TENNESSEE CONFERENCE HEALTH PLAN

Health Benefit Summary Plan Description

Revised: 01/01/2017

Table of Contents

TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC.

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC. Health Benefit Plan (the "Plan"). As a valued Plan Participant of TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC., we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Office of Administrative Services if You have questions.

Tennessee Conference Director of Administrative Services is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims and Caremark for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Conference assumes the sole responsibility for funding the Plan benefits out of general assets; however, Plan Participants help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of The Conference and there is no separate fund that is used to pay promised benefits.

The Plan Administrator believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protection apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

JAMES R. ALLEN, DIRECTOR OF ADMINISTRATIVE SERVICES
TENNESSEE CONFERENCE UNITED METHODIST CHURCH, INC.
304 S PERIMETER PARK DR STE 4
NASHVILLE TN 37211
615-327-1162

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document.

This document becomes effective on January 1, 2010.

PLAN INFORMATION

Plan Name	TENNESSEE CONFERENCE HEALTH PLAN
Name And Address Of The Conference	TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC. 304 S PERIMETER PARK DR STE 4 NASHVILLE TN 37211
Name, Address And Phone Number Of Plan Administrator	JAMES R. ALLEN, DIRECTOR OF ADMINISTRATIVE SERVICES TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC. 304 S PERIMETER PARK DR STE 4 NASHVILLE TN 37211 615-327-1162
Named Fiduciary	TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC.
The Conference's Identification Number Assigned By The IRS	62-0528600
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC. JAMES ALLEN 304 S PERIMETER PARK DR STE 4 NASHVILLE TN 37211 Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	The Conference and Plan Participant Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by The Conference.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Plan Participants and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.

Compliance

It is intended that this Plan comply with laws applicable to church plans and exempt from ERISA and COBRA. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year:		
• Per Person	$500	$1,000
• Per Family	$1,000	$2,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum:		
• Per Person	$2,000	$5,800
• Per Family	$5,500	$11,600
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	80%	80%
Chiropractic Services:		
• Maximum Visits Per Calendar Year	25 Visits	
• Paid By Plan After Deductible	80%	80%
Diabetic Counseling:		
• Paid By Plan After Deductible	80%	60%
Diabetic Shoes And Inserts:		
• Maximum Benefit Per Calendar Year	1 Pair	
• Paid By Plan After Deductible	80%	60%
Durable Medical Equipment:		
• Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
True Emergency Urgent Care:		
• Paid By Plan After Deductible	80%	80%
Non-true Emergency Urgent Care:		
• Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
True Emergency Room / Emergency Physicians: • Paid By Plan After Deductible	80%	80%
Non-True Emergency Room / Emergency Physicians: • Paid By Plan After Deductible	80%	60%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan	120 Days 100% (Deductible Waived)	100% (Deductible Waived)
Home Health Care Benefits: • Paid By Plan ***Note: Medical Necessity Will Be Reviewed After 60 Visits.*** ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.***	100% (Deductible Waived)	100% (Deductible Waived)
Hospice Care Benefits: • Paid By Plan	80% (Deductible Waived)	60% (Deductible Waived)
Hospice Home Care Benefits: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Hospital Services: **Pre-admission Testing:** • Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate: • Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Imaging Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-ray Charges: • Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges: • Paid By Plan After Deductible	80%	60%
Mental Health, Substance Use Disorder And Chemical Dependency Benefits: • Paid By Plan After Deductible	80%	60%
Physician Office Visit: • Paid By Plan After Deductible	80%	60%
Physician Office Services: • Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
• Maximum Benefit Per Calendar Year	$300	
Preventive / Routine Physical Exams:		No Benefit
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	
Immunizations:		
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	60%
Note: Out-Of-Network Coverage For Flu Shots Only.		
Preventive / Routine Diagnostic Tests, Lab And X-rays:		No Benefit
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	
Preventive / Routine Mammograms And Breast Exams:		No Benefit
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	
Preventive / Routine Pelvic Exams And Pap Test:		No Benefit
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	
Preventive / Routine PSA Test And Prostate Exams:		No Benefit
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		No Benefit
Included In Maximum From Age 50		
• Maximum Exams Every 5 Years	1 Exam	
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	
Note: No Age Limit Applies If Related To Positive Family History.		
Preventive / Routine Hearing Exams:		No Benefit
Included In Maximum		
• Paid By Plan	100% (Deductible Waived)	
After Maximum Is Satisfied		
• Paid By Plan After Deductible	80%	
Supplemental Accident Expense Benefits - Including Dental Injuries:		
• Paid By Plan Per Disability	100% Up To $300 (Deductible Waived)	
• Paid By Plan Per Disability After Deductible, After First $300	80%	60%
Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.		
Temporomandibular Joint Disorder Benefits (Diagnostic Only):		
• Paid By Plan After Deductible	80%	60%
Therapy Services:		
• Paid By Plan After Deductible	80%	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits		
Wigs, Toupees Or Hairpieces Related To Cancer Treatment:		
• Maximum Benefit Per Lifetime	$300	
• Paid By Plan After Deductible	80%	80%
All Other Covered Expenses:		
• Paid By Plan After Deductible	80%	60%

TRANSPLANT SCHEDULE OF BENEFITS
Applies To Cornea Transplants Only
Contact United HealthCare Regarding Coverage For All Other Organ Transplant Benefits

Transplant Services At A Designated Transplant Facility For Cornea Transplants Only:		
Transplant Services:		
• Paid By Plan After Deductible	80%	
Travel And Housing:		
• Maximum Benefit Per Transplant	$10,000	
• Paid By Plan After Deductible	80%	
Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.		
Donor Costs Relating To Organ Removal Are Covered Under The Recipient's Plan.		
	IN-NETWORK	**OUT-OF-NETWORK**
Transplant Services At A Non-designated Transplant Facility For Cornea Transplants Only:		
Transplant Services:		
• Paid By Plan After Deductible	80%	60%
• Maximum Benefit Per Transplant	$75,000	
• Paid By Plan After Deductible	80%	60%

CAREMARK PRESCRIPTION DRUG CARD BENEFIT SCHEDULE*

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your employer with any questions related to this coverage.

