SUMMARY PLAN DESCRIPTION

for

City of Germantown

Employee Benefit Plan

AS SET FORTH IN PLAN DOCUMENT
NO. SF- 100389
(Effective January 1, 2016)

NOTICE REGARDING MEDICARE PART D

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 71-72 for more details.

NON-GRANDFATHERED PLAN UNDER THE AFFORDABLE CARE ACT

This Plan is a Non-Grandfathered Plan under the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan can be directed to the Plan Administrator at City of Germantown. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

IMPORTANT NOTICE REGARDING MID-YEAR AMENDMENTS

A sixty (60) day advance notice to participants is now required by the Affordable Care Act for any plan changes that are made outside of renewal period that affect content in the summary of benefits and coverage (SBC).

NOTICE OF EXEMPTION

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, Group Health Plans must generally comply with the requirements listed below. However, the law also permits State and local governmental Employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the Employer, rather than provided through a health insurance policy. The City of Germantown has elected to exempt the City of Germantown Employee Benefit Plan from the following requirements.

1. Protection against limiting Hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan.

The exemption from these Federal requirements will be in effect for the 2014 Plan year beginning January 1, 2014 and ending December 31, 2014. The election may be renewed for subsequent plan years.

Note: This election was **not** renewed January 1, 2016.

CITY OF GERMANTOWN
EMPLOYEE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

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OPEN ACCESS PLUS (OAP) NETWORK

The benefits available under this Plan to you and your dependents are available through OAP Network. By using the OAP Network (Network), you can reduce your out-of-pocket expense and still choose from among the finest Hospitals and Physicians. Although you are not required to use OAP Network, there are many unique advantages if you use the OAP network. These advantages include:

- ***Quality*** *– The extensive OAP Network consists of leading Hospitals and respected Physicians, each with a strong reputation for providing quality care.*

- ***Freedom of Choice*** *– Unlike other health care Plans, you are free to select the Physician or Hospital of your choice. You can use a Non-Network Provider if you wish, but your benefits are better and you will pay fewer out-of-pocket expenses if you use an OAP Network Provider. However, the choice is always up to you.*

- ***Affordability*** *– You will save money when you use the OAP Network. Since the OAP Network has negotiated preferred rates from its Hospitals and Physicians, you pay a lower fee for most health care.*

Remember that your benefit package will better serve you when you use a Network Provider. The network is so extensive that the Physician of your choice may already participate as a Network Provider. It is always best to have a Physician or Hospital in mind before you need care, but please remember that the choice of the provider is always yours.

In order to make sure that you receive the preferred rates for using a Network Provider, **you must identify yourself**. Always present your health benefits card which identifies you as a Network patient each time you visit the Network Provider.

City of Germantown
Employee Benefit Plan
Schedule of Benefits
Effective January 1, 2016

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

The following is a summary of benefits under this Plan. The summary is subject to all other provisions, conditions, limitations and exclusions of this Plan. Benefits are only payable under this Plan for expenses which are Covered Medical Expenses.

Benefit	OAP Network Provider	Non-Network Provider
Annual Maximum Benefit Amount Per Covered Person	Unlimited	
Calendar Year Deductible Amounts Per Individual Per Family Unit	 $350 3 Individual Deductibles	
Maximum Out-Of-Pocket Amount Per Calendar Year Per Individual	$3,350 (not to exceed $13,200 per family)	Unlimited
Out-of-Pocket Amount includes coinsurance, co-pays and deductibles applied toward OAP Network medical and prescription benefits. **Vision Benefits, Dental Benefits and Non-Network benefits do not apply toward the OAP Network Maximum Out-of-Pocket Amount.** The following expenses do **not** count toward the Out-of-Pocket Maximum Amount and will **not** be paid at 100%, even when the Maximum Out-of-Pocket Expense has been met: • Chiropractic care; • Any penalties for failure to pre-certify; • Charges in excess Usual and Customary; or • Non-covered items.		
Percentage Payable All Covered Expenses unless otherwise stated	90% after deductible	65% after deductible
Primary Care Physician Office Visits *(Office Visit Charge Only.)* (PCP visits includes general practitioner, internist, family practitioner, pediatrician.)	$25 co-pay per visit, then 100% deductible waived	65% after deductible
Specialist Physician Office Visits *(Office Visit Charge Only.)*	$35 co-pay per visit, then 100% deductible waived	65% after deductible
Ambulance	90% after deductible	90% after deductible
Chiropractic Care ($500 Calendar Year Maximum)	50% after deductible	50% after deductible
Emergency Room Services (Physician/Facility) **Co-pay waived if admitted.**	$200 co-pay per visit, then 90% after deductible	$200 co-pay per visit, then 90% after deductible
Hearing Aids for employees and dependents under eighteen (18) years of age (Maximum of $1,000 per individual hearing aid per ear, every 3 calendar years.)	90% after deductible	65% after deductible
Second Surgical Opinion	100% deductible waived	100% deductible waived
Skilled Nursing Facility (100 days calendar year maximum)	90% after deductible	65% after deductible
Specialty Drugs	90% after deductible	Not Covered

Benefit	OAP Network Provider	Non-Network Provider
Treatment of Mental or Nervous Disorders or Substance Abuse (Inpatient)	90% after deductible	65% after deductible
Treatment of Mental or Nervous Disorders or Substance Abuse (Outpatient)	90% after deductible	65% after deductible
Pre-Admission Certification: If pre-admission certification is not obtained prior to an inpatient stay or outpatient surgery, for any treatment or care, the Plan payment for any expenses associated with the confinement will be reduced by 50% 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 twenty-four (24) hours of the admission. **PRE-ADMISSION CERTIFICATION DOES NOT GUARANTEE PAYMENT.** Benefit eligibility and/or reimbursement are the responsibility of the Plan Administrator.		
Preventive Care Benefits	100% deductible waived	65% after deductible

Charges for preventive care that are performed by a Preferred Provider (PPO) are covered with no cost sharing and include the following:

- Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF);
- Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA);
- Preventive care and screening for women as provided in the guidelines supported by HRSA; and
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).

The following preventive care services are covered by the plan. Coverage of some services is subject to age limits and/or risk exposure.

All members:

- Annual preventive health exams. More frequent preventive exams are covered for children up to age 2;
- All standard immunizations adopted by the CDC;
- Screening for colorectal cancer (age 50 – 75), high cholesterol and lipids, high blood pressure, obesity, diabetes and depression;
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases;
- Screening and counseling in primary care setting for alcohol misuse and tobacco; use; tobacco cessation counseling in the primary care setting will be limited to eight visits per year;
- One-time screening for Hepatitis C for adults age 45-70;
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year.

Women:

- Annual adult well-woman exam, including cervical cancer screening, annual sexually transmitted infection (STI) counseling, annual domestic violence screening and counseling and other USPSTF screenings with an A or B rating;
- Screening mammography at age 40 and older;
- Annual counseling and screening for human immune-deficiency virus (HIV) infection;
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits.
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility and gestational diabetes;
- Lactation counseling by a trained provider during pregnancy and/or in the postpartum period and costs for breastfeeding equipment. Rental or purchase price for one manual or electric breast

pump per delivery. Breast Pumps must be rented or purchased from participating DME. **Hospital grade breast pumps are excluded and not covered**.

- HPV (human papillomavirus) testing once every three years, beginning at age 30;
- All FDA approved contraceptive methods, sterilization procedures; and patient education and counseling for all women with reproductive capacity;
- Osteoporosis screening (age 60 or older);

Men:

- Screening for prostate cancer at age 50 and older;
- Screening for abdominal aortic aneurysm at age 65 – 75 (for men who have ever smoked);

Children:

- Screening of newborns for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia and cystic fibrosis;
- Screening for development delays and autism;
- Screening for iron deficiency;
- Vision screening;
- Screening for major depressive disorders.

The follow additional preventive services that are performed by a Preferred Provider (PPO) or Lifesigns are covered with no cost sharing and include the following:

Office Visit Any Age

36415	Venipuncture
71020	Chest X-ray
80050	General Health Panel
80061	Lipid Panel
81003	Urinalysis w/no micro
82270	Fecal Occult (Ages 50+)
82306	Assay of Vitamin D
82728	Ferritin
83036	Hemoglobin A1C
83540	Iron
83615	Lactate (LDH) enzyme
84100	Phosphorous
84436	Thyroxine
84439	T4 (Free)
84550	Uric Acid
86141	HSCRP
92551-2	Audiometry
93000	Resting EKG
94010	Spirometry
99090	Body Composition
99173	Visual Acuity
76536	Ultrasound - Head/Neck/Thyroid
76700	Ultrasound -Abdominal

AGE/GENDER OPTIONS:

84153	PSA - Males age 40+
93015	Treadmill Stress - Anyone ages 40+
77080	Bone Density - Females ages 50+, Males ages 60+
G0202	Mammogram - Females: one baseline for ages 35-39. Annually for ages 40+
Q0091	Obtaining screening Pap - Females ages 18+, at their discretion
G0101	Pelvic/Breast Exam - Females ages 18+
86701	HIV - For anyone at their discretion

PRESCRIPTION DRUG BENEFITS

Retail (Walk-In) Prescriptions (30 day supply)	
Generic Drug	$10 co-pay
Brand Name Drug	$40 co-pay
Percentage Payable after Copay	100%
Retail (Walk-In) Prescriptions (90 day supply)	
Generic Drug	$25 co-pay
Brand Name Drug	$100 co-pay
Percentage Payable after Copay	100%
Mail Order Prescriptions (30 day supply)	
Generic Drug	$10 co-pay
Brand Name Drug	$40 co-pay
Percentage Payable after Copay	100%
Mail Order Prescriptions (90 day supply)	
Generic Drug	$25 co-pay
Brand Name Drug	$100 co-pay
Percentage Payable after Copay	100%

VISION CARE BENEFITS

EYE EXAM Maximum per Covered Person for an eye exam in a 24 month period	$60
LENSES FOR GLASSES (PAIR) Maximum per Covered Person for a pair of lenses for glasses in a 24 month period	
Single Vision	$60
Bi-focal	$75
Tri-focal	$90
Lenticular	$80
FRAMES Maximum per Covered Person for frames in a 24 month period	$100
CONTACT LENSES Maximum per Covered Person for Contact Lenses in a 24 month period are limited to the following:	
To correct above 20/70, after cataract surgery, or as part of treating Keratoconus or Anisometropia	$200
Prescribed for other reasons	$150

HOW TO OBTAIN BENEFITS

Once you become eligible, this plan has the responsibility for seeing that you receive all the benefits to which you are entitled. In order to receive these benefits as quickly as possible, you must also assume some responsibility. To receive your maximum benefit, please choose a Preferred Provider.

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

WHEN YOU HAVE A CLAIM:

Step 1 Secure the proper claim form from your Employer or the claims office.

Step 2 Have your Physician fill out his portion of the form. Please make sure the Physician completes all of the information requested.

If your Physician provides his own claim form, you may submit it in place of the form provided by this plan provided the form contains basically the same information.

Step 3 In the case of hospital confinement, a form provided by the Hospital must be itemized by the Hospital.

Step 4 Attach all bills or receipts relative to the services provided. Make sure the bill clearly identifies what services were performed and what the charge was for each service.

Step 5 If you have any questions regarding steps 1–4, call for assistance: (615) 822-0483 or (800) 526-3919.

Step 6 If the claim is for a dependent, follow the first four (4) steps above and be sure to complete the portion of the claim form relating to your dependent.

Step 7 Forward completed claim forms and all related bills to the address listed on your ID card.

PLEASE NOTE THAT A PREFERRED PROVIDER IS REQUIRED TO FILE YOUR CHARGES FOR SERVICES RENDERED WHILE A NON-PREFERRED PROVIDER IS NOT.

DATES OF ELIGIBILITY AND COVERAGE

Employee Coverage

- **Eligible Period -** The eligibility period is as follows:

  1. All Employees, as defined above, and their eligible dependents, shall be eligible to enroll in the Plan for coverage on the first (1st) day following sixty (60) days of continuous employment.

  2. All Employees who are appointed or elected officials, and their eligible dependents, shall be eligible to enroll in the Plan for coverage on the first (1st) day following sixty (60) days of the date of appointment or the effective date of assuming office following election, respectively.

  Employees and their dependents that were eligible for coverage with the previous Plan being replaced by this Plan on April 30, 2013 will be immediately eligible under this Plan.

  Retirees and their dependents who meet the eligibility requirements in the "Coverage for Retirees" provision are eligible to enroll in the Plan.

  Rehiring a terminated employee. A terminated employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements.

- **When You are Eligible -** You are eligible for coverage on:
  1. On the plan effective date, if you have completed the eligibility waiting period, or if not
  2. On the completion of the eligibility waiting period stated above, unless otherwise stated.

- **When You are Covered -** Your coverage under the Plan shall become effective with respect to an Eligible Employee on the date of your eligibility, provided written application for such coverage is made on or before such date or within thirty-one (31) days of such date. If application is made after the initial date of eligibility, the employee shall be a Late Enrollee and, except as provided under the special enrollment provision, coverage for the employee shall become effective 90 days from the date the application is received by the Plan Administrator.

- **Enrollment -** To enroll for coverage, you must complete and sign a group enrollment form which is acceptable to the Plan and deliver it to your Employer.

Dependents Coverage

- **Eligible Persons -** Each person who is eligible for employee coverage will be eligible for dependent coverage.

- **When You Become Eligible -** You will be eligible for dependent coverage on the later of:
  (1) The date you become eligible for employee coverage; or
  (2) The date you acquire your first dependent.

