Health Benefits

Summary Plan Description

Nashville Electric Service

Effective Date: January 1, 2023

Administered by:

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INTRODUCTION

This document describes the Nashville Electric Service Health Plan (the "Plan" or the "Health Plan") effective January 1, 2023.

This document serves as both the written Plan document and the Summary Plan Description. It is very important to review this document carefully to confirm a complete understanding of the benefits available under the Plan.

Capitalized terms used in this Summary Plan Description that are not otherwise defined in specific provisions shall have the meanings set forth in Part XV.

This Plan is "self-insured" which means benefits are paid from Nashville Electric Service's general assets and are not guaranteed by an insurance company.

SCHEDULE OF BENEFITS

MEDICAL COVERAGE SCHEDULE OF BENEFITS				
GENERAL INFORMATION				
PLAN CATEGORY	**IN-NETWORK**		**OUT-OF-NETWORK**	
	PPO Medical Plan	**HRA Medical Plan**	**PPO Medical Plan**	**HRA Medical Plan**
Coinsurance	Plan will pay 85% of Provider's Reasonable Charge, except as specified in the Schedule of Benefits	Plan will pay 80% of Provider's Reasonable Charge, except as specified in the Schedule of Benefits	Plan will pay 65% of Provider's Reasonable Charge, except as specified in the Schedule of Benefits	Plan will pay 65% of Provider's Reasonable Charge, except as specified in the Schedule of Benefits
Health Reimbursement Account (HRA)	$0	Individual $400 Individual Plus One $800 Family $1,200	$0	Individual $400 Individual Plus One $800 Family $1,200
Wellness Incentive Reward for HRA	$0	Individual $200 Individual Plus One $300 Family $500	Not applicable	Not applicable
Deductible	Individual $250 Individual Plus One $500 Family $800	Individual $1,750 Individual Plus One $2,600 Family $3,500	Individual $230 Individual Plus One $460 Family $650	Individual $1,750 Individual Plus One $2,600 Family $3,500
	The Individual Deductible applies toward the Family Deductible. Eligible Expenses that apply to the In-Network Deductible are used to satisfy the Out-of-Network Deductible, and vice versa.			
Out-of-Pocket Limit (Includes only the Coinsurance Expense)	**PPO Medical Plan**	**HRA Medical Plan**	**PPO Medical Plan**	**HRA Medical Plan**
	Individual $2,000 Family $4,000	Individual $3,000 Individual Plus One $5,000 Family $6,000	Not applicable	Not applicable
	Under the Family Out-of-Pocket Limit, the Coinsurance in-network expenses for all family members combined will be used to satisfy the Family Out-of-Pocket Limit.			
Annual and Lifetime Maximum Benefit Essential Health Benefits			No Maximum Benefit	
Annual Maximum Benefit for Non-Essential Health Benefits			$2,000,000 Annual Maximum Benefit applies to covered services that constitute Non-Essential Health Benefits	
Lifetime Maximum Benefit Non-Essential Health Benefits			$2,000,000 Lifetime Maximum Benefit applies to covered services that constitute Non-Essential Health Benefits	

ESSENTIAL AND NON-ESSENTIAL HEALTH BENEFITS

Essential health benefits

Ambulatory Patient Services	Allergy Testing and Treatment
Emergency and Urgent Care Services	Ambulance
Hospitalization	Cardiac Rehabilitation
Chiropractic Care	Cochlear Implant
Laboratory Testing and Professional Services Including Clinical Trials Related to Phases I – IV and a Cancer Diagnosis	Diabetic Supplies/Insulin Pumps/Education and Nutrition Counseling
Radiology Services and Diagnostics Including X-ray, CT, PET, MRI, Nuclear Medicine	Hearing Aids (under age 18)
Maternity and Postnatal Newborn Care	Orthopedic Surgery
Mental Health Inpatient and Outpatient Services, Including Substance Use and Abuse Disorders and Behavioral Health	Home Health Care
Pediatric Services, Including Oral and Vision Care	Outpatient Facility – Surgery, Scopes
Prescription Drugs Including Self-Injectable and Specialty Medication	Outpatient Facility – Therapeutic (Dialysis, Chemo and Other Infusion Therapy, Radiation)
Preventive Care Including Immunizations, Screening, Wellness Services and Chronic Disease Management	Pregnancy and Prenatal Care, Well Baby Visits and Routine Care
Physician's Office – Sickness/Injury	Reconstructive Breast Surgery Following Mastectomy
Rehabilitative and Habilitation Services and Devices	Routine Eye Exam for Children
Skilled Nursing/Inpatient Rehabilitation	Temporomandibular Joint (TMJ) Disorder Outpatient Treatment
Tobacco Use Cessation	Transplant Services
The Following Durable Medical Equipment:	
Ambulation: Canes, Crutches, Walkers & Standard Wheelchairs	Respiratory: Apnea Monitors, Breathing Devices, Including Flowmeters, Tracheostomy Supplies, CPAP, BiPAP, Ventilators, Nebulizers, Oxygen and Related Equipment
Kidney: Dialysis Machines & Equipment	Hearing – Speech Language: Voice Prosthetics
Cardiology: Wearable External Defibrillator, Pacemaker Monitors	Diabetes and Self-Management: Glucose Monitoring Equipment
Muscle Skeletal: Orthotics for Scoliosis Procedures, Orthotic Devices for Diabetic Conditions	Pumps: External Ambulatory Infusion Pumps and Supplies, Enteral Feeding Tubing and Supplies
Prosthetic Devices: Replaces all or part of a missing body part, such as: Breast prosthetics and lymphedema sleeves, standard lower & upper limb prostheses, including external power prosthesis for hand and wrist, voice amplifier	

Subject to further regulatory guidance, the following have been determined to be Non-Essential Health Benefits. The Plan will enforce any existing annual or lifetime dollar limit on these benefits where coverage exists:

Non-Essential Health Benefits

Bariatric Treatment/Obesity Surgery	Dental Services (Except Pediatric)
Educational Services Except Diabetic Patient Education	Orthotic Braces
Ostomy Supplies	Podiatry and Routine Foot Care
Sleep Disorders	Transportation & Lodging
Vision Exams (except pediatric)	Wigs
The Following Durable Medical Equipment:	
Respiratory: IPPB Machine	Circulatory: Semi-electric Beds
Bowel & Bladder: Electronic Bowel Irrigation Devices; Incontinence Treatment Systems, Enuresis Alarms	Orthopedic: Gait Trainers, Heating & Cooling Devices, Lifts, Splints, Traction & Trapeze Items, Electronic Bone Growth Stimulators
Wound Management: Decubitus Care Mattresses, Trusses	Pain Management: Trans-electrical Nerve Stimulators (TENS units), Disposable Drug Delivery Systems
Erectile Treatment: Vacuum Erection Devices	Home Testing: Blood Pressure Cuffs, Home Coagulation Testing Kits
Prosthetics: that are either cosmetic or are an enhancement of a basic prosthesis – Eye, Nose, Ear, and Facial prostheses, custom protectors or external coverings for limb prostheses, microprocessors for limb prostheses, ultralight or non-standard material for limb prostheses, wigs	Hospital Beds & Certain Wheelchair Accessories

The following list reflects the Plan's good faith efforts to determine Essential Health Benefits. This is not necessarily a list of covered benefits and the participant should refer to other sections of this Summary Plan Description for covered benefits. This may not be a comprehensive and complete list and is subject to change based on additions and deletions from regulatory agencies.

The following detailed list of benefits will not include an annual or lifetime dollar limit.

Category of Service	Benefit Description		Category of Service	Benefit Description
Ambulatory Services	Freestanding Urgent Care Center – Facility and Physician		**Rehabilitative Care**	Pulmonary Rehabilitation - Facility
	Preoperative Examinations – Physician			Occupational Therapy – Outpatient or Office
	Preadmission Testing			Speech Therapy – Outpatient or Office
	Anesthesia - Outpatient and Office			Cardiac Rehabilitation – Facility
	Surgery Office – Physician			Physical Therapy – Outpatient or Office
	Surgery - Outpatient, Ambulatory or Surgical			Home Care Including Infusion Therapy

	Center – Facility and Physician			
	Chemotherapy – Facility and Physician			Certain Durable Medical Equipment (DME)
	Radiation Therapy – Facility and Physician			External Prosthesis and Orthotics
	Dialysis – Facility and Physician			Foot Orthotics for Diabetics
	Physician Office Visits (non-surgical)			Diabetes: DME
	Physician Supervised Testing			Medical Supplies
	Physical Therapy – Facility and Physician			Mastectomy Prosthesis
	Occupational Therapy – Facility and Physician			Skilled Nursing Facility
	Radiology and Imaging – Facility and Physician		**Habilitation Services**	Pulmonary Rehabilitation – Facility
	Laboratory and Pathology – Facility and Physician			Occupational Therapy – Outpatient or Office
	Injectable and IV Drugs			Speech Therapy – Outpatient or Office
Emergency Services	ER – Facility and Physician			Cardiac Rehabilitation – Facility
	Ambulance Service – Ground and Air			Physical Therapy – Outpatient or Office
Hospitalization	Inpatient Services			Home Care Including Infusion Therapy
	Acute Medical/Surgical Admission – Facility			Durable Medical Equipment (DME)
	Hospital Physician Visits Including Hospitalist			External Prosthesis and Orthotics
	Inpatient Consultation – Physician			Foot Orthotics for Diabetics
	Inpatient Surgery and Anesthesia			Diabetes: DME
	Inpatient Physical Rehab – Facility			Medical Supplies
	Inpatient Ancillary Services, e.g. Labs, X-rays			Mastectomy Prosthesis
	Blood Products			Skilled Nursing Facility
	Mastectomy Care		**Laboratory Services**	Preventive/Diagnostic Laboratory – Facility and Physician
	Internal Prosthetics		**Prescription Drugs**	Prescription Drugs Including Self-Injectable
	Observation Stay			Diabetes: Insulin, Supplies

