient physical therapy facility, Home Health Agency, Pharmacy, Physician, or Other Provider of health care services, which, at the time a Member receives Covered Services has an agreement with BCBST (or entity contracting with BCBST) to provide those health care services to Members under this Plan. A Network Provider may bill or seek reimbursement for Authorized Services from BCBST, except for the Member's Deductibles, Co-payments, or Co-insurance amounts.

Non-Network Pharmacy – A pharmacy other than a Participating Pharmacy.

Non-Network Provider – A Physician, Hospital, or Other Provider that has not contracted with

BCBST to furnish services and to accept BCBST's payment, plus applicable Deductibles and Co-payments, as payment in full for Covered Services.

Other Providers – The following providers may also provide services covered under the Plan:

- Suppliers of Durable Medical Equipment, appliances, and prosthesis;
- Suppliers of oxygen;
- Certified Ambulance service;
- Hospice;
- Pharmacy;
- Freestanding Diagnostic Laboratory;
- Home Health Care Agency; and/or
- Free-standing and mobile diagnostic or physical therapy facility.

Out-of-Pocket Maximum – The dollar amount stated in the Schedule of Benefits for which a Member is responsible for Covered Services during a Benefit Period. When the Network Out-Of-Pocket Maximum is reached, 100% is payable for other Covered Services received from a Network Provider during the remainder of the Benefit Period. However, the Non-Network Out-Of-Pocket Maximum must be reached before 100% is payable for other Covered Services received from a non-Network Provider during the remainder of the Benefit Period.

Outpatient – An individual who receives services or supplies while not an Inpatient. This term is also used to describe services provided in an Emergency room, Ambulatory Surgical Facility, Physician's office, or clinic.

Outpatient Surgery – Surgery performed in an Outpatient department of a Hospital, in a Physician's office, or Facility Other Provider.

Pensioner – A Regular Pensioner, a Disability Pensioner, or his or her surviving spouse who has met the guidelines to continue to participate in this Plan.

Physician – A licensed Physician legally entitled to practice medicine or perform Surgery. All Physicians must be licensed in Tennessee or in the state in which Covered Services are rendered.

Practitioner – A person licensed by the State to provide medical services.

Pre-admission Testing – X-rays, electrocardiograms, and laboratory tests made on an Outpatient basis before admission to the Hospital.

Prior Authorization or Authorization – A review conducted by the Plan, prior to the delivery of certain services, to determine if such services will be considered Covered Services.

Psychiatric Care – Treatment of a mental illness (abnormal functioning of the mind or emotions regardless of origin). Psychiatric Care includes treatment for drug addiction or alcoholism.

Residential Treatment Facility – A Facility-Other-Provider primarily engaged in providing treatment for alcoholism and drug abuse. A Residential Treatment Facility must be licensed, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and be recognized by us.

Regular Pensioner – A former Employee, or a survivor of a former Employee, who has retired and is receiving a pension from Metro. Employees (i) hired on or after January 1, 2013 or (ii) rehired on or after January 1, 2013 who had not earned a vested right to a pension in accordance with the Metropolitan Code of Laws prior to the date of rehire, must be eligible for an immediate service pension (early or normal – whether they chose to defer the pension or not) at the time of their employment termination in order to be eligible to keep their medical benefits as a Regular Pensioner. Contributions will be payable in accordance with provisions outlined in the Metropolitan Code and approved by the Board.

Service Area – Geographic areas in which Covered Services from Network Providers are available.

Skilled Nursing Facility – A facility that provides convalescent and rehabilitative care on an In-patient basis. Skilled nursing care must be provided by or under the supervision of a Physician. Neither of the following will be considered a Skilled Nursing Facility under this Plan:

- A facility which primarily provides minimal, custodial, ambulatory, or part time care; or
- A facility which treats mental illness, alcoholism, drug abuse, or pulmonary tuberculosis.

Special Care Unit – Areas of a Hospital where necessary supplies, medications, equipment, and a skilled staff are available to provide care to critically or seriously ill patients who require constant observation.

Sub-acute – Less marked in severity or duration than a corresponding acute state.

