RUTHERFORD COUNTY

EMPLOYEE BENEFIT PLAN

SELF-FUNDED PLAN DOCUMENT

Effective July 1, 1997
Restated February 12, 2009

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ARTICLE I – GENERAL INFORMATION

SECTION 1 – HEALTH PLAN (PLAN)

This Health Plan was established for the benefit of Eligible Employees and Eligible Dependents as defined herein, under the terms and conditions hereinafter set forth.

The name of the Plan shall be the Rutherford County Employee Benefit Plan. The purpose of the Plan is to provide health and any other such benefits.

SECTION 2 – PLAN AMENDMENT AND TERMINATION

The Employer establishes this Plan with the intention of maintaining it for an indefinite period of time. However, the Employer reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

1. The Employer shall have the right to amend this Plan (including any Plan provision applicable to retirees) in whole or in part. Amendments shall be by a resolution of the Board of Commissioners or other similar governing body of the Employer or by the written approval of an authorized official of the Employer.

2. The Employer reserves the right at any time to terminate the Plan (including that part, if any, applicable to retirees) by a written resolution of the Board of Commissioners or other similar governing body of the Employer or by the written approval of an authorized official of the Employer.

SECTION 3 – PLAN YEAR AND FISCAL YEAR

The plan year and fiscal year are not the same. The Plan year commences January 1 and ends on December 31(Calendar year).The Fiscal year commences July 1 and ends the following June 30th.

SECTION 4 – SCOPE OF COVERAGE OF PLAN

The provisions of coverage of this Plan shall be limited to those benefits as provided herein, only where accident, injury or illness have occurred, except as otherwise provided herein, when the Covered Person is otherwise eligible.

SECTION 5 – PLAN DOCUMENT CONTROLS

This document contains all provisions of the Plan. Any conflict or ambiguity arising between this document and any other document or communication, including but not limited to any Summary Plan Description, brochure, or oral or video presentation, describing the rights, benefits, or obligations of the Employer and Participants under the Plan shall be resolved in favor of this Plan Document.

ARTICLE II – DEFINITIONS

CERTIFICATE OF CREDITABLE COVERAGE

The term “Certificate of Creditable Coverage” shall mean the certification of coverage that must be provided to the Covered Person when coverage under this Plan ceases. The certification must be provided automatically within a reasonable time period after coverage ceases and in the twenty-four (24) month period after coverage ceases, upon request.

CHARGES

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with the Claims Administrator for a different amount.

CLAIMS ADMINISTRATOR

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

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) shall mean the federal law that allows employees, spouses, and/or dependents who are losing their health or dental benefits to continue the same insurance for a specific length of time under certain conditions pursuant to Article IV, Section14.

COBRA PARTICIPANT

COBRA participant shall mean a qualified beneficiary pursuant to Article IV, Section14 who continues his or her health care coverage under the provisions of the federal guidelines in the Consolidated Omnibus Budget Reconciliation Act of 1985 and Public Health Service Act as amended.

COMMITTEE

Committee shall mean the individuals comprising the Rutherford County Insurance Committee to whom the administrative duties and responsibilities of the plan are delegated pursuant to Article VIII and shall include any authorized representative of the committee. The committee shall be the plan administrator of each respective plan. The Insurance Committee is composed by law of the County Mayor; three County Commissioners; one member from the Rutherford County Education Association; four at-large members; six members who are employees of Rutherford County to include two members from the School Board; two members from the County General; one member from the Sheriff's Office, and one member from the Highway Department. The employee members from the School Board, County General, Sheriff's Office, and Highway Department must be enrolled in the Rutherford County health insurance plan. The Finance Director, Human Resources Director, and Insurance Director shall serve as ex-officio non-voting members.

COVERED MEDICAL EXPENSE

The term "Covered Medical Expense" shall mean those expenses which are outlined in Article VI and which are actually incurred by a Covered Person for treatment of an illness, injury or congenital defect, or in connection with the pregnancy of an Eligible Employee or the spouse of an Eligible Employee, subject to all the limitations outlined in Article VI. Further, "Covered Medical Expense" shall be limited to those expenses which are Medically Necessary, as defined below, and which are Reasonable, Usual and Customary Expenses, as defined below.

COVERED PERSON

"Covered Person" means the "Eligible Employee" and/or the "Eligible Dependent" who have become covered under the Plan.

CREDITABLE COVERAGE

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

Periods of Creditable Coverage will be credited for the purpose of reducing the Pre-Existing Condition Exclusion period of the Plan provided there is not a break in coverage of sixty-three (63) days or more. Waiting periods are not considered a break in coverage.

CUSTODIAL SERVICES

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

1. Services related to watching or protecting a person;

2. Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can usually be self-administered, and

3. Services not required to be performed by trained or skilled medical or paramedical personnel.

DATE CLAIM INCURRED

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

DURABLE MEDICAL EQUIPMENT

“Durable Medical Equipment” means equipment that:

1. can only be used to serve the medical purpose for which it is prescribed;
2. is not useful to the patient or other person in the absence of illness or injury;
3. is able to withstand repeated use; and
4. 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.

ELIGIBLE DEPENDENT

The term "Eligible Dependent" shall mean those persons eligible for coverage as Eligible Dependents on the date the Eligible Employee becomes eligible or on the date they acquire dependent status, as defined below:

1. A Spouse (if not legally separated), under a legally-valid existing marriage between persons of the opposite sex.
2. Unmarried natural child or adopted children. Stepchildren, children placed with the employee in anticipation of adoption, or children for whom the employee is legal guardian or has legal custody. Such children must be unmarried, be declared and legally qualify as a Dependent on the Employee’s federal personal income tax return filed for each year of coverage, maintain his/her principal place of residence with the Employee, and not have reached age 19 or 25 if a full-time student at an educational institution. (As for stepchildren, in the event of a court decree which gives one parent financial responsibility for medical and/or dental expenses, the parent as stated in the decree will have first responsibility for medical and/or dental expenses. Appropriate and legal documentation will be required to determine order of payment for medical and/or dental claims.) An educational institution includes elementary schools, junior and senior high schools, colleges, universities, technical schools, mechanical schools and night schools, but only while the dependent child is enrolled for the number of hours or classes that is considered full-time attendance at a similar day school. The term

3. A child is considered a "Foster Child" if:

A. medical expenses of the child are not covered by any other group coverage, or by the agency through which the child was placed; and

B. placement is for a minimum of 25 days per month and expected to exceed one (1) year; and

C. an application is received by the Employer to cover the child thirty (30) or more days prior to the placement or date the child began living with the employee, whichever is earlier.

4. The requirement that a child (as defined in 2. above) reside with the Employee in Order to be considered an eligible Dependent may be waived if:

A. such child attends school full-time and, when not attending school, lives with the employee in a regular parent-child relationship, or

B. the Employee is obligated by a "Qualified Medical Child Support Order" (a valid order, decree or judgment by a court - including approval of a settlement agreement) to pay the child's medical expenses or provide medical insurance on behalf of the child.

Each Qualified Medical Child Support Order (as defined above) shall specify:

1) the name and last known mailing address (if any) of the child covered by the order,

2) the period to which such order applies, and

3) the health, dental or other benefit plan to which the order applies.

The Employee will be required to provide certified copies of any Qualified Medical Child Support Order within 31 days of the date it is issued.

5. Eligibility for adopted children:

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

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

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

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

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

6. Child also includes a child who is over age 18, was covered under the plan on the day prior to the day his coverage under the Plan would have terminated due to his age and one who is mentally or physically unable to earn a living. The child must have been covered under the Plan on the day immediately before the day coverage would have terminated due to age, and proof of such disability must be submitted to the Employer within 31 days of the date the child's coverage would have terminated due to age. Periodic proof that the dependent child continues to be incapable of self-support will be required.

This provision also applies to children who become disabled between the age of nineteen (19) and age twenty-five (25) if they were a full-time student and covered by the Plan on the date of total disability. Coverage under this paragraph will terminate at age twenty-five (25).

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

To maintain coverage under the Plan for children over age 18, the Employee must furnish due proof to the Employer that the child is unmarried and that he continues to be primarily dependent upon the Employee for support and

maintenance and is not eligible for any other medical coverage.

If the Employee and the Employee's spouse are both covered Employees under the Plan, the Employee's children may be considered as Dependents of either the Employee or the Employee's spouse, but not of both.

ELIGIBLE EMPLOYEE

The term “Eligible Employee” shall mean any person who satisfies the Rules of Eligibility.

EMERGENCY SERVICES

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

EMPLOYER

The term “Employer” shall mean Rutherford County and all affiliated groups.

ENROLLMENT DATE

The term “Enrollment Date” shall mean the first day of the waiting period except in the case of a Late Enrollee, the Enrollment Date is the first day of coverage.

EXPENSE INCURRED

An expense is incurred when the service or the supply for which it is incurred is provided.

EXPERIMENTAL AND INVESTIGATIVE EXPENSE

The term “Experimental and Investigative Expense” shall mean the use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet generally recognized as accepted medical practice and any such items requiring federal or other governmental agency approval and for which such approval had not been granted at the time the services were rendered.

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

1. The term “Experimental” or “Investigational” means that the technology is either:

A. not of proven benefit for the particular diagnosis or treatment of the Covered Person’s condition; or

B. not generally recognized by the medical community, as reflected in the published peer-reviewed literature as effective or appropriate for the particular diagnosis or treatment of the Covered Person’s particular condition.

2. Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis of a Covered Person’s particular condition.

3. The Plan Administrator may, in its sole discretion, apply any or all of the following criteria in determining whether a technology is Experimental or Investigational, obsolete or ineffective:

A. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition.

B. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these criteria be met.

C. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes.

D. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.

E. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

F. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects) is possible in standard conditions of medical practice, outside clinical investigatory settings.

FAMILY AND MEDICAL LEAVE

Family and medical leave shall mean a leave of absence granted for a period not to exceed 12 work weeks in a 12 month period for an employee's serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. If an employee is out on approved servicemember FMLA, to care for a covered family member ("next of kin") who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grade, rank or rating, the leave duration may extend up to 26 workweeks of leave during a single 12-month period. Individuals on family and medical leave shall continue to receive the County's support of their health insurance premium. Initial approval for family and medical leave is at the discretion of each department head. Employees must have completed a minimum of 12 months of employment and worked 1250 hours in the 12 months immediately preceding the onset of leave.

FORMULARY

Formulary means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Formulary have been approved in accordance with parameters established by the P&T Committee. The Formulary is regularly reviewed and updated.

FULL-TIME EMPLOYEE or BENEFITS ELIGIBLE EMPLOYEE

"Full-Time Employee" means an employee who is:

1. performing all the normal duties of his/her job; and

2. regularly scheduled to work a full-time schedule as defined by his/her department

A Benefits Eligible employee includes:

1. An employee who is hired as a part-time or seasonal employee is eligible for coverage if that employee works at least eighty percent (80%) of his/her department's full-time schedule per week, at least thirty-six (36) weeks in the prior twelve (12) month period and has been employed for at least one (1) continuous year. The employee has thirty (30) days to enroll upon becoming eligible. It is the employee's responsibility to monitor and confirm eligibility status.

   If a full-time employee who has been continuously employed for one (1) year or more, changes to a part-time schedule, that employee will retain benefit eligibility if that employee continues to work a minimum of eighty percent (80%) of a full-time schedule per week.

2. an interim teacher who has worked in one (1) specific position for at least one hundred (100) days in a given year, as determined by the Board of Education.

HIPAA

HIPAA (Health Insurance Portability Accountability Act) shall mean the federal law pertaining to portability between health plans, pre-existing conditions, and has special enrollment provisions that may allow employees, spouses, and/or dependents to enroll under certain conditions. HIPAA also pertains to the Privacy Protections afforded individuals covered under the health plan as detailed under Article VII.

HOSPICE CARE

The term "Hospice Care" means the medically necessary medical services provided to a terminally ill patient in a hospital or rendered in a home environment. Services must be provided by a medically supervised team of professionals and volunteers on a twenty-four (24) hour on-call basis. Bereavement services to the family must be available.

HOSPITAL CONFINEMENT

The term “Hospital Confinement” shall mean that a person shall be deemed to be confined in a Hospital, if a room and board charge has been made or if he/she has been confined for a period of twenty-three (23) hours or more.

ILLNESS

The term “Illness” shall mean:

1. a disorder or disease of the mind or body; or
2. a pregnancy.

All illnesses which are due to the same cause or causes will be deemed to be one (1) illness.

IN-NETWORK

In-network shall mean the services received and the reimbursement level available when rendered by doctors, caregivers, and medical facilities participating in an agreement with the County’s contracted claims administrators. Services provided are subject to specific terms and rates. The benefit level when using providers in a health plan’s network is referred to as “in-network” on the benefit summary chart.

INSURANCE ADMINISTRATION

Insurance Administration, a Department of Rutherford County Government, shall mean the staff of the County Insurance Department. The staff is responsible for certain administrative functions necessary for administering the plan and may be designated as the committee’s representative.