Deductible Per Covered Person	$50 Per Calendar Year
Pharmacy Option (30 Day Supply Per Co-pay Up To A Maximum 90 Day Supply)	
Generic Drugs	$10 Co-pay After Deductible
Preferred Brand Name Drugs	$30 Co-pay After Deductible
Non-Preferred Brand Name Drugs	$60 Co-pay After Deductible
Mail Order Option (90 Day Supply)	
Generic Drugs	$25 Co-pay After Deductible
Preferred Brand Name Drugs	$75 Co-pay After Deductible
Non-Preferred Brand Name Drugs	$150 Co-pay After Deductible

***Note:** Prescription drugs not covered under the Drug Card Program may be covered under the Major Medical Benefits of this Plan if deemed medically necessary and not excluded by the Plan.

Specialty Pharmacy Program - *for certain high-cost drugs such as specialty oral and injectable medication*

The Co-pay for Specialty drugs will mirror either the Retail Network Pharmacy (for a 30-day supply) or Mail Order Drug Program (for a 90-day supply) Co-pays. The way the prescription is written by the Physician *(i.e., 30-day supply or 90-day supply)* will dictate the Co-pay. Contact Caremark at (800) 237-2767 to obtain specialty prescriptions.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total individual and family Deductible.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident, and Incurred during that calendar year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products. Note, this does not apply to Specialty Injectables covered by the medical Plan.
- Expenses Incurred as a result of failure to comply with prior authorization requirements for Hospital confinement.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by The Conference. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Plan Participants.

ELIGIBILITY REQUIREMENTS

An eligible Plan Participant may be:

A) A clergy or layperson regularly employed 30 or more hours per week (1) who is on the Conference payroll or who is classified by The Conference's Personnel Policy as a Plan Participant or (2) who is employed by a related ministry. Related ministries are the Area Foundation, Area Office, District Office, Wesley Foundation, and ministries that have entered into a formal covenant relationship recognized by the Conference Trustees; or
B) A clergy under full-time or 3/4 Episcopal appointment to a local United Methodist church within the bounds of the Tennessee Conference; or
C) A clergy who is recognized by the Conference Board of Ordained Ministry as a full-time student and who is serving a 1/4 time Episcopal appointment to a local United Methodist church within the bounds of the Tennessee Conference (formerly, a student local pastor).

Plan participants are eligible to be enrolled along with their eligible Dependents.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. A Plan Participant may retain eligibility for coverage under this Plan if the Plan Participant is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by The Conference 's leave policy, provided that contributions continue to be paid on a timely basis. The Conference's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not The Conference agrees to such reclassification, shall change a person's eligibility for benefits.

An eligible Plan Participant who is covered under this Plan and who retires under The Conference's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Eligible early Retiree Plan Participants are all retired Clergy and retired Conference Staff under age 65 who:

- Have attained age 62 and have 10 years of service in the Tennessee Conference or;
- Have 35 years of full time service.

Eligible early Retired Plan Participants may continue their enrollment for all benefits available under the Plan until age 65, provided:

- They were enrolled at the time of retirement and;
- They make any required contributions to the Plan for the coverage.

Each spouse of a Retired Plan Participant will remain eligible for all benefits under the Plan until the spouse attains age 65, provided he or she was enrolled at the time of the Retired Plan Participant's retirement and he or she continued to be an eligible Dependent. Each other eligible Dependent of a Retired Plan Participant will be eligible for continued enrollment for all benefits under the Plan until the date the dependent ceases to be an eligible Dependent, provided the Dependent was enrolled at the time of the Retired Plan Participant's retirement, but subject to such provisions as may be required by law under General Provisions, entitled "Special Enrollment Periods.

Note: Eligible Plan Participants and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment. See the Special Enrollment section.

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as a Plan Participant under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by The Conference.

- All surviving spouses of deceased full-time Clergy, including Conference Staff and lay participants are eligible for continued enrollment for all benefits under the Plan until age 65, provided they were enrolled under the Plan at the time of the decedent's death. Other eligible Dependents of a decedent will be eligible for continued enrollment after the decedent's death as long as the Dependents remain eligible Dependents (except that the eligible Dependent will not have to meet the following 2 requirements; (1) live with the participant in a parent Child relationship, or (2) receive 51% of their support from the participant), provided they were enrolled in the Plan at the time of the decedent's death and subject to such provisions as may be required by law under "Special Enrollment Provision".

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents who meet the eligibility criteria listed below:

  - A natural biological Child;
  - A step Child;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) permanent or temporary Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A foster Child. A foster child is covered based on the following:

    - If medical expenses of the child are not covered by any other group coverage or by the agency through which the child was placed, and
    - If placement is for a minimum of 25 days per month and is expected to be for more than one year, and
    - If application is received by the Plan Administrator at least 30 days before the placement or the date the child began living with the Participant.

- A Dependent does not include the following:

    - Any other relative or individual unless explicitly covered by this Plan.
    - A Dependent Child if covered as a Dependent of more than one Plan Participant.

Note: A Plan Participant must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Plan Participant shall not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of a Plan Participant newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits the following category:

- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

    - The Dependent must not be able to hold a self-sustaining job due to the disability; and
    - Proof must be submitted as required (Notice of Award of Social Security Income is acceptable); and
    - The Plan Participant must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

Coverage for a disabled Plan Participant whose premiums were paid in full by The Conference's apportionment prior to their disability will continue up to 24 months. In addition, the disabled Plan Participant may elect Optional Continuation of Coverage for up to 18 additional months with participant premium payment. If the disabled Plan Participant had been enrolled with Dependent coverage prior to the disability, Dependent coverage may remain in effect during this time period.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent does not meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Plan Participant for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the Optional Continuation of Coverage Section in this document.