Subscriber – An Employee or Pensioner who has satisfied the eligibility requirements and has been enrolled for coverage under this Plan.

Substance Abuse Treatment Facility – A provider of continuous, structured 24-hour-per-day programs of Inpatient treatment and rehabilitation for drug dependency or alcoholism. A Substance Abuse Treatment Facility must be licensed to provide this type of care by the state in which it operates and be recognized by us.

Surgery – Operative and cutting procedures, including:

- Use of special instruments;
- Endoscopic examinations (the insertion of a tube to study internal organs);
- Other invasive procedures;
- Treatment of broken and dislocated bones;
- Usual and related pre- and post-operative care when billed as part of the charge for Surgery; and;
- Other procedures that have been approved by us.

Transplant Maximum Allowable Charge (TMAC) – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for Organ Transplants. Each type of Organ Transplant has a separate TMAC. That determination will be based upon the contract with a Transplant Network Provider or the amount payable based on the fee schedule for the Covered Services rendered by Non-Network Providers.

Transplant Services – Medically Necessary and Appropriate Services listed as Covered under

the Transplant Services section of this Plan.

SECTION XII – NOTICES

MATERNITY AND NEWBORN COVERAGE

Your Plan provides maternity and newborn infant coverage. Federal law generally prohibits this Plan from restricting 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 normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. Federal law also generally prohibits the Plan from requiring that a Provider obtain authorization to prescribe a length of stay in excess of the above periods. Please refer to the Covered Services section of this Plan for details.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

Patients who undergo a mastectomy and who elect breast reconstruction in connection with the mastectomy are entitled to coverage for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphodemas

in a manner determined in consultation with the attending physician and the patient. The Coverage may be subject to Co-insurance and Deductibles consistent with those established for other benefits. Please refer to the Covered Services section of this Plan for details.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994

You may continue your Coverage and Coverage for your Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When you return to work from your military leave of absence, you will be given credit for the time you were covered under the Plan prior to the leave. Check with Metro to see if this provision will apply to you.

SECTION XIII –PRIVACY PRACTICES

PROVISION OF PROTECTED HEALTH INFORMATION TO COMPANY

The provisions of this section to the Medical PPO Plan for The Metropolitan Government of Nashville and Davidson County are supplemental to and controlling over any inconsistent terms of the Plan. It is intended to comply with the requirements of the privacy and security regulations promulgated under HIPAA regarding information that can be disclosed by the Plan to Company.

I. DEFINITIONS

The following terms shall have the meanings described in this paragraph I when capitalized. Other capitalized terms will have the meanings described in the Plan:

- **Administrator** - The committee, individual or individuals appointed by Metro to administer the Plan and to perform on behalf of the Plan those duties or actions specified in this Addendum
- **Electronic Protected Health Information or EPHI** - Electronic Protected Health Information as defined in 45 C.F.R. § 160.103
- **HIPAA** - The Health Insurance Portability and Accountability Act of 1996, as amended
- **Plan** - The Metropolitan Government of Nashville and Davidson County BlueCross BlueShield Medical PPO Plan for The Metropolitan Government of Nashville and Davidson County and its agents, health insurance issuer or PPO,
- **Privacy Regulations** - The regulations contained in 45 C.F.R. Parts 160 and 164
- **Protected Health Information or PHI** - Protected health information as defined in 45 C.F.R. 164.501, which is created or received by the Plan relating to a Participant
- **Required by Law** - Required by law as defined in 45 C.F.R. § 164.501
- **Security Incident** - Security incident as defined in 45 C.F.R. § 164.304
- **Security Regulations** - The regulations contained in 45 C.F.R. Parts 160, 162 and 164
- **Summary Health Information** - Summary health information as defined in 45 C.F.R. § 164.504(a) that is created or received by the Plan

II. PERMITTED DISCLOSURE OF ENROLLMENT/DISENROLLMENT INFORMATION

The Plan may disclose to Metro information on whether an employee or their dependents are participating in the Plan, or are enrolled in or have disenrolled from a health insurance issuer or PPO offered by the Plan.

III. PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to Metro, if Metro requests the Summary Health Information for the purpose of (a) obtaining contribution bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

IV. PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PLAN ADMINISTRATIVE PURPOSES

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph V and obtaining written certification pursuant to paragraph VII, the Plan may disclose PHI to Metro, provided Metro uses or discloses such PHI only for Plan Administration Purposes. As used in this paragraph, "Plan Administration Purposes or Functions" means administration functions performed by Metro on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by Metro in connection with any other benefit or benefit plan of Metro, and they do not include any employment-related functions. Notwithstanding the provisions of this Addendum to the contrary, in no event shall Metro be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

V. CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES

Metro agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information authorized under paragraph VIII) disclosed to it by the Plan, that Metro shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as Required by Law;
- Ensure that any agents, including a subcontractor, to whom Metro provides PHI received from the Plan agree to the same restrictions and conditions that apply to Metro with respect to PHI;
- Not uses or discloses PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Metro;
- Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which Metro becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. § 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- Make Metro's internal practices, books, and records relating to the use and disclosure of PHI

received from the Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with the Privacy Regulations;

- If feasible, return or destroy all PHI received from the Plan that Metro still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between Plan and Metro required by 45 C.F.R. § 504(f) (2) (iii) and described in paragraph VI, is satisfied.

VI. ADEQUATE SEPARATION BETWEEN PLAN AND METRO

Metro shall allow the Central HR Benefit Services Division, Benefit Board Support Staff, Benefit Administrative Staff which includes Assistant HR Director, Deputy Director – HR, and HR Director as well as the HIPAA privacy officer access to PHI. No other persons shall have access to PHI. These employees or classes of employees specified in this paragraph shall only have access to and use PHI to the extent necessary to perform the Plan Administration Functions that Metro performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Addendum, that employee shall be subject to disciplinary action by Metro for non-compliance pursuant to Metro's employee discipline and termination policies established pursuant to the Privacy Regulations.

VII. CERTIFICATION OF COMPANY

The Plan shall disclose PHI to Metro only upon the receipt of a certification by Metro that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f) (2) (ii), and that Metro agrees to the conditions of disclosure set forth in paragraph IV of this Amendment.

VIII. PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION AUTHORIZED BY A PARTICIPANT

The Plan may disclose Protected Health Information about a Participant in accordance with an authorization executed by the Participant that complies with 45 C.F.R. § 164.508 and to the extent permitted by the Privacy Regulations.

IX. REQUIREMENTS RELATED TO SECURITY REGULATIONS

By the effective date of the Security Regulations, Metro shall with respect to any EPHI (except when the only EPHI disclosed to Metro is disclosed pursuant to paragraphs II, III and VIII):

- Implement administrative, physical, and technical safeguards that reasonably and appropriately Protect the confidentiality, integrity, and availability of the EPHI that Metro creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation required by 45 C.F.R. § 164.504(f) (2) (iii) and described

in paragraph VI is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom Metro provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI; and Report to the Plan any Security Incident of which Metro becomes aware.

SECTION XIV – COORDINATION OF BENEFITS

COORDINATION OF BENEFITS

This plan document includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care "Plan." Rules of this Section determine whether the benefits available under this plan document are determined before or after those of another Plan. In no event, however, will benefits under this plan document be increased because of this provision.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the Plan's benefits are determined before or after those of another Plan.

1. **Definitions**. The following terms apply to this provision:

   a. "Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:

      (1) group, blanket, or franchise insurance;
      (2) a group BlueCross Plan, BlueShield Plan;
      (3) group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;
      (4) coverage under labor management trust Plans or employee benefit organization Plans;
      (5) coverage under government programs to which an employer contributes or makes payroll deductions;
      (6) coverage under a governmental Plan or coverage required or provided by law;
      (7) medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type coverages;
      (8) coverage under Medicare and other governmental benefits; and
      (9) any other arrangement of health coverage for individuals in a group.

   b. "Plan" does not include individual or family:

      (1) Insurance contracts;
      (2) Subscriber contracts;
      (3) Coverage through Health Maintenance (HMO) organizations;
      (4) Coverage under other prepayment, group practice and individual practice plans;
      (5) Public medical assistance programs (such as TennCare[sm]);
      (6) Group or group-type hospital indemnity benefits of $100 per day or less;

(7) School accident-type coverages.