INJURY

The term “Injury” shall mean a bodily injury caused by accidental, external means. Charges for care and services resulting from the commission or attempt to commit an assault, battery, felony or act of aggression, insurrection, rebellion or riot will not be considered an accident under the terms of this Plan.

JOINT CUSTODY

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

LATE ENROLLEE

The term “Late Enrollee” shall mean an individual who is enrolled for coverage after the date the individual was initially eligible to enroll.

LEAVE OF ABSENCE

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

LEGAL CUSTODY

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

LEGAL GUARDIAN

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

MAITENANCE TREATMENT

The term Maintenance Treatment means:

1. Treatment rendered to keep or maintain the patient's current status.

MAXIMUM REIMBURSABLE CHARGE

The Maximum Reimbursable Charge is the lesser of:

1. the provider’s normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

MEDICALLY NECESSARY

The term “Medically Necessary” shall mean those services, treatments or supplies provided by, or under the direction of, a Hospital or Physician that are required in the judgment of the Plan, to identify or treat an injury or illness and which are:

1. consistent with the symptoms or diagnosis and treatment of the Covered Person’s condition, disease, ailment or injury;

2. appropriate according to standards of good medical practice;

3. not solely for the convenience of a Covered Person, Physician, or Hospital; and

4. the most appropriate which can be safely administered to the Covered Person.

The fact that a Physician has prescribed, performed, ordered, recommended, or approved a service does not, in and of itself, mean that the Administrator will consider it Medically Necessary.

MEDICAL SUPPLIES

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

1. Prescribed by the patient’s physician;

2. Medically necessary and/or clinically necessary, as determined by the claims administrator, for treating an illness or injury;

3. Consistent with the diagnosis;

4. Recognized as therapeutically effective; and

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

NON-OCCUPATIONAL

The term “Non-occupational” shall mean with respect to injury, an injury which does not arise out of, and in the course of, any employment for wage, profit or remuneration and, with respect to disease, means a disease in connection with which the person is not entitled to benefits under any Worker’s Compensation Law or similar legislation.

OPEN-ENROLLMENT DATE

The Open-Enrollment Date shall mean be the month of November prior to the plan year.

NECESSARY SERVICES AND SUPPLIES

The term Necessary Services and Supplies includes:

1. any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;

2. any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and

3. any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

OTHER HEALTH CARE FACILITY

The term Other Health Care Facility means a facility other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, extended care facilities, rehabilitation Hospitals and subacute facilities.

OTHER HEALTH CARE PROFESSIONAL

The term Other Health Care Professional means an individual, other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Care Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

OUT OF NETWORK

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

OUT OF POCKET EXPENSES

Out-of-pocket expenses shall mean the sum of any deductibles and copayments required or incurred for any covered expense under the plans, except those expenses incurred for the treatment of mental health disorders and substance abuse, routine care, chiropractic care and pharmacy prescription co-payments, and expenses incurred for any services not in compliance with the medical management program.

OUTPATIENT

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

OUTPATIENT SURGERY

The term “Outpatient Surgery” shall mean Surgery performed in an Outpatient department of a Hospital, Physician’s office, or Ambulatory Surgical Facility.

PARTICIPATING PHARMACY

The term Participating Pharmacy means a retail pharmacy with which the Claims Administrator has contracted to provide prescription services to members; or a designated mail-order pharmacy with which the Claims Administrator has contracted to provide mail-order services to members.

PARTICIPATING PROVIDER

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with the Claims Administrator to provide covered services with regard to a particular plan under which the participant is covered.

PHARMACY AND THERAPUETICS COMMITTEE (“P&T”)

A committee of Participating Providers, Pharmacists, Medical Directors and Pharmacy Directors, which regularly reviews Prescription Drugs and Related Supplies for safety, efficacy, cost effectiveness and value. The P & T Committee evaluates Prescription Drugs and Related Supplies for addition to or deletion from the Formulary and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

PLAN

Plan shall mean the Rutherford County Employee Benefit Plan.

PLAN ADMINISTRATOR

The term “Plan Administrator” shall mean the Employer. The Employer may delegate to another party the authority to handle the day to day administrative functions of the Plan.

PRE-EXISTING CONDITION

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

Pregnancy shall not be considered a Pre-Existing Condition under the Plan. In addition, Pre-Existing Condition exclusions will not apply to newborns or children who are adopted or placed for adoption and enrolled in the Plan within thirty (30) days.

PRESCRIPTION DRUG

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

PRESCRIPTION ORDER

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

PREVENTIVE TREATMENT

The term Preventive Treatment means:

1. Treatment rendered to prevent disease or its recurrence.

PROVIDER

Provider shall be one of the following as licensed by the its appropriate State agency and shall mean:

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

   A. Is affiliated with a hospital under a contractual agreement with an established system for patient referral;

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

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

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

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

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

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

   A. Is under the medical supervision of a physician or a registered nurse;

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

C. Provides for nursing service continuously for 24 hours of every day;

D. Provides facilities for the full-time care of five or more patients;

E. Maintains clinical records on all patients; and

F. Is not an institution or part thereof primarily devoted to the care of the aged.

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

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

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

B. Psychologists licensed under this provision have: a doctorate in psychology from an accredited educational institution recognized by the HSP board as maintaining satisfactory standards; passed applicable examinations; has had at least one year of internship in an approved health services program; and has had at least one year of postdoctoral experience delivering health services within Tennessee under the supervision of a licensed HSP psychologist or has received equivalent experience outside of the state as determined by the HSP board. For purposes of this provision health services are defined as the delivery of direct, preventive, assessment and therapeutic intervention services to individuals whose growth, adjustment or function is actually impaired or may be at risk of impairment (TCA 63-11-208). All

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

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

10. Hospital shall mean an institution legally operating as a hospital which:

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

B. Is operated under the medical supervision of a staff of physicians and continuously provides nursing services by registered nurses for 24 hours of every day; and

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

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

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

12. A licensed professional counselor (LPC) shall mean a professional counselor licensed by the Tennessee Board of Professional Counselors, who is qualified by education and experience to treat mental health disorders resulting from social and psychological stress or health impairment.

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

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

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

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

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

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

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

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

21. Therapist shall include registered/licensed physical, occupational, respiratory and speech therapists.

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

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

QUALIFIED BENEFICIARY

Qualified beneficiary shall mean any employee or dependent who is defined under Article IV, Section 14 of the plan.

QUALIFYING EVENT

Qualified event as pertaining to COBRA shall mean:

1. The death of a covered employee;
2. A covered employee's termination of employment or reduction in work hours of an employee's employment;
3. The divorce or legal separation of a covered employee and his/her spouse;
4. A covered employee becoming entitled to Medicare Part A; or
5. A covered dependent child ceasing to meet the definition of an eligible dependent.

REASONABLE, USUAL AND CUSTOMARY EXPENSE

The term "Reasonable, Usual and Customary Expense" or "Reasonable Expense" shall mean the lesser of the usual, reasonable and customary fees or charges for the covered services rendered and the covered supplies furnished, as determined for the geographical area in which such services are rendered or supplies are furnished and the charge usually made by the provider for the services or supplies furnished.

RELATED SUPPLIES

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under this Prescription Drug Benefit, and spacers for use with oral inhalers.

RETIRED EMPLOYEE- Employed Prior to February 12, 2009

Employees and Elected Public Officials, who are at least fifty-five (55) years of age and have fifteen (15) years of service with the County prior to retirement and have been covered under the County group medical plan for a continuous five (5) year period prior to retirement, may continue coverage under this Plan after retirement.

Employees and Elected Public Officials, who are at least sixty-two (62) years of age and have ten (10) years of service with the County prior to retirement and have been covered under the County group medical plan for a continuous five (5) year period prior to retirement, may continue coverage under this Plan after retirement.

Employees and Elected Public Officials, who have thirty (30) years of service with the County prior to retirement, regardless of their age, and have been covered under the County group medical plan for a continuous five (5) year period prior to retirement, may continue coverage under this Plan after retirement.

All Medicare recipients are required to enroll and participate in both Medicare Part A and B.

RETIRED EMPLOYEE- Employed On or After February 12, 2009

The Retiree Medical Insurance program for benefit eligible employees beginning work on February 12, 2009 and thereafter provides for specific coverages and costs.
The plan limits the county's contribution to a monthly stipend. For those eligible retirees electing to participate in the insurance plan, the stipend will be applied to the total monthly premium with the balance being the responsibility of the retiree. Additionally, Medicare recipients are required to enroll and participate in both Medicare Part A and B. Pharmacy coverage is not provided.

Eligibility requirements are: Age 60 with twenty (20) years of service and fifteen (15) consecutive years in the medical insurance plan **or** any age with thirty (30) years of service and fifteen (15) consecutive years in the medical insurance plan.

REVIEW ORGANIZATION

The term Review Organization refers to an affiliate of the Claims Administrator or another entity to which the Claims Administrator has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

SHARED PARENTING

Shared parenting means a court approved parenting plan, describing the role each parent will have in the child's life, including a residential schedule indicating the times and places where the child will reside. Pursuant to TCA 36-6-410, the parenting plan shall designate the parent with whom the child is scheduled to reside a majority of the

time as the custodian of the child solely for the purpose of all other state and federal policies and any applicable policies of insurance that require a designation or determination of custody. If there is no designation in the plan, the parent with whom the child is determined to reside the majority of the time shall be deemed the custodian for the purposes of such statutes.

SIGNIFICANT BREAK IN COVERAGE

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

SPECIALIST

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

SURGICAL PROCEDURE

The term “Surgical Procedure” shall mean only the following:

1. a cutting operation;
2. suturing of a wound;
3. treatment of a fracture;
4. reduction of a dislocation;
5. radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor;
6. electro-cauterization;
7. diagnostic and therapeutic endoscopic procedures; or
8. injection treatment of hemorrhoids and varicose veins.

TERMINAL ILLNESS

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

TOTALLY DISABLED

The term “Totally Disabled” shall mean, with respect to Employees, disability to the extent that the Employee is not able to perform any of the usual and customary duties of his or her occupation, and, with respect to Dependents, cannot perform any of the usual and customary duties or activities of a person in good health and of the same age and sex.

TWO-PERSON COVERAGE

“Two-Person Coverage” is only available under this Plan for Retirees and their eligible Dependents.

URGENT CARE

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by the Claims Administrator, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

ARTICLE III – SCHEDULE OF BENEFITS (Plans 1 & 2)

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

	PLAN 1	PLAN 2

MAXIMUM BENEFIT PER PERSON		
Lifetime	$2,000,000	$2,000,000
ALCOHOL / CHEMICAL DEPENDENCY		
Preferred Provider Only		
Maximum Per Lifetime	$50,000	$50,000
Calendar Year Maximum		
Inpatient*	$10,000	$10,000
Outpatient	$2,000	$2,000

*Both Preferred and Non-Preferred Expenses can be used to satisfy the Out-of-Pocket Maximum.

	PLAN 1	PLAN 2
MENTAL / NERVOUS DISORDERS		
Preferred Provider Only		
Calendar Year Maximum		
Inpatient	60 days	60 days
	80%	80%
Outpatient	50 visits	50 visits
	80%	80%

	PLAN 1	PLAN 2
DEDUCTIBLE PER CALENDAR YEAR		
Preferred Provider*		
Per Person	$300	$500
Per Family	$600	$1,000
Non-Preferred Provider*		
Per Person	$500	$900
Per Family	$1000	$1,800

*Both Preferred and Non-Preferred Expenses can be used to satisfy the Deductible.

	PLAN 1	PLAN 2
PERCENTAGE PAYABLE		
Preferred Provider	80%	80%

Non-Preferred Provider	60%	60%

	PLAN 1	PLAN 2
OUT-OF-POCKET MAXIMUM (Including Calendar Year Deductible)		
Preferred Provider*		
Per Person	$1,750	$2,300
Per Family	$3,500	$4,600
Non-Preferred Provider*		
Per Person	$3,250	$4,600
Per Family	$6,500	$9,200

*Both Preferred and Non-Preferred Expenses can be used to satisfy the Out-of-Pocket Maximum.

A Medicare Eligible Retiree does not have to meet the Deductible or Out-Of-Pocket Maximums. In addition the Spouse of a Retiree who is Medicare Eligible does not have to meet the Deductible or Out-Of-Pocket Maximum.

	PLAN 1	PLAN 2
EMERGENCY ROOM DEDUCTIBLE		
Per Visit	$100	$100

This emergency room deductible is waived if services are for a medical emergency or if surgery is performed within twenty-four (24) hours of the emergency room visit.

THE FOLLOWING COVERED EXPENSES WILL BE PAID AT 100% WITH NO DEDUCTIBLE IF PROVIDED BY A PREFERRED PROVIDER:

1. Pre-Admission Testing
2. Second Surgical Opinions
3. Home Health Care
4. Skilled Nursing Facility

THE ABOVE COVERED EXPENSES WILL BE PAID AT 60% AFTER DEDUCTIBLE IF PROVIDED BY A NON-PREFERRED PROVIDER.