Maternity and Newborn Care	Maternity – Facility		**Preventive Care**	Refer to Routine/Well Care section for Adults and Dependent Children
	Maternity – Inpatient Physician/Midwife		**Pediatric Services (including oral care)**	Well Child Visits – Physician
	Delivery Anesthesia			Child Immunizations
	Prenatal and Postpartum Care			Diagnostic Eye Exam
	Complications of Pregnancy and Termination		**Chronic Disease Management**	Diabetes: Education
	Newborn Nursery – Facility			Office Visits and Consultations
	Newborn Care – Physician			Consultations Office/Outpatient
Behavioral Health Treatment – Mental Health Services	Inpatient – Facility and Physician			Medical Benefit Management Programs and Services
	Outpatient – Facility			Diagnostic Eye Exam
	Outpatient and Office – Physician			
	Partial Hospitalization			

COVERED SERVICES				
This listing of Covered Services appears in alphabetical order to better assist the Participant in locating the different benefit allowances for the specific Covered Services. Refer to the Medical Benefits section for a detailed description of the actual covered expenses. Some benefits may be limited and reference should be made in Part I – Medical Benefits. Benefits under the Plan are only payable for expenses which are Eligible Expenses. If you retired from NES on or before January 1, 2017, you will pay 0% coinsurance for accidental injury and out-patient surgery. All payments will be based on the Provider's Reasonable Charge.				
COVERED SERVICE/PLAN CATEGORY	**IN-NETWORK**		**OUT-OF-NETWORK**	
Allergy Testing, Treatment & Serum	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Ambulance Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit
Anesthesia Services	Inpatient: After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	Inpatient: After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	Inpatient: After the Deductible, PPO Plan pays 85% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%	Inpatient: After the Deductible, HRA Plan pays 80% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%
	Outpatient: PPO Plan pays 85%	Outpatient: HRA Plan pays 85%	Outpatient: PPO Plan and HRA Plan pays 65% for Out-of-Network Professional charges incurred during a visit to an In-Network facility	
Bariatric Treatment	After the Deductible, PPO Plan and HRA Plan pays 50% Out-of-pocket limits do not apply		After the Deductible, PPO Plan and HRA Plan pays 50% Out-of-pocket limits do not apply	
Birthing Center Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Cardiac Rehabilitation Therapy - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
Chemotherapy - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Chiropractic Services - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit
	Note: Subject to a Maximum Benefit of 40 visits per calendar year.			
Clinical Trial Refer to the Covered Services section for details	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Diagnostic Tests - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan pays 85% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%	After the Deductible, HRA Plan pays 80% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%
	Note: When the Participant uses the Preferred Lab Network, the Plan pays 100%. Refer to the benefit description Diagnostic Tests – Outpatient for more details on this benefit.			
Durable Medical Equipment	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
Emergency Care in Emergency Department of Hospital for Medical Condition	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit
			For Out-of-Network Professional charges incurred during a visit to an In-Network Hospital emergency department, PPO Plan pays 85% subject to the Out-of-Pocket Limit after the Deductible	For Out-of-Network Professional charges incurred during a visit to an In-Network Hospital emergency department, HRA Plan pays 80% subject to the Out-of-Pocket Limit after the
Emergency Care in Emergency Department of Hospital for Accidental Injury	PPO Plan pays 85% of all Eligible Expenses (not to exceed Provider's Reasonable and Customary Charges) incurred following the accident provided the initial treatment and medical services are received within 72 hours of the accident	HRA Plan pays 85% of all Eligible Expenses (not to exceed Provider's Reasonable and Customary Charges) incurred following the accident provided the initial treatment and medical services are received within 72 hours of the accident	PPO Plan and HRA Plan pays 35% of all Eligible Expenses (not to exceed Provider's Reasonable and Customary Charges) incurred following the accident provided the initial treatment and medical services are received within 72 hours of the accident.	
Erectile Dysfunction Treatment	After the Deductible, for Diabetic Participants, PPO Plan pays 85%; for Non-Diabetic Participants, Plan pays 50% and Out-of-Pocket Limits do not apply	After the Deductible, for Diabetic Participants, HRA Plan pays 80%; for Non-Diabetic Participants, Plan pays 50% and Out-of-Pocket Limits do not apply	After the Deductible, for Diabetic Participants, Plan pays 65%; for Non-Diabetic Participants, Plan pays 50% and Out-of-Pocket Limits do not apply	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
Hearing Aids and Tests for Hearing Aids	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
	Hearing aids are covered for a dependent child under age 18 prescribed by a licensed audiologist or physician. Coverage is limited to 1 hearing aid per ear every third plan year and includes the hearing aid, dispensing fee, molds and impressions. Replacements are not covered if lost. **No coverage is provided for tests for hearing aids.**			
Home Health Care Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Hospital Room and Board During Inpatient Confinement Note: Friday and Saturday admissions will not be covered except in cases of an emergency or accidental injury or where surgery is performed the following day.	Room and Board Services: PPO Plan pays 100% after Deductible	Room and Board Services: HRA Plan pays 100% after Deductible	Room and Board Services: PPO Plan pays 100% after Deductible	Room and Board Services: HRA Plan pays 100% after Deductible
	Note: For semi-private room, payment is based on semi-private room rate. For private room rate, payment is based on semi-private room rate plus 50% of the difference between the private room and semi-private room rate.			
	Ancillary Services: After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	Ancillary Services: After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	Ancillary Services: After the Deductible, PPO Plan and HRA Plan pays 65%	
Inhalation Therapy - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Kidney Dialysis - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Maternity Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
Hospital Medical Services During Inpatient Confinement	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Medical and Surgical Supplies	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%* *Wigs will be covered at 85%	
Office Visits for Non-Routine Care	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Occupational Therapy	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Organ Transplants	Refer to Transplant Services benefit for Organ Transplant benefit			
Pathology	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan pays 85% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%	After the Deductible, HRA Plan pays 80% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%
Patient Education Programs for Diabetes Management	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Physical Therapy Services - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
Physician Medical Services During an Inpatient Hospital Confinement	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan pays 85% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%	After the Deductible, HRA Plan pays 80% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%
Podiatry Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Private Duty Nursing Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Prosthetic Appliances	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Psychiatric Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Radiation Therapy - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
Radiology	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan pays 85% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%	After the Deductible, HRA Plan pays 80% for Out-of-Network Professional charges incurred during a visit to an In-Network facility, otherwise 65%
Reconstructive & Cosmetic Surgery	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Routine Nursery Care of Well Newborn	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Routine/Well Care For Adult	PPO Plan pays 100%	HRA Plan pays 100%	PPO Plan and HRA Plan pays $0	
Routine/Well Care For Dependent Child (to Age 18)	PPO Plan pays 100%	HRA Plan pays 100%	PPO Plan and HRA Plan pays $0	
Second & Third Surgical Opinion	PPO Plan pays 100%	HRA Plan pays 100%	PPO Plan pays 100%	HRA Plan pays 100%
Skilled Nursing Facility Services	Room and Board Services: PPO Plan pays 100% after Deductible	Room and Board Services: HRA Plan pays 100% after Deductible	Room and Board Services: PPO Plan pays 100% after Deductible	Room and Board Services: HRA Plan pays 100% after Deductible
	Note: For semi-private room, payment is based on semi-private room rate. For private room rate, payment is based on semi-private room rate plus 50% of the difference between the private room and semi-private room rate.			
	Ancillary Services: After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	Ancillary Services: After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	Ancillary Services: After the Deductible, PPO Plan and HRA Plan pays 65%	

COVERED SERVICE/PLAN CATEGORY	IN-NETWORK		OUT-OF-NETWORK	
Sleep Disorders	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Speech Therapy – Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
Male Sterilization Procedures	Inpatient: After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	Inpatient: After the Deductible, PPO Plan and HRA Plan pays 65%	
	Outpatient: PPO Plan pays 85%	Outpatient: HRA Plan pays 85%	Outpatient: PPO Plan pays 65%	Outpatient: HRA Plan pays 65%
Surgical Services	Inpatient Surgical Services: After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	Inpatient Surgical Services: After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	Inpatient Surgical Services: After the Deductible, PPO Plan and HRA Plan pays 65%	
	Outpatient Surgical Services: PPO Plan pays 85%	Outpatient Surgical Services: HRA Plan pays 85%	Outpatient Surgical Services: PPO Plan and HRA Plan pays 65%	
Telehealth	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%	
TMJ Treatment - Outpatient	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit. Outpatient TMJ Surgical Services: Plan pays 85%	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit. Outpatient TMJ Surgical Services: Plan pays 85%	After the Deductible, PPO Plan pays 65% Outpatient TMJ Surgical Services: PPO Plan pays 65%	After the Deductible, HRA Plan pays 65% Outpatient TMJ Surgical Services: HRA Plan pays 65%

Tobacco Cessation	Refer to Part III Prescription Drug Benefits		
COVERED SERVICE/PLAN CATEGORY	**IN-NETWORK**		**OUT-OF-NETWORK**
Transplant Services	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%
Urgent Care Services in Urgent Care Facility	After the Deductible, PPO Plan pays 85% subject to the Out-of-Pocket Limit	After the Deductible, HRA Plan pays 80% subject to the Out-of-Pocket Limit	After the Deductible, PPO Plan and HRA Plan pays 65%

PART I. MEDICAL BENEFITS

This Part describes the Participant's Medical Benefits. The Plan will cover the Medical Benefits when services:

1. Are authorized by a Physician; and

2. Are rendered and billed by a Provider; and

3. Qualify as a Covered Services; and

4. Are Medically Necessary.

For Medical Benefits, payment of the Provider's Reasonable Charge, or the actual charge, whichever is less, will be provided for all Covered Services. With respect to the Preferred Providers, the Provider's Reasonable Charge will be based on the Negotiated Rate set forth in the PPO contract. For a Non-Preferred Providers, the Provider's Reasonable Charge will be the UCR Charge.

All payments will be subject to any applicable Copayments, Deductible, Coinsurance, maximum benefits and other provisions and limitations in this Summary Plan Description and the Schedule of Benefits. All benefit payments will be made based on the procedure code assigned by the Provider for the specific procedure or service rendered and billed by that Provider.