Each Contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

c. "This Plan" refers to the part of the employee welfare benefit plan under which benefits for health care expenses are provided.

"Other Plan" applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other contracts when benefits are determined.

d. “Primary Plan/Secondary Plan”.

(1) The order of benefit determination rules state whether This Plan is a "Primary Plan" or "Secondary Plan" as to another plan covering you.

(2) When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

(3) When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

(4) When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

e. "Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one or more Plans covering the Member for whom the claim is made.

(1) When a Plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid.

(2) We will determine only the benefits available under This Plan. You are responsible for supplying us with information about Other Plans so we can act on this provision.

f. "Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which you have no coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

g. "Complying Plan" is a plan that has a coordination of benefit’s provision that complies with either Tennessee’s state regulation on coordination of benefits or the National Association of Insurance Commissioners proposed coordination of benefits language. In addition, a Complying Plan’s coordination of benefits provision is designed in such a manner that it can coordinate benefits between plans with similar coordination of benefits terms.

2. **Order of Benefit Determination Rules**. This Plan determines its order of benefits using the first of the following rules that applies:

   a. Non-Dependent/Dependent

      The benefits of the Plan that covers the person as an Employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that:

      (1) if the person is also a Medicare beneficiary and,

      (2) if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

         i. benefits of the Plan of an active Employee covering the person as a Dependent;

         ii. Medicare;

         iii. benefits of the Plan covering the person as an Employee, Member, or Subscriber.

   b. Dependent Child/Parents Not Separated or Divorced

      Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

      (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

      (2) If both parents have the same birthday, the benefits of the Plan that has covered one parent longer are determined before those of the Plan that has covered the other parent for a shorter period of time.

      (3) However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

   c. Dependent Child/Separated or Divorced Parents

      If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

      (1) First, the Plan of the parent with custody of the child;

      (2) Then, the Plan of the spouse of the parent with the custody of the child; and

      (3) Finally, the Plan of the parent not having custody of the child.

      (4) However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or

provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2(b), Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee

The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

e. Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan that has covered an Employee, Member, or Subscriber longer are determined before those of the Plan that has covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

(2) The start of the new Plan does not include:

i. A change in the amount of scope of a Plan's benefits;
ii. A change in the entity that pays, provides or administers the Plan's benefits;
iii. A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan).

(3) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a Member of the Group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first.

f. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These Plans are called "Non-complying Plans."

Rules. This Plan coordinates its benefits with a Non-complying Plan as follows:

(1) If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

(2) If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.

(3) If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

(4) If:

(a) The Non-complying Plan reduces its benefits so that the Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

(b) Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to you or on your behalf an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

3. **Effect on the Benefits of this Plan**. This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

a. Benefits of This Plan will be reduced when the sum of:

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

(2) the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;

exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

b. When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.

c. The administrator will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:

(1) the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and

(2) the order of benefit determination rules requires us to determine benefits before those of the Other Plan.

4. **Right to Receive and Release Needed Information**.

Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. To the extent permitted by applicable laws, including HIPAA, we may get needed facts from, or give them to any other organization or person, and we need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

5. **Facility of Payment**.

A payment under Another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term "Payment Made" includes providing benefits in the form of services; in which case, Payment Made means reasonable cash value of the benefits provided in the form of services.

6. **Right of Recovery**.

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

a. The persons it has paid or for whom it has paid;

b. Insurance companies; or

c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION WITH MEDICARE

This provision applies when benefits are available under this Plan and Medicare, and if Medicare is the primary plan. Benefits will be reduced under this Plan so that the sum of the benefits payable under both this Plan and Medicare will not be more than the total amount covered under this Plan. Payments by this Plan will be based on Medicare allowance. This provision applies for Members who retired from Metro after October 1, 1993. If a Pensioner who is eligible for

Medicare does not elect both Parts A and B of Medicare, benefits will be reduced by this Plan and benefits will be provided for Part B at 20% of billed charges.