	PLAN 1	PLAN 2
PREVENTIVE CARE / ROUTINE CARE (PPO Only)*		
Copay per visit	$20	$20

*Includes but not limited to: routine pap smear, routine PSA, routine well-child visit, and routine physical exam.

OTHER PLAN PROVISIONS

1. Room and Board Limits:

A. Semi Private or Private…….Average Semi-Private

B. Intensive Care……Negotiated Rate

2. Lab – associated with In-Network office visits (Not subject to Deductible):

A. Percentage Payable (Plan 1)……..100%

B. Percentage Payable (Plan 2)…….....100%

3. Pre-Admission Certification:

A. If a pre-admission certification is not obtained prior to a hospital confinement, for any treatment or care, the Plan payment for any expenses associated with the confinement will be reduced by $500 and such reduction will not go toward the Out-of Pocket maximum. This provision does not apply to admissions for a Medical Emergency or if surgery is performed within 24 hours of the admission.

B. While in-network, it is the provider's obligation to obtain pre-admission certification. If you are using out-of network providers it is your obligation to obtain pre-admission certification.

	PLAN 1	PLAN 2
OUTPATIENT SURGERY AND RELATED EXPENSES		
Percentage Payable		
Preferred Provider (After Deductible)	80%	80%
Non-Preferred Provider (After Deductible)	60%	60%

	PLAN 1	PLAN 2
CHIROPRACTIC CARE		
Visits Per Year	26	NOT COVERED
Maximum Payable / Visit	$17.50	NOT COVERED
Calendar Year Deductible*	$150	NOT COVERED

*The Chiropractic Care deductible is separate from the regular Plan Calendar Year Deductible. The Chiropractic Care deductible does not count towards the regular Plan Calendar Year Deductible nor does the regular Plan Calendar Year Deductible count towards the Chiropractic Care deductible.

	PLAN 1	PLAN 2
DIABETES TRAINING		
Deductible Waived		
Percentage Payable	100%	100%
Limited to two (2) sessions per Covered Person Per Lifetime		
Maximum Per Session	$125	$125

	PLAN 1	PLAN 2
SKILLED NURSING FACILITY / REHABILITATION FACILITY		
Inpatient:		
Limit Calendar Year Days	100	100
Percentage Payable		
Network Provider	80%	80%
Non-Network Provider	60%	60%

TMJ COVERAGE

Phase I $1,500 lifetime maximum, subject to deductibles and coinsurance.

Phase II Not Covered, with exception of surgery.

	PLAN 1	PLAN 2

PRESCRIPTION DRUG BENEFIT		
WALK-IN PRESCRIPTIONS [up to a thirty (30) day supply]		
Co-Payment:		
Generic (filled at a participating pharmacy)	$5	$5
Generic (filled at Care Here Clinic)	0%	0%
Preferred Brand	20%	20%
Non-Preferred Brand	35%	35%
MAIL-ORDER PRESCRIPTIONS [ninety (90) day supply]		
Co-Payment:		
Generic	$15.00	$15.00
Preferred Brand	20%	20%
Non-Preferred Brand	35%	35%
OUT-OF-POCKET MAXIMUM		
Per Person	$1,100	$1,100
Per Family	$2,200	$2,200

PLAN 3

Available to Benefit Eligible Non Retirees Only
Health Reimbursement Agreement (HRA)

MAXIMUM BENEFIT PER PERSON	
Lifetime	$ 2,000,000
ALCOHOL / CHEMICAL DEPENDENCY	
Preferred Provider Only	
Maximum Per Lifetime	$ 50,000
Inpatient*	$ 10,000
Outpatient	$ 2,000
*Benefits for Inpatient Alcohol and/or Chemical Dependency treatment programs will be limited to two (2) programs per lifetime.	
MENTAL / NERVOUS DISORDERS	
Preferred Provider Only	
Calendar Year Maximum	
Inpatient	60 Days

	90%
Outpatient	50 Visits
	90%

Health Reimbursement Agreement (HRA) Funding

The HRA Deductible is comprised of two (2) components. The funds contributed by the county are one (1) component and the second (2nd) component is the amount for which the employee is responsible. The money in the fund is used to pay first dollar Medical and Pharmacy Expenses. The County's funding is applied first to these expenses.

HRA FUND ALLOCATIONS			
	County Contributes	Employee Responsibility	Total
Individual Coverage	$ 750	$ 750	$ 1,500
Family Coverage	$ 1,500	$ 1,500	$ 3,000

HRA DEDUCTIBLE PER CALENDAR YEAR	
Preferred Provider*	
Per Person	$ 1,500
Per Family	$ 3,000
Non-Preferred Provider*	
Per Person	$ 2,500
Per Family	$ 5,000
*Both Preferred and Non-Preferred Expenses can be used to satisfy the Deductible	

The Family deductible is a "Collective" deductible meaning that the entire amount must be met by one or more individuals. The individual deductible is only if you have employee coverage only. Also, it is a "Combined" deductible meaning that all Medical **AND** Pharmacy expenses accumulate together.

HRA PERCENTAGE PAYABLE	
Preferred Provider	90%
Non-Preferred Provider	60%

HRA OUT-OF-POCKET MAXIMUM (Including Calendar Year Deductible)	
Preferred Provider*	
Per Person	$ 5,000
Per Family	$ 10,000

Non-Preferred Provider*	
Per Person	$ 10,000
Per Family	$ 20,000
*Both Preferred and Non-Preferred Expenses can be used to satisfy the Out-of-Pocket Maximum.	
HRA EMERGENCY ROOM	
Preferred Provider	90% of eligible expenses after deductible
Non-Preferred Provider	60% of eligible expenses after deductible

THE FOLLOWING COVERED EXPENSES WILL BE PAID AT 100% WITH NO DEDUCTIBLE IF PROVIDED BY A PREFERRED PROVIDER:

1. Pre-Admission Testing
2. Second Surgical Opinions
3. Home Health Care
4. Skilled Nursing Facility

THE ABOVE COVERED EXPENSES WILL BE PAID AT 60% AFTER DEDUCTIBLE IF PROVIDED BY A NON-PREFERRED PROVIDER.

PREVENTIVE CARE/ROUTINE CARE (PPO Only)

100% coverage of eligible expenses, no annual maximum.

(Includes but not limited to: routine pap smear, routine PSA, routine well-child visit and routine physical exam.)

OTHER HRA PLAN PROVISIONS

ROOM AND BOARD LIMITS	
Semi-Private or Private	Average Semi-Private
Intensive Care	Negotiated Rate
LAB (Associated with In-Network office visits)	
Percentage Payable subject to deductible	90%

PRE-ADMISSION CERTIFICATION
If a pre-admission certification is not obtained prior to a hospital confinement, for any treatment or care, the Plan payment for any expenses associated with the confinement will be reduced by $500 and such reduction will not go toward the Out-of Pocket maximum. This provision does not apply to admissions for a Medical Emergency or if surgery is performed within 24 hours of the admission. While in-network, it is the provider's obligation to obtain pre-admission certification. If you are using out-of-network providers it is your obligation to obtain pre-admission certification.

OUTPATIENT SURGERY AND RELATED EXPENSES	
Percentage Payable	
Preferred Provider (After Deductible)	90%
Non-Preferred Provider (After Deductible)	60%

CHIROPRACTIC CARE	
Preferred Provider (After Deductible)	90%
Non-Preferred Provider (After Deductible)	60%

DIABETES TRAINING*	
Preferred Provider (After Deductible)	90%
Non-Preferred Provider (After Deductible)	60%
*Limited to two (2) sessions per Covered Person Per Lifetime.	

SKILLED NURSING FACILITY / REHABILITATION FACILITY	
Inpatient	
Limit Calendar year Days	60
Percentage Payable	
Network Provider (After Deductible)	90%
Non-Network Provider (After Deductible)	60%

TMJ COVERAGE	
Phase I	$ 1,500 lifetime maximum, subject to deductibles and coinsurance.
Phase II	Not Covered, with exception of surgery.

PRESCRIPTION DRUG BENEFIT	
SUBJECT TO FUND	
WALK-IN PRESCRIPTIONS [Up to a thirty (30) day supply]	
Co-Payment:	
Generic (filled at a participating pharmacy)	30%
Generic (filled at Care Here Clinic)	0%
Preferred Brand	40%
Non-Preferred Brand	50%
SUBJECT TO FUND	
MAIL-ORDER PRESCRIPTIONS [Ninety (90) day supply]	
Co-Payment:	
Generic (filled at a participating pharmacy)	30%
Preferred Brand	40%
Non-Preferred Brand	50%

ARTICLE IV – RULES OF ELIGIBILITY

SECTION 1 - ELIGIBLE AFFILIATES

The following subsidiary or affiliated units are included under this Plan.

1. Rutherford County Retirees
2. Community Care of Rutherford County
3. Board of Education Lunch Room Employees
4. Board of Education Certified Employees
5. Board of Education Classified Employees
6. Rutherford County Highway Department
7. Rutherford County General Government
8. Smyrna/Rutherford County Airport Authority

Effective February 16, 1996, no other affiliated groups, i.e. other agencies or groups connected with Rutherford County, will be eligible for coverage under this Plan. This provision is not applicable to subsidiary or affiliated groups that were on the Plan prior to February 16, 1996 listed above.

SECTION 2 - ELIGIBLE EMPLOYEES

1. All Full-Time Employees and Elected Public Officials.

RETIRED EMPLOYEE- Employed Prior to February 12, 2009

Employees and Elected Public Officials, who are at least fifty-five (55) years of age and have fifteen (15) years of service with the County prior to retirement and have been covered under the County group medical plan for a continuous five (5) year period prior to retirement, may continue coverage under this Plan after retirement.
Employees and Elected Public Officials, who are at least sixty-two (62) years of age and have ten (10) years of service with the County prior to retirement and have been covered under the County group medical plan for a continuous five (5) year period prior to retirement, may continue coverage under this Plan after retirement.

Employees and Elected Public Officials, who have thirty (30) years of service with the County prior to retirement, regardless of their age, and have been covered under the County group medical plan for a continuous five (5) year period prior to retirement, may continue coverage under this Plan after retirement.

All Medicare recipients are required to enroll and participate in both Medicare Part A and B.

RETIRED EMPLOYEE- Employed On or After February 12, 2009

The Retiree Medical Insurance program for benefit eligible employees beginning work on February 12, 2009 and thereafter provides for specific coverages and costs.
The plan limits the county's contribution to a monthly stipend. For those eligible retirees electing to participate in the insurance plan, the stipend will be applied to the total monthly premium with the balance being the responsibility of the retiree. Additionally, Medicare recipients are required to enroll and participate in both Medicare Part A and B. Pharmacy coverage is not provided.

Eligibility requirements are: Age 60 with twenty (20) years of service and fifteen (15) consecutive years in the medical insurance plan **or** any age with thirty (30) years of service and fifteen (15) consecutive years in the medical insurance plan.

REGARDLESS of EMPLOYMENT DATE

If the retired employee experiences a life change requiring the addition of a spouse or child to the plan, they may add that additional member at their own cost. Rutherford County will not contribute to that additional member's premium cost. **Retired employees may not add dependents during the annual Open Enrollment period.**

Any retiree or member who leaves the plan will not be allowed reentry into the plan.

Creditable Service: In accumulating years of service toward satisfying retiree continuation for medical benefits, employees will receive credit for all military

service time that has been credited as service time for retirement purposes by the Tennessee Consolidated Retirement System. The employee must advise the Plan Administrator that such military credit has been given, and this information must be verified with the retirement system.

If a retired Employee dies while covered and his dependents are also covered, a surviving spouse and any dependent children may continue primary medical coverage until the surviving spouse is age sixty-five (65), remarries, or goes to work full time and is eligible for health insurance coverage, whichever occurs first. The surviving spouse's medical coverage with Rutherford County will become secondary when such dependent becomes eligible for Medicare Part A and Medicare Part B. If just the dependent children are covered at the time of the retired Employee's death or are covered at the time the surviving spouse reaches age sixty-five (65), they may continue coverage until the time at which they would have normally been terminated or until they become covered under any other similar plan of benefits.

A Benefits Eligible employee includes:

An employee who is hired as a part-time or seasonal employee is eligible for coverage if that employee works at least eighty percent (80%) of his/her department's full-time schedule per week, at least thirty-six (36) weeks in the prior twelve (12) month period and has been employed for at least one (1) continuous year. The employee has thirty (30) days to enroll upon becoming eligible. It is the employee's responsibility to monitor and confirm eligibility status.

If a full-time employee who has been continuously employed for one (1) year or more, changes to a part-time schedule, that employee will retain benefit eligibility if that employee continues to work a minimum of eighty percent (80%) of a full-time schedule per week.