PRE-CERTIFICATION PROVISIONS AND CASE MANAGEMENT

The Plan requires that the Participant obtain Pre-Certification in advance of receiving certain services, as set forth in this section. In addition, the Plan has a separate requirement that requires that the Participant provide notification following a Hospital Admission when such admission is not scheduled and occurs through the Emergency Room or Department of a Hospital. These requirements are described in detail in this section of the Summary Plan Description.

The purpose of these Pre-Certification and notification requirements is to assist the Plan in determining the Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (e.g., appropriate length of stay or the appropriate number of visits or treatments). Compliance with the pre-certification and notification requirements is not a guarantee of benefit payment.

Under the Plan, a Medical Management Company will conduct and manage the Pre-Certification and Emergency Admission Notification process. This means that the Participant should contact the Medical Management Company at the telephone number appearing on the Identification Card to facilitate this process. In each instance, the Participant may satisfy this requirement by having the Hospital, Admitting Physician or a family member contact the Medical Management Company to provide the required Pre-Certification or notification.

Pre-Certification for Scheduled Admissions

Pre-Certification must be obtained for every **scheduled** Hospital, Skilled Nursing Facility, Rehabilitation Facility, and Long-Term Acute Care Facility admission. These admissions are referred to as "Scheduled Admissions." There are different notification and/or pre-certification requirements for Non-scheduled Hospital Admissions (Emergency Admissions).

In order to obtain Pre-Certification, the Participant should contact the Medical Management Company when there is a Scheduled Admission prior to the admission. When Pre-Certification is provided, a certain number of Inpatient days for the stay will be assigned. If the Participant fails to follow the Pre-Certification guidelines, **Coverage will not be provided**. In addition, if an admission for which Pre-Certification is being obtained is determined to be non-Medically Necessary, no benefits are payable at all.

Special Note Regarding Confinements for Maternity Services: Pre-Certification of Hospital Admissions for Maternity Services is not required for any Hospital Confinement for such services unless the Confinement exceeds 48 hours for a routine vaginal delivery and 96 hours for a cesarean section delivery.

Notification for Non-Scheduled Admission

If a Participant is admitted to a Hospital for a Non-Scheduled Admission, notice of the admission must be provided to the Medical Management Company no later than the next working day after the date of admission. However, failure to notify the Medical Management Company within the next working day will not result in any penalty or loss of Coverage provided the notification occurs no later than 30 days following the date of admission. The review will be performed with the Participant's Physician to determine if a continued Hospital stay is Medically Necessary. If the Participant fails to follow the notification guidelines for a Non-Scheduled Admission, **Coverage will not be provided**.

A Non-Scheduled Admission is an emergency or unplanned admission to the Hospital. Non-Scheduled Admissions frequently occur through the Emergency Department of a Hospital.

Other Pre-Certification Requirements

Pre-certification must also be obtained whenever Participant is to receive home health care services through a Home Health Care Agency or private duty nursing services, unless such services have already been approved through Case Management. Case Management is described on the next page.

In order to obtain Pre-Certification, the Participant should contact the Medical Management Company when there is a Scheduled Admission prior to receiving the home health care and private duty nursing services. If the Participant fails to follow the Pre-Certification guidelines, **Coverage will not be provided**. In addition, if an admission for which Pre-Certification is being obtained is determined to be non-Medically Necessary, no benefits are payable at all.

Continued Stay Review and Discharge Planning

During a Participant's Hospital stay, a Continued Stay Review will be conducted. This review applies to all Hospital admissions. The purpose of Continued Stay Review is to enable the Health Plan to re-evaluate the Medical Necessity of a continued Hospital stay. It may be necessary to obtain additional information concerning the Participant's Hospital stay to conduct a Continued Stay Review.

Review for Discharge Planning occurs during Hospitalization Review. The purpose is to identify patients requiring extended care following discharge and determine the most appropriate setting for continued care.

Case Management

Case Management is a voluntary program and it is designed to inform patients of more cost-effective settings for treatment. Case Management typically applies when an individual has a chronic or ongoing condition, or a catastrophic condition, that is expected to result in significant claim costs for the Plan. In this event, on an exception basis, benefits may be provided for settings and/or procedures not expressly covered under the Plan, if the setting and/or procedure will assist the Plan Sponsor in managing the Plan's medical costs. All requests for Case Management will be individually reviewed by the Plan.

If a Participant requests an alternative setting or procedure under Case Management, the Plan Sponsor has the right to deny Coverage for such setting or procedure and benefits pursuant to the terms of the Plan, exclusive of this provision.

HOSPITAL/DOCTOR/SERVICES BILL AUDIT

Providers generally do a good job in accurately charging for service they provide, however, sometimes errors in Provider bills are made – errors that could cost the Covered Person and the Plan money. The employee is in a good position to know what services and types of care the employee or covered dependent received. The Bill Audit provides a financial incentive for employees and dependents to become more aware of the high cost of health care by reviewing their bills for errors.

To participate in the program, the employee should:

1. Review the bill (not EOB) for incorrect charges.

2. Inform the Compensation and Benefits Section [615-747-3942] of any overcharges.
3. Turn copies of the bill into the Compensation and Benefits Section.
4. The claims processor will investigate the discrepancy and report any adjustments made.

The employee will then be reimbursed 50% of the recovered amount, up to a maximum of $250. If the employee needs any help in auditing the Provider bill, the employee should contact the Compensation and Benefits Section.

PREFERRED PROVIDER (PPO) ARRANGEMENT

The Plan offers a broad network of providers within the network selected by the Plan Sponsor. The Plan provides the highest level of benefits when Participants utilize Preferred Providers. Preferred Providers are those who are contracted with the network(s) indicated on the Identification Card. Services provided by Non-Preferred Providers will generally be covered at a lower benefit level than services received from a Preferred Provider. Refer to the Schedule of Benefits to determine the benefit amounts for services rendered by a Preferred Provider and a Non-Preferred Provider.

Preferred Providers must accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Description of Benefits Offered

When an Eligible Employee becomes a Participant, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Eligible Medical Expenses. In no event will Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Medical Expenses.

Each Participant will be entitled to reimbursement for his/her documented Eligible Medical Expenses incurred during the Plan Year in an annual amount not to exceed the Deductible amount specified in the Summary of Benefits. The maximum dollar limit for reimbursements may be changed by the Plan Administrator in subsequent Plan Years and will be communicated to Employees through the SPD or other document.

To the extent a Participant has an available amount, at the end of any plan year, such Participant is entitled to carryover all such available amount or the allowable portion of any unused HRA fund, up to the amount of the Deductible, to the subsequent Plan Year for use in that year, or any future periods in which the Participant remains eligible under the Plan.

Employer Contributions

(a) NES funds the full amount of the HRA Accounts.
(b) No Funding Under Cafeteria Plan. Under no circumstances will your HRA be funded with salary reduction contributions.

Funding of the Plan

All the amounts payable under this Plan will be paid from the general assets of NES. Nothing herein will be construed to require NES or the Plan Administrator to maintain any fund or to segregate any amount for the

benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in any fund, account or asset of NES from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

The HRA Fund and medical coverage is combined with a fund of contributions made by NES. The HRA Fund can be used to pay for Eligible Medical Expenses during the plan year. Amounts paid by the HRA Fund for Covered Services count only toward the Annual Deductible. The HRA Fund does not apply to the Dental, Vision and Prescription benefits.

When a Participant receives an NES contribution to his/her HRA Account, it effectively reduces the overall amount of the Annual Deductible described below. The Annual Deductible does not count toward the Out-of-Pocket Maximum.

Any dollars in the HRA Fund are used first to pay for medical expenses before your share of the Deductible is due. Once the Fund is exhausted, your share of the Deductible must be met before you enter the Co-insurance phase.

Preventative services such as your annual physical are covered at 100% and do not apply against the HRA Fund.

If at the end of the Plan Year, the HRA Fund has dollars remaining, the HRA Fund balance will roll over to the next Plan Year thereby lowering your Deductible.

NES will contribute to your HRA Fund:

Individual Coverage	$400
Individual Plus Spouse or Children Coverage	$800
Family Coverage	$1,200

After the HRA Fund is exhausted, there is a Deductible that must be met. The Deductible is:

Coverage Type	Total Deductible	HRA Fund	Your Portion of Deductible
Individual Only	$1,750	$400	$1,350
Individual Plus Spouse or Children	$2,600	$800	$1,800
Family	$3,500	$1,200	$2,300

After the total Deductible is met, you enter the Coinsurance portion of the plan for Covered Services up to your Out-of-Pocket Maximum. The Out-of-Pocket Maximum is the most you could pay during the Benefit Period for your share of the cost of covered medical services. In this event, 100% of Eligible Medical Expenses will be paid for the remainder of the Benefit Period.

Prorated HRA Fund

If you become enrolled with a coverage effective date after January 1st, your HRA Fund may be prorated based upon the date in which your coverage becomes effective.

If during the same year that your coverage becomes effective, you add a Dependent as a result of an eligible change in status, the HRA Fund may be increased based upon your coverage level on your insurance effective date. If you change from dependent or family coverage to individual coverage at any point during the year, the HRA Fund will not be decreased or prorated.

Establishment of HRA Account

The Plan Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) Crediting of Accounts. A Participant's HRA Account will be credited at the beginning of each period as determined by NES or the Plan Administrator with the applicable dollar amount and increased by any carryover of unused Account balance from a prior Period(s) of Coverage.

(b) Debiting of Accounts. A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Eligible Medical Expenses incurred during the Period of Coverage.

(c) Available Amount. The amount available for reimbursement of Eligible Medical Expenses is the amount credited to the Participant's HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

Carryover of Accounts (HRA Rollover)

If any available amount remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance will be carried over to reimburse the Participant for Eligible Medical Expenses incurred during a subsequent Period of Coverage. The carryover dollars plus the annual contribution to your HRA fund cannot exceed the Deductible. On or around April 1 of the following year, the carryover dollars will be included in your HRA account.

HRA Carryover Example:

Coverage	2018 HRA Contribution from NES	HRA Used Toward Deductible	HRA Carryover After All Claims Processed	HRA Carryover Plus 2019 HRA Contribution
Employee Plus Spouse or Children	$800	$400	$800 - $400 = $400	$400 + $800 = **$1,200**

Reimbursement Procedure

The Plan Administrator will pay the Benefits provided under this Plan as soon as is administratively feasible. The Plan Administrator may reimburse an Eligible Medical Expense arising during the Period of Coverage at any time during the period that begins when the expense is incurred and any unused Benefits may be carried forward, up to the amount of the Deductible, for use in future years.