- **When You are Covered -** A dependent will be considered eligible for coverage on the date the employee becomes eligible, subject to all limitations and requirements of this plan, and in accordance with the following:
  a. Newborn children of a Covered Employee will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a dependent of the employee within thirty-one (31) days of the child's date of birth. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother.

b. A spouse will be considered an Eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a dependent of the employee within thirty-one (31) days of the date of marriage.

c. If a dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that dependent will be considered an Eligible Dependent from the date of such court order, decree, or marriage, provided that this new dependent is properly enrolled as a dependent of the employee within thirty-one (31) days of the court order, decree, or marriage.

d. A child may become eligible for dependent coverage as set forth in a qualified medical child support order. The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.

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

  a. If the employee makes such written request on or before the date or within thirty-one (31) days of the date he 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 written 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 effective 90 days from the date the application is received by the Plan Administrator.

  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 application to cover such dependent is required.**

- **Enrollment -** To enroll for dependent coverage, you must complete and sign a group enrollment form which is acceptable to the Plan and deliver it to your Employer.

- **Coverage Status Change -** A Covered Person may not be covered as both a dependent and an employee. If a covered dependent is eligible to be enrolled as an employee, enrollment may be effective on the first day of employment.

- **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.

SPECIAL ENROLLMENT PERIOD

1. New Eligible Dependents

If an employee acquires a new dependent through marriage, birth, adoption, placement for adoption, guardianship, custody, or a Qualifying Medical Child Support Order, such dependent as well as the employee, spouse and any other dependents that are not currently covered under the Plan may enroll for coverage under the Plan, provided written request for coverage is made within thirty-one (31) days of the acquisition of the new dependent.

Coverage shall become effective on the date of the acquisition of the dependent (i.e. birth, marriage, placement for adoption), respectively.

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

2. Loss of Other Coverage - An employee or dependent who is eligible for coverage under the Plan but not currently covered may enroll for coverage if:

a. The Eligible Employee or Eligible Dependent loses other coverage under another Group Health Plan or other health insurance coverage for reasons other than failure to pay premiums on a timely basis or termination of coverage for cause; and
b. The Eligible Employee or Eligible Dependent was not enrolled under this Plan because of such other coverage; and
c. The coverage lost was either (i) under a COBRA continuation provision and the coverage under such provision was exhausted; or (ii) was not under a COBRA continuation 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, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), or reduction in the number of hours of employment) or Employer contributions toward such coverage were terminated, or a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual); or a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or a loss of coverage when a Plan no longer offers coverage to a class of similarly situated individuals (for example, part-time employees); or a loss of Medicaid coverage under title XIX of the Social Security Act (Medicaid) or under a state child health plan (CHIP) under title XXI of such due to loss of eligibility for such coverage; and
d. The employee makes application under the Plan within thirty-one (31) days of losing such other coverage or within sixty (60) days of losing Medicaid or CHIP coverage or within sixty (60) days of obtaining eligibility for a state premium assistance subsidy under Medicaid or CHIP (Please note which special enrollment event you have when making application).

In addition to the employee or dependent that loses other coverage (or obtains eligibility for a state premium assistance subsidy under Medicaid or CHIP), coverage may be added for any additional family members (employee, spouse, and dependents) who meet the definition of an Eligible Employee or Eligible Dependent during this special enrollment event who are not currently covered under the Plan.

Coverage will become effective the first day following the date the written request for enrollment is received.

Proof of such special enrollment event will need to be provided along with your written request for coverage before coverage can become effective.

For Employees and Dependents who are enrolled in the Plan and voluntarily drop coverage, application to re-enroll in the Plan is not permitted unless an employee or dependent has a special enrollment event.

TERMINATION OF COVERAGE

- **Employee Termination Date of Coverage -** Your coverage will terminate on the earliest of:
  a. The date on which your eligibility in an eligible class ceases;
  b. The date the Plan terminates;
  c. The end of the period in which a contribution is due for coverage but not paid;
  d. The date on which your employment with the Plan Sponsor ceases; or
  e. The date of the month on which you request that your coverage be terminated, provided your request is made on or before that date;

- **Dependent Termination Date of Coverage -** A covered dependent's coverage will terminate on the earliest of:
  a. The date on which the coverage for the Eligible Employee terminates;
  b. The date on which the dependent no longer meets the Plan's definition of a dependent;
  c. The end of the period for which any required contribution is made, if the Eligible Employee fails to make any further required contributions; or
  d. The date the Eligible Employee is no longer in a class eligible for dependent coverage.

Regardless of the termination dates stated above, according to TCA §56-7-2366, coverage for a spouse divorced in Tennessee will end as specified in the divorce decree, not to exceed 30 days following finalization of divorce.

The Employer or Plan has the right to rescind any coverage of the employee and/or Retiree and/or dependents for cause, making a fraudulent claim or an intentional misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the employee and/or covered Retirees and/or coverer dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims paid are in excess of the employee's and/or Retiree's and/or dependents paid contributions.

COVERAGE FOR RETIREES

You are eligible to continue to participate in the Plan as a Retiree of the participating Employer if you are an active Full-Time Employee of the participating Employer who qualifies for retirement and who has attained five (5) years or more of creditable service with the participating Employer's retirement plan. An active Full-Time Employee is one who was employed by the participating Employer on the day before the retirement annuity begins. The Employee and Dependents must have been participants in the medical plan five (5) years immediately prior to the commencement of their retirement annuity, and must have been active Participants in the medical plan the day before the retirement annuity begins, The Employee must enroll at the time the retirement annuity commences to continue in the medical plan. If the Retiree does not enroll (including Eligible Dependents) at that time, the Retiree and Eligible Dependents will not be eligible to enter the medical plan at a later date. Upon the death of a Retiree, coverage will continue for the covered surviving spouse and dependents of the Retiree (that meet the definition of an Eligible Dependent). A Retiree cannot add any newly acquired dependents after the retirement date nor can a surviving spouse add any newly acquired dependents. If a dependent terminates coverage, the dependent is not eligible for coverage in the future.

Employees hired on or after January 1, 2007 must have attained ten (10) years or more of creditable service with the participating Employer's retirement plan and participated in the medical plan for ten (10) years immediately prior to the commencement of their retirement annuity date to remain covered in the City of Germantown health plan at retirement.

Those Employees who retired on or prior to December 31, 2007 and who were participants in the City of Germantown health plan on July 19, 2013 and continued to participate in the City of Germantown health plan on December 31, 2013 will continue to qualify to remain covered in the City of Germantown health plan; upon attaining Medicare eligibility the City of Germantown health plan will become secondary coverage for such Retiree. Effective January 1, 2008 an Employee who retires at normal or early retirement age who qualifies to retain the City of Germantown health plan shall be charged a premium as determined by the City of Germantown to participate in the health plan. An Employee who takes early retirement and qualifies to retain the City of Germantown health plan shall be charged a premium which will be a minimum of 150% of the normal retiree premium as determined by the City of Germantown. Those Employees who take early retirement from and after May 1, 2009 will not be eligible to participate in the City of Germantown health plan.

Effective April 1, 2009, the eligible requirements to qualify as a Retiree of this Plan have changed. You are eligible to continue to participate in the Plan as a Retiree of the participating Employer if you are a Full Time Employee who retires at age sixty-two (62) or older or if you are in the designated class of Fire and Police who retires at age fifty-five (55) or older and has met the length of service requirement and was enrolled in the medical plan as outlined above. Upon changing the Retiree policy, the participating Employer offered a thirty (30) day window for Eligible Employees to elect early retirement. If an Eligible Employee elected early retirement, their Retiree coverage would be effective May 1, 2008 and would not be subject to the changes in the policy to be effective April 1, 2009.

Effective July 1, 2012, you are eligible to participate in the health care plan if you qualify as an early Retiree from the City of Germantown Retirement Plan. You must be enrolled in the health care plan for a minimum of fifteen (15) years immediately prior to the commencement of your early Retiree date.

The only exception to the above is in the case of the Employee who retires and the Employee and Eligible Dependents are both age sixty-five (65) or older, are both eligible for Medicare Parts A and B, are enrolled in Medicare Parts A and B and the medical plan becomes secondary coverage to Medicare. The Eligible Dependent of the Employee must have been a participant in the medical plan for three years immediately prior to the commencement of the retirement annuity and must be an active participant in the medical plan the day before the retirement annuity begins.

All of the other stipulations required above must be met to continue medical coverage at retirement if the Employee and Eligible Dependents are age sixty-five (65) or older.

Medicare Part A and B coverage is MANDATORY. Upon retirement all employees and dependents who attain the age of Medicare eligibility must enroll in Medicare Parts A and B and automatically Medicare becomes the primary coverage.

Notwithstanding anything to the contrary in this plan, no Employee who retires from the City of Germantown after January 1, 2008 (or Eligible Dependent of any such Retiree) shall upon such Employee's attainment of the age of Medicare eligibility qualify for coverage under the medical, vision or any other benefit in the City of Germantown health plan except for prescription drug and dental coverage. No Employee who retires from the City of Germantown after January 1, 2014 (or Eligible Dependent of any such Retiree) shall upon such Employee's attainment of the age of Medicare eligibility qualify for coverage under the medical, prescription drug, vision, or any other benefit in the City of Germantown health plan except for dental coverage. In lieu of any benefit under the City of Germantown health plan, the City of Germantown offers a subsidy to qualified Retirees when they reach the age of Medicare eligibility. The subsidy begins only when the qualified Retiree reaches Medicare eligibility and no longer qualifies to participate in the City of Germantown health plan. For those Employees who retire prior to December 31, 2013 the subsidy is $200.00 for single coverage and $300.00 for family coverage. Effective after January 1, 2014, until amended by the City of Germantown, the subsidy amount is $200.00 for single coverage or family coverage for those Employees who retire after January 1, 2014. To qualify for the subsidy the Retiree must not participate in the City of Germantown health plan except for dental. Upon the death of the Retiree the subsidy ceases regardless of whether or not such deceased Retiree died leaving surviving dependents.

Employees who retired prior to March 1, 1993 at age fifty-five (55) or older and who had ten (10) years or more of service credit with the City Retirement Plan will have an eligibility date of July 1, 1993 if the Retired Employee: (a) meets the active service requirement, (b) has made application on or before such date; and (c) made contribution designated by the City. Only employees who had coverage on the date the Retired Employee retired from the City are eligible. The employees may not apply for coverage after July 1, 1993.

If your employment ends and you return to active employment, you will be considered a new employee and subject to the waiting period. The only exception would be if you return to active employment directly from City of Germantown COBRA coverage, you would not be required to satisfy any waiting period.

CONTINUATION OF COVERAGE DURING PERIODS OF EMPLOYER-CERTIFIED DISABILITY, LEAVE OF ABSENCE OR LAYOFF

When a Full-Time Employee covered under the Plan ceases work due to a disability leave, approved leave of absence or lay-off, benefits for an employee and their Eligible Dependents may continue for up to one year at the active employee rates depending upon circumstances surrounding employment and plan eligibility.

COVERAGE OF DEPENDENT STUDENT
ON MEDICALLY NECESSARY LEAVE OF ABSENCE

Michelle's Law allows your Group Health Plan to continue coverage for seriously ill college students who are covered dependents under this health Plan for up to one year while on Medically Necessary leaves of absence.

Medically Necessary Leave of Absence - The extension of coverage applies to a dependent child's leave of absence from, or any other change in enrollment at, a postsecondary educational institution (including institutions of higher education as defined in Section 102 of the Higher Education Act of 1965) on account of a serious Illness or Injury from which the child is suffering while covered under a health plan that would otherwise cause the child to lose dependent status for purposes of coverage.

Length of Continued Coverage - Coverage continues until the earlier of: (1) one year from the start of the Medically Necessary leave of absence, or (2) the date on which such coverage would otherwise terminate under the terms of the health Plan.

Definition of Dependent Child - The child must be enrolled as a dependent under this health Plan and qualify for coverage on the basis of being a student at a postsecondary educational institution, immediately before the Medically Necessary leave of absence involved.

Certification by Physician - Written certification must be provided by a treating Physician of the dependent child certifying that such individual is suffering from a serious Illness or Injury that would require a Medically Necessary leave of absence (or other change of enrollment)..

Notice – The Group Health Plan (and a health insurance issuer providing coverage in connection with a health Plan) is required to provide notification, in plain language, describing the terms of the continued coverage available under this law. This description should be included with any notice regarding a requirement for certification of student status for coverage under the Plan.

Continued Application in Case of Changed Coverage - A dependent child is entitled to the same level of benefits during a Medically Necessary leave of absence as the child had before taking the leave. Moreover, if any changes are made to the health Plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to dependent children under the Plan.

The terms of this Plan shall at all times be construed and administered to comply with Michelle's Law (P.L. 110-381), including regulations and guidance to be issued by the appropriate agencies releasing guidance on this law.

FAMILY AND MEDICAL LEAVE ACT OF 1993

If a Covered Employee is employed at a worksite where the Employer employs at least fifty (50) employees within a seventy-five (75) mile radius of the workplace, an employee may continue to be covered for benefits under the Plan during a period of qualified leave under the Family and Medical Leave Act of 1993.

Up to twelve (12) work weeks of coverage (or a total of twenty-six (26) work weeks in the case of caregiver leave for an injured or ill service member) during any twelve (12) month period is available to employees who have been employed for at least one (1) year, worked at least 1,250 hours over the previous twelve (12) months and request leave for one (1) of the following reasons:

1. To care for the employee's child after birth, or placement for adoption or foster care;
2. To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
3. For a serious health condition that makes the employee unable to perform the employee's job; or
4. For any qualifying exigency (as the Secretary shall by regulation, determine) arising out of the fact that a spouse, son or daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation; or
5. To care for the employee's spouse, son or daughter, or parent, or next of kin who is a member of the Armed Forces, including a member of the National Guard, who has been injured or become ill while on active duty.