An interim teacher who has worked in one (1) specific position for at least one hundred (100) days in a given year, as determined by the Board of Education.

SECTION 3 - ELIGIBILITY FOR COVERAGE AND WAITING PERIOD

All Full-Time Employees and their Dependents are eligible to enroll in the Plan, for coverage on the 1st day of the month following employment date. This is the Eligibility Waiting Period.

Employees, Dependents and Retirees who were eligible for coverage with the previous plan being replaced by this Plan on June 30, 1997 will be eligible under this Plan.

SECTION 4 - DATES OF ELIGIBILITY AND COVERAGE

1. Date of Eligibility – Employee Coverage

An Employee becomes Eligible:

A. On the Plan Effective Date, if he has completed the Eligibility Waiting Period, or if not…

B. On the first (1st) day of the month following the date he completes the Eligibility Waiting Period.

2. Date of Eligibility – Dependent Coverage
An Eligible Employee will be eligible for Dependent Coverage on the later of:
A. The date he becomes eligible for coverage; or

B. The date he acquires his first Dependent.

3. Dependent Eligibility

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

A. Newborn children of a covered Employee will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Employee within thirty (30) days of the child's date of birth. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother.

B. A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Employee within thirty (30) days of the date of marriage.

C. If a Dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled as a Dependent of the Employee within thirty (30) days of the court order, decree, or marriage.

D. A child may become eligible for Dependent Coverage as set forth in a Qualified Medical Child Support Order. The Plan Administrator will establish

E. Effective date for adopted children is as follows:

1) Coverage will be effective for a child(ren) upon placement for adoption provided that the child(ren) is properly enrolled as a Dependent of the Employee within thirty (30) days of the placement for adoption.

2) Restrictions based on Pre-Existing Conditions at time of placement for adoption will be prohibited.

3) Definitions – For Purposes of this subsection:

   i. Child – The term "child" means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained age eighteen (18) as of the date of such adoption or placement for adoption.

   ii. Placement for Adoption – the term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. This child's placement with such person terminates upon the termination of such legal obligation.

SECTION 5 – EFFECTIVE DATE OF COVERAGE

1. Employee Effective Date

Employee coverage under the Plan shall become effective with respect to an eligible Employee on the date of his eligibility, provided Online request for such coverage is made on or before such date or within thirty-one (31) days of such date. If application is made after the initial date of eligibility, the Employee shall be a Late Enrollee and, except as provided under "Special Enrollment Period" below, coverage for the Employee shall become effective on the next Open-Enrollment Date.

2. Dependent Effective Date

A Dependent of an Employee who makes an Online request for Dependent Coverage hereunder shall be subject to the provisions of this section, become covered as follows:

A. If the Employee makes such online request on or before the date or within thirty-one (31) days of the date he becomes eligible for Dependent Coverage, he shall become covered, with respect to those persons who are then his Dependents, on the date he becomes eligible for Dependent Coverage.

B. Except as otherwise provided under "Dependent Eligibility", (i.e., for newborn, adopted and newly acquired dependents) or as provided under "Special Enrollment Period" below, if the Employee makes such Online request after the date on which he is eligible for Dependent Coverage, those persons who are then his Dependents shall be Late Enrollees, and shall become covered on the next Open-Enrollment Date.

C. If all Eligible Dependents have coverage in effect at the time an Employee acquires an additional Eligible Dependent, coverage of such Dependent will be effective upon the date he or she is acquired. Separate Online application to cover such Dependent will not be required.

3. Enrollment

To enroll for coverage, a person must complete the Online Enrollment process utilizing the benefit system software package. This system is accessible by internet connectivity.

SECTION 6 – SPECIAL ENROLLMENT PERIOD

If an Employee loses coverage under another group health plan and (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and the Employee makes Online application under the Plan within thirty (30) days of losing coverage, then he will be allowed to enroll in the Plan. However, the Pre-Existing Condition clause will apply.

In addition, if the Employee acquires a new Dependent through marriage, birth or adoption and the Employee makes Online application under the Plan within thirty (30)

days, he and the Dependents will be allowed to enroll in the Plan. The Pre-Existing Condition clause will apply to the Employee and spouse but not the new Dependent children.

The Effective Date of Coverage under this Section will be the date of termination of the prior coverage or the date a new Dependent is acquired.

SECTION 7 – COVERAGE STATUS CHANGE

A Covered Person may not be covered as both a Dependent and an Employee. If a covered Dependent is eligible to be enrolled as an Employee, enrollment may be effective on the first day of any month.

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

SECTION 8 – EMPLOYEE CONTRIBUTION

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

SECTION 9 – TERMINATION OF COVERAGE

1. Eligible Employee Coverage

A. Coverage will terminate on the earliest of:

1) The date the Plan terminates

2) The date a contribution is due for coverage but not paid; or

3) The last day of the month in which his employment with the Plan Sponsor ceases;

2. Eligible Dependent Coverage

A. The coverage of a dependent of an Eligible Employee will terminate on the earliest of:

1) the date on which coverage for the Eligible Employee terminates;

2) the date on which the Eligible Employee is no longer eligible for Dependent Coverage;

3) the date on which the Dependent no longer meets the Plan's definition of a Dependent;

4) the last day of the period for which any required contribution is made, if the Eligible Employee fails to make any further required contributions; or

5) the date the Eligible Employee is no longer in a class eligible for Dependent Coverage.

SECTION 10 – LEAVE OF ABSENCE

Notwithstanding SECTION 2 above, continuous coverage during a leave of absence is permitted for up to one (1) year if:

1. the Employer continues to consider the Employee an Eligible Employee and all other employee benefits are also continued;

2. the leave is for a specific period of time established in advance of the leave;

3. the purpose of the leave is documented; and

4. A new one (1) year leave period will begin only after the Employee has been back at work, performing their normal duties for a full six (6) months. If they return to a leave of absence before six (6) months, the original leave will have considered to be continued.

SECTION 11 – TOTAL DISABILITY

1. Available benefits are payable secondary to Medicare under the following conditions:

A. The Employee must not have any lapse in coverage between their termination date and becoming qualified for Social Security Medicare Benefits for totally disabled persons.

B. The Employee must not have any other secondary coverage in force.

C. The Employee must be under age sixty-five (65) and must have completed at least ten (10) years of service with the Employer (the last five (5) years of which they were on the Employee Benefit Plan prior to total disability termination).

D. The Employee must have filed and qualified for Medicare Disability.

2. Coverage for a disabled Employee will terminate when:

A. The Employee is no longer considered qualified under Medicare Disability.

B. The Employee attains age sixty-five (65).

C. The Employee becomes covered under any other health care plan that provides similar benefits.

SECTION 12 – ELIGIBLE RETIREES

Retirees eligible for coverage under this Plan and their Eligible Dependents shall be eligible for Plan Options 1 and 2 subject to guidelines based upon date of employment as previously noted in this plan document

A Medicare Eligible Retiree does not have to meet the Deductible or Out-Of-Pocket Maximums. In addition the Spouse of a Retiree who is Medicare Eligible does not have to meet the Deductible or Out-Of-Pocket Maximum.

SECTION 13 – QUALIFIED MEDICAL CHILD SUPPORT ORDERS ("QMCSOs")

1. Coverage of Children or Alternate Recipients Named or Designated in QMCSOs.

Notwithstanding anything in this Plan to the contrary, the Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order received by the Plan and determined by the Plan to be qualified.

2. Medical Child Support Orders

A Medical Child Support Order is a court order which:

A. Provides for child support or health benefit coverage with respect to a child of a participant under the Plan;

B. is made pursuant to a state domestic relations law; and

C. either relates to benefits under the Plan; or

D. enforces a law relating to medical child support under Section 1908 of the Federal Social Security Act.

3. Qualified Medical Child Support Orders

A Qualified Medical Child Support Order is a medical child support order which:

A. creates, assigns and recognizes a child's right to receive benefits for which a participant is eligible under the Plan;

B. clearly specifies the name and last known mailing address of the participant and the child;

C. clearly specifies the type of coverage that is to be provided by the Plan to the child;

D. clearly specifies the time period for which the order applies;

E. clearly specifies the Plan or Plans to which the order applies; and

F. does not require the Plan to provide any benefits not already provided (except as specified in Section 1908 of the Social Security Act).

4. Procedures for Medical Child Support Orders and Qualified Medical Child Support Orders

A. Within ten (10) days of receipt of a Medical Child Support Order, the Plan Administrator shall notify the participant and each child named in the Medical Child Support Order ("alternate recipient") that a Medical Child Support Order has been received.

B. The notice shall inform the participant and each alternate recipient of the Plan's procedures for determining whether Medical Child Support Orders are qualified applying the standards set out in paragraphs (2) and (3) above.

C. The Plan Administrator then within thirty (30) days, shall determine whether the Medical Child Support Order is qualified applying the standards set out in paragraphs (2) and (3) above. The Plan Administrator may seek the assistance of Plan legal counsel in making this decision.

D. If the Plan Administrator determines that information in the Order is insufficient or the order is otherwise deficient, the Plan Administrator shall

E. If the Order is resubmitted, it shall again be reviewed by the Plan Administrator for compliance in accordance with the standards set out in paragraphs (2) and (3) above and pursuant to the other provisions set out herein. Upon resubmission, the Plan Administrator shall have fifteen (15) days to determine whether the resubmitted order is qualified.

F. Upon determining whether the Order is qualified, the Plan Administrator shall notify the participant and each alternate recipient of that determination.

G. If the Medical Child Support Order is deemed qualified, the participant and the alternate recipient shall be notified of the eligibility of the alternate recipient for benefits and of the Plan's procedures for providing benefits.

H. At the time that the alternate recipient is notified of his or her eligibility, the alternate recipient shall also be notified of his or her rights to designate a representative to receive copies of notices sent out with respect to the Medical Child Support Order. All notices shall also be sent to the enrolled parent who is a participant in the Plan.

SECTION 14 – CONTINUATION OF COVERAGE UNDER COBRA

Definitions

For purposes of this Continuation of Coverage Under COBRA provision, the following definitions apply:

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

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

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

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

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

6. “Qualified Beneficiary” means:

   A. A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan;

   B. A covered spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below; and

   C. A newborn or newly adopted child of a Covered Employee who is continuing coverage under COBRA.

7. “Qualifying Event” means the following events which, but for Continuation Coverage, would result in the loss of coverage of a qualified Beneficiary:

   A. Termination of a Covered Employee’s employment (other than for gross misconduct) or reduction in his hours of employment;

   B. The death of the Covered Employee;

   C. The divorce or legal separation of the Covered Employee from his spouse;

   D. The Covered Employee becoming entitled to Medicare coverage; or

   E. A child ceasing to be eligible as a Dependent child under the terms of the Plan.

8. “Totally Disabled” or “Total Disability” means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

HEALTH INSURANCE CONTINUATION INFORMATION:

COBRA CONTINUATION COVERAGE

This information is intended to provide information about your rights and responsibilities to elect continuation coverage as created by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It does not change your current status under any group health plan(s). Because of COBRA, you and your family may be eligible to continue plan coverage at your own expense, if you lose coverage due to certain events. Please read this information carefully and save it for future reference.

COBRA QUALIFYING EVENTS (and duration of coverage): Once you, and any family members, become covered by the above plan, there are specific COBRA events called "qualifying events", that may cause you or your family to lose coverage. Those qualifying events and the duration of continuation coverage are:

1. Employee's termination of employment (voluntary or involuntary) - 18 months

2. Employee's reduction in hours of employment - 18 months

3. Death of the employee - 36 months

4. Employee's entitlement to Medicare (only if plan coverage is lost) - 36 months for family members only.

5. Divorce or legal separation from the employee - 36 months for family members only.

6. Dependent child ceases to meet plan's definition of dependent child - 36 months for dependent child only.

7. Bankruptcy (Title XI) of the above employer- special rules for retirees only.

An exception applies to a flexible spending account, which reimburses medical expenses. In general, continuation coverage ends at the end of the flexible spending account plan year in which the COBRA event occurred.

The situation could happen where you have not experienced a qualifying event, but your coverage has been terminated "in anticipation of" a qualifying event, such as a divorce or legal separation. COBRA continuation will not be offered until the qualifying event has actually occurred and timely reported. Continuation would be offered from the date of the event and not the prior date coverage was lost.

HOW IS A COBRA EVENT REPORTED?: The employer is responsible for reporting an employee's death, termination of employment, reduction in hours of employment, or Medicare entitlement (if plan coverage is lost). COBRA continuation coverage may be denied if your employment is terminated due to gross misconduct.

The covered employee or a family member is responsible for notifying the employer/plan administrator of a divorce, legal separation or a child losing dependent status within 60 days of the loss of coverage due to the event. Check your plan booklet regarding eligibility and termination of eligibility provisions. Failure to notify the employer/plan administrator within 60 days will eliminate any rights to COBRA continuation. The employer/plan administrator will accept written notification **ONLY**. A form for you to report a COBRA qualifying event is provided with this Information. See the section "EVENT NOTICE PROCEDURE." You should keep a copy of any notices you report.