The Plan Administrator will not pay the Benefits provided under this Plan for any medical claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid

through any other health insurance plan, Section 125 "cafeteria" plan or other similar medical expense reimbursement arrangement.

Wellness Incentive Reward Program

The HRA allows you to earn incentive dollars that are added to your HRA account by NES if you, and your covered spouse if applicable, each qualify and participate in at least four of the following Wellness activities. One of the four activities must be the annual routine examination. The measurement period will be October of the previous year through September of the current year. The Wellness incentive will be rewarded on or about January 1 of the following year and then added to your HRA account.

Coverage Level	Wellness Incentive Reward
Individual Only	$200
Individual Plus Spouse or Children	$300
Individual Plus Family	$500

Activities eligible for Wellness incentive reward

1. Annual routine examination (eligible participants must include this activity)
2. Annual flu shot and/or other recommended immunizations
3. Biometric screening/health risk assessment
4. Discussion of biometric screening report with certified health educator
5. Tobacco cessation
6. Disease management participation for cardiac, diabetes, cancer, and pulmonary diseases
7. Case management participation
8. Obesity weight loss program
9. Routine eye exam
10. PSA test and/or prostate exam
11. Colonoscopy
12. Mammogram
13. Routine oral exam and teeth cleaning

Coordination of Health Care Flexible Spending Account

If coverage for an Eligible Medical Expense is provided under both a health care Flexible Spending Account (FSA) and the HRA Plan, then the amounts available under the HRA Plan must be exhausted before reimbursements can be made from the FSA. The FSA may then reimburse Participants for those eligible costs that are not covered by the HRA Plan.

COVERED SERVICES

The following are Covered Services under the Plan in alphabetical order.

Abortion Services

The Plan will cover surgical services in relation to the performance of an abortion when such services are rendered and billed by a Physician in a covered setting provided the abortion is performed to terminate a pregnancy that is Medically Necessary to save the life and/or health of the mother. The Plan will also cover

abortions when the pregnancy is the result of a rape or incest. In addition, the Plan will cover medical or surgical complications that are the direct result of the Participant receiving an abortion.

Accidental Bodily Injury

The Plan will cover Injuries that are the direct result of an accident when such services are rendered by a Physician, Hospital or Other Provider in a covered setting. To be covered under the Plan, the Participant must seek treatment for the accidental Injury within 72 hours following the Injury.

Allergy Injections and Tests

The Plan will cover allergy injections and allergy treatment, the serum and allergy testing when such services are performed by a Physician in the Physician's office or other covered setting.

Ambulance Service

Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured:

1. From the Participant's home, scene of accident or medical emergency to a Hospital;
2. Between Hospitals;
3. Between Hospital and Skilled Nursing Facility; or
4. From a Hospital or Skilled Nursing Facility to the Participant's home.

Air transportation is only covered when such transportation is Medically Necessary because of a life-threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for Inpatient care.

All trips must be to the closest facility that can provide Covered Services appropriate for the Participant's condition.

Ambulatory Surgical Facility Services

The Plan will cover services rendered and billed by an Ambulatory Surgical Facility in connection with the performance of a covered surgical procedure performed in such facility.

Anesthesia Services

The Plan will cover the administration of anesthesia by an in network or out-of-network Physician or Other Professional Provider on an Inpatient or Outpatient basis and when such surgery is performed in an in-network facility when such Physician or Other Professional Provider is not the surgeon or assistant at surgery.

Bariatric Treatment

The Plan will cover services for bariatric treatment, surgical repair, reversal, conversion, and revision including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery. After the Deductible is met, the Plan will pay 50% of Provider's Reasonable and Customary Charge. The Out-of-Pocket limits do not apply for any bariatric treatment services.

Bariatric surgery is a treatment for morbid obesity, a condition in which a person is more than 100 lbs. (45.4.kg) or 100% over ideal body weight. Ideal body weight is based on a body mass index (BMI = weight in kg/[height in meters]2)

- A healthy range of weight is 18.5 to 24.9 kg/m2 (125 to 168 pounds)
- Overweight is 25 to 29.9 kg/m2 (169 to 202 pounds)
- Class 1 obesity is 30 to 34.9 kg/m2 (203 to 236 pounds)
- Class 2 obesity is 35 to 39.9 kg/m2 (237 to 270 pounds)
- Class 3 obesity is equal to or greater than 40 kg/m2 (greater than 271 pounds)

The Plan will cover services for bariatric treatment for plan Participants with Class 2 or Class 3 obesity when the following patient criteria are met:

1. Presence of morbid obesity has persisted for at least five (5) years, defined as either: BMI exceeding 40; OR BMI greater than 35 in conjunction with any of the following severe co-morbidities: coronary heart disease, type 2 diabetes, clinically significant obstructive sleep apnea or hypertension; AND
2. Patient has completed growth (18 years of age or documentation of completion of bone growth): AND
3. Patient has attempted weight loss in the past without successful long-term weight reduction; AND
4. Patient has participated in a physician-supervised nutrition and exercise program documented in the medical record. The physician-supervised nutrition and exercise program must meet ALL the following criteria:
    a. Must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; and
    b. Must be six (6) months or longer in duration; and
    c. Must occur within the two (2) years prior to surgery; and
    d. Must be documented in the medical record by an attending physician who does not perform bariatric surgery; and
5. Patient has participated in pre-surgical psychological assessment as a potential bariatric surgery candidate.

Birthing Center Services

The Plan will cover the following services in connection with Maternity Services provided to a Participant when such services are rendered and billed by a Birthing Center:

1. Operating room and equipment used therein;
2. Delivery room and equipment used therein;
3. Other treatment rooms and equipment used therein;
4. Prescribed drugs;
5. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
6. Medical and surgical dressings, supplies, casts and splints;
7. Blood, blood transfusions and other blood-related services; and
8. Diagnostic Services.

Cardiac Rehabilitation Therapy – Outpatient

The Plan will cover Cardiac Rehabilitation Programs in connection with the rehabilitation of the Participant following a myocardial infarction or coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician in a Facility. Treatment must begin within 12 weeks following the end of the initial treatment of the medical condition/myocardial infarction.

Outpatient cardiac rehabilitation therapy is subject to a Maximum Benefit of 60 visits per Participant per calendar year.

Chemotherapy – Outpatient

The Plan will cover chemotherapy treatment rendered by a Physician or Other Professional Provider when such treatment is rendered in a covered setting.

Chiropractic Services – Outpatient

The Plan will cover Chiropractic Treatment when rendered by a Physician or a Chiropractor on an Outpatient basis and in a covered setting. Chiropractic Treatment means treatment of the spine by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease or injury. Treatment must be for acute conditions where rehabilitation potential exists, and the skills of a Physician or Other Professional Provider are required.

Outpatient Chiropractic Treatment is subject to a Maximum Benefit of 40 visits per Participant per calendar year.

Clinical Trials

The Plan will cover routine patient care costs related to a Phase I, Phase II, Phase III or Phase IV clinical trial for cancer for Participants diagnosed with cancer in accordance with §56-7-2365 of the Tennessee Code.

The Participant's treating physician must recommend participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential benefit to the Participant. The clinical trials purpose must not be to exclusively test toxicity but must have a therapeutic intent.

The clinical trial must:

6. Involve a drug that is exempt, under federal regulations from new drug application; or
7. Be approved by one of the following: one of the National Institutes of Health; the Federal Food and Drug Administration, in the form of an investigational new drug application, the Federal Department of Defense; or the Federal Veteran's Administration.

Dental Implants

The Plan will cover dental implants as part of the Medical Benefits.

Diagnostic Tests - Outpatient

After the Deductible, the PPO Plan pays 85% and the HRA Plan pays 80% for In-Network or Out-of-Network Professional charges, including Pathologists charges, incurred during a visit to an In-Network facility, otherwise the PPO Plan and the HRA Plan pays 65%. The Plan will cover Outpatient diagnostic test rendered by a Laboratory or Other Facility Provider when the Participant has specific symptoms and such tests and procedures are needed to detect and diagnose a Sickness or Injury. Outpatient diagnostic tests include, but are not limited to, Outpatient diagnostic tests for pre-admission testing and allergy testing. Specific services covered under this benefit include:

1. Laboratory examinations;
2. X-ray tests or examinations;
3. EKGs;
4. EEGs; and
5. MRIs, MRAs, PET, and CT Scans.

In addition to the standard diagnostic benefit as described above, the Plan includes the Quest Lab Card Program. The purpose of this program is to save the Participant money on Outpatient laboratory tests. When the Participant uses the Quest Lab Card Program or Lab Corp, the Participant is not required to pay any applicable Deductible or Coinsurance requirement for laboratory specimens sent to those facilities for processing. If the specimen is actually taken at a Laboratory that is not a Quest Lab Card facility, the charges associated with taking the specimen (e.g., blood draw) will be paid subject to the Deductible and Coinsurance that apply to any other Diagnostic Service.

When the Physician orders laboratory testing, to receive the benefit the Participant should mention the Quest Lab Card Program and request that the specimens be sent to that facility.

Durable Medical Equipment

The Plan will cover the rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician and which are required for a therapeutic use by the Participant. Rental costs must not be more than purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use. Repair or replacement of purchased durable medical equipment which is Medically Necessary due to normal use, or growth of a child will be considered an Eligible Expense.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the Participant's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished will be covered based on the usual charge for the equipment which meets the Participant's medical needs.

Durable medical equipment includes but is not limited to items such as crutches, wheelchairs, hospital beds, etc.

Emergency Care in Emergency Department

The Plan will cover treatment of an Illness or Injury that is considered to be a Medical Emergency when such services are rendered in the Emergency Department of a Hospital. Covered Services include those Medically Necessary services and supplies provided by the Hospital following the Participant's admission to the

Emergency Department for an Illness or Injury and include the services provided by the Physician and Other Professional Providers.