EFFECTIVE DATE OF PLAN PARTICIPANT'S COVERAGE

Your coverage will begin on the later of:

- If You apply within 31 days of hire, Your coverage will become effective Your date of hire; or
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 31 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, eligible Plan Participants and Retirees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Plan Participants and covered Retirees will be able to make a change in coverage for themselves and their eligible Dependents.

Coverage waiting periods are waived during the annual open enrollment period for covered Plan Participants, covered Retirees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be in the month of July. The Conference will give eligible Plan Participants written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person’s coverage; and
- The Effective Date of coverage shall be July 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Plan Participants.

Note: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of a new Dependent.

LOSS OF HEALTH COVERAGE

Current Plan Participants and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

- You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

    - Optional Continuation of Coverage and that coverage was exhausted; or
    - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
    - Terminated and no substitute coverage is offered; or
    - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
    - No longer receiving any monetary contribution toward the premium from the other employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents <u>may not</u> enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Plan Participants and their Dependents, Optional Continuation of Coverage Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

Retired Plan Participants who are Covered Persons have a special opportunity to enroll newly acquired Dependents for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Plan Participant, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 31 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Plan Participants and their Dependents may be eligible for a Special Enrollment period if the Plan Participant and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Plan Participant must request coverage under this Plan within 60 days after the date the Plan Participant and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage (Note: Eligible individuals must submit their enrollment forms prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the first calendar month following an approved request for coverage; or
- In the case of loss of coverage, the first day of the month following loss of coverage.

TERMINATION

For information about continuing coverage, refer to the Optional Continuation of Coverage section of this SPD.

PLAN PARTICIPANT'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by The Conference except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to 12 months, provided that the applicable Plan Participant contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- Surviving spouses of deceased full-time Clergy, including Conference Staff and lay participants are eligible to re-enroll in this Plan at any time provided they were originally enrolled under the Plan at the time of the descendant's death. Coverage will continue until age 65; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Plan Participant resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or

- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Enrollment Section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as a Plan Participant under this Plan; or

- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours or lay-off and You qualify for eligibility under this Plan again at a later date, You must meet all requirements of a new Plan Participant. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Office of Administrative Services.

OPTIONAL CONTINUATION OF COVERAGE

What is Optional Continuation of Coverage?

Optional Continuation of Coverage is group health plan coverage that is offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries"). The right to Optional Continuation of Coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Participants who have not experienced a Qualifying Event (in other words, similarly situated non-0ptional continuation of Coverage beneficiaries). If regular coverage ends, Plan Participants have the option to continue coverage as provided in this section. Please contact the Office of Administrative Services.

Who is a Qualified Beneficiary?

In general, a Qualified Beneficiary is an eligible Participant or eligible Dependent who was covered and loses coverage due to a Qualifying Event can elect Optional Continuation of Coverage.

What is a Qualifying Event?

A Qualifying Event is any event described in the Plan that would result in the Plan Participant or Dependent losing coverage (i.e. cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of Optional Continuation of Coverage:

- The death of a covered Participant.
- The divorce or legal separation of a covered Participant from the Participant's Spouse.
- A covered Participant's enrollment in the Medicare program.
- Participant or Dependent loss of eligibility.
- A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (e.g., attainment of the maximum age for dependency under the Plan).
- The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a Plan Participant does not return to employment at the end of the FMLA leave and all other Optional Continuation of Coverage conditions are present.
- If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Plan Participant and family members will be entitled to Optional Continuation of Coverage even if they failed to pay the Plan Participant portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last?

Qualified Beneficiaries must elect Optional Continuation of Coverage within a 60-day election period. The election period shall begin on the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and shall end on the later of:

- 60 days following the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event; or
- 60 days following the date notice is provided to the Qualified Beneficiary of her or his right to elect Optional Continuation of Coverage. If coverage is not elected within the 60-day election period, the Qualified Beneficiary's rights to elect Optional Continuation of Coverage are forfeited. For each Qualified Beneficiary who timely elects Optional Continuation of Coverage, Optional Continuation of Coverage will begin on the later of:
  - On the date of the Qualifying Event; or
  - On the date that Plan coverage would otherwise have been lost.

Is a covered Plan Participant or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

In general, the Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Participant or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- A Dependent Child's ceasing to be a Dependent Child under the generally applicable requirements of the Plan.
- The divorce or legal separation of the covered Plan Participant.
- The Participant is no longer employed, no longer under full-time Episcopal appointment to a church in the Tennessee Conference, or otherwise no longer eligible for coverage under the Plan.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect Optional Continuation of Coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

IMPORTANT: For the other Qualifying Events (divorce or legal separation of the Participant and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the Plan Administrator in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax, email or hand-deliver your notice to the department listed below, at the following address:

Tennessee Annual Conference
c/o Director of Administrative Services
304 S. Perimeter Park Dr., Suite 4
Nashville, Tennessee 37211
(615) 327-1169 (fax)
treasurer@tnumc.org

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- The **name of the plan (Tennessee Conference, United Methodist Church, Inc.)** under which you lost or are losing coverage,
- The **name and address of the Participant** covered under the plan,
- The **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- The **Qualifying Event** and the **date** it happened.
- If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension. Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, Optional Continuation of Coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect Optional Continuation of Coverage. Covered Participants may elect Optional Continuation of Coverage for their spouses, and parents may elect Optional Continuation of Coverage on behalf of their children. For each Qualified Beneficiary who elects Optional Continuation of Coverage, Optional Continuation of Coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives Optional Continuation of Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of Optional Continuation of Coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator, as applicable.