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

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

When foreseeable, the employee shall provide notice for leave for call to active duty (or notification of impending call or order to active duty) of a family member as soon as is Reasonable and practicable. An Employer may require that a request for such leave be supported by a certification issued at such time and in such manner as the Secretary may by regulation prescribe. If the Secretary issues a regulation requiring such certification, the employee shall provide, in a timely manner, a copy of such certification to the Employer.

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

The terms of this Plan shall at all times be construed and administered to comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

EMPLOYEES ON MILITARY LEAVE

These provisions summarize Continuation of Coverage under this Plan for employees absent from work due to military service. The Plan intends to provide benefits as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and any amendments thereof.

As an employee you have a right to choose this Continuation of Coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty and absence from work to determine the employee's fitness for any of the designated types of duty.

Employees who are dishonorably discharged from the military are not eligible.

Under the law, the employee must give the Employer written or oral advance notice of the military leave, if it is practical to do so. A designated, authorized officer of the branch of the military in which the employee will be serving may also provide such notice directly to the Employer.

If you choose Continuation of Coverage, the Employer is required to offer you coverage identical to that provided under the Plan prior to your military leave. Like COBRA coverage, such coverage may be continued for up to twenty-four (24) months during a period of military service.

If you feel that you might have continuation rights under USERRA, please contact your Human Resources Department as soon as possible.

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 by applying the standards set out in paragraphs (2) and (3) above. The administrator may seek the assistance of Plan legal counsel in making this decision.

d. If the administrator determines that information in the order is insufficient or the order is otherwise deficient, the administrator shall notify the participant and alternate recipient of the deficiency, in order to allow the medical child support order to be corrected.

e. If the order is resubmitted, it shall again be reviewed by the 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 administrator shall have fifteen (15) days to determine whether the resubmitted order is qualified.

f. Upon determining whether the order is qualified, the 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.

CONTINUATION OF COVERAGE UNDER COBRA

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

2. Right to Elect Continuation Coverage - If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event, he may elect to continue coverage under the Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Employer. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:
   a. The date of the Qualifying Event; or
   b. The date he was notified of his right to continue coverage.

3. Notification of Qualifying Event **-** If the Qualifying Event is divorce, legal separation or a dependent child's ineligibility under a Plan, the Qualified Beneficiary must notify the Employer of the Qualifying Event within sixty (60) days of the Qualifying Event or the date on which the Qualified Beneficiary would lose coverage because of the Qualifying Event, whichever is later, in order for coverage to continue. In addition, a Totally Disabled Qualified Beneficiary must notify the Employer in accordance with the section below entitled "Total Disability" in order for coverage to continue. An individual who becomes eligible to elect assistance from the Trade Assistance Act must notify the Employer in accordance with the section below entitled "Temporary Extension

of COBRA Election Period for Certain Individuals" in order for coverage to continue. Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

The person designated by the Employer to receive notice of the Qualifying Event from qualified beneficiaries is:

Benefits Administrator/HR Coordinator/HR Director
City of Germantown
1930 Germantown Road South
Germantown, TN 38183
901-757-7250

4. Length of Continuation Coverage
   a. A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Plan for up to eighteen (18) months from the date of the Qualifying Event.
   b. A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, legal separation or entitlement to Medicare, and dependent children who have become ineligible for coverage may continue coverage under the Plan for up to thirty-six (36) months from the date of the Qualifying Event.

5. Total Disability
   a. In a case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled within sixty (60) days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for dependents who were covered under the continuation coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer prior to the end of eighteen (18) months of continuation coverage that he was disabled within sixty (60) days of the date of the Qualifying Event.
   b. The Employer will charge the Qualified Beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this section.
   c. If during the period of extended coverage for Total Disability (continuation coverage months 19 – 29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:
      (1) The Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and
      (2) Continuation of Coverage shall terminate on the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

6. Temporary Extension of COBRA Election Period for Certain Individuals.
   a. In general. In the case of a non-electing Trade Adjustment Assistance (TAA)-eligible individual and notwithstanding 2. Right to Elect Continuation Coverage above, such individual may elect continuation coverage under this part during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.
   b. Commencement of coverage; no reach-back. Any continuation coverage elected by a TAA-eligible individual under 6. a. shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.
   c. Preexisting conditions. With respect to an individual who elects continuation coverage pursuant to 6. a., the period
      (1) Beginning on the date of the TAA-related loss of coverage, and

(2) Ending on the first day of the 60-day election period described in paragraph 6. a., shall be disregarded for purposes of determining the 63-day periods referred to in section 701(c)(2), section 2701(c)(2) of the Public Health Service Act, and section 9801(c)(2) of the Internal Revenue Code of 1986.

d. Definitions. For purposes of this subsection:

(1) "Non-electing TAA-Eligible Individual" means a TAA-eligible individual who

(a) Has a TAA-related loss of coverage; and

(b) Did not elect continuation coverage under this part during the TAA-related election period.

(2) "TAA-Eligible Individual" means

(a) An eligible TAA recipient (as defined in paragraph (2) of section 35(c) of the Internal Revenue Code of 1986), and

(b) An eligible alternative TAA recipient (as defined in paragraph (3) of such section).

(3) "TAA-Related Election Period" means, with respect to a TAA-related loss of coverage, the 60-day election period under this part which is a direct consequence of such loss.

(4) "TAA-Related Loss of Coverage" means, with respect to an individual whose separation from employment gives rise to being a TAA-eligible individual, the loss of health benefits coverage associated with such separation.

7. Termination of Coverage - Continuation coverage will automatically end earlier than the applicable eighteen (18), twenty-nine (29) or thirty-six (36) month period for a Qualified Beneficiary if:

a. The required monthly contribution for coverage is not received by the Employer within thirty (30) days following the date it is due;

b. The Qualified Beneficiary is or becomes covered under any other Group Health Plan as an employee or otherwise. If the other Group Health Plan contains an exclusion or limitation relating to a Pre-Existing Condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for continuation coverage as long as the exclusion or limitation relating to the Pre-Existing Condition applies to the Qualified Beneficiary (or, if sooner, until the expiration of the applicable eighteen (18), twenty-nine (29), or thirty-six (36) month COBRA period);

c. For Totally Disabled qualified beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such beneficiary is no longer Totally Disabled;

d. the Qualified Beneficiary becomes, after the date of election of COBRA Continuation Coverage, entitled to Medicare benefits; or

e. The Employer ceases to offer any Group Health Plans.

8. Multiple Qualifying Events - If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum continuation coverage is eighteen (18) or twenty-nine (29) months, and a second Qualifying Event occurs during the eighteen (18) or twenty-nine (29) month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage", to continue coverage under the Plan for up to thirty-six (36) months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was a Covered Employee becomes entitled to benefits under Medicare (whether or not this is a Qualifying Event), a Qualified Beneficiary (other than the Covered Employee) may elect to continue coverage for a maximum of thirty-six (36) months from the date of the initial Qualifying Event, to the extent of another period of continuation coverage is not required by law under COBRA.

9. Continuation Coverage - The continuation coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Plan offered to similarly situated Covered Employees and their dependents. The continuation coverage is also subject to the rules and regulations under COBRA. If COBRA permits qualified beneficiaries to

add dependents for continuation coverage, such dependents must meet the definition of dependent under the Plan.

10. Carryover of Deductibles and Plan Maximums - If continuation coverage under the Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable deductible and co-payment features for the year will be carried forward into the continuation coverage elected for that year.

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

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

DEFINITIONS

The terms listed if used will have these meanings:

- **ACCIDENT -** A sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

- **AMBULATORY SURGICAL FACILITY -** A legally operated facility which:
  1. Is approved by the appropriate state regulatory authority;
  2. Is capable of performing surgery on the same day basis;
  3. Maintains a medical staff;
  4. Maintains continuous medical care for the patient while confined; and
  5. Is not used primarily as an office or clinic for Physician or other professional private practice.

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

- **ANNUAL -** Calendar year (January 1 through December 31).

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

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

- **BRAND NAME** - A trade name medication.

- **CLEAN CLAIM -** A claim form which has no defect or impropriety; does not lack any required substantiating documentation per the applicable health benefit plan necessary to enable TPA to determine whether a health care service or the receipt of such service is a Covered Medical Expense or Covered Person as defined in this Plan Document; does not contain a defect that requires an investigation; or does not involve any particular circumstances requiring special treatment per the health benefit plan that prevents timely processing.

  A Clean Claim must be submitted on a UB92 form (or its successor) and accurately contains all the following information: patient name, patient's date of birth, member identification number, Hospital's name, address and tad ID number, date(s) of service or purchase, diagnosis narrative or ICD-9 code (or its successor), procedure narrative or CPT-4 code, services and supplies provided, Physician's name and license number, the Hospital's charges and any other attachments or information mutually agreed upon in writing by the Parties.

  A Clean Claim has no billing errors. Examples of billing errors include but are not limited to duplicate charges, charges for supplies, medications, tests, or services that were not ordered or received, unbundled charges, charges for services that should be included in the room charge, charges for services that the patient refused, data entry, coding or keying errors, inaccurate operating room time, inaccurate number of days as admitted patient, and line items that do not meet criteria for appropriateness or exceed Maximum Allowable Charge of the Plan (as defined by the Plan).

  Prompt payment deadlines will be initiated upon receipt of a Clean Claim and all required substantiating documentation.

A claim exceeding $5,000 requires that an itemized bill be provided to the Plan before it can be considered a Clean Claim.

- **COBRA -** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

- **COVERED MEDICAL EXPENSE -** Those expenses which are outlined in this Plan Document and which are actually Incurred by a Covered Person for treatment of an Illness, Injury, congenital defect, or in connection with Pregnancy, subject to all other provisions, conditions, limitations and exclusions of this Plan as shown in the summary of benefits and as determined elsewhere in this document. Further, Covered Medical Expenses shall be limited to those expenses which are Medically Necessary services or supplies that are covered under this Plan.

  A Covered Medical Expense incurred using a Preferred Provider shall further be limited to the network negotiated rates and any applicable Plan limits. A Covered Medical Expense incurred using a Non-Preferred Provider shall further be limited to the negotiated discount, if applicable, or Reasonable, Usual and Customary and any applicable Plan limits.

  The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

- **COVERED PERSON -** The “Eligible Employee”, “Retiree” and/or the “Eligible Dependent” that have become covered under the Plan.

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

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

- **DEDUCTIBLE -** An amount of money that must be paid by a Covered Person for Covered Medical Expenses before the Plan will reimburse additional Covered Medical Expenses incurred during that Calendar Year.

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

- **DETOXIFICATION -** The process whereby an alcohol-intoxicated person, or person experiencing the symptoms of Substance Abuse, is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to that patient to a minimum.

- **DIAGNOSTIC SERVICE -** A test or procedure performed for specified symptoms to detect or to monitor an Illness or Injury. It must be ordered by a Physician or other professional provider.

- **DURABLE MEDICAL EQUIPMENT -** 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.

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

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

1. A spouse (if not legally separated), under a legally-valid existing marriage of an Eligible Employee hired on or before June 30, 2013 whose spouse was an active participant in the plan as an Eligible Dependent on or before June 30, 2013.

   Except as provided under "special enrollment period" under Article VI, Section 6, on and after July 1, 2013 an Eligible Employee cannot add a spouse as an Eligible Dependent who (i) was not already an active participant in the plan as an Eligible Dependent on or prior to June 30, 2013, or who at any time on or after July 1, 2013 was not an active dependent participant in the plan as an Eligible Dependent of the Employee and (ii) who has alternative health coverage available through such spouse's employer or otherwise. Except as provided under "special enrollment period" under Article IV, Section 6, spouses of Employees hired on or after July 1, 2013 who have alternative health coverage available through the spouse's employer or otherwise are not Eligible Dependents for the City of Germantown Health Plan.

2. The Eligible Employee's sons, daughters, stepchildren, adopted children (including children placed for adoption), and children for whom employee or spouse have been appointed legal guardian may be covered up to age twenty-six (26) years.

3. Any child determined by the Employer to be covered under a Qualified Medical Child Support order.

4. A handicapped child who has attained age twenty-six (26) years provided such child is:
   a. Unwed;
   b. Mentally or physically incapable of earning his own living. Proof of incapacity must be furnished to the Plan Supervisor within thirty-one (31) days of his attainment of the limiting age. Periodic proof that the dependent child continues to be incapable of self-support will be required;
   c. Dependent upon the employee for support and maintenance; and
   d. A Covered Person on the day immediately prior to attaining the limiting age.

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.

A spouse or child who is covered under the Plan as an employee will not be eligible as a dependent.

If the employee and the employee's spouse are both Covered Employees under the Plan, the employee's children may be considered as dependents of either the employee or the employee's spouse, but not of both.

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

- **ELIGIBLE EMPLOYEE -** Any employee of the Employer who satisfies the rules of eligibility as set forth in the eligibility provisions of this Plan.

- **EMERGENCY SERVICES -** A medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

- **EMPLOYEE -** A regular full-time employee of the Employer who is:
  1. Performing all the normal duties of his job; and
  2. Working at least thirty (30) hours per week, or an employee who qualifies as a full-time employee under the Patient Protection and Affordable Care Act's Large Employer Shared Responsibility regulations to the extent said regulations are applicable; or
  3. Is a person who is an appointed official for the City of Germantown and holds one of the following offices: City Attorney, City Administrator, City Clerk/Recorder or Police Chief; or
  4. Is a person who prior to January 1, 2014 is an appointed official for the City of Germantown holding one of the following offices: Prosecuting Attorney or Assistant City Attorney, or
  5. Is a person who is an elected official of the City of Germantown and holds one of the following offices: Mayor, Alderman, and Judges. Except as provided in (6) below, In the event an elected official Is not re-elected, coverage will cease.
  6. Notwithstanding (5) immediately above, an elected official who has served two or more terms in office prior to July 1, 2014, and who was an active participant in the Plan on July 1, 2014.