Erectile Dysfunction (ED) Treatment (Diabetic Participant)

The Plan will cover expenses and treatment for erectile dysfunction (ED) including but not limited to care, treatment, services, supplies, or medication for ED which arises from a diagnosis of Diabetes.

ED is the inability to achieve and maintain an erection and may result from multiple causes such as diabetes, kidney disease, hormonal imbalance, multiple sclerosis, atherosclerosis, vascular disease or neurological disease. ED may also be caused by trauma such as injury to the penis, spinal cord, prostate, bladder or pelvis. In addition, ED may be caused by trauma, and drug and/or alcohol use/abuse, as well as smoking.

Covered Treatment: The first step in treating ED is to determine if there is an underlying condition and treating the condition accordingly. If unresolved, treatment is typically progressive in nature, beginning with the least invasive modality and advancing to surgical implantation using prosthetic devices.

The following therapies are considered standard treatment for ED: oral phosphodiesterase type 5 (PDE-5) inhibitors, intra-urethral alprostadil, intracavernous vasoactive drug injection, vacuum constriction devices, and penile prosthesis implantation. Any device authorized must be FDA approved.

Erectile Dysfunction (ED) Treatment (Non-Diabetic Participant)

The Plan will cover expenses and treatment for erectile dysfunction (ED) including but not limited to care, treatment, services, supplies, or medication for ED which arises from a diagnosed medical condition or organic state. After the Deductible is met, the Plan will pay 50% of Provider's Reasonable and Customary Charge. The Out-of-Pocket limits do not apply for any erectile dysfunction treatment services.

1) Prescription medications
2) Various medical devices
3) Surgical implantation

ED is the inability to achieve and maintain an erection and may result from multiple causes such as diabetes, kidney disease, hormonal imbalance, multiple sclerosis, atherosclerosis, vascular disease or neurological disease. ED may also be caused by trauma such as injury to the penis, spinal cord, prostate, bladder or pelvis. In addition, ED may be caused by trauma, and drug and/or alcohol use/abuse, as well as smoking.

Covered Treatment: The first step in treating ED is to determine if there is an underlying condition and treating the condition accordingly. If unresolved, treatment is typically progressive in nature, beginning with the least invasive modality and advancing to surgical implantation using prosthetic devices. The following therapies are considered standard treatment for ED: oral phosphodiesterase type 5 (PDE-5) inhibitors, intra-urethral alprostadil, intracavernous vasoactive drug injection, vacuum constriction devices, and penile prosthesis implantation. Any device authorized must be FDA approved.

Gender Dysphoria and Gender Reassignment Surgery (Section 1557)

Medically Necessary services and treatments for Participants diagnosed with gender dysphoria, including but not limited to: mental health care as otherwise provided herein, prescription drug therapy, including related hormone therapy and gender reassignment surgery. The following requirements and limitations apply.

Procedure Eligibility Requirements:

a. Mastectomy for female-to-male Participants:
    i. A Referral Letter from a Qualified Mental Health Professional;
    ii. A persistent, well-documented diagnosis of gender dysphoria;
    iii. Participant must be at least 18 years old and have the capacity to make a fully informed decision and consent to treatment; and
    iv. If the Participant suffers from significant medical or mental health concerns, they must be reasonably well controlled.

A trial of hormone therapy is not a pre-requisite to approval for a mastectomy.

b. Gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to female Participants):
    i. Two Referral Letters from Qualified Mental Health Professionals, one in a purely evaluative role;
    ii. A persistent, well-documented diagnosis of gender dysphoria;
    iii. Participant must be at least 18 years old and have the capacity to make a fully informed decision and consent to treatment;
    iv. If the Participant suffers from significant medical or mental health concerns, they must be reasonably well controlled; and
    v. Twelve months of continuous hormone therapy as appropriate to the Participant's gender goals (unless the Participant has a medical contraindication or is otherwise unable or unwilling to take hormones). If testosterone is used for hormone therapy, participant is required to have an adequate trial and treatment failure with injectable testosterone cypionate prior to the use of topical testosterone products.

c. Genital reconstructive surgery (i.e. vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male Participants; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female Participants):
    i. Two Referral Letters from Qualified Mental Health Professionals, one in a purely evaluative role;
    ii. A persistent, well-documented diagnosis of gender dysphoria;
    iii. Participant must be at least 18 years old and have the capacity to make a fully informed decision and consent to treatment;
    iv. If the Participant suffers from significant medical or mental health concerns, they must be reasonably well controlled;
    v. Twelve months of continuous hormone therapy as appropriate to the Participant's gender goals (unless the Participant has a medical contraindication or is otherwise unable or unwilling to take hormones). If testosterone is used for hormone therapy, participant is required to have an adequate trial and treatment failure with injectable testosterone cypionate prior to the use of topical testosterone products; and
    vi. Twelve months of living in a gender role that is congruent with the Participant's gender identity (real life experience).

Limitations and Exclusions:

a. Gender reassignment surgery is limited to one procedure per Participant per lifetime;
b. Certain procedures performed as a component of gender reassignment surgery may be determined by the Plan Administrator in its discretion to be cosmetic and will not be covered. Examples of

cosmetic procedures, include, but are not limited to: body contouring (including breast augmentation and liposuction), hair removal, hair transplants, voice modification surgery or lessons, skin resurfacing, facial implants and reconstruction;

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

Definitions

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

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

Home Health Care Services

Home Health Care Services may be provided to the Participant in the Participant's home as a Medically Necessary alternative to Inpatient care. A Home Health Care Provider must provide non-custodial services according to a Physician-prescribed course of treatment that has been previously approved by the Plan. Covered Services include skilled nursing services, Diagnostic Services and therapy services.

Pre-certification must also be obtained whenever Participant is to receive home health care services through a home health care services provider, unless such services have already been approved through Case Management. Refer to the **"PRE-CERTIFICATION PROVISIONS AND CASE MANAGEMENT"** Section in Part I for details.

Hospital Services During an Inpatient Confinement

The Plan will cover certain Hospital Services when the Participant is hospitalized as an Inpatient in a Hospital. The following room and board expenses and ancillary services are considered covered Inpatient Hospital Services:

1. **Room and Board**. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. The Plan will base payment of the room and board expenses in a private room on 100% of the semi-private room rate plus 50% of the difference in cost between the private room rate and semi-private room rate. Coverage includes a bed in a special care unit approved by the Plan.

2. **Ancillary Services**. Ancillary Services received during a Hospital Confinement include, but are not limited to:

a. Operating room and equipment used therein;
b. Delivery room and equipment used therein;
c. Other treatment rooms and equipment used therein;
d. Prescribed drugs;
e. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
f. Medical and surgical dressings, supplies, casts and splints;
g. Blood, blood transfusions and other blood-related services;
h. Diagnostic Services;
i. Radiation therapy;
j. Intravenous chemotherapy;
k. Kidney dialysis;
l. Inhalation therapy;
m. Physical Therapy;
n. Occupational Therapy; and
o. Speech Therapy.

Pre-Certification must be obtained for every scheduled Hospital admission. Refer to the section entitled "Pre-Certification Provisions and Case Management" for details.

Kidney Dialysis – Outpatient

The Plan will cover Outpatient kidney dialysis treatment when such services are rendered and billed by a Provider. Treatment must be rendered in a covered setting (e.g., Outpatient department of a Hospital).

Maternity Coverage

Inpatient Services. Coverage will be provided for the services rendered by a Hospital or Professional Provider in connection with the Maternity Services for a Participant, other than maternity services and any complications arising therein with dependent daughters. The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Dependent Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g. the Participant's Physician, Certified Nurse Midwife, or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not require that a Physician or other Provider obtain authorization for prescribing a length of stay unless the length of stay will exceed 48 hours for a vaginal deliver or 96 hours for a cesarean section

Pre-Natal and Post-Natal Office Visits. Coverage will be provided for Office Visits in connection with pre-natal and post-natal care and treatment of the mother. Pre-natal and post-natal Office Visits will be treated as a Maternity Service and will be covered in the same manner as all other Maternity Services. However, the initial pre-natal Office Visit may be covered under the Physician Office Visit benefit (refer to the Schedule of Benefits) if the Physician does not bill the initial Office Visit as part of the overall obstetrical bill.

Medical and Surgical Supplies

The Plan will cover medical and surgical supplies that serve a specific medical purpose and are purchased by the Participant for use in the home. Covered medical and surgical supplies include, but are not limited to, the following:

1. Oxygen;
2. Surgical dressings;
3. Casts and splints;
4. Braces;
5. Catheters;
6. Colostomy and ileostomy bags and supplies required for their use;
7. Soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye; and
8. Intravenous solutions unless such serum and IV solutions are obtained from a Pharmacy (refer to Prescription Drug Benefits);
9. Wigs or hair piece, limited to the first wig that is needed as the result of loss of hair due to chemotherapy treatment and/or radiation therapy treatments.

Occupational Therapy

The Plan will cover Occupational Therapy when rendered by a Physician or Occupational Therapist in a covered Outpatient setting. Occupational Therapy means therapeutic use of work, self-care, and play activities to increase development and prevent disability. It may include adaptation of task or environment to achieve maximum independence and to enhance the quality of life. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Professional Provider are required.

Organ Transplants

Refer to the Transplant Services benefit.

Pathology

After the Deductible, the PPO Plan pays 85% and the HRA Plan pays 80% for In-Network or Out-of-Network Professional charges, including Pathologists charges, incurred during a visit to an In-Network facility, otherwise the Plan pays 65%. All services under the Plan shall be paid in network when prescribed by an in-network facility.

Patient Education Programs

The Plan will cover patient education programs in connection with teaching the Participant how to manage his or her diabetic condition in a covered Inpatient or Outpatient setting, including services performed in an office visit setting.

Physical Therapy Services - Outpatient

The Plan will cover Physical Therapy when rendered by a Physician or Physical Therapist in a covered Outpatient setting. Physical Therapy means treatment by physical means including modalities such as

whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Professional Provider are required.

Such treatment does not include treatment of the spine which is covered under the chiropractic benefit. Refer to the benefit entitled "Chiropractic Services – Outpatient" for a description of the chiropractic benefit.