WHO CAN ELECT COBRA CONTINUATION COVERAGE?: Each employee, spouse and dependent child covered under the plan the day before the qualifying event is a COBRA "qualified beneficiary", who may elect continuation. In addition, any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation will be a qualified beneficiary. COBRA continuation coverage is the same plan coverage the employer provides to similarly situated employees or family members who have not had a COBRA event. However, life and disability coverage are not part of COBRA continuation coverage.

In order to elect, you do not have to provide any evidence of insurability. HMO coverage may be region-specific. A COBRA qualified beneficiary outside of the region may experience reduced coverage similar to that of active employees outside of the region. COBRA qualified beneficiaries have the same plan options as active employees, under the same terms and conditions as active employees. A qualified beneficiary on COBRA may add a dependent under the same plan procedure required of active employees

Once notified of a loss of coverage due to a COBRA qualifying event, the employer/plan administrator will notify you or your family member in writing of your right to elect continuation coverage. If the employer/plan administrator has retained a COBRA service provider, the information may come from that entity. COBRA continuation information will be sent to your address last reported to the employer. Therefore, it is important to keep the employer informed of your current address.

HOW TO ELECT COBRA CONTINUATION: Each qualified beneficiary has an independent right to elect COBRA continuation and is allowed 60 days to elect. Covered employees may elect continuation coverage on behalf of their spouses, and parents may elect on behalf of their children. The 60 days begins from the date your written notice is postmarked or the date coverage is lost, whichever is later. The plan does not have to provide coverage during the 60-day election period.

Generally, coverage will be reinstated once COBRA continuation is elected and paid for in a timely manner. The employer/plan administrator reserves the right to verify your eligibility, if you elect COBRA. If you are not eligible, your coverage can be terminated retroactively. If a qualified beneficiary is incapacitated during the election period, the spouse or a legal representative for the qualified beneficiary or the estate may make the election.

PAYING FOR COBRA CONTINUATION COVERAGE: Once you elect COBRA continuation, you have 45 days from the date of your election to pay for coverage back to the date coverage was lost. All payment for retroactive coverage must be made by the end of the 45 days. Subsequent payments are due on the first day of the coverage period. There is a 30-day grace period for each monthly payment. Failure to postmark payment by the end of a grace period is late payment. A late payment will not be accepted. Coverage will terminate with no possibility of reinstatement. Payment for continuation coverage is at your expense. The cost may be different from what you

were paying for coverage before your event. You may be charged up to 102% of the plan cost for your coverage.

EXTENDING THE COBRA PERIOD: If you are a spouse or dependent child and your initial COBRA event results in a continuation period of 18 months, that period may be extended to a maximum of 36 months if another qualifying event, which causes a loss of coverage, occurs during the initial 18-month period. The other event would include death of the employee, divorce or legal separation or a dependent child ceasing to be a dependent under the terms of the plan. Due to other government rules, most plans are not allowed to terminate coverage when an employee becomes entitled to Medicare. Therefore, a covered employee's Medicare entitlement will usually not permit an extension. The additional event must be reported within 60 days. Please use the enclosed form and see the section "EVENT NOTICE PROCEDURE."

If you, or any of your covered dependents, are determined to be disabled by the Social Security Administration, continuation for all qualified beneficiaries may be extended from 18 to 29 months. To be eligible for this extension you must meet three (3) criteria:

1. Social Security must determine that the disability existed prior to or during the first 60 days after your COBRA event.

2. Social Security must make its determination before the end of the initial 18-month period.

3. You must provide evidence of Social Security's determination within 60 days of: the loss of plan coverage, the date of the event or the date of Social Security's determination, whichever is latest.

Evidence is a copy of your Social Security Disability Award letter. The plan may charge up to 150% for the 19th through the 29th month, if the disabled qualified beneficiary is among those continuing coverage. If Social Security subsequently determines that the disabled qualified beneficiary is no longer disabled, it must be reported within 30 days of the determination. To report a Social Security disability/no longer disabled determination, please use the enclosed form and see the section "EVENT NOTICE PROCEDURE." It is your responsibility to apply for a disability benefit from Social Security. You should contact Social Security with questions and for procedures.

TERMINATING COBRA CONTINUATION: COBRA continuation coverage may end early under any of the following circumstances:

1. The employer no longer provides group health plan coverage to any employees,

2. Payment for continuation coverage is not made by the end of the grace period,

3. After COBRA is elected you, your spouse or dependents become covered under another group health plan that does not apply any exclusion or limitation with respect to any pre-existing condition you or your family may have,

4. After the date COBRA is elected, if an individual becomes enrolled in Medicare coverage will be terminated only for such individual,

5. If continuation coverage was extended for up to 29 months due to disability, the individual is no longer disabled.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA): The WHCRA requires a group health plan to notify you, as a participant or beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for (a) all stages of reconstruction on the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses; and (d) treatment of physical complications of the mastectomy, including lymphedema. This coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your benefits booklet or contact the employer/plan administrator.

PLAN REQUIREMENTS FOR COVERED EMPLOYEES AND COBRA QUALIFIED BENEFICIARIES TO PROVIDE NOTICE: Covered employees and COBRA qualified beneficiaries are responsible to provide notice of certain events that affect plan coverage. The following is the plan's procedure for giving notice of those events. It is important to follow this procedure so additional information can be provided about how plan coverage is affected. If notice of an event is not made, not made timely or not made with adequate information, plan coverage can be modified, including reduction or termination of coverage with no COBRA continuation.

The events that are the responsibility of a covered employee or COBRA qualified beneficiary to give notice of are:

1. Divorce or legal separation of a covered employee from his or her spouse

2. A dependent child ceases to meet the plan's definition of dependent child

3. Occurrence of a second COBRA event during an 18-month period of COBRA continuation

4. Social Security Disability determination of disability

5. Social Security determination of "no longer disabled"

The plan will accept written information only. Verbal information will not be accepted unless timely confirmed in writing. In order to adequately give notice of the event, a minimum of information must be provided. Minimum information must include the plan coverage that is affected (such as Group Health Plan); the name(s) of the covered employee or COBRA qualified beneficiary who experienced the event, which event occurred and the date it occurred. Additional information that is helpful is the address and phone of the person(s) who experienced the event. A plan form is available for reporting convenience. However, other written format will be accepted as long as it includes the minimum information described above.

The plan will require evidence of the event. Acceptable evidence is a signed certification by the covered employee or COBRA qualified beneficiary that the event has occurred as represented. However, in the case of a Social Security disability determination, a copy of the Social Security Disability Notice of Award letter must be provided. Or, if Social Security has determined that a disability no longer exists, a copy of that Social Security document will be acceptable evidence.

Notice of an event must be timely. Notice is timely if it is made within 60 days after the later of: the date of the event or the date plan coverage is lost due to the event. In the case of a Social Security disability determination, notice is timely if it is made within 60 days of the latest of: the date Social Security makes its determination (as found in the Disability Notice of Award letter) or the date of the COBRA event or the date coverage is lost due to the event. If the person is already on COBRA continuation, notice must also be made before the end of the initial 18 months of continuation. In the case of a person who Social Security determines is no longer disabled, notice is timely if it is made within 30 days after the Social Security determination. Any notice that is not timely may result in loss of coverage or reduced coverage with no COBRA continuation. The covered employee, the person who experienced the event or a representative of either, may make notice. A notice by one of the foregoing individuals will satisfy the notice responsibility on behalf of all related individuals with respect to the event.

Notice must be made to the person or department within the employer's organization that is responsible for plan administration or customarily handles plan enrollment.

EVENT NOTICE PROCEDURE: (Instructions for Communicating a COBRA Event) Whether you are an active employee, family member of an active employee or already on COBRA continuation, you may experience an event that affects your plan coverage. You must provide notice of the event so that you and/or your family can be provided with information regarding the impact of the event on your plan or continuation eligibility. If you do not provide notice, plan coverage can be modified or terminated. Please complete the form COBRA Event Notice to communicate the event. Other written format will be acceptable as long as it provides the same information. Verbal notice WILL NOT be accepted unless it is confirmed in writing. You must complete a separate COBRA Event Notice form (or other written format) for each event and each plan.

The information necessary to communicate the event is requested on the COBRA Event Notice form. However, other written format is acceptable as long as it contains the name(s), address and phone number of the covered employee and/or other covered dependents experiencing the event, plan coverage, the event, and date of the event. You must provide evidence that the event has occurred. Acceptable evidence is your signed certification, except in the case of a Social Security disability determination. For a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter. Or, a copy of Social Security's determination that you are no longer disabled.

Submit the COBRA Event Notice form (or other acceptable format) and evidence to the Employer/Plan Administrator or as directed on the COBRA Event Notice form.

Your notice of an event must be made within 60 days after the later of: the date of the event or the date you lose coverage due to the event. If you are reporting a Social Security Disability determination, notice must be reported within 60 days after the date of the event, the date of the loss of plan coverage or the date of Social Security's determination, whichever is the latest AND before the end of your 18 months of COBRA continuation, if you are on COBRA. If Social Security determines that you are no longer disabled, notice must be made within 30 days of the determination.

COBRA Event Notice

Covered employees and COBRA continuees should use this form to report a COBRA event listed below.

Employer: _____ Plan: _____

Employee Name: _____ SSN: _____

I am reporting (check one of the following):

___ Divorce Divorce Decree Date: _____

___ Court Approved Legal Separation Legal separation Date: _____

___ A dependent child who ceases to meet plan's definition of dependent child

Date child is not a dependent:_____

Date Coverage Lost:_____

___ Social Security Administration Determination of Disability or No Longer Disabled

Disability Date: _____ No Longer Disabled Date: _____

You must supply evidence of the event. Acceptable evidence is your signed certification below. Except in the case of a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter, or a copy of their determination that you are no longer disabled. You must report within 60 days from the latest of: the date of the event, the date coverage is lost as a result of the event or the date of the Social Security determination, if applicable. Please refer to Event Notice

Procedure for specific instructions or your summary plan description or COBRA General Notification for more specific information.

Name(s), address and phone of persons losing coverage because of event:

_____

_____

I declare that I am the covered employee or person who experienced the event or representative of either and certify that the above event has occurred as represented.
_____Date: _____

This form must be submitted to:

Insurance Department
Rutherford County Government
303 North Church St., Suite 201
Murfreesboro, TN 37130
Phone:615-898-7715
Please keep a copy for your files.

ARTICLE V – COST CONTAINMENT PROVISIONS

SECTION 1 – PRE-ADMISSION CERTIFICATION

Certification Requirements - Out-of-Network

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

1. as a registered bed patient;
2. for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
3. for the treatment of Mental Health or Substance Abuse in an Intensive Outpatient Therapy Program.
4. for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 72 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of

pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by $500 for Hospital charges made for each separate admission to the Hospital:

unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 72 hours after the date of admission.

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

1. inpatient Hospital services;
2. inpatient services at any participating Other Health Care Facility;
3. residential treatment;
4. nonemergency ambulance; or
5. transplant services.

SECTION 2 – CASE MANAGEMENT

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

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

SECTION 3 – PRE-ADMISSION TESTING

Necessary x-ray and laboratory tests done in connection with and before admission to the Hospital for scheduled surgery will be reimbursed at the rate listed in the Schedule of Benefits.

There is no dollar limit to this provision, however, Physician's charges will be reimbursed at the usual and customary charges.

SECTION 4 – PREFERRED PROVIDER ORGANIZATION

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

As a Covered Person under the Preferred Provider Option, the Covered Person will receive a directory of participating Hospitals and Physicians. He will also receive notice of changes to the list of Preferred Providers.

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

DEFINITIONS

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

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

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

4. EMERGENCY – means a sudden unexpected serious medical condition that, without immediate medical attention could result in death or cause impairment to bodily functions.

If the Covered Person received treatment or services as a result of an Emergency, benefits will be paid on the basis of a Preferred Provider, whether or not the services were performed by a Preferred Provider.

If services are not offered by a Preferred Provider or if a Covered Person is traveling outside the geographical area of the Preferred Provider Organization, benefits will be paid as if the provider was in the Preferred Provider Organization.

If the Covered Person receives treatment or services from a Non-Preferred Provider and the Covered Person had no option in the selection of the provider, benefits will be paid as if the provider was in the Preferred Provider Organization. If there is any question concerning the Covered Person's responsibility in the provider selection it will be determined by the Plan Supervisor.

ARTICLE VI – BENEFITS BY TYPE OF COVERAGE

SECTION 1 – COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

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

1. DEDUCTIBLE

The Deductible is stated in the Schedule of Benefits. This amount of each Covered Person's Covered Medical Expenses must be satisfied each Calendar Year before benefits become payable under the Plan.