  The term "Employee" does not include leased, part-time, seasonal or temporary employees, or an independent contractor.

- **EMPLOYER -** City of Germantown.

- **ESSENTIAL HEALTH BENEFITS -** Include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care.

- **EXPERIMENTAL AND INVESTIGATIVE EXPENSE -** The use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet generally recognized as accepted medical practice and any 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.

  "Experimental and Investigative Expense" also means 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 Medicare Standards 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 (i.e. Journal of the American Medical Association, The New England Journal of Medicine) of as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition.
  2. Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis of a Covered Person's particular condition.
  3. The Plan Administrator may, in its sole discretion, apply any or all of the following criteria in determining whether a technology is Experimental or Investigational, obsolete or ineffective.

a. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition.
b. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these criteria be met.
c. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes. This evidence must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects and is possible in standard conditions of medical practice, outside clinical investigatory settings.

- **EXTENDED CARE FACILITY -** An institution which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Illness, and which has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or registered graduate nurses; and
  a. Maintains daily clinical records on each patient and has available the services of a Physician under an established agreement;
  b. Provides appropriate methods for dispensing and administering drugs and medicine; and
  c. Has transfer arrangements with one (1) or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one (1) Physician; excluding any institution which is other than incidentally a rest home, a home for the aged, or a place for the treatment of Mental or Nervous Disorders or Substance Abuse.

- **FAMILY UNIT -** The Covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

- **FORMULARY -** The term “Formulary” means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

- **GENERIC DRUG -** A Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

- **GENETIC INFORMATION -** The term “Genetic Information” means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic Information does not include information about the age or gender of an individual.

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

  The term “genetic information” means, with respect to any individual, information about:
  a. Such individual’s genetic tests;
  b. The genetic tests of family members of such individual; and
  c. The manifestation of a disease or disorder in family members of such individual.

  The term “genetic information” includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its participants on the basis of such genetic information.

- **HIPAA -** The Health Insurance Portability and Accountability Act of 1996, as amended.

- **HOME HEALTH AGENCY -** A public or private agency or organization, or its subdivision which:
  1. Is mainly engaged in providing skilled nurse care and other therapeutic services;
  2. Uses policies and standards set by associated professional people;
  3. Is supervised by one or more: qualified doctors, and Registered Nurses (R.N.);
  4. Keeps clinical records on all patients; and
  5. Is licensed or approved by state or local law as a Home Health Agency.

  A "Home Health Agency" does not include any agency or organization which is mainly for the care and treatment of Mental or Nervous Disorders.

- **HOME HEALTH CARE PLAN -** A "Home Health Care Plan" must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

- **HOME HEALTH CARE SERVICES AND SUPPLIES -** Home Health Care Services and Supplies shall include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

- **HOSPICE CARE SERVICES AND SUPPLIES -** Hospice Care Services and Supplies means those services and supplies provided through a Hospice Agency and under a Hospice Care Plan and include inpatient Care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

  A "Hospice Agency" is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

  A "Hospice Care Plan" is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

  A "Hospice Unit" is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six (6) months.

- **HOSPITAL -** A Hospital shall mean only a lawfully operated institution that provides:
  1. Twenty-four (24) hour nursing services by registered nurses;
  2. A staff of one (1) or more Physicians licensed to practice medicine;
  3. Inpatient therapeutic and diagnostic services of Injury or Illness; and
  4. Facilities for major surgery or has a formal arrangement with another institution for surgical facilities.

  In no event will "Hospital" include a rest or nursing home, home for the aged, convalescent home, skilled nursing facility or a place for primarily treating Mental or Nervous Disorders or Substance Abuse.

- **HOSPITAL CONFINEMENT -** 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 -** 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 Illness.

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

- **INCURRED -** The date the service is rendered or the supply is obtained.

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

- **INTENSIVE CARE UNIT -** Intensive Care Unit or "ICU" means a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". An ICU has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

- **LATE ENROLLEE -** An individual who did not request enrollment during the initial enrollment period.

- **LEAVE OF ABSENCE** - A leave of absence of an Employee that has been approved by his participating Employer, as provided for in the participating Employer's rules, policies, procedures and proactive.

- **LEGAL GUARDIAN -** A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

- **MEDICAL CARE FACILITY -** A Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

- **MEDICAL EMERGENCY -** A medical condition manifesting itself by acute symptoms of sufficient severity including severe pain that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

- **MEDICAL NON-EMERGENCY CARE -** Care which can safely and adequately be provided other than in a Hospital.

- **MEDICALLY NECESSARY -** 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.

- **MEDICARE -** The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

- **MENTAL OR NERVOUS DISORDERS -** Those mental health or psychiatric diagnostic categories that are listed in the current edition of the International Classification of Disease published by the U.S. Department of Health and Human Services, unless those services are specifically excluded in this Plan.

- **MICHELLE'S LAW -** means H.R. 2851.

- **MORBID OBESITY -** A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

- **NETWORK -** The Preferred Provider Organization (PPO) network of providers offering discounted fees for services and supplies to Covered Persons. The network will be identified on the Covered Person's Plan Identification Card.

- **NO FAULT AUTO INSURANCE -** The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

- **NON-HOSPITAL FACILITY/TREATMENT FACILITY -** A legally operated institution which is primarily engaged in providing treatment for Mental or Nervous Disorders or for the treatment of Substance Abuse, which meets the following requirements:
  1. Has rooms for resident inpatients;
  2. Is equipped to treat Mental or Nervous Disorders or Substance Abuse;
  3. Has a resident psychiatrist/Physician on duty or on call at all times; and
  4. Charges the patient for the expense of confinement.

- **NON-OCCUPATIONAL -** With respect to Injury, an Injury which does not arise out of, and in the course of, any employment for wage, profit or remuneration and, with respect to disease, means a disease in connection with which the person is not eligible to benefits under any worker's compensation law or similar legislation.

- **OUT-OF-POCKET EXPENSE -** The cost to the Covered Person for deductible, coinsurance, copayments, penalties and non-covered expenses.

- **OUTPATIENT CARE AND/OR SERVICES -** Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

- **PHARMACY -** A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

- **PHYSICIAN -** A doctor who is duly qualified and legally licensed to practice medicine and who is legally authorized to and does use the designation M.D.; or who is a duly licensed doctor of osteopathy who uses the designation D.O. The term includes surgeons and other specialists who meet the preceding definition. Also considered "Physician" under this Plan for the purpose of benefit payments are:
  1. A duly licensed podiatrist (chiropodist) for the treatment of foot conditions covered by this Plan;
  2. A duly licensed Dentist for any dental work or oral surgery covered by this Plan;
  3. A duly licensed optometrist;
  4. A duly licensed psychologist;

5. A duly licensed chiropractor;
6. A certified licensed nurse-midwife;
7. A certified registered nurse anesthesiologist;
8. A certified licensed nurse practitioner; or
9. A member of the clinical staff of a community mental health center, who is licensed and who has a master's degree in psychology, nursing or social work for purpose of outpatient treatment at a community health center of Mental or Nervous Disorders.

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

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

- **PLAN PARTICIPANT -** Any Employee, Retiree or Dependent who is covered under this Plan.

- **PLAN YEAR -** Calendar year (January 1 - December 31).

- **PRE-EXISTING CONDITION -** Effective January 1, 2014 this Plan will no longer apply pre-existing conditions exclusions to Participants covered under the Plan.

- **PREGNANCY -** Childbirth and conditions associated with Pregnancy, including complications.

- **PRESCRIPTION DRUG -** Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

- **PRIMARY CARE PHYSICIAN -** A general practitioner, internist, family practitioner, or pediatrician.

- **PROVIDER -** A Physician or other practitioner or facility defined or listed herein. Services rendered must be within the scope and limitations of the license of the Provider performing the service and the service is covered under this Plan.

- **RETIRED EMPLOYEE -** A former Employee of the Employer who was retired while employed by the Employer under the formal written health plan of the employer and who elects to contribute to the Plan the contribution required from the Retired Employee.

- **RETIREE - The term "Retiree" means an Employee who is an active Full-Time Employee of the participating Employer who qualifies for retirement and who has attained five (5) years or more of creditable service with the participating Employer's retirement plan. An active Full-Time Employee is one who was employed by the participating Employer on the day before the retirement annuity begins. The Employee and Dependents must have been participants in the medical plan five (5) years immediately prior to the commencement of their retirement annuity, and must have been active Participants in the medical plan the day before the retirement annuity begins, The Employee must enroll at the time the retirement annuity commences to continue in the medical plan. If the Retiree does not enroll (including Eligible Dependents) at that time, the Retiree and Eligible Dependents will not be eligible to enter the medical plan at a later date. Upon the death of a Retiree, coverage will continue for the covered surviving spouse and dependents of the Retiree (that meet the definition of an Eligible Dependent). A Retiree cannot add any newly acquired dependents after the retirement date nor can a surviving spouse add any newly acquired dependents. If a dependent terminates coverage, the dependent is not eligible for coverage in the future.**

Employees hired on or after January 1, 2007 must have attained ten (10) years or more of creditable service with the participating Employer's retirement plan and participated in the medical plan for ten (10) years immediately prior to the commencement of their retirement annuity date.

Those Employees who retired on or prior to December 31, 2007 and who were participants in the City of Germantown health plan on July 19, 2013 and continued to participate in the City of Germantown health plan on December 31, 2013 will continue to qualify to remain covered in the City of Germantown health plan; upon attaining Medicare eligibility the City of Germantown health plan will become secondary coverage for such Retiree. Effective January 1, 2008 an Employee who retires at normal or early retirement age who qualifies to retain the City of Germantown health plan shall be charged a premium as determined by the City of Germantown to participate in the health plan. An Employee who takes early retirement and qualifies to retain the City of Germantown health plan shall be charged a premium which will be a minimum of 150% of the normal retiree premium as determined by the City of Germantown. Those Employees who take early retirement from and after May 1, 2009 will not be eligible to participate in the City of Germantown health plan.

Effective April 1, 2009, the eligible requirements to qualify as a Retiree of this Plan have changed. You are eligible to continue to participate in the Plan as a Retiree of the participating Employer if you are a Full Time Employee who retires at age sixty-two (62) or older or if you are in the designated class of Fire and Police who retires at age fifty-five (55) or older and has met the length of service requirement and was enrolled in the medical plan as outlined above. Upon changing the Retiree policy, the participating Employer offered a thirty (30) day window for Eligible Employees to elect early retirement. If an Eligible Employee elected early retirement, their Retiree coverage would be effective May 1, 2008 and would not be subject to the changes in the policy to be effective April 1, 2009.

Effective July 1, 2012, you are eligible to participate in the health care plan if you qualify as an early Retiree from the City of Germantown Retirement Plan. You must be enrolled in the health care plan for a minimum of fifteen (15) years immediately prior to the commencement of your early Retiree date.

The only exception to the above is in the case of the Employee who retires and the Employee and Eligible Dependents are both age sixty-five (65) or older, are both eligible for Medicare Parts A and B, are enrolled in Medicare Parts A and B and the medical plan becomes secondary coverage to Medicare. The Eligible Dependent of the Employee must have been a participant in the medical plan for three years immediately prior to the commencement of the retirement annuity and must be an active participant in the medical plan the day before the retirement annuity begins.

All of the other stipulations required above must be met to continue medical coverage at retirement if the Employee and Eligible Dependents are age sixty-five (65) or older.

Medicare Part A and B coverage is MANDATORY. Upon retirement all employees and dependents who attain the age of Medicare eligibility must enroll in Medicare Parts A and B and automatically Medicare becomes the primary coverage.

Notwithstanding anything to the contrary in this plan, no Employee who retires from the City of Germantown after January 1, 2008 (or Eligible Dependent of any such Retiree) shall upon such Employee's attainment of the age of Medicare eligibility qualify for coverage under the medical, vision or any other benefit in the City of Germantown health plan except for prescription drug and dental coverage. No Employee who retires from the City of Germantown after January 1, 2014 (or Eligible Dependent of any such Retiree) shall upon such Employee's attainment of the age of Medicare eligibility qualify for coverage under the medical, prescription drug, vision, or any other benefit in the City of Germantown health plan except for dental coverage. In lieu of any benefit under the City of Germantown health plan, the City of Germantown offers a subsidy to qualified Retirees when they reach the age of Medicare eligibility. The subsidy begins only when the qualified Retiree reaches Medicare eligibility and no longer qualifies to participate in the City of Germantown health plan. For

those Employees who retire prior to December 31, 2013 the subsidy is $200.00 for single coverage and $300.00 for family coverage. Effective after January 1, 2014, until amended by the City of Germantown, the subsidy amount is $200.00 for single coverage or family coverage for those Employees who retire after January 1, 2014. To qualify for the subsidy the Retiree must not participate in the City of Germantown health plan except for dental. Upon the death of the Retiree the subsidy ceases regardless of whether or not such deceased Retiree died leaving surviving dependents.

Employees who retired prior to March 1, 1993 at age fifty-five (55) or older and who had ten (10) years or more of service credit with the City Retirement Plan will have an eligibility date of July 1, 1993 if the Retired Employee: (a) meets the active service requirement, (b) has made application on or before such date; and (c) made contribution designated by the City. Only employees who had coverage on the date the Retired Employee retired from the City are eligible. The employees may not apply for coverage after July 1, 1993.

- **SICKNESS -** A Covered Person's Illness, disease or Pregnancy (including complications).

- **SKILLED NURSING CARE FACILITY / REHABILITATION FACILITY -** A legally operating institution or distinct part of an institution which has a transfer agreement with one (1) or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services, or an institution which primarily provides treatment of Mental or Nervous Disorders, Substance Abuse or tuberculosis except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such facility by a CMS approved accreditation body.