Physician Medical Services During a Hospital Confinement

The Plan will cover certain Medical Services that are rendered and billed by a Physician when the Participant is hospitalized as an Inpatient in a Hospital. The following services are considered covered Medical Services during a Participant's Hospital Confinement:

1. **Physician In-Hospital Visits**. The Plan will cover one Physician visit per day from the Participant's treating Physician during a Participant's Hospital Confinement.

2. **Intensive Care**. The Plan will cover the constant care and treatment while the Participant is confined in an intensive care unit.

3. **Care by Multiple Physicians**. When the Participant's condition requires the skills of separate Physicians, the Plan will cover the medical care and treatment by two or more Physicians received during the same Hospital Confinement.

4. **Other Physician Consultations**. When the Participant's Physician requests another Physician's consultation, the Plan will provide Coverage for such consultation but will limit Coverage to one such consultation per Hospital admission. Staff consultations required by Hospital rules are excluded from Coverage.

Physician's Office Visit for Non-Routine Care or Treatment

The Plan will cover charges incurred during a visit to the Participant's Physician for non-routine care in connection with a specific Injury or Illness. Covered Services include screening examinations, evaluation procedures, medical care, treatment or services directly related to assist in the diagnosis or treatment of a specific Injury or Illness which is known or reasonably suspected. Eligible Expenses include services rendered by the Participant's Physician, Nurse Practitioner and Physician Assistant.

Podiatry Services

The Plan will cover podiatry services rendered by a Podiatrist or a Physician in a covered setting (e.g., Physician's office or Emergency Department of a Hospital). Covered services include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal of bunions, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot. Routine foot care including the trimming of toenails, treatment of corns, calluses, bunions, and foot orthotics including treatment for fallen arches are not covered unless the Participant has a diabetic condition that necessitates medical attention for such routine foot care. The Plan will cover orthotic devices when the Participant has a diabetic condition.

Preventive Care

Charges for Preventive Care services. Benefits mandated through the Affordable Care Act legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).
See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered;

Preventive and Wellness Services for Adults and Children – In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

Women's Preventive Services – With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:
http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/.

Private Duty Nursing Services

Coverage is provided for services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician. Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising, and feeding.

Inpatient Services - Services that are determined to be of such nature or degree of complexity that the Provider's regular nursing staff cannot give them.

Home Services - Services that are determined to require an R.N. or L.P.N.'s continual skills. Benefits are not provided for a nurse who usually lives in the Participant's home or is a member of the Participant's immediate family.
Pre-certification must also be obtained whenever the Participant is to receive home health care services through a private duty nursing service, unless such services have already been approved through Case Management. Refer to the **"PRE-CERTIFICATION PROVISIONS AND CASE MANAGEMENT"** section in Part I for details.

Prosthetic Appliances

The Plan will cover the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic appliances and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or

2. Replace all or part of the function of a permanently useless or malfunctioning body organ.

Covered prosthetic appliances include prostheses in connection with breast reconstruction following a covered mastectomy procedure.

Psychiatric Services

The Plan will cover Psychiatric Services for the care and treatment of a psychiatric condition. Psychiatric Services will be covered on Inpatient and Outpatient basis, including services for the care and treatment of alcoholism, drug addiction and substance abuse. A psychiatric condition will be treated the same as any other Illness for purposes of determining available Covered Services. In addition, individual psychotherapy and psychological testing will be covered.

Psychiatric Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, Residential Treatment, or Community Mental Health Facility.

Radiation Therapy – Outpatient

The Plan will cover radiation therapy when rendered by a Physician or Other Professional Provider in a covered setting on an Outpatient basis.

Radiology

After the Deductible, the PPO Plan pays 85% and the HRA Plan pays 80% for In-Network or Out-of-Network Professional charges, including Radiologists charges, incurred during a visit to an In-Network facility, otherwise the Plan pays 65%. All services covered under the Plan shall be paid in network when prescribed by an in-network facility.

Reconstructive and Cosmetic Surgery

When performed in a covered facility setting, the Plan will cover reconstructive surgery to restore bodily functions or correct deformity. Such surgical procedure will be treated the same as any other surgical procedure. Coverage is limited to problems caused by an accidental injury which occurred no more than one year prior to the surgery and a congenital birth defect. In addition, Coverage will be provided for the following services to an individual who receives benefits in connection with a mastectomy:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan will not cover expenses in connection with or treatment only to improve appearance. This exclusion does not include procedures to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes;

Rehabilitation Facility

The Plan will cover certain services when the Participant is confined as an Inpatient in a Rehabilitation Facility for the care and treatment of an Illness or Injury requiring acute rehabilitation services. The admission to the Rehabilitation Facility must occur within 14 days following a Medically Necessary Hospital stay that lasted a minimum of 3 days. The following room and board expenses and ancillary services will be covered:

1. **Room and Board**. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by the Plan. Use of a private room, will be covered at the facility's semi-private room rate;

2. **Ancillary Services**. Ancillary Services received during a Confinement in an Acute Rehabilitation Facility include, but are not limited to:

    a. Treatment rooms and equipment used therein;
    b. Prescribed drugs;
    c. Medical and surgical dressings, supplies, casts and splints;
    d. Blood, blood transfusions and other blood-related services;
    e. Diagnostic Services;
    f. Inhalation therapy;
    g. Physical Therapy;
    h. Speech Therapy; and
    i. Occupational Therapy

Pre-Certification must be obtained for every scheduled Rehabilitation Facility admission. Refer to the "**PRE-CERTIFICATION PROVISIONS AND CASE MANAGEMENT"** section in Part I above for details.

Routine Nursery Care of Well Newborn

The Plan will cover the routine nursery care of the newborn infant. The infant's routine nursery care charges will not be covered as part of the mother's Hospital bill, and the infant will only be covered if the infant has

been enrolled for Coverage under the Plan pursuant to the enrollment requirements described in this Summary Plan Description. This benefit does not include a Physician's examination of the newborn infant following delivery of the newborn. These Physician examinations will be covered under the "Routine/Well Care for Dependent Children" benefit.

Routine/Well Care for Adult

The Plan will cover preventive care services without imposing any cost-sharing requirements such as deductibles and coinsurance in accordance with:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Immunizations for routine use in children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Preventive care and screenings for women, infants, children, and adolescents set forth in comprehensive guidelines supported by the Health Resources and Services Administration.

Copies of the recommendations and guidelines may be found here:
http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/.

Coverage will include visits to an In-Network Physician for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventive medical care, treatment or services not directly related to a specific Injury, Illness or pregnancy-related condition which is known or reasonably suspected. This benefit applies to the Covered Employee, covered Spouse and covered Dependent Child who is age 18 and older. Refer to the **"Routine/Well Care for Dependent Child"** section below for a description of the routine and well care benefit for Dependent Children who are under the age of 18.

Specific services covered under this benefit include:

1. One annual office visit for routine care;
2. One annual routine Physician examination;
3. One annual routine gynecological exam and routine papilloma virus testing;
4. One annual routine mammogram (including 3D mammogram) for women for all covered females who are age 18 and older;
5. One annual routine PSA test, including screening for all covered males who are age 18 and older;
6. One annual routine flexible sigmoidoscopy including colonoscopy;
7. One annual routine digital rectal examination;
8. Routine diagnostic tests including, but not limited to, the following: tuberculosis skin tests; urinalysis; hematocrit/hemoglobin; cholesterol; triglyceride; blood glucose; EKG; stool occult for blood; and routine diagnostic x-ray services;
9. Routine immunizations;
10. Influenza and pneumococcal inoculations;
11. One annual routine Diphtheria inoculation;
12. One annual routine Tetanus booster injection;
13. Anemia screening;
14. Screening for gestational diabetes;
15. Screening for syphilis and gonorrhea and counseling for sexually transmitted infections;
16. Screening and counseling for human immune-deficiency virus;

17. Screening for hepatitis B and hepatitis C virus;
18. One lactation counseling per pregnancy by a trained provider during pregnancy or in the post-partum period;
19. Screening for Rh incompatibility for pregnant women and follow-up testing for women at high risk;
20. Screening for urinary tract or other infection in women; and
21. FDA-approved contraceptive methods, sterilization procedures, and counseling for women with reproductive capacity.

Eligible Expenses include services rendered by a Physician, Nurse Practitioner and Physician Assistant.

Refer to the "**Preventive Care"** subsection in this **"Covered Services"** section above for additional information.

Routine/Well Care for Dependent Child

The Plan will cover preventive care services without imposing any cost-sharing requirements such as deductibles and coinsurance in accordance with:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Immunizations for routine use in children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Preventive care and screenings for women, infants, children, and adolescents set forth in comprehensive guidelines supported by the Health Resources and Services Administration.

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/.

For a Dependent Child up to the age of 18, Coverage will include visits to an In-Network Physician for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventive medical care, treatment or services not directly related to a specific Injury, Illness or pregnancy-related condition which is known or reasonably suspected. Such preventive medical care and services will be updated as the *HRSA Guidelines* are updated. Specific services covered under this benefit include:

1. Office visit for routine care;
2. Physician examination of newborn infant while the infant is still in the Hospital following delivery and prior to discharge from the Hospital;
3. Routine Physician examination for the first year of the Dependent Child's life at periods determined by the Physician;
4. Routine Physician examinations after the first year of the Dependent Child's life;
5. Routine immunizations;
6. Phytonadione (Vitamin K) injection;
7. Influenza inoculations;
8. Pneumonia inoculations;
9. Routine papilloma virus test;
10. Screening for human immune-deficiency virus
11. Screening for cervical dysplasia;

12. Routine diagnostic laboratory examinations in connection with: blood test for Phenylketonuria; blood test for Hypothyroidism; tuberculosis skin test; hematocrit or hemoglobin tests; urinalysis; and routine diagnostic X-ray services;
13. Hemoglobinopathies screening including sickle cell screening;
14. Dyslipidemia screening for children at higher risk of lipid disorders;
15. Vision and hearing screening;
16. Developmental screening for children under age 3;
17. Behavioral assessments;
18. Autism screening at ages 18 and 24 months;
19. Depression screening for adolescents;
20. Counseling and screening for sexually transmitted infection
21. Oral health screening; and
22. Obesity screening and counseling for children aged 6 and older.