2. FAMILY LIMIT ON DEDUCTIBLES

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

3. DEDUCTIBLE AMOUNTS

Accumulation Period for incurring Covered Medical Expenses equal to Cash Deductible for Employees and Dependents will be a Calendar Year.

4. MAXIMUM OUT-OF-POCKET

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

5. MENTAL OR NERVOUS CONTIONS / ALCOHOLISM OR CHEMICAL DEPENDENCY TREATMENT

Treatment of mental and nervous conditions and charges for alcoholism or chemical dependency treatments are paid at the percentage stated in the Schedule of Benefits, after the deductible has been satisfied, up to the maximum amounts stated in the Schedule of Benefits.
Any Covered Medical Expenses for mental and nervous disorders or alcoholism or chemical dependency treatment will not be included in determining the maximum "cash out-of-pocket expenses, nor will such charges ever be paid at 100%.

6. LIFETIME MAXIMUM BENEFIT

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

7. BENEFITS FOR EXPENSES DUE TO PREGNANCY

Benefits are payable for pregnancy-related expenses on the same basis as for disease, but only for female Employees, wives of male Employees and female Covered Dependent children.

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

8. COMMON ACCIDENT – OTHER MEDICAL SERVICES

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

9. COVERED MEDICAL EXPENSES

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

Covered Medical Expenses are those charges listed below:

A. HOSPITAL SERVICES

The following services and supplies will be covered when received in and billed by a Hospital:

1) Inpatient Services

   i. Room, board, and general nursing care in a

      a) Semi private room, or

      b) Private room (benefits up to the Hospital's most common semi-private room rate), or

      c) Room in a special care unit as approved by the Utilization Review company.

   ii. use of operating, delivery, and treatment rooms;

   iii. drugs and medicines, including take-home drugs;

   iv. sterile dressings, casts, splints, and crutches;

   v. anesthetics and their admission;

   vi. Diagnostic Services; and

   vii. certain Therapy Services.

   Benefits will not be provided for room and board charges incurred on the date of discharge, unless both admission and discharge occur on the same day.

2) Outpatient Services

   The following will be considered Covered Services when rendered in the Outpatient department of a Hospital.

i. treatment of accidental injuries;

ii. treatment of an illness that occurs suddenly and requires immediate medical attention;

iii. removal of sutures, anesthetics, and their administration, and other surgical services provided by a Hospital employee other than the surgeon or assisting surgeon; and

iv. drugs, crutches, and medical supplies.

3) Pre-Admission Testing

Certain tests and studies are commonly required before a scheduled Hospital admission. Such tests and studies will be considered Covered Services when rendered by a Hospital prior to an admission as an Inpatient (and billed by such Hospital).

B. SURGERY

Surgical procedures (to include oral Surgery for the removal of impacted teeth) are considered Covered Services when performed by a Physician or Professional Other Provider.

1) Outpatient Surgery

Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.

2) Multiple Surgical Procedures

When two (2) or more covered surgical procedures are performed through the same incision, the most expensive procedure will be covered at the full benefit amount and the other procedure(s) will be covered at 50% of the benefit amount.

3) Assistant Surgeon

Benefits will be provided for surgery performed by a Physician who actively assists the operating Surgeon in the performance of a covered surgical procedure provided:

i. no intern, resident, or other staff doctor is available; and

ii. such procedure is recognized as requiring an assistant Surgeon.

Benefits will be limited to no more than 20% of the UCR for Covered Services rendered by the primary surgeon.

4) Anesthesia Services

Benefits will be provided for the administration of anesthetics used in connection with a covered surgical procedure and ordered by the attending Physician. The anesthesia must be administered by a Provider other than the operating or assisting surgeon.

Benefits will also be provided for the administration of anesthesia and associated facility expenses in conjunction with dental procedures where it is medically necessary for the patient to undergo deep sedation/general anesthesia.

5) Second Surgical Opinion Consultation

i. Benefits will be provided for second surgical opinion and related diagnostic tests obtained within three (3) months of the first opinion.

ii. If the second surgical opinion conflicts with the first opinion, benefits will be provided for a third opinion and related diagnostic tests.

iii. Second and third surgical opinions must be given by a Physician who is not in the same medical group or practice as (a) the Physician who initially recommended the surgery <u>or</u> (b) the Physician who rendered the second or third surgical opinion.

C. MEDICAL SERVICES

1) Inpatient Medical Services

i. When the Covered Person is confined in a Hospital, the attending Physician's charges for professional care and visits by a Professional Other Provider are covered.

ii. Except for staff consultations required by Hospital rules, benefits will be provided for consultation services when requested by the attending Physician.

2) Outpatient Medical Services

Benefits may be provided for the following services when rendered by a Physician or Professional Other Provider:

i. treatment of accidental injuries;

ii. treatment of an illness that occurs suddenly and requires immediate medical attention; and

iii. home and office visits for the examination, diagnosis, and treatment of an illness or injury.

D. DIAGNOSTIC SERVICES

The following services are covered:

1) x-ray and other radiology services;

2) laboratory and pathology services;

3) cardiographic, encephalographic, and radioisotope tests;

4) Mammography screening, provided such examinations are conducted upon the recommendation of the Covered Person's Physician with equipment designed and used primarily for such examinations.

5) allergy testing

E. THERAPY SERVICES

The following forms of therapy are covered:

1) Radiation therapy;

2) Chemotherapy;

3) Dialysis treatment;

4) Physical therapy

5) Respiratory therapy, and

6) Speech therapy

Charges by a licensed speech therapist must be to restore speech loss or correct speech impairment due to:

i. a birth defect where therapy follows corrective surgery;

ii. childhood autism

iii. an injury, or

iv. an illness

Therapy must be in accordance with a Physician's exact orders as to type, frequency and duration and the prognosis or history of the individual receiving the treatment or therapy must indicate to the Plan a reasonable chance of improvement;

F. MATERNITY SERVICES

The Plan covers pregnancy and childbirth on the same basis as an illness.

G. AMBULANCE SERVICE

Benefits will be provided for ambulance service:

1) from the Covered Person's home or the scene of an accident or medical Emergency to the nearest Hospital where appropriate medical or surgical services are available;

2) between Hospitals;

3) between a Hospital and a Skilled Nursing Facility; and,

4) round trip transportation will be provided for the patient and, if required by the attending Physician, one (1) companion on a commercial airline for prearranged treatment at a Center of Excellence Provider. This applies only if the facility is such a distance that the patient can not be transported by ground transportation or if the Attending Physician feels that air transportation is necessary. This will also include transportation to and from the airport in the city where the treatment will be provided.

For purposes of this Plan, "Ambulance" shall mean a specially-designed and equipped vehicle or aircraft, used only for transporting the sick and injured unless (4) above applies.

H. OUTPATIENT PRIVATE DUTY NURSING AND SKILLED NURSE VISITS.

1) Benefits are available for certain private duty nursing services and skilled nurse visits when Medically Necessary and rendered by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), provided:

i. professional skills of an R.N. or L.P.N. (as compared with other nursing skill levels) are Medically Necessary to provide the appropriate level of care; and

ii. such services are ordered by a Physician.

Inpatient private duty nursing services in an acute care Hospital are, however, excluded.

2) Benefits will be reduced (according to the Schedule of Benefits) if services are provided by a Non-Preferred Provider.

I. SKILLED NURSING FACILITY

Benefits for Inpatient care in a Skilled Nursing Facility are provided on the same basis as benefits for other Inpatient Hospital services.

J. DENTAL SERVICES

This Plan Document does not provide benefits for routine dental care. Benefits are available for removal of impacted teeth or for dental work needed as the result of an accidental injury to the jaw, natural teeth, mouth or face. To be covered, the accident must occur on or after the date the Covered Person's coverage begins. Benefits are also available for TMJ as described under “Other Benefit Plan Provisions”.

An injury due to chewing or biting or received in the course of other dental procedures will not be considered an accidental injury.

Benefits will also include the placement of dental implants that are necessary to restore a major bodily function when prescribed following a surgical procedure to the jaw. The surgical procedure must have been a result of a disease that threatened normal bodily functions. Only those teeth that were removed as a result of the surgery will be a covered expense regarding implants. To be covered, the surgery and implants both must have occurred on or after the date the Covered Person’s coverage begins.

K. EYEGLASSES OR CONTACT LENSES

Benefits are available for one (1) set of glasses and contact lens following cataract surgery. Benefits are available for additional contact lenses or glasses if medically necessary.

L. PRESCRIPTION DRUGS

Benefits are available for outpatient prescription drugs for use by a Covered Person through the prescription drug card program.

To be considered covered, the drug must be:

1) approved for general use by the Food and Drug Administration,

2) prescribed in writing by a licensed Physician on or after the Covered Person's coverage begins,
3) dispensed by a licensed Pharmacist, and

4) not be available for purchase without a prescription.

Also covered under the prescription drug card is the cost of injectable insulin, syringes, test tape for diabetics. Erectile Dysfunction medications are covered, but limited to a monthly quantity limit of 8 pills.

Exception: Injectables not covered under the prescription drug card may be reimbursed under the comprehensive major medical expenses.

M. DURABLE MEDICAL EQUIPMENT

Benefits are provided for the rental or, if deemed by the Administrator as appropriate, the purchase of Durable Medical Equipment when Medically Necessary and prescribed in writing by a Physician. Under no circumstances will the Plan pay more than the purchase price of the 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 Covered Person's physical development – and is not as a result of improved technology or loss, theft, or damage.

When the equipment is rented and the rental extends beyond the original prescription, a Physician must re-certify that the equipment is Medically Necessary for continued treatment. If a re-certification is not submitted, benefits will cease on the date through which benefits were previously prescribed.

N. PROSTHETIC APPLIANCES

Benefits are provided for prosthetic appliances if needed to replace all or part of an absent or malfunctioning body part, including surrounding tissue. Benefits are also available to fit, adjust, repair, or replace an appliance, provided the need for this arises from normal wear or the Covered Person's physical development – not as a result of improved technology or loss, theft, or damage to the appliance or device.

O. HOME HEALTH CARE

Subject to the other terms and conditions of this Plan Document, benefits will be provided as stated in the Schedule of Benefits – for the following services when rendered by and billed by a Home Health Care Agency:

1) part time or intermittent nursing care by a visiting R.N. or L.P.N. (not to include Private Duty Nursing);

2) Physical therapy and Respiratory therapy by persons licensed to perform such services;

3) oxygen and its administration; and

4) Diagnostic Services

Benefits will be provided only for Covered Services prescribed by the Covered Person's attending Physician.

No Home Health Care benefits will be provided for:

i. transportation services;

ii. services rendered primarily for Custodial Care;

iii. dietitian services;

iv. social case work or homemaker services;

v. maintenance therapy; or

vi. food, including home-delivered meals.

P. HOSPICE HOME CARE BENEFITS

Benefits will be provided under this Paragraph for specific types of services related to the care of a terminally ill Patient (where life expectancy is six (6) months or less). Benefits will be paid at 100%, not subject to the Deductible amount, provided the diagnosis of terminal illness is certified by the Covered Person's primary or attending Physician.

The following will be considered Covered Services when provided by a Participating or Approved Hospice;

1) skilled nursing by a Registered Nurse, Licensed Practical Nurse, or a nurse's aide working under the supervision of a Registered Nurse;

2) medical social services by a Social Worker that is certified by the state in which the Hospice is operating and employed by the Hospice agency and under the direction of the Covered Person's Physician;

3) reasonable expense for medication prescribed for the control or palliation of the Covered Person's terminal illness, necessary medical equipment, and supplies;

4) services of a Home Health Aide furnished by the Hospice and supervised by a Registered Nurse;

5) services of a Home Health Aid to provide personal care necessary for the maintenance of safe and sanitary conditions in areas of the house used by the Covered Person;

6) Physical therapy and Respiratory therapy provided for the purposes of symptom control or to enable the patient to maintain activities of living at home and basic functional skills; and,

7) bereavement counseling, consisting of services provided to the patient's immediate family after the patient's death. Counseling visits are limited to two (2) visits provided within three (3) months after the patient's death.

The following will not be considered Covered Services under this Paragraph:

1) charges for services greater than the rate set in advance by the Participating or Approved Hospice Agreement;

2) housekeeping services, delivered or prepared meals, and convenience and comfort items not related to the palliation or management of the Covered Person's terminal illness;

3) supportive environmental items such as air conditioners, air fresheners, ramps, handrails, or intercom systems;

4) transportation, chemotherapy, radiation therapy, enteral and parenteral feeding, Private Duty Nursing, home hemodialysis, or medical research;

5) visits made to the home by a Physician;

6) Inpatient care at any facility. This includes Inpatient care provided in a Hospice, Hospital, Skilled Nursing Facility, intermediate care facility, or any other institution;

7) Psychiatric Care;

8) services provided by volunteer agencies or pastoral counseling services; and

9) items, services, or supplies not specified as Covered Services.