- **SPECIALIST PHYSICIAN -** A Physician specializing in a defined field of medicine other than those defined as a Primary Care Physician herein.

- **SPINAL MANIPULATION/CHIROPRACTIC CARE -** Spinal Manipulation or Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

- **SUBSTANCE ABUSE -** Alcoholism or Substance Abuse disorders that are listed in the current edition of the International Classification of Disease published by the U.S. Department of Health and Human Services, unless those services are specifically excluded in this Plan. The fact that a disorder is listed in the current edition of the International Classification of Disease published by the U.S. Department of Health and Human Services does not mean that treatment of the disorder is a covered expense.

- **SURGICAL PROCEDURE -** Surgical Procedure shall include those procedures as defined by the American Medical Association (AMA) and (Centers for Medicare and Medicaid Services (CMS) as standard practice for the industry.

- **TEMPOROMANDIBULAR JOINT SYNDROME (TMJ) -** The symptoms associated with, or exhibited as a malfunction of, the temporomandibular joint. These are frequently caused but not exclusive to:
  1. Improper or incorrect space between the maxilla and mandible;
  2. Improper dental occlusion; and
  3. Muscular spasm in the TMJ area.

- **TPA -** Third Party Administrator.

- **TOTALLY DISABLED -** With respect to employees, disability to the extent that the employee is not able to perform any of the Usual and Customary duties of his/her occupation, and, with respect to dependents, cannot perform any of the Usual and Customary duties or activities of a person in good health and of the same age and gender.

- **UNIFORMED SERVICES -** The Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned Corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

- **USUAL AND CUSTOMARY (U&C), AND REASONABLE -** Covered Medical Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

  The term "usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

  The term "customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

  The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply customary.

  Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios and/or manufacturer's retail pricing (MRP) for supplies and devices.

  The term "Reasonable" and/or "Reasonableness" shall mean services or supplies, or fees for services or supplies that in the administrator's decision are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable. Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s). This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration.

COST CONTAINMENT PROVISIONS

- **CASE MANAGEMENT AND CLINICAL REVIEW:** 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 clinical 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.

- **PRE-ADMISSION CERTIFICATION:**

> **PRE-ADMISSION CERTIFICATION DOES NOT GUARANTEE PAYMENT. Benefit eligibility and/or reimbursement are the responsibility of the Plan Administrator.**

Elective inpatient admissions and outpatient surgeries must be certified within two (2) days in advance of the scheduled admission or outpatient surgery. Pre-admission certification of Hospital days is a pre-service claim.

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

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

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

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

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

- **OAP NETWORK -** This Network option is a health care benefit program designed to give you a financial incentive to use a designated group of Hospitals and Physicians. The choice of Network Providers is based on a range of services, geographic locations, cost-effectiveness, and quality health care.

  Under this option, you will continue to have a complete freedom of choice of Hospitals and Physicians. However, the major medical reimbursement percentage may be greater if you use the services of a Network Provider.

  DEFINITIONS:

  PROVIDER - Any health care facility (for example, a Hospital) or person (for example, a Physician) duly licensed to render covered medical care or services.

  NETWORK PROVIDER - A provider who has entered into an agreement with the Network, to provide services to individuals enrolled as members of the organization.

  NON-NETWORK PROVIDER - A Provider who has **NOT** entered into an agreement with the Network, to provide services to individuals enrolled as members of the organization.

  EMERGENCY - A sudden unexpected 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 Network Provider whether or not the services were performed by a Network Provider.

  If services are not offered by a Network Provider, benefits will be paid as if the Provider was in the Network.

  If the Covered Person receives treatment or services from a Non-network Provider and the Covered Person had no option in the selection of the provider (for example, charges by a Non-Network pathologist, radiologist or anesthesiologist in a Network Hospital), benefits will be paid as if the provider was in the Network. If there is any question concerning the Covered Person's responsibility in the provider selection it will be determined by the Plan.

EMPLOYEE ASSISTANCE PROGRAM

Your Employer recognizes the need to provide a resource for those personal and family stresses that affect everyone at one time or another. The Employee Assistance Program "EAP" is a confidential way for individuals, couples, and families to obtain professional help to reduce the impact of everyday stresses. EAP services include assessment, counseling, and referral for such problems as Mental or Nervous Disorders, family and marital problems, emotional stress, depression and anxiety, Substance Abuse, parent/child conflict, and family budgeting.

This program is maintained separately and independently from the Plan. Your personal information will be kept strictly confidential by the program administrator.

Contact the EAP Administrator: Concern at 901-458-4000 for more information.

VISION CARE BENEFITS

Vision Care provides benefits for routine care of the eyes when services are provided by an ophthalmologist, optometrist or optician. Eligible expenses are for routine eye care for which there is no diagnosis due to an Illness or Injury and which are not covered under any other provisions of the Plan. Eligible expenses will be paid as stated in the Schedule of Benefits.

Benefits will **not** be provided for the following:

1. Medical or surgical treatment of an eye Injury or eye disease;

2. Charges covered under any other provision of the Plan;

3. Charges for safety goggles or sunglasses, including prescription sunglasses;

4. Charges for replacement of lost or stolen contact lenses or glasses;

5. Any expenses, other than vision care, which are excluded or limited under the comprehensive major medical benefits provision of the Plan;

6. Charges for orthoptics (eye muscle exercises), vision training or subnormal vision aids;

7. Charges for non-prescription lenses; and

8. Charges for contact lenses unless prescribed in one of the following cases:
   a. When a Covered Person's vision cannot be corrected to 20/70 in the better eye except by the use of contact lenses.
   b. A Covered Person needs contact lenses after cataract surgery.
   c. A Covered Person is being treated for a condition such as Keratoconus or Anisometropia and contact lenses are routinely used as part of the treatment.

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.

- **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.

- **FAMILY LIMIT ON DEDUCTIBLES -** Three (3) Individual Deductibles 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.

- **MAXIMUM "OUT-OF-POCKET" EXPENSES -** The maximum out-of-pocket expense for any Calendar Year is outlined in the Schedule of Benefits. Covered Medical and Prescription 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: chiropractic care, penalties, charges in excess of Usual and Customary, or other non-covered items, nor will these items ever be paid at 100%. There is no out of pocket expense maximum for Non-Preferred Provider covered expenses.

- **BENEFITS FOR EXPENSES DUE TO PREGNANCY -** Benefits are payable for Pregnancy-related expenses on the same basis as any Illness for female Employees, spouses and dependent children.

  There is no coverage for the newborn child of a dependent child.

  The Newborn's and Mothers Health Protection Act of 1996 provides that 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).

- **COVERED MEDICAL EXPENSES -** The term "Covered Medical Expense" shall mean those expenses which are outlined in this Plan Document and which are actually Incurred by a Covered Person for treatment of an Illness, Injury, congenital defect, or in connection with Pregnancy, subject to all other provisions, conditions, limitations and exclusions of this Plan as shown in the summary of benefits and as determined elsewhere in this document. Further, Covered Medical Expenses shall be limited to those expenses which are Medically Necessary services or supplies that are covered under this Plan.

  A Covered Medical Expense incurred using a Preferred Provider shall further be limited to the network negotiated rates and any applicable Plan limits. A Covered Medical Expense incurred using a Non-Preferred Provider shall further be limited to the negotiated discount, if applicable, or Reasonable, Usual and Customary and any applicable Plan limits.

  The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The following is a list of Covered Medical Expenses which are subject to the above provisions of the plan:

(1) The actual charge made by the Hospital for room and board will be considered as a covered expense.

(2) Charges made by the Hospital for services and supplies required for treatment of Illness and Injury rendered to a bed patient in a Hospital, including professional medical visits rendered by a Physician for the usual professional services (admission, discharge and daily visits). Covered expenses also include consultations with a Physician requested by the Covered Person's Physician.

(3) Charges for Physician office services, Physician's fees and surgery performed by a Physician.

If a Physician performs two (2) or more Surgical Procedures through the same incision, the most expensive procedure will be covered at the full benefit amount and the other procedures will be covered at 50% of the benefit amount.

Also covered are charges for an assistant surgeon not to exceed 20% of primary surgeon's allowable amount.

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

Cosmetic surgery is excluded under this Plan unless it pertains to the following:

(a) Reconstruction of the breast on which a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance, breast prostheses (whether internal or external, following mastectomy) and four surgical bras per calendar year, lymphedema stockings for the arm, and treatment of physical complications of mastectomy;
(b) Breast reduction surgery if documented to be Medically Necessary;
(c) Reconstructive surgery, i.e., reparative or therapeutic surgery done after an Illness or Injury to restore the patient's appearance; or
(d) Cosmetic surgery deemed necessary as a result of a congenital defect affecting bodily function of a child.

(4) Charges for sterilization procedures. However, reversal of a sterilization procedure is not a covered expense.

(5) Charges for services, care or treatment in connection with allergy testing, allergy injections, or allergy serum.

(6) Dental services rendered by a Physician for removal of bony impacted teeth, removal of cysts and tumors or for the treatment of a fractured jaw or if Injury to sound natural teeth, including replacement of the teeth as a result of an Accident, excision of bony benign growths of jaw and hard palate; external incision and drainage of cellulitis and Hospital charges incurred while Hospital confined.

(7) Nursing services rendered by a registered nurse, or by a licensed practical nurse if a registered nurse is not available, provided, in either case, the nurse is not a close relative. The term "close relative" includes the Covered Person, the spouse, child, grandchild, brother, sister or parent of the Covered Person, or persons who normally reside with the Covered Person.

(8) Diagnostic x-ray examinations and laboratory examinations.

(9) Prescription drugs and medicines, including insulin and syringes used for its administration, diabetic supplies including but not limited to, lancets, blood glucose monitors and test strips, insulin pumps, infusion devices and attachments, as well as, all FDA approved contraception methods as prescribed by Physician.

(10) Charges for IUD and insertion of IUD at physician's office will be covered at 100% deductible waived when using a Preferred Provider and subject to Deductible and coinsurance when using a Non-Preferred Provider.

(11) Outpatient self-management training and medical nutrition counseling for diabetes management required by a patient's Physician will be considered a Covered Medical Expense for the patient if visits are certified Medically Necessary by the Physician upon diagnosis, significant change in a patient's symptoms or condition, or re-education or refresher training.

(12) Surgical supplies, surgical dressings, casts, splints, trusses, braces, crutches and initial prescribed orthotics.

(13) Blood and blood plasma (if not replaced).

(14) Charges made for an anesthetic and the administration of the anesthetic, including the services of a C.R.N.A.

(15) Prosthesis to replace lost physical eyes or limbs. Also considered as a Covered Medical Expense for prosthesis will be the charge incurred for surgical supplies required to aid any impaired physical eye or limb in its natural body function. Subsequent repair, modification or replacement of the prosthesis is covered only if the attending Physician certifies in writing that such replacement is Medically Necessary due to (1) a physical change in the condition of the patient's site of attachment, (2) the normal, physical growth of a dependent child, or (3) the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.

(16) Charges made for rental or purchase price of Durable Medical Equipment (i.e. a wheelchair, Hospital-type bed, oxygen and the rental of the equipment required for the administration of oxygen), provided a Physician certifies that it is essential in the treatment of an Injury or Illness under a treatment plan which is from time to time reviewed and updated. The equipment must be able to withstand repeated use. It must be primarily and customarily used to serve a medical purpose and it must generally not be useful except for treatment of Injury or Illness.

Durable Medical Equipment shall **not** include personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, whirlpools, spas, elevators, wheelchair ramps, and non-Hospital adjustable beds;

(17) Charges for a Physician made for second surgical opinions and, when necessary, for third surgical opinions.

(18) Charges for transportation service by professional ambulance:
a) From the Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital where appropriate medical or surgical services are available;
b) Between Hospitals; and
c) Between a Hospital and an Extended Care Facility;
d) Expenses for air ambulance (helicopter) or air transportation (airplane) must be Medically Necessary and have appropriate medical team or assistance for patient.

e) From Hospital to home when Medically Necessary (must obtain prior authorization to be covered).

(19) Charges for treatment rendered to a newborn child prior to initial discharge from the Hospital for:
a) An abnormal congenital condition;
b) An Illness contracted at birth;
c) An Illness related to prematurity; or
d) Well baby care for a newborn child placed in a well-child care unit of a Hospital. Well baby care consists of:
(1) Hospital charge for nursery care;
(2) Hospital special charges;
(3) Surgeon's charges for circumcision; and
(4) Doctor's charges for visits during this Hospital Confinement;

Charges for well-baby care of a newborn will be applied toward the Plan of the newborn child.

(20) Charges by a licensed birthing center or outpatient surgical center for Medically Necessary treatment and supplies for a covered Surgical Procedure.

(21) Charges for initial contact lens or initial eyeglasses following cataract surgery.

(22) Charges for treatment of Mental or Nervous Disorders and treatment of Substance Abuse. Such charges are payable as stated in the Schedule of Benefits. Physician visits are limited to one visit per day. Psychiatrists (M.D.), psychologists (Ph.D), counselors (Ph.D), or masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioner must be under the direction of and must bill the Plan through these professionals.

(23) Charges for approved treatment of autism spectral disorders for covered dependents less than twelve (12) years of age. For treatment to be approved, the intervention must be designed and overseen directly by qualified, well-trained professional behavior analysts. Detailed assessment to determine initial treatment goals must be provided as well as ongoing objective measurement of learner progress. The treatment of autism spectral disorders is defined to include medical, psychiatric, psychological therapeutic care; applied behavior analysis and rehabilitative care as covered expenses.