Eligible Expenses include services rendered by a Physician, Nurse Practitioner and Physician Assistant.

Skilled Nursing Facility Services

Covered Services for an Inpatient of a Skilled Nursing Facility are the same as those shown in the "**Hospital Services During an Inpatient Confinement**" section above.

Coverage is subject to the following requirements:

1. The Participant must be admitted to the Skilled Nursing Facility within 14 days following a Medically Necessary Hospital stay that lasted a minimum of 3 days; and

2. Services must be Medically Necessary as a continuation of treatment for the condition for which the Participant was hospitalized.

Pre-Certification must be obtained for every scheduled Skilled Nursing Facility admission. Refer to the **"Pre-Certification Provisions and Case Management"** section in Part I for details.

Sleep Disorders

The Plan will cover the diagnosis and treatment of a sleep disorder when services are rendered and billed by a Physician or Other Professional Provider in a covered setting. For purposes of determining what services will be covered in connection with this benefit, a "sleep disorder" will be considered the same as any other Illness under this Summary Plan Description.

Smoking Cessation Programs

Refer to Tobacco Cessation Programs in this section of Covered Services.

Speech Therapy – Outpatient

The Plan will cover Speech Therapy when rendered and billed by a Physician or Speech Therapist in a covered Outpatient setting and when such therapy is Medically Necessary as the result of a stroke, Illness or Injury involving the vocal cords or is otherwise deemed Medically Necessary. Treatment must be either post-operative or for the convalescent stage of an active illness or disease.

Sterilization Services

The Plan will cover surgical services in connection with a voluntary sterilization procedure when such services are rendered and billed by a Physician. In addition, any services rendered by a Hospital, Ambulatory Surgical Facility or Other Facility Provider in which such procedure is performed and that are rendered and billed by such Facility Provider will also be covered by the Plan. Reversal of sterilization is not covered under the Plan.

Surgical Services

Surgery performed by a Physician is covered on an Inpatient or Outpatient basis. Inpatient basis includes surgery performed by a Physician while the Participant is an Inpatient in a Hospital. Outpatient basis includes Surgical Services performed in a Facility or a Physician's Office. Surgical services also include:

1. **Surgical Assistance**. Services of a Physician who helps the Participant's surgeon in performing covered major surgery when a house staff member, intern or resident cannot be present. In this instance, the Provider's Reasonable Charge for services of a Physician who assists the surgeon in performing a covered surgery will be determined as 20% of the surgeon's charge for the surgery;

2. **Multiple Surgical Procedures**. When more than one surgical procedure is performed through the same body opening during one operation, the Participant is covered only for the most complex procedure, unless more than one body system is involved or the procedures are needed for the handling of multiple traumas.

When more than one surgical procedure is performed through more than one body opening during one operation, the Participant is covered for the most complex procedure and for a portion of the benefit for the less complex procedure(s).

Telehealth

The Plan shall comply with Tennessee Code Annotated §56-7-1018 whereby services provided by a licensed healthcare provider by Telehealth shall be covered by the Plan to the extent the service would have been covered had it been rendered in a traditional in-person format. Plan provisions, limitations, exclusions and cost-sharing requirements shall apply to Telehealth services as they do any other covered service.

Telehealth means the use of real-time interactive audio, video or other telecommunications or electronic technology by a licensed healthcare provider to deliver a healthcare service to a patient within the scope of practice of the licensed healthcare provider at a site other than the site at which the patient is located.

Telehealth does not include: an electronic mail message between a licensed healthcare provider and a patient or a facsimile transmission between a licensed healthcare provider and a patient.

TMJ Treatment - Outpatient

The Plan provides limited Outpatient Coverage for Participants with Temporomandibular Joint Dysfunction (TMJ). In addition to providing Coverage for Outpatient Diagnostic Services in connection with TMJ, the Plan will cover the therapeutic IM injection into the Temporomandibular Joint and orthopedic devices and the adjustment to such devices when such services are rendered and billed by a Physician. Orthodontic treatment performed and orthodontic appliances purchased in connection with the treatment of TMJ will not be covered as a Medical Benefit under the Plan.

Tobacco Cessation Programs

The Plan will cover certain FDA-approved nicotine replacement products and prescription drugs for tobacco cessation. Refer to **Part III, PRESCRIPTION DRUG BENEFITS FOR COVERED PRESCRIPTION DRUGS**.

Transplant Services

The Plan will cover services in connection with the transplant procedures described in this section when such services are rendered and billed by a Physician and/or Hospital. Such services will be referred to as Transplant Services and include all Covered Services described in this Summary Plan Description as such services would be available for the treatment of any other Illness. In addition to the actual transplant procedure and the Hospital Confinement in connection therewith, the Plan will cover expenses for the acquisition and transportation of the organ or tissue, and all subsequent treatments, medications or covered other charges in connection with the transplant procedure.

Under the Plan, a covered transplant procedure includes the following human organ and tissue transplants:

1. Kidney transplant;
2. Pancreas transplant;
3. Cornea transplant;
4. Bone Marrow transplant;
5. Stem Cell transplant;
6. Heart transplant;
7. Lung transplant;
8. Heart/lung transplant; and
9. Liver transplant.

Under this benefit, Coverage will be limited to Eligible Expenses incurred by a Participant who is a recipient of the transplant. However, the Plan will cover a donor's Eligible Expenses if the donor does not have other coverage under another benefit plan.

Urgent Care Services in Urgent Care Facility

The Plan will cover services rendered by an Urgent Care Facility in connection with the treatment and diagnosis of an Illness or Injury, and include the services provided by the Physician and Other Professional Providers while the Participant is receiving treatment in the facility. Under this benefit, Coverage will be provided for screening examinations, evaluation procedures, medical and surgical care, treatment or services directly related to a specific Injury or Illness which is known or reasonably suspected.

EXCLUSIONS OR LIMITATIONS FOR THE MEDICAL BENEFITS

Admissions Primarily for Diagnostic Studies The Plan will not cover room, board and general nursing care for Hospital admissions mainly for diagnostic studies;

Admissions Primarily for Physical Therapy The Plan will not cover room, board and general nursing care for Hospital admissions mainly for Physical Therapy;

Alternative Treatments The Plan will not cover treatments that are deemed to be "alternative treatments" including but not limited to the following: acupressure; acupuncture; naturopathy; psychosurgery; massage therapy; megavitamin therapy; nutritionally based alcoholism therapy; holistic or homeopathic care including drugs; ecological or environmental medicine; hypnotherapy; hypnosis or hypnotic anesthesia; hippotherapy; and sleep therapy;

Bariatric Treatment The Plan will not cover bariatric medical or surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity (example: cosmetic surgery to remove excess skin due to bariatric surgery);

Biofeedback The Plan will not cover expenses in connection with biofeedback;

Braces and Artificial Limbs The Plan will not cover expenses related to replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is a sufficient change in the Participant's physical condition to make the original device no longer functional;

Certain Counseling Services The Plan will not cover marriage counseling, family counseling, pastoral counseling, financial counseling, legal counseling and custodial care counseling, except as specifically set forth in this Summary Plan Description;

Certain Examinations and Services The Plan will not cover examinations or medical services the Participant receives specifically for the purpose of employment, recreation, insurance, school attendance or licensure;

Custodial Services The Plan will not cover expenses or services for custodial care or for services not needed to diagnose or treat an Injury or Sickness and will furthermore not cover Hospital Confinements for custodial care or for custodial treatment for a psychiatric or substance abuse disorder;

Educational or Training The Plan will not cover expenses or services or supplies primarily for educational, vocational or training purposes;

Erectile Dysfunction The Plan will not cover erectile dysfunction treatment resulting from a diagnosis of psychological-induced impotence indication;

Exercise Program The Plan will not cover expenses related to exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, or physical therapy covered by the Plan;

Felony or Illegal Activity The Plan will not cover expenses incurred because of a Participant's voluntary involvement or participation in a felony or an illegal activity, including a riot or act of civil disobedience;

Genetic Testing The Plan will not cover expenses related to Genetic Testing;

Governmental Unit or Program The Plan will not cover expenses to the extent governmental units or governmental programs provide benefits;

Hearing Aids The Plan will not cover expenses for hearing aids or examinations for prescribing or fitting them; except as specified in the Schedule of Benefits section in this Summary Plan Description;

Hospice Services The Plan will not cover expenses for services received from a hospice provider;

Inappropriate Charges The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the AMA or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;

Infertility Services The Plan will not cover expenses for in-vitro fertilization, artificial insemination, reversal of sterilization and all other services in connection with an infertility condition. Charges for assisted reproductive technologies, including but not limited to, in vitro fertilization, artificial insemination, GIFT or ZIFT will not be covered;

Learning Disability Therapy The Plan will not cover learning disability charges;

Legal Obligation to Pay The Plan will not cover expenses for which the Participant has no legal obligation to pay in the absence of this or like coverage;

Lifestyle Improvement Services The Plan will not cover lifestyle improvement services or charges, including but not limited to, physical fitness programs and equipment, spas, air conditioners, humidifiers, personal hygiene and convenience items, mineral baths, massage and dietary supplements;

Maternity Services for Dependent Daughters The Plan will not cover maternity services or any complications associated with pregnancy and maternity for dependent daughters;

Medicare The Plan will not cover expenses payable under Medicare Part A, Part B and Part D if the Medicare-eligible individual has declined to enroll for Medicare benefits. In addition, the Plan will coordinate payments with Medicare as set forth in the "Coordination of Benefits and Order of Benefits Determination" section;

Non-Covered Services The Plan will not cover services that are not specified in this Summary Plan Description as Covered Services;

Non-Medically Necessary Services The Plan will not cover services or supplies that are not considered to be Medically Necessary;

Orthotic Devices The Plan will not cover orthotic devices unless the Participant has a diabetic condition that necessitates coverage for orthotic devices;

Podiatry Services The Plan will not cover expenses for foot care unless the Participant has a diabetic condition that necessitates medical attention for such routine foot care;

Prior to Effective Date or After Termination Date The Plan will not cover expenses incurred prior to the Participant's Effective Date or after the termination date except as specified in this Summary Plan Description;