COORDINATION OF BENEFITS – END STAGE RENAL DISEASE

This provision applies when benefits are available under this Plan and benefits are also available under Medicare because a participant has End Stage Renal Disease ("ESRD"). Medicare has special Coordination of Benefits rules for individuals covered by virtue of ESRD who are also covered by an employer group health plan. Under the terms of the Medicare rules and this Plan, during the 30 months after a Member is eligible for Medicare, the Plan is the Primary plan and Medicare is the Secondary plan. After the 30 month period, Medicare becomes the Primary plan for individuals and the Plan becomes the Secondary Plan. Under the Plan, benefits are determined and paid as if the Member with ESRD has enrolled in Medicare even if the Member has not enrolled in Medicare. A Member who enrolls in Medicare can enroll after becoming eligible for Medicare but must enroll before the 30-month period that commences upon Medicare eligibility to avoid paying higher premiums to Medicare. The Member must pay the Part B premium.

Once Medicare becomes the Primary plan, the employee contribution may be changed to reflect the fact that Medicare is the Primary payer. Please see Medicare's rules to determine when you are eligible for Medicare by virtue of ESRD.

SECTION XV — MISCELLANEOUS

SEVERABILITY

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or non-enforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

APPENDIX 1

The Benefit Board Of
The Metropolitan Government of Nashville and Davidson County
Grievance and Appeal Standard for Health Claims

Employees and, if applicable, their beneficiaries, must follow the procedures described in the applicable plan documents for filing claims and grievances or appeals in cases where claims have been denied.

The Administrator will apply the standards and procedures described below for adjudicating claims for Grievances and Level 1 Appeals. The Board will apply the standards and procedures described below for adjudicating claims for Level 2 Appeals.

Grievances

Level 1 Appeals

If a claim for benefits is denied in full or in part, the Administrator or its delegate will notify the claimant in writing within a reasonable period of time, but not later than 90 days after the claim is filed. If special circumstances require extra time for processing, the deadline may be extended for another 90 days. The claimant will be notified before the end of the initial 90-day review period of the reasons for the delay and the date by which he or she may expect a decision.

The claimant also will be notified of the standards used in determining benefit eligibility, the unresolved issues that prevent a decision on his or her claim, and the additional information needed to resolve those issues. The claimant will have at least 45 days to respond to the Administrator or its delegate's request for additional information.

If a claim is denied, the notice of denial will state the reasons for the denial and the plan provisions on which the denial is based. It also will inform the claimant of any additional information or material required to support his or her claim, why the information or material is necessary, and the procedure that must be followed to have the Administrator or its delegate review the denial of the claim.

If the claimant does not receive a notice of delay or a notice of denial within the applicable timeframe described above, or if the Administrator fails in a significant way to follow the procedures described above, the claimant can assume that the claim was denied and may proceed to the appeal stage described in the section below.

Level 2 Appeals

If a claim is denied (or if it is considered to have been denied because the claimant did not receive a written response from the Administrator by the applicable deadline), the claimant or his or her beneficiaries may write to the Board to appeal the denial. The claimant must appeal a denial within 60 days of receipt of the denial or it is deemed denied (i.e., the applicable deadline for the claimant having received a denial). The appeal should include an explanation of why the claimant thinks the denial is incorrect.

The claimant or his or her beneficiaries may see all documents, guidelines, and other materials that relate to the claim, submit any issues and comments in writing to the Board, and, if the claimant wishes, have someone act as his or her representative in the review procedure.

Appeals will be given a full and fair review by the Board.

If an appeal is denied, the Board must provide the claimant with written notice of this denial within a reasonable period of time, but not more than 60 days after receipt of the appeal. There may be times when this 60-day period has to be extended. However, this extension is allowed only when there are special circumstances, which must be communicated to the claimant in writing within the initial 60-day period. If there is an extension, a decision will be made as soon as possible, but not later than a total of 120 days after the Board receives the appeal.

The Board's final decision on an appeal will be communicated to the claimant in writing and will include the reason or reasons the appeal was denied.