(24) Therapy Services:
a) Charges for cardiac rehabilitation therapy as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a medical care facility as defined by this Plan;
b) Charges for chemotherapy including supplies and services of technicians;
c) Charges for radiation therapy including supplies and services of technicians;
d) Charges by licensed physical therapist or qualified occupational therapist. Charges must be (a) in accordance with a Physician's exact orders as to type, frequency and duration; and (b) to improve a bodily function;
e) Charges by a licensed speech therapist. The therapy must be to restore speech loss or correct speech impairment due to:
1. A birth defect where therapy follows corrective surgery;
2. An Injury;
3. Autism for covered dependents less than twelve (12) years of age; or
4. An illness other than mental or nervous disorder or learning disorder (other than listed above).

Therapy must be in accordance with a Physician's exact orders as to type, frequency and duration;

f) Charges for dialysis therapy.
g) Charges for rehabilitation therapy;
h) Charges for pulmonary rehabilitation.

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

(25) Charges for chiropractic care and treatment for diathermy, subluxations or misplacement of vertebrae, or strains and sprains of soft tissue related to the spine when performed by a licensed chiropractor. Such charges shall be limited as stated in the Schedule of Benefits.

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

(27) Charges for services made by a skilled nursing care facility (See SKILLED NURSING CARE FACILITY PROVISION).

(28) Charges for specific type of hospice services when provided by a licensed participating hospice or licensed approved hospice (See HOSPICE CARE PROVISION).

(29) Charges for treatment of Temporomandibular Joint Disorder (TMJ).

(30) Charges for surgical treatment of Morbid Obesity under a treatment Plan approved by the Plan Administrator.

(31) Charges for cochlear implants.

(32) Charges for preventive care are covered as stated in the Schedule of Benefits.

(33) As part of the Affordable Care Act, Non-Grandfathered Plans may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in an approved clinical trial for a qualified individual. Therefore, charges for routine patient care costs incurred by a qualifying individual during participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition will be covered under the plan.

A “qualified individual” is someone who is eligible to participate in an “approved clinical trial” and either the individual’s doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

An “approved clinical trial” is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application).

A “life-threatening condition” is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

HOSPICE CARE BENEFITS

This Hospice Care benefit is to cover specific types of services that are related to the care of a Terminally Ill patient. "Terminally Ill" means life expectancy is six (6) months or less. The diagnosis of Terminal Illness must be certified by the patient's primary or attending Physician.

1. HOSPICE CARE SERVICES AND SUPPLIES - This Plan will pay for those services and supplies provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period. Such services include the following:
   (1) Charges by an approved hospice facility;
   (2) Skilled nursing by a registered nurse, a licensed practical nurse, or a nurse's aide working under the supervision of a registered nurse;
   (3) Medical social services by a social worker that is certified by the state in which the hospice is operating and employed by the hospice agency and under the direction of the patient's Physician;
   (4) Reasonable expense for medication prescribed for the control or palliation of the patient's terminal Illness, necessary medical equipment and supplies provided by the approved hospice;
   (5) Home health aide services furnished by the hospice and supervised by a registered nurse. Home health aides to provide personal care services that are necessary for the maintenance of safe and sanitary conditions in the areas of the house used by the patient;
   (6) Physical therapy and inhalation therapy provided for the purposes of symptom control or to enable the patient to maintain activities of living at home and basic functional skills; and
   (7) Bereavement counseling consisting of services provided to the patient's immediate family after the patient's death. Counseling must be given within six (6) months after the patient's death.

2. HOSPICE CARE LIMITATIONS - The following are to be excluded:
   (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 patient's terminal Illness;
   (3) Comfort items not directly related to relieving pain or managing the patient's terminal Illness;
   (4) Supportive environmental items such as air conditioners, air fresheners, ramps, handrails, or intercom systems;
   (5) Transportation, chemotherapy, radiation therapy, enteral and parenteral feeding, home hemodialysis, and other services supportive to research, diagnosis and lengthening patterns of treatment;
   (6) Visits made to the home by a Physician;
   (7) Psychiatric care; and
   (8) Services provided by volunteer agencies or pastoral counseling services and items, services or expenses not specifically stated as covered under this benefit.

TISSUE AND ORGAN TRANSPLANT PROVISION

Expenses incurred in connection with any organ or tissue transplant in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized medical review specialist.

1. What is Covered - This provision covers the Reasonable expense for specific services and supplies related to covered transplant procedures. The services and supplies must be performed or prescribed by the patient's attending Physician. In addition, they must be Medically Necessary.

   Covered expenses include charges to treat immediate and direct complications of a covered transplant procedure. These expenses also include directly-related follow-up care.

   The types of services specifically covered are:
   a. Hospital room and board;
   b. Services of regular Hospital staff;
   c. The use of Hospital treatment facilities, equipment, or supplies;
   d. Professional fees of the following Providers: attending Physician; consulting Physician; anesthesiologists; and professional members of the surgical transplant team who are not employed by the Hospital.
   e. Skilled nursing facility expenses – this includes room, board, general nursing care, and the use of the facility's equipment and supplies;
   f. Drugs and medications which require a Physician's prescription;
   g. Clinical and pathological lab services – include interpreting the findings;
   h. Private duty (special) nursing charge – includes full-time or visiting nursing care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). The patient's private duty nurse may not be an immediate relative – by blood, marriage, or adoption – including the patient's: spouse; parents; children; brothers and sisters; and other members of the patient's household.
   i. Physiotherapy – in connection with recovery from a covered transplant procedure;
   j. medical equipment and supplies prescribed to care for and treatment of the organ transplant patient;
   k. X-rays or other imaging procedures for diagnostic purposes;
   l. Home health care provided by a Home Health Agency;
   m. Surgical, storage, and transportation costs to get donated organ when the organ is used in a covered transplant procedure; and
   n. Travel expenses to and from the site of a covered transplant procedure for the organ recipient and one (1) other individual, by ground or air ambulance, or other public conveyance and two (2) persons to ride with recipient, if the recipient is a minor, if the patient resides more than 75 miles from the facility.

2. Transplant Exclusions

   In addition to the limitations and exclusions to medical expense benefits, the following are not Covered Medical Expenses:
   a. Expenses incurred for more than two (2) re-transplantations of the same type of organ per person, per lifetime;
   b. Payment to an organ donor or the donor's family as compensation for an organ or for the written consent needed to get an organ;
   c. Expenses in connection with an attempted transplant procedure which was not performed, regardless of the reason.

HOME HEALTH CARE PROVISION

Home Health Care charges for a Covered Person will be eligible as described in this provision. The benefits payable under this provision are subject to the deductible and percentage payable shown in the Schedule of Benefits.

Charges will be eligible when:

1. A Home Health Care Treatment Plan is submitted in writing by the attending Physician prescribing the Plan for continued treatment, which includes an estimate of duration. The Physician must re-certify the need for continued care; and
2. In the absence of Home Health Care, the Covered Person would be required to be an inpatient at a Hospital or Extended Care Facility.

Major medical charges for home health care will include:

1. Services on a part-time or intermittent basis by a registered nurse, licensed practical nurse or home health aide;
2. Service performed by a licensed physical, occupational, speech and/or respiratory therapist, in accordance with the provisions stated in Covered Medical Expenses; or
3. Medical support services and supplies such as drugs and medicines prescribed by the Physician, laboratory services and other supplies that would have been covered under the Plan if the Covered Person had remained in the Hospital or Extended Care Facility.

In addition to charges not covered by the Limitations and Exclusions Section of the Plan, charges for the following home health care services are not covered:

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

SKILLED NURSING CARE FACILITY PROVISION

Benefits for services provided at a Skilled Nursing Care Facility, Rehabilitation Facility, or Extended Care Facility will be paid to a Covered Person provided:

1. Only charges for room and board, skilled nursing care and other per day charges are covered;
2. The charges will be considered covered expenses only if:
   a. A doctor prescribed a written treatment Plan and supervises the care and treatment;
   b. The facility maintains the treatment Plan in addition to medical records on each patient;
   c. In the absence of skilled nursing care, the Covered Person would be required to be an inpatient at a Hospital.
3. The patient is confined as a bed patient in the facility; and
4. The confinement starts immediately following a Hospital Confinement or a period of home health care utilization.

LIMITATIONS AND EXCLUSIONS TO MEDICAL EXPENSE BENEFITS

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

1. ABORTION - No payment will be made for any charges incurred in connection with abortion procedures or Pregnancy related conditions resulting in abortion unless such procedures are therapeutic in nature and are Medically Necessary to protect the life of the mother.

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

2. ACUPUNCTURE - No payment will be made for any charges incurred as the result of, or in connection with, acupuncture, whether or not administered by a medical doctor.

3. ANESTHESIA BY HYPNOSIS OR FOR NON-COVERED SERVICES - No payment will be made for any charges for anesthesia by hypnosis or charges for anesthesia for non-covered services.

4. CIVIL DISTURBANCE / CRIMINAL ACTS / ILLEGAL OCCUPATION - No payment will be made for any expenses incurred as a result of participating in a riot or civil disturbance, or while committing or attempting to commit an assault or felony or criminal act or engaging in an illegal occupation.

5. CLAIMS FORMS - No payment will be made for any charge made by a doctor or other Provider of medical services for completing claim forms required by the Plan for the processing of claims.

6. COURT ORDERED TREATMENT – No payment will be made for charges resulting from any court-ordered rehabilitative treatment, service or supply including medical, surgical, Mental or Nervous Disorders or Substance Abuse treatment.

7. CONVENIENCE ITEMS - No payment will be made for food supplements, equipment or supplies made or used for physical fitness, athletic training or general health upkeep.

8. CUSTODIAL CARE - No payment will be made for any charges for any type of Custodial Care or charges incurred while a person is confined in an institution which is primarily a place of rest, a place for the aged or a nursing home.

9. DENTAL EXPENSES - No payment will be made for any expenses incurred for dental work, except for those stated in Covered Medical Expenses.

10. DEVELOPMENTAL DELAY - No payment will be made for developmental disorders, including learning disabilities, or mental retardation.

11. EDUCATIONAL TRAINING - No payment will be made for any charges which are incurred for education, training, or room and board while the person is confined in an institution which is primarily a school or institution of learning or training.

12. ELECTIVE SERVICES / COSMETIC SERVICES - No payment will be made for any charges incurred for any treatment or Surgical Procedure or service performed that is of an elective nature. This exclusion applies to such items as cosmetic surgery and breast implants.

    This exclusion does **not** apply to:

    (a) Reconstruction of the breast on which a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance, breast prosthesis (whether internal or external, following mastectomy) and four surgical

bras per year, lymphedema stockings for the arm, and treatment of physical complications of mastectomy;

(b) Breast reduction surgery if documented to be Medically Necessary;

(c) Reconstructive surgery, i.e., reparative or therapeutic surgery done after an Illness or Injury to restore the patient's appearance;

(d) Cosmetic surgery deemed necessary as a result of a congenital defect affecting bodily function in a child.

13. EXCESS CHARGES - No payment will be made for any otherwise Covered Medical Expense in excess of any applicable pre-negotiated or negotiated rates, the Maximum Allowable Charge, or any applicable plan limits.

14. EXPERIMENTAL / INVESTIGATIONAL - No payment will be made for charges which are Experimental or Investigational in nature or which have not been approved by the Food and Drug Administration. This exclusion does not apply to routine patient costs for items and services furnished in connection with participation of a qualifying individual in an approved clinical trial as described under Covered Medical Expenses.

15. FAMILY SERVICES - No payment will be made for any services rendered to a Covered Person by his or her spouse; parent(s) or parent(s) in law; child(ren); brother(s) or brother(s) in law; sister(s) or sister(s) in law; grandparents, or persons who normally reside with the Covered Person.

16. FERTILITY / INFERTILITY - No payment will be made for any charges incurred as the result of, or in connection with any charges for fertility or infertility testing or treatment, beyond the initial diagnosis.

17. FOOT CARE / PODIATRY - No payment will be made for routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails (except for removal of nail matrix or root), fallen arches, weak feet, and chronic foot strain, unless the treatment is an approved Surgical Procedure or Medically Necessary.

18. FOOT ORTHOTICS - No payment will be made for shoe inserts or corrective shoes.

19. GOVERNMENT COVERAGE - No payment will be made for any charges that are incurred while the individual is confined in any Hospital that is operated by the United States government or any agency of the United States government, unless excluding them is prohibited by law.

20. GOVERNMENT / MILITARY - No payment will be made for expenses incurred as a result of, or in connection with, the care or treatment of an Injury or Illness due to war or any act of war; “war” includes insurrection or armed aggression resisted by the armed forces of any country, combination of countries, or international organization, whether or not war is declared.

21. HAIR LOSS / WIGS - No payment will be made for any charge for services or supplies for hair loss, including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician, except for one wig following radiation or chemotherapy.

22. HAZARDOUS HOBBY OR ACTIVITY - No payment will be made for care and treatment of an Injury or Illness that results from engaging in a hazardous hobby or activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of Hazardous hobbies or activities are skydiving, auto racing, hang gliding, bungee jumping, mountain climbing, or motorcycle racing and competitions.

23. INCARCERATION - No payment will be made for any charges incurred for treatment of any participant while confined in a prison, jail, or other penal institution.

24. LASIK SURGERY/ RADIAL KERATOTOMY - No payment will be made for any services or supplies for radial keratotomy, lasik surgery, or similar procedure for the correction of a refractive error of the eye.

25. MARRIAGE COUNSELING – No payment will be made for any charges for marriage counseling, including pre-marital counseling.

26. MASSAGE THERAPY - No payment will be made for charges incurred for massage therapy, unless applied in conjunction with other active physical therapy modalities for specific covered Illness or Injury and approved as Medically Necessary by the Plan Administrator.