When may a Qualified Beneficiary's Optional Continuation of Coverage be terminated?

During the election period, a Qualified Beneficiary may waive Optional Continuation of Coverage. Except for an interruption of coverage in connection with a waiver, Optional Continuation of Coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- The last day of the applicable maximum coverage period.
- The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- The date upon which The Conference ceases to provide any group health plan (including successor plans) to any Plan Participant.
- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-Optional Continuation of Coverage beneficiaries, for example, for the submission of a fraudulent claim.
- In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make Optional Continuation of Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What is the maximum coverage period for Optional Continuation Of Coverage?

The maximum coverage period ends 18 months after the Qualifying Event.

What is the premium for Optional Continuation of Coverage?

Contact the Office of Administrative Services. The Plan requires monthly payments.

What is Timely Payment for payment for Optional Continuation of Coverage?

Payment is due on the first of the month and coverage terminates if payment is not received by the end of the month.

If You Have Questions.

If you have questions about your Optional Continuation of Coverage, you should contact the Office of Administrative Services.

Keep your Plan Administrator 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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

The Conference offers COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Plan Participants on leave for military service must be treated as if they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Plan Participants on leave of absence or furlough. If The Conference has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Plan Participants on military leave. Reinstatement following a military leave of absence cannot be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Plan Participant fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

A Plan Participant or an appropriate officer of the uniformed service in which his or her service is to be performed must notify The Conference that the Plan Participant intends to leave the employment position to perform service in the uniformed services. A Plan Participant should provide notice as far in advance as is reasonable under the circumstances. The Plan Participant is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Plan Participants will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the Optional Continuation of Coverage Section, to the extent these COBRA-like requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Plan Participant is not required to pay more than the amount he or she would have paid as an active Plan Participant. For periods of 31 days or longer, if a Plan Participant elects to continue health coverage pursuant to USERRA, such Plan Participant and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Plan Participants and their Dependents may be eligible for both Optional Continuation of Coverage and USERRA at the same time. Election of either the Optional Continuation of Coverage or USERRA extension by a Plan Participant on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Plan Participant will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for Optional Continuation of Coverage extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to www.umr.com, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  58 – UnitedHealthcare Options PPO Network

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

  ZM – Multiplan Shared Savings

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

- **The Program for Cornea Transplant Services at Designated Transplant Facilities is:**

  OptumHealth

- **The Program for All Other Transplant Services, excluding Cornea, at Designated Transplant Facilities is:**

  United HealthCare Insurance Company (UHIC)

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Covered Services provided by a radiologist, anesthesiologist, or pathologist when services are provided at a Network facility or referred by a Network provider, even if the provider is an Out-of-Network provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital
- The In-Network level of benefits may be applied when an Out-of–Network provider is used during a true Emergency, provided the Out-of-Network provider is the closest medically-appropriate provider and a transfer to an In-Network provider occurs as soon as medically appropriate**.**

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the PPO benefit level by the prior Claims Administrator but which are not considered at the PPO benefit level by the current Claims Administrator may be paid at the applicable PPO benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Plan Participant or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **Allergy Treatment** including: injections, testing and serum.

2. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically appropriate Hospital.

3. **Anesthetics and their Administration.**

4. **Breast Reductions** if Medically Necessary (i.e., not merely cosmetic).

5. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

6. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:

   - had a heart attack in the last 12 months; or
   - had coronary bypass surgery; or
   - a stable angina pectoris.

   Services covered include:

   - Phase I, while the Covered Person is an Inpatient.
   - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

7. **Cataract or Aphakia Surgery** as well as protective lenses following such procedure.

8. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

9. **Circumcision** and related expenses when care and treatment meet the definition of Medically Necessary. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

10. **Cleft Palate And Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

11. **Contraceptives:** This Plan provides benefits for Prescription contraceptives regardless of purpose. Prescription contraceptives that require a Physician to insert a device will be processed under the Covered Medical Benefits in this SPD.

12. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.

13. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 6 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

14. **Diabetic Counseling.**

15. **Diabetic Shoes And Inserts** (one pair per calendar year if Medically Necessary)**.**

16. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling.

17. **Dialysis**: Charges for dialysis for the treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

18. **Durable Medical Equipment:** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment is subject to review under the Care Management Provision of this SPD, if applicable.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
    - If the equipment is purchased, benefits will be payable for subsequent repairs excluding batteries, or replacement only if required:
      - due to the growth or development of a Dependent Child;
      - when necessary because of a change in the Covered Person’s physical condition; or
      - because of deterioration caused from normal wear and tear.

      The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

19. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

20. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. The Covered Person must obtain prior authorization for services in advance. (Refer to the Care Management section of this SPD). The following benefits are covered:

    - Room and board.

    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

21. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.
    - Covered charges do not include Palliative Foot Care.

22. **Genetic Counseling** based on Medical Necessity.

23. **Genetic Testing** when Medically Necessary.

24. **Hearing Services** include exams, tests, services and supplies including Preventive Care, or to diagnose and treat a medical condition.

25. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

26. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapist; nutrition counseling services provided by or under the supervision of a registered dietician.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

27. **Hospice Home Care Services.**

28. **Hospital Services (Includes Inpatient Services, Surgical Centers And Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

29. **Hospital Services (Outpatient).**

30. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person.

    Infertility Services does not include Genetic Testing. (See General Exclusions for details).

31. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

32. **Maternity Benefits** for Covered Persons include:

    - Prenatal and postnatal care.
    - Hospital or Birthing Center room and board.
    - Obstetrical fees for routine prenatal care.
    - Vaginal delivery or Cesarean section.
    - Medically Necessary diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwifes.

33. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

34. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage (%) of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

35. **Nursery And Newborn Expenses Including Circumcision** are covered for the following Children of the covered Plan Participant or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

36. **Occupational Therapy.** (See Therapy Services below)

37. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Excision of exostosis of jaws and hard palate.

38. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

39. **Oxygen And Its Administration.**

40. **Pharmacological Medical Case Management** (Medication management and lab charges).

41. **Physical Therapy.** (See Therapy Services below)

42. **Physician Services** for covered benefits.

43. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

44. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. Note: Paper (script) claims obtained at a retail pharmacy are covered under the prescription benefit, or through Caremark's mail order program.

45. **Preventive / Routine Care** as listed under the Schedule of Benefits.

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

    - Evidence-based items or services that have in affect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
    - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

46. **Private Duty Nursing Services** when care is required 24 hours a day.

47. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

    - Due to the growth or development of a Dependent Child; or
    - When necessary because of a change in the Covered Person's physical condition; or
    - Because of deterioration caused from normal wear and tear.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

48. **Radiation Therapy and Chemotherapy.**

49. **Radiology and Interpretation Charges.**

50. **Reconstructive Surgery** includes surgery to restore bodily function that has been impaired by a congenital Illness or anomaly, Accident, or from an infection or other disease of the involved part.

51. **Respiratory Therapy.** (See Therapy Services below)

52. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

53. **Sexual Function:** Diagnostic Services and Prescription drugs (unless covered under the Prescription Benefits section in this SPD) in connection with treatment for male or female impotence.

54. **Sleep Disorders** if Medically Necessary.

55. **Sleep Studies.**

56. **Speech Therapy.** (See Therapy Services below)

57. **Sterilizations (Voluntary).**

58. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of the SPD.)

59. **Supplemental Accident Expenses Benefit** as shown on the Schedule of Benefits.

60. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

61. **Temporomandibular Joint Disorder (TMJ) Services** includes diagnostic services. This does not cover orthodontic services.

62. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Speech therapy** by a Qualified speech therapist including therapy for stuttering due to a neurological disorder.

    The Plan allows coverage for occupational, physical, or speech therapy for Developmental Delays due to an Accident or Illness such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy.

63. **Transplant Services** (Refer to Transplant sections of this SPD).

64. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

65. **Wigs, Toupees, Hairpieces** for hair loss due to cancer treatment. Benefits are limited to $300 per lifetime.

66. **X-ray Services** for covered benefits.

MORBID OBESITY CARE

Surgical Treatment

Surgical treatment of Morbid Obesity will be covered provided the Plan Participant meets the definition of Morbid Obesity and the proposed surgery meets Medical Necessity for Coverage. The Plan Participant must contact UMR Care Management for complete criteria requirements. Only one bariatric surgical procedure will be allowed per Plan Participant.

Surgical treatment must be rendered as follows:
1. Surgical treatment must be rendered in a Centers of Excellence facility as defined by the American Society for Metabolic and Bariatric Surgery, and
2. Surgical treatment must be rendered by a United Options Network Provider.
3. Surgeons must be designated through a Centers of Excellence Program and must be participating United Options Network Providers.

Coverage will not include:
1. Services that are considered Experimental, Investigational or Unproven.
2. Services that are not FDA approved.
3. Implantable sleeve (Endo Bypass System) and laparoscopic greater curve plication.
4. Treatment outside of a Centers of Excellence.
5. Treatment rendered by a United Options Non-Participating Provider.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietician.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a therapist or a registered dietician.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS
(Applies to Cornea Transplants Only)

Refer to the Care Management section of this SPD for prior authorization requirements

This coverage provides a choice for transplant care. Use of a Designated Transplant Facility provides incentives to You and Your covered Dependents. This coverage does not require that a Designated Transplant Facility be used in order to receive benefits, but it is preferred. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition / Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition / Procurement and transplantation, if a Covered Person is the recipient.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a non-designated facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects or Injuries are not covered unless the donor is a Covered Person on the Plan.

Benefits are payable for the following transplants:

- Cornea.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or a donor if the recipient is also a Covered Person under this Plan)

If the Covered Person lives more than 50 miles from the transplant facility, the Plan will pay for the travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or

- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:

  - Airfare.
  - Tolls and parking fees.
  - Gas/Mileage.

- Lodging at or near the transplant facility including:

  - Apartment rental.
  - Hotel rental.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.

- Expenses for Organ and Tissue Acquisition / Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational or Unproven.

- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) compendium.

- Expenses related to, or for, the purchase of any organ.

TRANPLANT BENEFITS
(Applies to All Other Transplants)

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your employer with any questions related to this coverage.

This Plan provides benefits for human organ and tissue transplantation through the Managed Transplant Program underwritten by the United HealthCare Insurance Company, 185 Asylum St, Hartford, CT 06103. Benefits under this plan are fully explained in the United HealthCare Insurance Company (UHIC) Transplant Benefit Policy and Certificate of Coverage. Human organ or tissue transplant services for eligible Plan Participants are covered under this separate policy, according to its terms and conditions. Transplant claims will be paid by United HealthCare Insurance Company as described in the insurance policy.

Any charge that is covered in whole or in part under this Insurance Policy shall not be considered a covered benefit under this SPD. Any health care services received at any time that are not related to the transplant, as well as transplant-related health services received before or after the benefit period will be covered under the terms and conditions of this SPD.

Benefits offered for human organ and tissue transplants are subject to the following conditions:

- Eligibility - the Plan Participant and any dependent(s) are also subject to the eligibility terms under the Managed Transplant Program underwritten by the United HealthCare Insurance Company.

- Policy terms - the Plan Participant and any dependent(s) must meet all the terms and conditions stated in the UHIC Transplant Benefit Policy and Transplant Benefit Certificate of Coverage, and are also subject to the policy's limitations.