Q. HOME INFUSION THERAPY: PRE-TREATMENT CERTIFICATION OF SERVICES

1) Benefits are available for Home Infusion Therapy including supervision and management by a Physician of such services, when Medically Necessary and approved by the Administrator.

R. CARDIAC REHABILITATION

The following Cardiac Rehabilitation services are covered:

1) Phase I includes Inpatient rehabilitation services that begin during hospitalization and extend until discharge.

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

S. WOMEN'S HEALTH AND CANCER RIGHTS ACT

Charges incurred by a Covered Person for the following covered expenses:

1) Reconstruction of the breast on which the mastectomy has been performed.

2) Surgery and reconstruction of the other breast to produce a symmetrical appearance.

3) Prosthesis and physical complications; and

4) Treatment of physical complications of mastectomy.

SECTION 2 – ALCOHOLISM AND CHEMICAL DEPENDENCY PROVISION

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

1. Percentage Payable

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

2. Covered Medical Expense for Treatment While Not Hospital Confined

Covered Medical Expense for professional charges for treatment of alcoholism and drug addiction, while not confined in a hospital, is limited to charges made by a licensed clinical social worker. Charges made by certified addiction counselors are also covered medical expenses, but only if the treatment is rendered in connection with an accredited outpatient substance abuse program. Charges made by marriage and family therapists are not covered medical expenses.

SECTION 3 – MENTAL AND NERVOUS DISORDER PROVISION

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

1. Percentage Payable

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

2. Covered Medical Expense for Treatment While Not Hospital Confined

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

SECTION 4 – PRE-EXISTING CONDITIONS EXCLUSION

1. Pre-Existing Condition Exclusion Period. Claims resulting from Pre-Existing Conditions, as defined in the Plan, are excluded from coverage under the Plan except as specified below:

   A. The maximum Pre-Existing Condition exclusion period shall be six (6) consecutive months (eighteen (18) in the case of a Late Enrollee) from the Covered Person's Enrollment Date minus the Covered Person's period of Creditable Coverage. After this period, the Pre-Existing Conditions Exclusion will no longer apply and any eligible expenses incurred thereafter will be considered. Periods of Creditable Coverage before a sixty-three (63) day period of no Creditable Coverage (other than a period of no Creditable Coverage attributable to this Plan's waiting period) shall not reduce the Pre-Existing Condition exclusion period.

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

   C. Exceptions to the Pre-Existing Conditions Exclusions

   1) In no event shall the total amount payable under this exception exceed the maximum amount payable under this Plan as if the Pre-Existing Conditions Exclusion were not present.

   2) No item of expense incurred before the effective date of this Plan shall be payable under this Plan

   3) In no event shall the term "this Plan" be construed to include the coverage replaced.

SECTION 5 – LIMITATIONS AND EXCLUSIONS TO MEDICAL EXPENSE BENEFITS

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

1. No payment will be made for any charges for services or supplies not prescribed or performed by a Physician or Professional Other Provider (as defined in the Definitions Section);

2. No payment will be made for any charges for services or supplies which are not Medically Necessary;

3. No payment will be made for any charges for services provided before the Covered Person's coverage begins or for a Pre-Existing Condition during the Pre-Existing Waiting Period;

4. No payment will be made for any charges for services or supplies provided in connection with an Experimental and Investigative treatment, drugs, procedure, or supply;

5. No payment will be made for any charges for any work-related illness or injury (unless resulting from self-employment not subject to Worker's Compensation insurance requirements);

6. No payment will be made for any charges for services or supplies furnished without cost under the laws of any government;

7. No payment will be made for any charges for illness or injury resulting from war (occurring after the Covered Person's coverage begins);

8. No payment will be made for any charges for services for which the patient is not required or legally obligated to pay;

9. No payment will be made for any charges for 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);

10. No payment will be made for any charges for services or supplies provided in connection with a surgical procedure primarily to improve appearance or which are provided in order to correct or repair the results of prior surgical procedure, the primary purpose of which was to improve appearance. Surgery needed to restore an impaired bodily function is covered if the condition occurs while the Covered Person is under this Plan and results from:

    A. disease;
    B. birth defect;
    C. Surgery (excluding non-functional scar revision); or
    D. accidental injury.

11. No payment will be made for any charges for self-treatment or services provided by any person related to the Covered Person by blood or marriage, including the Covered Person's Spouse, parent, child, legal guardian, aunt, uncle, stepchild, or any person who resides in the Covered Person's immediate household;

12. No payment will be made for any charges for services rendered by other than a Hospital, Facility Other-Provider, or listed Other Providers;

13. No payment will be made for any charges for services paid under any other group, blanket or franchise insurance coverage, other health insurance plan, union welfare plan, or labor-management trust plan;

14. No payment will be made for any charges for personal hygiene and convenience items (such as air conditioners, humidifiers, or physical fitness equipment);

15. No payment will be made for any charges for telephone consultations, charges incurred due to failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records;

16. No payment will be made for any charges for hospital admissions which are primarily for diagnostic studies;

17. No payment will be made for any charges for whole blood, blood components, and blood derivatives if donated or replaced;

18. No payment will be made for any charges for custodial care, such as help in walking, getting in or out of bed, or any service that could be performed by a family member or nonprofessional personnel;

19. No payment will be made for any charges for routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails, fallen arches, weak feet, and chronic footstrain, unless an approved surgical procedure;

20. No payment will be made for any charges for eyeglasses, contact lenses, or replacement of cataract lenses, and examinations for and the fitting of eyeglasses and contact lenses, except as stated in Covered Medical Expenses;

21. No payment will be made for any charges for hearing aids and examinations for the fitting of hearing aids;

For the purpose of this Plan, “hearing aids” shall include any procedure or device designed to restore or enhance the Covered Person’s ability to hear, including but not limited to, audiant bone conduction, electromagnetic, and/or surgically-implanted devices.

22. No payment will be made for any charges for surgery to change sex and related services;

23. No payment will be made for any charges for services and supplies provided by a Licensed Independent Practitioner of Social Work except for covered treatment for alcoholism/chemical dependency and mental disorder;

24. No payment will be made for any charges for services or supplies for, or in connection with, artificial insemination, in vitro fertilization, or any other procedure used to create a pregnancy;

25. No payment will be made for any charges for services covered under Medicare except as required by Federal law;

26. No payment will be made for any charges for non-medical self-care or self-help training and any related diagnostic testing or medical social services;

27. No payment will be made for any charges for any services or supplies designed to correct refractive errors of the eyes;

However, surgery for removal of cataracts, including surgical implant of a prosthetic lens following cataract extraction, will be considered a Covered Service. In addition, benefits are available for one (1) set of glasses and contact lenses following cataract surgery. Benefits are available for additional contact lenses or glasses if medically necessary.

28. No payment will be made for any charges for an artificial heart or any other artificial organ, or any associated expense;

29. No payment will be made for any charges for services or supplies for the reversal of sterilization;

30. No payment will be made for any charges for services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary;

31. No payment will be made for any charges for charges in excess of the Usual, Customary and Reasonable charge (UCR) for a service or supply;

32. No payment will be made for any charges for any balance of charges, Deductibles, or co-insurance resulting from the Covered Person's failure to comply with applicable requirements of any other individual or group contract, including: Pre-Admission Certification, second surgical opinion consultation, Outpatient Surgery, or Concurrent Care Review Programs;

33. No payment will be made for any charges which are incurred for services, treatment, or surgical procedures rendered in connection with any overweight condition, unless the Covered Person is morbidly obese and the treatment is medically necessary.

34. No payment will be made for any charges for any charges for services and supplies rendered to a Covered Person which require the approval of the Administrator, when such approval is not given;

35. No payment will be made for any charges for services or supplies rendered prior to the Effective Date or after the Covered Person's coverage is terminated, except as otherwise specified;

36. No payment will be made for any charges for room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day;

37. No payment will be made for any charges for 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;

38. No payment will be made for any charges for staff consultations required by Hospital rules;

39. No payment will be made for any charges for 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;

40. No payment will be made for any charges for 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;

41. No payment will be made for any charges for inpatient private duty nursing in an acute care Hospital;

42. No payment will be made for any charges for over-the-counter drugs (not requiring a prescription), unless specifically designated as covered by this Plan; prescription devices; vitamins, except those which by law require a prescription; prescription drugs dispensed in a doctor's office;

43. No payment will be made for any charges for court ordered treatment of a Covered Person unless benefits are otherwise payable;

44. No payment will be made for any charges for 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 (See Other Plan Provisions for coverage related to TMJ);

45. No payment will be made for any charges for medical treatment for which the Covered Person has been (or may be) reimbursed under a mass tort or class action lawsuit, settlement or judgment;

46. No payment will be made for any charges for services or supplies for dental care, except as specified in Covered Medical Expense; and

47. No payment will be made for any charges for a drug, service, or medical treatment or procedure which is Experimental or Investigative as defined in Article II.

48. No payment will be made for any charges for No payment will be made for any charges incurred as the result of, or in connection with, intentionally self-induced illness or intentionally self-inflicted injury or voluntarily taking of drugs except those taken as prescribed by a Physician. However, such charges will be payable if they are incurred due to a medical condition.

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

50. No payment will be made for prescription drugs not purchased through the prescription drug card program. However, Injectables not covered under the prescription drug card may be reimbursed under comprehensive major medical expenses.

SECTION 6 – COORDINATION OF BENEFITS

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

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

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

1. group, blanket, franchise insurance coverage;

2. hospital or medical service organizations, group practice and other prepayment coverage;

3. any coverage under any labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

4. any coverage under governmental programs, except Medicaid coverage provided by any state, or any coverage required or provided by any statute, including no fault auto insurance.

**However, There will be no coordination of benefits for outpatient prescription drugs that are covered specifically under the Prescription Drug Card.

ALLOWABLE EXPENSES:

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

CLAIMS DETERMINATION PERIOD:

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

BENEFIT DETERMINATION:

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

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

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

1. The other plan – the plan covering the spouse as an employee – will pay first.

2. This Plan – which covered the spouse as an Eligible Dependent – will pay second and will coordinate with the other plan.

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

1. Except in cases involving Dependent children whose parents are separated or divorced, this paragraph shall apply. When the other plan has adopted rules similar to intent to (a) below, (a) shall apply. Otherwise, subparagraph (b) below shall be used in determining the order of benefit payment.

   A. The plan covering the parent whose date of birth occurs earlier in a calendar year shall pay first and the other plan shall pay second. If both parents have the same birthday, the plan which has been in effect the longest shall pay first.

   B. The plan covering the father as an employee shall pay first, and the plan covering the mother as an employee shall pay second.

2. In the event of a claim on a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the plan covering the parent who has custody of the child shall pay first and the other plan shall pay second.

3. In the event of a claim on a Dependent child whose parents are divorced, and the parent with custody of the child has remarried, the plan covering the parent who has custody of the child shall pay first, the plan covering the step-parent shall pay next, and the plan covering the parent who does not have custody shall pay last.

4. In the event of a claim on a Dependent child whose parents are separated or divorced, where there is a court decree establishing financial responsibility for the health care expenses of such child, the plan covering the parent with financial responsibility shall pay first, and the other plan shall pay last, regardless of paragraphs 2. and 3. above.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION:

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

RIGHT OF RECOVERY:

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

GENERAL:

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

COORDINATION WITH STATE MEDICAID PROGRAMS:

Payments for benefits shall be made in accordance with any assignment required by a state medicaid or medical assistance plan.

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

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

SECTION 7 – SUBROGATION

1. SUBROGATION

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

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

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

2. REIMBURSEMENT

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

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

3. ATTORNEYS' FEES

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

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

4. PLAN'S RIGHT OF RECOVERY

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

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

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

ARTICLE VII – "HIPAA" PRIVACY RULE AND THE "504" PROVISIONS

SECTION 1 – GHP'S DESIGNATION OF PERSON / ENTITY TO ACT ON ITS BEHALF

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Rutherford County Insurance Committee to take all actions required to be taken by the GHP in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Rutherford County Insurance Committee).

SECTION 2 – DEFINITIONS

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Amendment.

1. **Plan** (also referred to as "GHP") means the Rutherford County Employee Benefit Plan.

2. **Plan Documents** mean the GHP's governing documents and instruments (i.e., the documents under which the GHP was established and is maintained), including but not limited to the **DOCUMENT NO.SF – 01075**

3. **Plan sponsor** means "plan sponsor" as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan sponsor is Rutherford County Insurance Committee.