27. MATERNITY RELATED ULTRASOUNDS / ECHOGRAMS / AMNIOCENTESIS - No payment will be made for any ultrasound, echogram or amniocentesis procedures related to Pregnancy unless such procedures are necessitated by a complication of Pregnancy and Medically Necessary. Testing for the purpose of fetal age or sex or solely because of maternal age shall not be considered due to a complication of Pregnancy. (Exception: The Plan will cover two (2) routine ultrasounds per Pregnancy.)

28. MISSED APPOINTMENTS - No payment will be made for charges for missed appointments.

29. NEWBORN OF A DEPENDENT CHILD - No charges will be made for care and treatment of a newborn child of a dependent child.

30. NO ATTENDING PHYSICIAN - No payment will be made for any charges for any services or supplies which are not recommended and approved by an attending Physician.

31. NO OBLIGATION TO PAY - No payment will be made for any charges which are incurred by an individual for which the individual or Eligible Employee is not legally required to pay, or for which no charge would be made in the absence of insurance.

32. NON-COMPLIANCE - No payment will be made for all charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

33. NON-COVERED PROVIDER - No payment will be made for any charge for services or supplies received from a Physician or a Hospital that does not meet the definition of a Provider as set forth in the definition section of this Plan.

34. NON-COVERED SERVICES / NOT MEDICALLY NECESSARY:
    a. No payment will be made for any charges that are not Medically Necessary. The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself make it Medically Necessary or make the charge a covered expense even though it is not specifically listed as an exclusion.
    b. No payment will be made for any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a specific Illness or accidental bodily Injury, except as outlined under Covered Medical Expenses.
    c. No payment will be made for any charges incurred as the result of, or in connection with, inpatient care or services rendered solely for observation or diagnostic testing or for care and services, whether inpatient or outpatient, rendered solely as preventive measures, except as outlined under Covered Medical Expenses.
    d. No payment will be made for charges incurred due to complications resulting from any treatment, services, or supplies which are otherwise excluded under this Plan.

35. NON-PRESCRIPTION MEDICINES AND SUPPLIES - No payment will be made for non-prescription medicines and supplies that can be purchased without a prescription from a licensed Physician.

36. NON-TIMELY FILING - No payment will be made for any charges submitted more than 12 months after the charges were incurred.

37. NOT SPECIFICALLY LISTED - No payment will be made for any charges incurred for services, supplies, or other care which is not specifically listed as covered expenses under this Plan.

38. OBESITY - No payment will be made for any charges which are incurred for services, treatment or Surgical Procedures rendered in connection with any overweight condition, unless the person is Morbidly Obese.

39. PERSONAL COMFORT ITEMS - No payment will be made for any charge for personal comfort or beautification items, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, nonprescription drugs and medicines, usual and normal home medical supplies and first-aid items, non-hospital adjustable beds, television or telephone use, rest cures, or expenses actually incurred by other persons.

40. PRIOR EFFECTIVE DATE / FOLLOWING TERMINATION DATE - No payment will be made for any charge for services or supplies for which a charge was incurred before a person was covered under this Plan or after coverage terminates under this Plan.

41. PRIVATE DUTY NURSING (INPATIENT HOSPITAL) – No payment will be made for charges for private duty nursing during an inpatient Hospital Confinement, except as outlined under covered transplant services.

42. REVERSAL OF STERILIZATION PROCEDURE – No payment will be made for the reversal of sterilization procedures. However, charges for an initial sterilization procedure will be covered.

43. SELF-INFLICTED INJURY/ILLNESS - No payment will be made for any charges incurred as the result of, or in connection with, intentionally self-induced Illness or intentionally self-inflicted Injury or voluntarily taking of drugs except those taken as prescribed by a Physician. However, such charges will be payable if they are incurred due to a medical condition (physical or mental) or domestic violence.

44. SEX TRANSFORMATION/GENDER IDENTITY DISORDERS - No payment will be made for any charges incurred as a result of any treatment of gender identity disorders, surgical sex transformations or any Experimental or clinical investigative procedures.

45. SEXUAL DYSFUNCTION / INADEQUACIES - No payment will be made for any charges incurred as the result of, or in connection with, services or supplies related to sexual dysfunctions or inadequacies.

46. SLEEP DISORDERS - No payment will be made for care and treatment of sleep disorders unless deemed Medically Necessary.

47. STAND-BY PHYSICIAN/EQUIPMENT - No payment will be made for stand-by surgeons, Physicians and equipment.

48. SURROGATE PREGNANCY – No payment will be made for any charges for a surrogate Pregnancy.

49. TAX AND SHIPPING - No payment will be made for taxes and shipping charges levied on Medically Necessary items and services. This exclusion does not apply to surcharges required by law to be paid by the Plan in applicable states.

50. TELEPHONE CONSULTATIONS - No payment will be made for changes for telephone consultations.

51. TRAVEL OR ACCOMMODATIONS - No payment will be made for charges for travel and accommodations, whether or not recommended by a Physician, except for ambulance charges and charges outlined under covered transplant services.

52. TRAVEL OUTSIDE OF THE UNITED STATES – No payment will be made for charges incurred outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies.

53. VITAMINS - No payment will be made for charges for vitamins, unless specifically provided under the prescription drug card program.

54. WORKERS' COMPENSATION / EMPLOYMENT RELATED CONDITIONS – No payment will be made for charges incurred as the result of or in connection with any activity pertaining to any act of employment for profit, gain, or compensation for which the Covered Person receives a W-2 or 1099 from an Employer, or for which you file a self-employment schedule for federal income taxes; or charges incurred as a result of a disease, illness or condition for which benefits would, or could, have been payable if the Covered Person had purchased available workers compensation insurance, or benefits paid under any workers compensation act, any occupational disease act or any other similar such benefit program. Failure by the Covered Person, for any reason, to provide workers compensation for occupational activities, not associated with their employment with the City of Germantown, shall in no way obligate the City of Germantown to pay for or reimburse for any injuries, sickness, or disease.

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

COORDINATION OF BENEFITS

The coordination of benefits provision provides rules for the order of payment of covered expenses when a Covered Person is covered under this Plan and another group plan, including Medicare, as outlined below. The plan that pays first according to the benefit determination rules will pay as if there were no other plan involved. The secondary and subsequent plans will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed the amount of benefits it would pay had it been the primary plan.

For example, if this Plan is secondary, the benefits payable are calculated and the primary plan's payment is subtracted from this Plan's payment. If this Plan's payment is greater than the primary plan's payment, the benefit payment is the difference between the two plans. If this Plan's benefits are equal to or less than the primary plan's payment, no benefit payment is due. Total reimbursement will never be more than the secondary plan would have paid**. The balance due, if any, is the responsibility of the Covered Person. This method of coordinating benefits is called maintenance of benefits.**

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.

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, Usual 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".

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. Regardless of 2. and 3. above, when the parents of a child are separated or divorced and there is a court decree establishing financial responsibility for the health care expenses of a child, the plan covering the parent with financial responsibility will pay first, the plan covering the parent without financial responsibility will pay second, and the plan covering the step-parent (if applicable) will pay last.

In claims involving Retirees, the plan covering an individual as an employee (or as the employee's dependent) who is neither laid-off nor retired pays benefits first. The plan covering the individual as a laid-off or Retired Employee (or as that individual's dependent) pays benefits second.

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) , or for, or with respect to, whom such payments were made, any insurance companies, any other organizations or any further claims made to this Plan by the Covered Person.

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

COORDINATION WITH STATE MEDICAID PROGRAMS: Payments for benefits shall be made in accordance with any assignment required by a state medical 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.

SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

PAYMENT CONDITION

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

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

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

SUBROGATION

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

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus Reasonable costs of collection.

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

4. If the Plan participant(s) fails to file a claim or pursue damages against:
   - (a) the responsible party, its insurer, or any other source on behalf of that party;
   - (b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   - (c) any policy of insurance from any insurance company or guarantor of a third party;

(d) worker’s compensation or other liability insurance company; or,
(e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)’ recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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

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

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

EXCESS INSURANCE

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

The Plan’s benefits shall be excess to:
(a) The responsible party, its insurer, or any other source on behalf of that party;
(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
(c) Any policy of insurance from any insurance company or guarantor of a third party;
(d) Worker’s compensation or other liability insurance company or
(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

SEPARATION OF FUNDS

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

WRONGFUL DEATH

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b) To provide the Plan with pertinent information regarding the Sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
    c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or coverage.

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

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

OFFSET

Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

MINOR STATUS

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

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

LANGUAGE INTERPRETATION

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

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

CLAIMS APPEALS PROVISIONS

CLAIMS REVIEW AND INTERNAL APPEALS PROCEDURES

1. The Plan's claims procedures vary depending on the type of claim filed. The Covered Person's claims may be any one of the following four (4) types of claims:
   - Pre-Service Claim – A pre-service claim is a claim for medical care under the Plan for which prior approval for the care, in whole or in part, is a condition to receiving the medical care.
   - Concurrent Care Claim – A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.
   - Post-Service Claim – A claim for medical care for which the medical care has already been received by the Covered Person.
   - Urgent Care Claim – A claim in which the application of the time period for making a determination of a pre-service claim or concurrent care claim would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum capacity (in the view of a prudent layperson 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.**

2. 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, and you fail to provide sufficient information to decide the claim, the claim will be denied or the time for response will be extended. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the specified information. If you fail to properly submit the claim in accordance with the Plan procedures for filing a claim, you will be notified orally or in writing within five (5) days of the date that you attempted but failed to properly file a claim in accordance with the applicable rules and regulations and given instructions on how to properly file a claim. You may request that the notification be given in writing. The only claims that will qualify as pre-service claims under this Plan are non-urgent Hospital admissions and non-urgent 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 twenty-four (24) 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 through 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.

3. **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:
   a. The specific reason or reasons for the denial;
   b. The specific provisions of the Plan on which the denial is based;

c. 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;
d. 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;
e. 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;
f. 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
g. 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.

4. **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:
a. Provide you the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits;
b. 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;
c. 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;
d. 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;
e. 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;
f. 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
g. 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 in 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 twenty-four (24) 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.

5. Additional Claims and Appeals provided under PPACA

The following changes provided under PPACA impact how claims and appeals are handled and apply to your Plan:

a. You have the right to appeal a rescission of coverage determination.

b. If any new or additional evidence is relied upon or generated by us during the determination of an appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

6. 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:

a. The specific reason or reasons for the denial;

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

c. 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.

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

e. 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;

f. 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

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

7. 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 Health Cost Solutions, Inc. 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; 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;; admission and discharge summary; physical therapy notes; emergency room notes; anesthesia time; invoice for device, prosthesis or implant. All necessary Health Cost Solutions, Inc. forms are available on the Health Cost Solutions, Inc. website at www.managebenefits.com.
- **Claim Filing Period** – Notwithstanding any provision of this Plan to the contrary, no benefits shall be payable under this Plan to any Covered Person or Provider who fails to submit a claim for benefits within the *Non-Timely Filing Limit*, set forth in the Limitations and Exclusions to Comprehensive Major Medical Expense Benefits. The Plan Administrator (or its delegate for claims-payment purposes), however, in its sole discretion, may accept a claim after such time has elapsed if extenuating circumstances or excusable neglect prevented the Covered Person or Provider from making a claim during such period or if any such circumstances or neglect prevented a claim from being timely received by the Plan Supervisor. In the event this Plan has an arrangement with one (1) or more preferred Provider organizations (PPO), a longer claim filing period specified in a contract between the PPO and the Providers included in the PPO may be honored by this Plan in the discretion of the Plan Administrator. Each Covered Person, beneficiary or other interested person shall file with the Plan Administrator such pertinent information as the Plan Administrator may specify, and in such manner and form as the Plan Administrator may specify or provide.
- **Disability Determination** - If the Plan offers an extension of coverage for those participants on the basis of disability (as set forth in the Schedule of Benefits) and the Plan Supervisor is responsible for making the determination as to whether a participant is indeed disabled, the following different rules apply to the disability determination:
  a. 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.
  b. You will have one hundred eighty (180) days in which to appeal the adverse benefit determination to the Plan Administrator.
  c. 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.

FEDERAL EXTERNAL REVIEW PROCEDURES FOR SELF-FUNDED PLANS: Group Health Plans must allow claimants to request an external review of a claim within four months of receiving notice of an adverse benefit determination or final internal adverse benefit determination. If the deadline falls on a

weekend or federal holiday, the deadline is extended to the next business day. There are two types of external review, standard and expedited. Procedures for these reviews are outlined below.

1. STANDARD EXTERNAL REVIEW PROCEDURES

- **Request for External Review -** Group Health Plans must allow claimants to request an external review of a claim within four (4) months of receiving notice of an adverse benefit determination or final internal adverse benefit determination. If the deadline falls on a weekend or federal holiday, the deadline is extended to the next business day.

- **Preliminary Review** - Within five (5) business days of receiving the request for external review, the Group Health Plan must complete a preliminary review the request to determine whether:
  a. The claimant is or was covered under the Plan at the time the health care item or service was requested, or in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
  b. The adverse benefit determination or final adverse benefit determination does not relate to the claimant's failure to meet the Plan's eligibility requirements;
  c. The claimant has exhausted the Plan's internal appeal process, unless the claimant is not required to do so under the interim final regulations; and
  d. The claimant has provided all the information and forms required to process an external review.

  Within one (1) business day of completing the preliminary review, the Plan must issue a written notice to the claimant (or their authorized representative, if applicable). If the request is complete but not eligible for external review, the notice must include the reasons it is not eligible and contact information for the DOL's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notice must describe the information or materials needed to complete the request and the Plan must allow the claimant to perfect the request within the four (4) month filing period, or forty-eight (48) hours after receipt of the notice, whichever is later.