PRESCRIPTION BENEFITS

Administered by Caremark

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

Drugs and medicines prescribed by a licensed Physician and dispensed by a licensed pharmacist are covered by the Plan, except as otherwise provided by the Plan. Outpatient Prescription Drugs will be covered subject to the applicable Co-pay amounts and any limitations as stated in the Schedule of Benefits.

A Covered drug must be Medically Necessary and approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or Physician.

DEFINITIONS

Generic Drug means a Prescription Drug that 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.

Pharmacy means a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Preferred Brand means a list of carefully selected medications that can assist in maintaining quality care for patients while helping to reduce the cost of Prescription Drug benefits under the Plan.

Prescription Drug means any drug that under Federal Drug Administration (FDA) or state law requires a written Prescription by a Physician. Drugs that are available without a Prescription are considered non-legend drugs.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. Newly approved drugs may be subject to review by the Plan Sponsor before being covered or may be excluded altogether. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed.

For a specific up-to-date list of covered and/or excluded Prescription Drugs, contact Caremark.

The following are **excluded** through the Prescription Drug program (this list is **not** all-inclusive):

- Applicable exclusions listed under General Exclusions section of this SPD.
- Prescription products if a prior authorization was necessary but not received or denied.
- Prescription products that are available over-the-counter.
- Prescription products that do not have Food and Drug Administration (FDA) approval for the purpose for which prescribed.
- All illegal drugs or supplies, even if prescribed by a duly licensed individual.
- Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation claim, or any municipal, state or Federal program.

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.

This Plan does not coordinate Prescription benefits.

For any Prescription Drug questions, please contact Caremark at the following:

CAREMARK
9501 E SHEA BLVD
SCOTTSDALE AZ 85260
877-430-8624

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to get prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

MENTAL HEALTH BENEFITS

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, maximum fee schedule or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. (Coverage does not include services provided in a community-based residential facility or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and
- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and
- Must be provided by one of the following:
  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - A state licensed or certified Social Worker practicing within the scope of his or her license or certification.
  - Licensed Professional Counselor.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a Covered Benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

  - Sexual/gender identity disorders; or
  - "V" codes (including marriage counseling).

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, Usual and Customary amount or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders and chemical dependency. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program which is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance related disorders. (Coverage does not include services provided in a community-based residential facility or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and
- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and
- Must be provided by one of the following:
  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located, or a therapist with a Ph.D., or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or a counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance abuse and chemical dependency disorders.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - A certified addiction counselor.
  - A state licensed or certified social worker practicing within the scope of his or her license or certification.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

CARE MANAGEMENT

Utilization Management

Utilization Management is the process of evaluating whether services, supplies or treatment is Medically Necessary and appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. Prior Authorization is not required to certify Medical Necessity for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Care Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the Medical Necessity, effectiveness and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in a Hospital, Extended Care Facilities, or residential treatment facilities.
- Organ and tissue transplants for cornea.
- Home Health Care.

- Durable Medical Equipment over $1,500 or any Durable Medical Equipment rentals over $500/month.
- Prosthetics over $1,000.
- Inpatient stays in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- This Plan includes benefits for human organ and tissue transplantation, other cornea, which require Prior Authorization from United HealthCare Insurance Company (UHIC). These benefits are fully explained in the United HealthCare Insurance Company (UHIC) Certificate of Coverage.
- Surgical Treatment of Morbid Obesity.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of $500 will be applied per admission if a Covered Person receives services but does not obtain the required Prior Authorization for:

- Inpatient stays in a Hospital, Extended Care Facilities, or residential treatment facilities.
- Organ and tissue transplants for cornea.
- All Inpatient stays for Mental Health Disorders.
- Inpatient stays in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- This Plan includes benefits for human organ and tissue transplantation, other cornea, which require Prior Authorization from United HealthCare Insurance Company (UHIC). These benefits are fully explained in the United HealthCare Insurance Company (UHIC) Certificate of Coverage.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD.

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case to case management for review. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points including the following criteria: length of stay, level of care, readmission and utilization, as well as The Conference or self-referrals. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and determination will be issued within 30 calendar days of the receipt of request within Care Management, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Case Management

Case Management services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as The Conference or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine/Nurse Chat

NurseLine service is a health information line that is available 24 hours per day, seven days a week that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

Nurse Chat is an online source of health and wellness information that is available 24 hours per day, 7 days per week. Covered Persons have one-on-one secure, real-time access to registered nurses through the Health Center on umr.com. These nurses provide information on a variety of health and wellness topics. Note: Triage is not part of the Nurse Chat experience. If a Covered Person needs triage assistance, Nurse Chat refers the Covered Person to NurseLine.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- Where an individual is covered under one plan as a Dependent and another plan as a Plan Participant, member or subscriber, the plan that covers the person as a Plan Participant, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Plan Participant plan beneficiary to be eligible for primary benefits from The Conference's benefit plan.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that Optional Continuation of Coverage or state continuation coverage should always pay secondary when the person who elected Optional Continuation of Coverage is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Plan Participant: If an individual is covered under one plan as an active Plan Participant (or Dependent of an active Plan Participant), and is also covered under another plan as a retired or laid off Plan Participant (or Dependent of a retired or laid off Plan Participant), the plan that covers the person as an active Plan Participant (or Dependent of an active Plan Participant) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation coverage under Optional Continuation of Coverage or state law: If a person has elected continuation of coverage under Optional Continuation of Coverage or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as a Plan Participant, member, subscriber or retiree longer is primary.