SECTION 3 – THE GHP'S DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE RUTHERFORD COUNTY INSURANCE COMMITTEE – REQUIRED CERTIFICATION OF COMPLIANCE BY RUTHERFORD COUNTY INSURANCE COMMITTEE

1. Except as provided below with respect to the GHP's disclosure of summary health information, the GHP will (a) disclose Protected Health Information to the Rutherford County Insurance Committee or (b) provide for or permit the disclosure of Protected Health Information to the Rutherford County Insurance Committee by a health insurance issuer with respect to the GHP, *only if* the GHP has received a certification (signed on behalf of the Rutherford County Insurance Committee) that:

   A. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Rutherford County Insurance Committee, consistent with the "504" provisions;

   B. the Plan Documents have been amended to incorporate the Plan provisions set forth in this Amendment; and

   C. the Rutherford County Insurance Committee agrees to comply with the Plan provisions as modified by this Amendment

SECTION 4 – PERMITTED DISCLOSURE OF INDIVIDUALS' PROTECTED HEALTH INFORMATION TO THE RETHERFORD COUNTY INSURANCE COMMITTEE

1. The GHP (and any business associate acting on behalf of the GHP), or any health insurance issuer servicing the GHP will disclose individuals' Protected Health Information to the Rutherford County Insurance Committee only to permit the Rutherford County Insurance Committee to carry out plan administration

2. All disclosures of the Protected Health Information of the GHP's individuals by the GHP's business associate, health insurance issuer, to the Rutherford County Insurance Committee will comply with the restrictions and requirements set forth in this Amendment and in the "504" provisions.

3. The GHP (and any business associate acting on behalf of the GHP), may not, and may not permit a health insurance issuer, to disclose individuals' Protected Health Information to the Rutherford County Insurance Committee for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Rutherford County Insurance Committee.
4. The Rutherford County Insurance Committee will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

5. The Rutherford County Insurance Committee will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the GHP (or from the GHP's health insurance issuer), agrees to the same restrictions and conditions that apply to the Rutherford County Insurance Committee with respect to such Protected Health Information.

6. The Rutherford County Insurance Committee will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Rutherford County Insurance Committee.
7. The Rutherford County Insurance Committee will report to the GHP any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Rutherford County Insurance Committee becomes aware.

SECTION 5 – DISCLOSURE OF INDIVIDUALS' PROTECTED HEALTH INFORMATION – DISCLOSURE BY THE RUTHERFORD COUNTY INSURANCE COMMITTEE

1. The Rutherford County Insurance Committee will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

2. The Rutherford County Insurance Committee will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526.

3. The Rutherford County Insurance Committee will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.528.

4. The Rutherford County Insurance Committee will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the GHP available to the U.S. Department of Health and Human Services for purposes of determining compliance by the GHP with the HIPAA Privacy Rule.

5. The Rutherford County Insurance Committee will, if feasible, return or destroy all individuals' Protected Health Information received from the GHP (or a health insurance issuer with respect to the GHP) that the Rutherford County Insurance Committee still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Rutherford County Insurance Committee will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Rutherford County Insurance Committee will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The Rutherford County Insurance Committee will ensure that the required adequate separation, described in SECTION 7 below, is established and maintained.

SECTION 6 – DISCLOSURES OF SUMMARY HEALTH INFORMATION AND ENROLLMENT AND DISENROLLMENT INFORMATION TO THE RUTHERFORD COUNTY INSURANCE COMMITTEE

1. The GHP, or a health insurance issuer with respect to the GHP, may disclose summary health information to the Rutherford County Insurance Committee without the need to amend the Plan Documents as provided for in the "504" provisions, if the Rutherford County Insurance Committee requests the summary health information for the purpose of:

   A. Obtaining premium bids from health plans for providing health insurance coverage under the GHP; or

   B. Modifying, amending, or terminating the GHP.

2. The GHP, or a health insurance issuer with respect to the GHP, may disclose enrollment and disenrollment information to the Rutherford County Insurance

SECTION 7 – REQUIRED SEPARATION BETWEEN THE GHP AND THE RUTHERFORD COUNTY INSURANCE COMMETTEE

1. In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Rutherford County Insurance Committee who may be given access to individuals' Protected Health Information received from the GHP or from a health insurance issuer servicing the GHP.

   A. Insurance Department
   B. Finance Department
   C. Human Resources Department of the County and Board of Education

2. This list reflects the employees, classes of employees, or other workforce members of the Rutherford County Insurance Committee who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Rutherford County Insurance Committee provides for the GHP. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Rutherford County Insurance Committee) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

3. The Rutherford County Insurance Committee will promptly report any such breach, violation, or noncompliance to the GHP and will cooperate with the GHP to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

ARTICLE VIII – MISCELLANEOUS PROVISIONS

SECTION 1 – MEDICAL EXAMINATION

No medical examination shall be required of any Eligible Employee or Eligible Dependent to secure this coverage initially. However, the Plan shall have the right, through their medical examiner, to examine the Eligible Employee or Eligible Dependent

as often as they may reasonably require during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

SECTION 2 – ON-THE-JOB INJURY NOT AFFECTED

This Plan is not in lieu of any On-the-Job Injury or Occupational Disease Law. This Plan does not affect any requirement for coverage under any On-the-Job Injury law or Occupational Disease Law.

SECTION 3 – GOVERNING LAW

This Plan is created and accepted in the State of Tennessee. All questions pertaining to the validity, or interpretation of, the Plan, or any questions concerning the acts and transactions of the Plan, or any other matter that affects the Plan shall be determined under Federal law, where applicable Federal law exists. If there is no applicable Federal law, the laws of the State of Tennessee shall apply in all matters.

SECTION 4 – SEVERABILITY CLAUSE

Should any provision of the Plan or any amendments made to the Plan, be determined or judged to be unlawful, such illegality shall apply only to the provision in question and shall not apply to any other provisions of the Plan, unless such illegality shall make impractical or impossible the functioning of the Plan.

SECTION 5 – MEDICAL ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The Plan will not take into account whether a Covered Person is eligible for, or is currently receiving, medical assistance under a State Medicaid Plan either in enrolling the Covered Person as an Employee or Dependent or in determining or making any payment of benefits to the Covered Person.

If the Covered Person is eligible for, or is currently receiving, medical assistance from a State Medicaid Plan, this Plan will pay the Covered Person's benefits in accordance with any assignment of rights made by the Covered Person, or on the Covered Person's behalf.

To the extent payment has been made to the Covered Person under a State Medicaid Plan, and this Plan has a legal liability to make payments for the same items or services, then payment under this Plan will be made in accordance with any State law which provides that the State has acquired the Covered Person's rights under this Plan to payment for those items and services.

SECTION 6 – NOTICE AND PROOF OF CLAIM

1. A written notice of the injury or of the illness for which the individual is making claim must be given to the Plan within ninety (90) days of the first day of the illness or injury for which claim is made and all forms, bills and information necessary to pay the claim must be provided within ninety (90) days of the first day of the illness or injury for which claim is made.

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

3. As soon as the Plan receives notice of the claim, the Plan will furnish forms which are customarily used by the Plan for the filing of claims. If such forms are not furnished within fifteen (15) days after the Plan has received notification of the claim, the individual shall be considered to have complied with all requirements of the Plan as to submitting claims, time periods fixed in the Plan for filing claims, and filing of other information required by the Plan.

SECTION 7 – PAYMENT OF BENEFITS

1. Benefits are payable to the Eligible Employee whether the claim is on the Eligible Employee or on one of the Employee's Eligible Dependents. If benefits are assigned, however, benefits will be paid to the assignee instead of directly to the Eligible Employee. Benefits are payable when the required forms have been submitted to the Plan.

2. If an individual, in the Plan's opinion, is not capable of giving a valid receipt for payments due and no guardian has been appointed for such person, the Plan may make payment to the individual or individuals who, in their opinion, has assumed the care and principal support of the individual. If the individual should die before all amounts that are due have been paid, the Plan may, at their option, make payment to the executor, or administrator of the estate of the individual, or to his surviving spouse, parent, child, or children or to any individual who, is entitled to the benefits.

3. Any payments that are made by the Plan in accordance with these provisions shall fully discharge the liability of the Plan to the extent of the payments.

SECTION 8 – ILLEGAL OCCUPATION OR COMMISSION OF FELONY

The Plan will not be liable for loss to which a contributing cause was the commission of, or attempt to commit, a felony by the person whose injury or illness is the basis of claims, or to which a contributing cause was such person's being engaged in an illegal occupation.

SECTION 9 – CLAIMS REVIEW AND APPEALS PROCEDURE

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

1. Pre-Service Claim – a Pre-Service Claim is a claim for medical care under the Plan for which prior approval for the care, in whole or in part, is a condition to receiving the medical care.

2. Concurrent Care Claim – a previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.

3. Post-Service Claim – a claim for medical care for which the medical care has already been received by the covered person.

4. Urgent Care Claim – a Claim in which the application of the time period for making a determination of a Pre-Service Claim or Concurrent Care Claim would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum capacity (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the Covered Person's medical condition) or will subject the Covered Person to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the Covered Person's condition). An Urgent Care Claim also includes a Claim for Emergency care or an admission made pursuant thereto. **This Plan does not require prior approval for Emergency or Urgent Care Claims.**

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

Pre-Service Claim

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

Urgent Care Claim (Pre-Service)

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

Concurrent Care Claim

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

reduction or termination to allow you to appeal and obtain a determination prior to the effective date of the reduction or termination of your ongoing course of treatment.

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

Post-Service Claim

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

The period of time within which a benefit determination is required to be made shall begin at the time your claim is filed. A claim is properly filed when submitted electronically or by mail to the address on the Covered Person's I.D. card and received by the Plan Supervisor. If the period of time to make a benefit determination is extended due to your failure to submit information necessary to decide a claim other than an Urgent Care Claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to you until you respond to the request for additional information whichever is earlier.

NOTICE OF BENEFIT DETERMINATION

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

1. The specific reason or reasons for the denial;

2. The specific provisions of the Plan on which the denial is based;

3. A description of any additional material or information necessary for you to perfect your claim, together with an explanation as to why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review;

5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such a rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to you upon request;

6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7. If the claim was an Urgent Care Claim, a description of the expedited review process applicable to such claims.

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

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

APPEALING AN ADVERSE BENEFIT DETERMINATION/DENIED CLAIM

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

1. Provide you the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits;

2. Provide that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

3. Provide for a review that takes into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination;

4. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by the Employer of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal or the subordinate of such individual;

5. Provide that, in deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Employer shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional may not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

7. Provide, in the case of an Urgent Care Claim, for an expedited review process pursuant to which (i) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious methods.

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

Pre-Service/Concurrent Care Claim

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

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

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

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

1. The specific reason or reasons for the denial;

2. The specific provisions of the Plan on which the denial is based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

4. A statement describing the Plan's voluntary appeal process, if any;

5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such a rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to you upon request;

6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7. A statement that you and the Plan may have voluntary alternative dispute resolutions options available.

Miscellaneous Information Regarding Claims

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

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

Disability Determination

If the Plan offers an extension of coverage for those participants on the basis of disability and the Plan Supervisor is responsible for making the determination as to whether a participant is indeed disabled, the following different rules apply to the disability determination:

1. The claims reviewer will notify you of an adverse benefit determination within forty-five (45) days of receipt of the claim. The claims reviewer may take two (2) extensions of thirty (30) days each if for reasons beyond the control of the claims reviewer.

2. You will have one hundred eighty (180) days in which to appeal the adverse benefit determination to the Plan Administrator.

3. The Plan Supervisor will notify you of an adverse benefit determination within forty-five (45) days of the date the Plan Supervisor received the appeal. The Plan Administrator may take a forty-five (45) day extension if for reason beyond the control of the Plan Administrator.

SECTION 10 – NON-ALIENATION AND ASSIGNMENT

The Plan shall not be liable for any debt, liability, contract or tort of any Covered Person. The Plan shall pay all benefits due and payable for Covered Charges directly to the Covered Person who incurred the Covered Charges, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law, provided however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service provider, provided further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service provider shall be binding on the Plan only if:

1. the Plan Administrator is notified of such assignment prior to payment of benefits;

2. the assignment is made on a form provided by, or approved by, the Plan Administrator; and

3. the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator.

SECTION 11 – FUNDING

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

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

All benefits payable under this Plan, whether funded by the Employer or by Employee (or Retiree) or Dependent contributions, shall be paid from the general assets of the Employer.

SECTION 12 – FAILURE TO ENFORCE

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

SECTION 13 – STATEMENTS and FRAUD

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representation will void the Plan benefits. No such representation may be used in defense to claim under the Plan unless a copy of the instrument containing such representation is or has been furnished to the Covered Person. Fraudulent acts such as an intentional misrepresentation of the truth in claiming dependents or submitting claims will result in the termination of plan benefits for the employee and the employee's dependents. Fraudulent acts may also result in legal prosecution. Such acts will be determined by the Insurance Director following careful and thorough review. A determination of fraud will be subject to the appeals process.

SECTION 14 – PLAN ADMINISTRATOR DISCRETION

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan Document, the decisions of the Plan Administrator shall be final and binding on the Employee, Dependents, and all other persons. Subject to the stated purposes and provisions of this Plan Document, the Plan Administrator shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan Document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious.

IN WITNESS WHEREOF, this instrument has been approved and executed this _____ day of _____, 20___.

RUTHERFORD COUNTY

BY: _____