- **Referral to Independent Review Organization** - The Group Health Plan must assign an independent review organization (IRO) to conduct the external review. The IRO must be accredited by URAC or by a similar nationally recognized accrediting organization. To avoid bias and ensure independence, the Plan must contract with at least three IROs and rotate claims assignments among them. The IRO may not be eligible for financial incentives based on the likelihood that the IRO will support the denial of benefits.

  A contract between a Plan and an IRO must provide that:
  a. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
  b. The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit, within ten (10) business days, additional information in writing that the IRO must consider. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days

     Within five (5) business days after the assignment of the IRO, the Plan must provide to the IRO the documents and information considered in making the adverse benefit determination or final adverse benefit determination. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination. Within one (1) business day of making its decision, the IRO must notify the claimant and the Plan.
  c. If the IRO receives information from the claimant, it must forward it to the Plan within one (1) business day. The Plan may then reconsider its adverse benefit determination or final internal adverse benefit determination, but may not delay

the external review. The external review may be terminated because of the reconsideration only if the Plan decides to reverse its decision and Provider coverage or payment. The Plan must provide written notice of its decision to the claimant and the IRO within one (1) business day, and the IRO must terminate the external review upon receiving the notice.

d. The IRO will review all documents that are timely received. The IRO will review the claim de novo (i.e., from the beginning) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

e. The IRO must provide written notice of the final external review to the claimant and the Plan within forty-five (45) days of receiving the request for external review.

f. The IRO must maintain records of all claims and notices associated with the external review process for six (6) years. It must make the records available for examination by the claimant, Plan, or state or federal oversight agency upon request, unless the disclosure would violate state or federal privacy laws.

- **Reversal of Plan's Decision -** Upon receipt of a notice of a final external review decision, reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment for the claim, including immediately authorizing or immediately paying benefits.

2. EXPEDITED EXTERNAL REVIEW PROCEDURES

- **Request for Expedited External Review -** A Group Health Plan must allow a claimant to make a request for an expedited external review after receiving an adverse benefit determination if:
  a. The timeframe for a standard review would seriously jeopardize the health or life of the claimant and the claimant has filed a request for an expedited internal appeal; or
  b. The final adverse determination involves an admission, availability of care, continued stay or health care item or service for which the claimant has received emergency services but has not been discharged from a facility.

- **Preliminary Review -** The Plan must determine whether the request meets the standards for an external review immediately upon receiving the request for expedited external review. It must also immediately send a notice to the claimant of its determination regarding eligibility for review.

- **Referral to Independent Review Organization -** If the Plan determines that the request is eligible for external review, it will assign an IRO in accordance with the standard external review requirements. The Plan must provide all necessary documents and information related to the claim to the assigned IRO electronically or by telephone or fax or any other available expeditious method. The assigned IRO must consider any information that is available and appropriate under the procedures for standard review. The assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

- **Notice of Final External Review Decision -** The Plan must require the IRO to notify the claimant of the final external review decision as expeditiously the claimant's medical condition or circumstances require, but no more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Plan within forty-eight (48) hours of providing the initial notice.

GENERAL PLAN PROVISIONS

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

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

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

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

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

- **PAYMENT OF CLAIM:** All benefits are payable to the Covered Employee. If such benefits are not paid as of the date the Covered Employee dies, or if the Covered Employee is a minor, or in the Plan Administrator's judgment, is not capable of giving a legally binding receipt for payment of any benefit, the Plan Administrator at its option, may pay the benefit to:
  1. any person appearing to the Plan Administrator to be entitled to the payment by reason of having incurred funeral or other expenses for the last illness or death of the Covered Employee; or
  2. one (1) or more of the following relatives of the Covered Employee: spouse, parent(s), child(ren), brother(s) or sister(s).

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

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

  The Plan Administrator has the right to allocate:
  1. the Comprehensive Medical Expense Benefit Deductible Amount, if any to any eligible charges; and
  2. the benefits to any assignee. Such actions will be binding of the Covered Persons and the assignees.

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

- **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.

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

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

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

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

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

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

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

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

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

- **NOT AN EMPLOYMENT CONTRACT** - By creating this plan and providing benefits under the plan, the employer in no way guarantees employment for any employee or participant under this plan. Participation in this plan shall in no way assure continued employment with the employer.

- **ADDRESSES, NOTICE AND WAIVER OF NOTICE** - Each participant shall furnish the employer with his correct mailing address. Any communication, statement or notice addressed to a participant at his last mailing address as filed with the employer will be binding on such person. The employer or plan administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this plan. Any notice required under the plan may be waived by such person entitled to such notice.

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

INFORMATION OF INTEREST

Plan Sponsor, Plan Administrator and Named Fiduciary
City of Germantown
1930 Germantown Road South
Germantown, TN 38183
901-757-7250

Name of Plan
City of Germantown Employee Benefit Plan

Plan Number
501

Type of Employer
Single Employer

Employer Identification Number
62-6014996

Agent for Service of Legal Process
City of Germantown
1930 Germantown Road South
Germantown, TN 38183
901-757-7250

Plan Year
January 1st - December 31st

Plan Document Number
SF-100389

Group Number
100389

TPA, Plan Supervisor & Claims Processor:
Health Cost Solutions, Inc.
P.O. Box 1439
Hendersonville, Tennessee 37077

COBRA – INITIAL NOTICE
** VERY IMPORTANT NOTICE **

A federal law, called COBRA, requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage"). This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.
The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1995 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling n coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the covered spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- The death of your spouse;
- The termination of your spouse's employment (for reasons other than gross misconduct);
- Reduction in your spouse's hours of employment;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- Divorce or legal separation from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The termination of the covered parent-employee's employment (for reasons other than gross misconduct);
- Reduction in the covered parent-employee's hours of employment;
- The parent-employee's divorce or legal separation;
- The parent-employee becomes entitled to Medicare benefits (Part A, Party B, or both); or
- The child stops being eligible for coverage as a "dependent child" under the Plan.

The following paragraph only applies to Plans who offer retiree health coverage: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying event (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage), you must notify the Plan Administrator within sixty (60) days after the qualifying event occurs. You must provide this notice to Health Cost Solutions at P.O. Box 1439 Hendersonville, TN 37077.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminated, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employees hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be Totally Disabled within sixty (60) days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), and you notify the Plan Administrator prior to the end of the eighteen (18) months of Continuation of Coverage you and your entire family may be entitled to receive an additional eleven (11) months of COBRA continuation of coverage for a total maximum on twenty-nine (29) months. A copy of the official notification letter from the Social Security Administration must be sent to Health Cost Solutions at P.O. Box 990, Hendersonville, TN 37077.

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits(under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan has the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Health Cost Solutions
COBRA/HIPAA Specialist
P.O. Box 990
Hendersonville, TN 37077
(800) 526-3919

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Benefits Administrator/HR Coordinator/HR Director at 901-757-7250 or at 1930 Germantown Road South, Germantown, TN 38183.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 901-757-7250 for more information.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborn's and Mothers Health Protection Act of 1996 provides that 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).

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with City of Germantown and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **City of Germantown has determined that the prescription drug coverage offered by the City of Germantown Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you do decide to enroll in a Medicare prescription drug plan and drop your drug coverage with City of Germantown, you must also drop your health coverage with City of Germantown because the prescription drug coverage is not offered as stand alone coverage. Be aware that you may not be able to get this coverage back if it is dropped. Again, your medical coverage is combined under the City of Germantown Employee Benefit Plan with your drug coverage and they must be selected together. You cannot drop one without the other.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

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

Contact the person listed below for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through City of Germantown changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1, 2016
Name of Entity/Sender:	City of Germantown
Contact--Position/Office:	Benefits Administrator/HR Coordinator/HR Director
Address:	1930 Germantown Road South, Germantown, TN 38183
Phone Number:	901-757-7250

PLEASE READ THIS NOTICE CAREFULLY AND KEEP IT WHERE YOU CAN FIND IT.

NOTICE REGARDING MEDICARE

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

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

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

FOR ACTIVE FULL-TIME EMPLOYEES AGE 65 AND OVER

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

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

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

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

Please contact the plan administrator for assistance and information regarding this notice.

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

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

If you are the spouse of an active full-time employee and you are age sixty-five (65) or over, you may elect whether your primary health coverage will be provided by Medicare or by this plan. For an explanation of this provision, and other pertinent information, please read the previous section addressed to active full-time employees age sixty-five (65) or over.

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

NOTICE REGARDING MEDICARE SECONDARY PAYER RULES

If this group health plan is secondary to Medicare, the total payments from Medicare plus the payment from the plan will not exceed the plan's normal benefits.

Below is a list of several common situations when Medicare may pay first or second:

If the patient…	And this condition exists…	Then this program pays 1st…	And this program pays 2nd…
Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment…	The employer has less than 20 employees…	Medicare	Group Health Plan
Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment…	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals…	Group Health Plan	Medicare
Has an employer retirement plan and is age 65 or older or disabled and age 65 or older	This patient is entitled to Medicare….	Medicare	Retiree Coverage
Is disabled and covered by a Large Group Health Plan through his or her own current employment or through a family member's current employment…	The employer has less than 100 employees….	Medicare	Large Group Health Plan
Is disabled and covered by a Large Group Health Plan through his or her own current employment or through a family member's current employment…	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals…	Large Group Health Plan	Medicare
Has End Stage Renal Disease and Group Health Plan Coverage…	Is in the first 30 months of eligibility or entitlement to Medicare….	Group Health Plan	Medicare
Has End Stage Renal Disease and Group Health Plan Coverage…	After 30 months…	Medicare	Group Health Plan
Has End Stage Renal Disease and COBRA coverage…	Is in the first 30 months of eligibility or entitlement to Medicare….	COBRA	Medicare
Has End Stage Renal Disease and COBRA coverage…	After 30 months…	Medicare	COBRA
Is age 65 or older OR is disabled and covered by Medicare and COBRA	The patient is entitled to Medicare…	Medicare	COBRA

Should the Medicare Secondary Payer rules be revised, the order of benefit determination will be based upon the current, applicable Medicare Secondary Payer rules.

NOTICE REGARDING THE "HIPAA PRIVACY RULE"

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

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact: our Privacy Contact Benefits Administrator/HR Coordinator/HR Director at 901-757-7250 or at 1930 Germantown Road South, Germantown, TN 38183.

This notice of privacy practices describes how the group plan may use and disclose protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information held by the group plan. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services, including payment for such services.

The group plan is required to abide by the terms of this notice of privacy practices. The group plan may change the terms of its notice, at any time. The new notice will be effective for all protected health information held by the group plan at that time. Within 60 days following any revision, the group plan will send you a revised notice of privacy practices. The group plan will also notify you every three years regarding the availability of the notice and how to obtain a copy. You may obtain a copy by calling the office and requesting that a copy be sent to you in the mail.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Payment: Your protected health information will be used and disclosed, as needed, for the group plan or its agents to process payment for your health care services. This may include certain activities that are undertaken before health care services are approved or paid, such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the group plan or its agents to obtain approval for the hospital admission. Your demographic and eligibility information may be disclosed to health care providers to verify coverage and to authorize treatment.

Treatment: Your protected health information may be shared with health care providers to assist them in providing appropriate treatment, including coordination and management of care. For example, the group plan or its agents may work with your treatment providers to coordinate the services provided to you.

Health Care Operations: Your protected health information will be used, as needed, for the group plan to conduct its standard internal operations, including proper administration of records, evaluation of the quality of treatment, evaluation of program costs and trends, and to assess the care and outcomes of your case and others like it.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization

The group plan may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: The group plan may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: The group plan may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability or other related purposes.

Health Oversight: The group plan may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Legal Proceedings: The group plan may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: The group plan may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the group plan's premises) and it is likely that a crime has occurred.

Serious Threats to Safety: Consistent with applicable federal and state laws, the group plan may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The group plan may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, the group plan may use or disclose protected health information of individuals who are armed forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. The group plan may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by the group plan as authorized to comply with workers' compensation laws and other similar legally-established programs.

Group Plan Sponsor: The group plan may disclose your protected health information to the plan sponsor as necessary for the plan sponsor to provide administrative assistance to the group plan.

Required Disclosures: Upon appropriate request, the group plan must make disclosures to the Secretary of the Department of Health and Human Services to investigate or determine the Group Plan's compliance with the requirements of Section 164.500 et. seq.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that the group plan has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as the group plan maintains the protected health information. A "designated record set" contains medical and billing records and any other records that the group plan uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the group plan's privacy contact if you have questions about access to your records held by the group plan.

You have the right to request a restriction of your protected health information. This means you may ask the group plan not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The group plan is not required to agree to a restriction that you may request

You have the right to request to receive confidential communications from the Group Plan by alternative means or at an alternative location. The group plan will accommodate reasonable requests. The group plan may also condition this accommodation by asking you for information as to how payments for premiums will be handled or specification of an alternative address or other method of contact. The group plan will not request an explanation from you as to the basis for the request. Please make this request in writing to the group plan's privacy contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as the group plan maintains this information. In certain cases, your request for an amendment may be denied. If the group plan denies your request for amendment, you have the right to file a statement of disagreement and the group plan may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the group plan's privacy contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures made by the Group Plan, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this notice of privacy practices. It excludes disclosures the group plan may have made to you, for a facility directory, to family members or friends involved in your care, or pursuant to written authorization from you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to the group plan or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the group plan. You may file a complaint with the group plan by notifying the privacy contact of your complaint. The group plan will not retaliate against you for filing a complaint.

You may contact the group plan's privacy contact, Benefits Administrator/HR Coordinator/HR Director at 901-757-7250 for further information about the complaint process.

This notice was published and becomes effective on 01.01.13.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084

INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm _Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565