- If an active Plan Participant is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Plan Participant, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
    - You continue to be actively employed by The Conference and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
    - You continue to be actively employed by The Conference, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
    - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include Optional Continuation of Coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
    - You are no longer actively employed by The Conference; and
    - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have Optional Continuation of Coverage through the Plan; or
    - You or a covered family member has Medicare coverage based on a disability, plus You also have Optional Continuation of Coverage through the Plan. Medicare normally pays first, however an exception is that Optional Continuation of Coverage may pay first for Covered Persons with ESRD until the end of the 30-month period; or
    - You or Your covered spouse have retiree coverage plus Medicare coverage; or
    - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

In all instances where an eligible Plan Participant is also a TRICARE beneficiary, TRICARE will pay secondary to The Conference provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid Covered Expenses on Your behalf for an Illness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the Covered Expenses that the Plan has paid that are related to the Illness or Injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any covered benefit you received for that Illness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused Covered Expenses to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate Your covered benefits, deny future covered benefits, take legal action against You, and/or set off from any future covered benefits the value of covered benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common-Fund Doctrine" or "Attorney's Fund Doctrine" will defeat this right. You are responsible for all attorneys' fees after the Plan has been reimbursed to the fullest extent from the overall settlement or judgment funds.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You will hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon our request, You will assign to us all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party and filing suit in Your name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If a third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered Covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in the Covered Medical Benefits section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

2. **Acupuncture Treatment.**

3. **Alternative / Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

4. **Appointments Missed:** An appointment the Covered Person did not attend.

5. **Aquatic Therapy.**

6. **Assistance With Activities of Daily Living.**

7. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.

8. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

9. **Bereavement Counseling.**

10. **Biofeedback Services**.

11. **Blood:** Blood donor expenses.

12. **Blood Pressure Cuffs / Monitors.**

13. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

14. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

15. **Claims** received later than 12 months from the date of service.

16. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

17. **Counseling Services** in connection with financial or marriage counseling.

18. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

19. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

20. **Custodial Care** as defined in the Glossary of Terms of this SPD.

21. **Dental Services:**

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

22. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

23. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

24. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

25. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.

26. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

27. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment.

28. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

29. **Family Planning:** Consultation for family planning.

30. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

31. **Foot Care (Podiatry):** Routine foot care.

32. **Genetic Counseling** other than based on Medical Necessity unless covered elsewhere in this SPD.

33. **Genetic Testing** unless covered elsewhere in this SPD.

34. **Hearing Services:**

    - Purchase or fitting of hearing aids unless covered elsewhere in this SPD.
    - Implantable hearing devices unless covered elsewhere in this SPD.

35. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

36. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

37. **Infertility Treatment:**

    - Fertility tests.
    - Surgical reversal of a sterilized state which was a result of a previous surgery.
    - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
    - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
    - Embryo transfer.
    - Freezing or storage of embryo, eggs, or semen.
    - Genetic testing.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.

38. **Lamaze Classes** or other child birth classes.

39. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

40. **Liposuction** regardless of purpose.

41. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

42. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

43. **Massage Therapy.**

44. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

45. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

46. **Nocturnal Enuresis Alarm** (Bed wetting).

47. **Non-Custom-Molded Shoe Inserts.**

48. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

49. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

50. **Nursery and Newborn Expenses** for grandchildren of a covered Plan Participant or spouse.

51. **Nutrition Counseling** unless covered elsewhere in this SPD.

52. **Nutritional Supplements, Vitamins and Electrolytes**.

53. **Orthognathic, Prognathic and Maxillofacial Surgery.**

54. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.

55. **Panniculectomy / Abdominoplasty** unless determined by the Plan to be Medically Necessary.

56. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

57. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.

58. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

59. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

60. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

61. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

62. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

63. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.

64. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

65. **Services** that should legally be provided by a school.

66. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

67. **Sex Therapy.**

68. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

69. **Sexual Function:** Non-surgical and surgical procedures in connection with treatment for male or female impotence.

70. **Standby Surgeon Charges.**

71. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

72. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

73. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.

74. **Telemedicine - Telephone or Internet Consultations:** Consultations made by a Covered Person's treating Physician to another Physician.

75. **Temporomandibular Joint Disorder (TMJ) Services:**

    - Surgical treatment.
    - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

    This does not cover orthodontic services.

76. **Tobacco Addiction:** Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine unless covered elsewhere in this SPD.

77. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

78. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

79. **Vision Care** unless covered elsewhere in this SPD.

80. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

81. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

82. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

83. **Weight Control:** Treatment, services or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness, unless covered elsewhere in this SPD.

84. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

90. **Worker's Compensation,** for or in connection with charges caused by an occupational Injury or Illness (unless resulting from employment not subject to Workers' Compensation insurance requirements), except for Clergy who are Plan Participants of a small church with fewer than five Plan Participants and are not covered by Workers' Compensation T.C.A. §50-6-106(5); expenses for a Covered Participant for an accidental Injury or illness arising out of or in the course of any employment for wage or profit or which is covered by Workers' Compensation or Occupational Disease Policy, or any expenses payable under compromise settlement agreements arising from a Worker's Compensation claim.

90. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the Care Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Plan Participant
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual And Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile, see surgery and assistant surgeon under the covered benefits for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Plan Participant, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Plan Participant or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person’s behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal seven days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.

- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following addresses:

Send Post-Service Claim Medical appeals to
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Send Pharmacy appeals to:
PLAN ADMINISTRATOR
TENNESSEE CONFERENCE, UNITED METHODIST CHURCH, INC.
304 S PERIMETER PARK DR STE 4
NASHVILLE TN 37211
FAX 615-327-1169

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that you receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If a Plan Participant is on a family or medical leave of absence that meets the eligibility requirements under FMLA, The Conference will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Plan Participant has written approved leave from The Conference.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

A Plan Participant may choose not to retain group health coverage during an FMLA leave. When the Plan Participant returns to work following the FMLA leave, the Plan Participant's coverage will usually be restored to the level the Plan Participant would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

Most participants in the Tennessee Conference Health Plan are not covered by FMLA. If this affects You, please contact the Plan Sponsor concerning Your FMLA eligibility.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 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 48 hours (or 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 48 hours (or 96 hours).

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Pediatric Vaccines regulation, whereby The Conference will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Plan Participant benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Plan Participants, classes of Plan Participants or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Treasurer/Director of Administrative Services, Assistant Benefits Officer, Assistant to Treasurer, Broker/Consultant

This list includes every Plan Participant, class of Plan Participants or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Plan Participants or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Plan Participants or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means The Conference.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Conference as Plan Sponsor fully intends to maintain this Plan indefinitely; however, The Conference, acting through its elected Plan Administrator and Health Plan Committee, reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by Optional Continuation of Coverage beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of The Conference.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and The Conference.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or for treating condition of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Clergy - As defined by The Book of Discipline of the United Methodist Church. Persons who are not Clergy are referred to in this Plan as “Lay Persons.”

Child (Children) means any of the following individuals with respect to a Plan Participant: a natural biological Child; a step Child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Plan Participant's or Spouse’s permanent or temporary Legal Guardianship; a foster Child; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

Conference Staff - Includes all permanent, full time common law Employees of the Tennessee Conference. For purposes of this Plan only, permanent, full time Employees of the Wesley Foundations, Beersheba Assembly, Cedar Crest Camp, the Nashville Area Foundation, and the Nashville Area Episcopal Office may also be enrolled and included in this Plan as Conference Staff.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, which is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means a Plan Participant, Retiree or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Disabled Participant:

- Participants who are designated disabled by the General Board of Pension and Health Benefits; or
- Participants who are not covered by a GBOPHB disability benefit, and who are unable to perform the reasonable and customary duties of their own occupation.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the Enrollment Date is the first day coverage begins.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use 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, if applicable.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology3 or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: Basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship/Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury, disease or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Morbid Obesity means:
1. A Body Mass Index (BMI) that is greater than or equal to 40, or
2. There are serious (life-threatening) medical condition(s) exacerbated by, or caused by obesity not controlled despite maximum medical therapy and patient compliance with medical treatment plan, a BMI greater than or equal to 35.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefits means any medical benefit that is not an Essential Health Benefit. Please refer to the Essential Health Benefits definition.

Optional Continuation Of Coverage, see pages 22 - 23.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means TENNESSEE CONFERENCE HEALTH PLAN.

Plan Participant – see Eligibility and Enrollment section of this SPD.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means The Conference who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug, that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventative / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered or certified by the state in which the provider practices.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Retired Plan Participant (Retiree), see Eligibility Requirements, pages 13 - 14.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Urgent Care is the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have an Injury or Illness that requires immediate care but is not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

You, Your means the Plan Participant.

Attachment A

Additional Benefits as of January 1, 2010

This Attachment is not considered a part of the Plan and may be amended by the Conference at any time for any reason.

The following benefits and enrollment information are further described in other summaries or booklets which are available from the Office of Administrative Services upon request. Most are also available on the Conference's website, www.tnumc.org under the "Administration and Finance" tab.

Dental Benefits administered through Assurant Employee Benefits, available to most Health Plan participants and dependents:

- Voluntary Dental PPO –
  - This dental plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. Benefits are paid after any applicable deductible has been met, up to the annual maximum. You may find a DHA provider by visiting the Assurant Employee Benefits web site at *www.assurantemployeebenefits.com* – Select "For Members" – "Find a dentist" – "DHA (Dental Health Alliance)" or call customer service at 800.442.7742.

- Prepaid Dental Plan –
  - This prepaid dental plan offers benefits through a network of Plan Dentists. When you enroll for benefits, treatments you receive from your selected Plan Dentist will be provided at reduced fees called copayments. You can find a dental provider in the Heritage Series Provider Network by visiting the Assurant Employee Benefits web site at *www.assurantemployeebenefits.com* – Select "For Members" – "Find a dentist" – "Heritage Series". Or call customer service at 800.443.2995. Availability of Plan Dentist and Plan Specialist varies depending on location.

Disability and Death Benefits:

- **Eligible Clergy:** The Comprehensive Protection Plan (CPP) provides death, long-term disability and other survivor benefits for **Clergy** and their family. The plan is administered by the General Board of Pension and Health Benefits of The United Methodist Church.
  - Most clergy eligible for coverage under this Health Plan are also eligible for CPP. Generally, you are eligible to participate in CPP if your conference or salary-paying unit sponsors the plan and you satisfy the eligibility requirements which include full-time Episcopal appointment and plan compensation equal to or greater than 60% of the Denominational Average Compensation or the Conference Average Compensation, whichever is less. There may be special arrangements for other individuals. Other eligibility rules may apply.

    Plan Features:

    - Benefits are payable upon the death of an active or retired participant, his or her spouse or surviving spouse, and his or her children under age 19.
    - Supplemental benefits for surviving spouses may be available upon the death of an active participant.
    - Educational benefits for surviving children may be available upon the death of an active or retired participant.

- Comprehensive disability benefits include:

  - Monthly benefit payments
  - Annual increases
  - Continued retirement contributions
  - Rehabilitation and vocational services
  - Assistance with application for Social Security disability benefits

  For additional information, please review the CPP summary plan which may be found by visiting the General Board of Pension and Health Benefits web site at *www.gbophb.org* – Select – "Health and Welfare" – "Comprehensive Protection Plan (CPP)" – "CPP Summary Plan Description".

- **Lay Persons** who are full-time permanent employees of the Tennessee Conference may be eligible for disability and death benefits similar to those offered to Clergy through CPP. Check with the Office of Administrative Services for more information about these benefits for Lay Employees of the Tennessee Conference. Other lay persons who are not Conference employees should check with their church employer or other salary paying unit.