Sterilization Reversal The Plan will not cover expenses for the reversal of a sterilization procedure;

Telephone Consultations, Missed Appointments, Claim Form Completion The Plan will not cover expenses for telephone consultations, missed appointments, or completion of claim forms;

Waived Cost Sharing The Plan will not pay for services for which an Out-of-Network Provider waives any cost sharing component of the Plan (Deductible, co-payments, etc.);

Weekend Admissions The Plan will not cover Friday and Saturday admissions except in cases of an emergency or accidental injury or where surgery is performed the following day;

Weight Control or Related Treatments The Plan will not cover exercise programs and dietary products or supplies for controlling or reducing weight and obesity. The Plan will not cover weight loss programs, whether they are prescribed or recommended by a physician or under medical supervision;

Wigs The Plan will not cover expenses for care and treatment for hair loss including wigs (except that the first wig will be covered following chemotherapy treatment), hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

PART II. DENTAL BENEFITS

<table>
<tr><th colspan="6">DENTAL COVERAGE
SCHEDULE OF BENEFITS</th></tr>
<tr><th colspan="6">GENERAL INFORMATION</th></tr>
<tr><td></td><td>Class 1 Services Preventive Services</td><td>Class 2 Certain Diagnostic & Palliative Services</td><td>Class 3 Services Basic Restorative & Periodontic Services</td><td>Class 4 Services Major Restorative Services</td><td>Class 5 Orthodontia Services (Limited to Dependent Children Through Age 18)</td></tr>
<tr><td>Coinsurance</td><td>Plan pays 100% of Provider’s Reasonable Charge</td><td colspan="3">Plan pays 80% of Provider’s Reasonable Charge</td><td>Plan pays 50% of Provider’s Reasonable Charge</td></tr>
<tr><td>Deductible</td><td>Not applicable</td><td colspan="4">Individual Deductible: $50
Family Deductible: $100</td></tr>
<tr><td>Maximum Benefit</td><td colspan="4">$2,500 per Participant per Benefit Period</td><td>$2,500 per Participant per Lifetime</td></tr>
<tr><th colspan="6">COVERED SERVICES</th></tr>
<tr><td colspan="6">This section describes the Participant’s Dental Benefits. The Plan will provide Dental Benefits when services:
1. Are authorized by a Dentist; and
2. Are rendered by a Dentist or Dental Hygienist; and
3. Are billed by or on behalf of a Dentist; and
4. Qualify as a Covered Service; and
5. Are based on accepted standards of dental practice as determined by the American Dental Association.</td></tr>
</table>

Payment for Dental Benefits will be based on the Provider's Reasonable Charge or the actual charge, whichever is less. All payments will be subject to any applicable Deductible, Coinsurance, maximum benefits and other provisions and limitations in this Summary Plan Description and the Schedule of Benefits. The Maximum Benefit for Orthodontia services is separate from the Maximum Benefit that applies to all other covered dental services.	
Expenses for the following covered services are considered incurred on the date the type of dental service for which the charge is made is completed. They must be billed by or for a Dentist.	
Preventive Services (Class 1 Services) 1. Periodic oral examinations, limited to 2 per 12-month period; 2. Routine prophylaxis (cleaning of teeth), limited to 2 per 12-month period; 3. Topical application of fluoride, with or without a routine prophylaxis), limited to 2 occurrences per 12-month period; 4. Full mouth dental x-rays; and 5. Bitewing x-rays (single film, two films, four films and vertical), limited to 2 occurrences per 12-month period.	Plan pays 100% of Provider's Reasonable Charge
Diagnostic and Palliative Services (Class 2 Services) 1. Emergency palliative treatment; and 2. Oral examinations in connection with Class 2 services (other than routine oral examination and diagnosis).	Plan pays 80% of Provider's Reasonable Charge
Basic Restorative and Periodontal Services (Class 3 Services) 1. Consultations in connection with Class 3 services; 2. Limited oral evaluations in connection with Class 3 services; 3. X-rays (intraoral, extraoral, posterior, sialography and tomographic survey) in connection with Class 3 services; 4. Extractions, simple and surgical; 5. Oral surgical procedures; 6. General anesthesia and injectable drugs for therapeutic reasons in connection with Class 3 services; 7. Sealants limited to one per tooth with no age restriction 8. Space maintainers; 9. Amalgam restorations, resin based composite restorations, and re-cementing services; 10. Sedative fillings; 11. Pulp capping and pulpotomy; 12. Endodontic therapy; 13. Adjustment, re-basing, re-lining and repairs to dentures; 14. Tissue conditioning; 15. Pulp vitality tests; 16. Diagnostic casts; and 17. Oral pathology.	Plan pays 80% of Provider's Reasonable Charge

Major Restorative Services (Class 4 Services) 1. Installation of full or partial removable dentures; 2. Replacement of dentures, overdentures and partial dentures, limited to replacements no more than once every 5 years; 3. Installation of full resin-based composite coverage of tooth; 4. Gold foils; 5. Inlays, onlays, crowns, including prefabricated resin crowns, if regular fillings would not restore the tooth/teeth adequately; 6. Maxillofacial prosthetics; 7. Gingivectomy; 8. Osseous surgery; 9. Periodontal scaling and root planning and periodontal maintenance procedures; and 10. Other restorative services, such as casts, pin retention, and core build-up.	Plan pays 80% of Provider's Reasonable Charge
Orthodontia Services (Class 5 Services) The Plan will cover Orthodontia Services for Dependent Children through the age of 18 years. Orthodontia Services are services for the correction of the position and alignment of the teeth, and include, but are not limited to the following services: 1. X-rays, limited to cephalometric films and oral/facial images; 2. Diagnostic casts; 3. Placement of braces on the teeth; 4. Adjustment of braces at regular intervals as determined by the Dentist; and 5. Dental consultations as deemed Medically Necessary for the course of the approved orthodontia treatment program.	Plan pays 50% of Provider's Reasonable Charge

DENTAL SERVICES DUE TO INJURY

The Plan will cover services rendered by a Physician or Other Professional Provider in connection with emergency repair due to Injury to sound natural teeth provided such treatment begins no later than 90 days and is completed no more than one year following the onset of the injury. In addition, the Plan will cover dental implants as part of the Medical Benefits.

PRE-DETERMINATION OF BENEFITS

If the Participant's Dentist plans a course of dental treatment (especially one that will be costly), the Participant's Dentist is encouraged to obtain a pre-determination of benefits. A pre-determination of benefits may be obtained by submitting a claim form outlining the treatment plan the Dentist intends to follow in treating the Participant. This should be provided to the Plan, or the Plan's Claims Administrator, prior to the start of the course of treatment. The claim form should include the following information:

1. A detailed description of the work to be done; and
2. An estimate of the anticipated dental charges.

In addition to the claim form, any existing diagnostic aids and x-rays should be provided. The purpose of a dental pre-determination of benefits is to assist the Dentist and Participant in determining what will be covered under the Plan prior to the services being rendered. Coverage must be in effect when the actual dental services are provided for the services to be covered under the Plan even if the Participant's Dentist has obtained a pre-determination of benefits. It is important to note that pre-determination of benefits is not required and will not result in a loss of Coverage if a pre-determination of benefits is not submitted to the Plan.

MULTIPLE METHODS OF DENTAL TREATMENT

The Plan may feel that there is more than one way to treat the Participant's dental condition. When there are two or more methods of treatment for the same condition which meet commonly accepted standards of dental practice, the Plan will pay for the least expensive treatment. This applies even if the Participant and the Participant's Dentist have chosen a more costly treatment.

In order to determine the benefit amounts for dental covered services, the Plan may ask for X-rays and other diagnostic and evaluative materials. If these materials are not provided, the Plan will determine the benefit amounts based on the information that is available. This may reduce the amount of benefits which otherwise would have been payable.

EXCLUSIONS FOR THE DENTAL BENEFITS

No dental benefits are provided for any of the following:

Anesthesia The Plan will not cover local anesthesia or partial anesthesia, including intravenous sedation (except for Class 3 Services);

Appliances and Restoration for Vertical Dimension The Plan will not cover appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion. Full mouth equilibration is one example of such a service;

Congenital Malformation The Plan will not cover services or supplies for the treatment or correction of a congenital malformation unless Medically Necessary;

Cosmetic Services The Plan will not cover services or supplies primarily cosmetic or aesthetic. Examples include capping teeth to cover stains; charges for personalization or characterization of crowns, full or partial dentures or fixed bridgework;

Dental Visits to Home or in Hospital The Plan will not cover Charges for dental visits at home or in a Hospital, unless these visits are in connection with dental surgery or emergency care;

Duplicate Devices The Plan will not cover duplicate prosthetic devices or appliances;

Effective Date and Termination Date Rules The Plan will not cover dental services or supplies that are provided before this Dental Coverage goes into effect or after it is terminated. In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before Coverage goes into effect, even if the prosthetic device or crown is installed after Coverage goes into effect. If impressions are taken while Coverage is in effect, but the prosthetic device or crown is installed after Coverage terminates, then charges for the prosthetic device or crown will not be covered. In the case of the replacement of missing teeth, the Plan will not cover dental services or supplies for the replacement of a missing tooth or teeth that was missing prior to the effective date of Coverage;

Excess Charges The Plan will not cover charges that are considered excess charges because; the Participant transferred from one Dentist to another during a course of treatment; the Participant missed an appointment; services were rendered by more than one Dentist; or services were repeated needlessly;

Inappropriate Charges The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the ADA or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;

Labial Veneers The Plan will not cover labial veneers other than for the 12 upper and lower anterior teeth;

Lost or Stolen Supplies The Plan will not cover dental services and supplies to replace a lost or stolen crown, bridge or full or partial denture;

Medicaid The Plan will not cover any service available under Medicaid;

Non-Dental Services The Plan will not cover non-dental services, such as filling out claim forms, or any service or supply which is not specified as a Dental Covered Service;

Oral Hygiene Instruction or Programs The Plan will not cover plaque control programs, oral hygiene, nutritional or dietary instruction, or tobacco counseling for the control and prevention of oral diseases;

Orthodontia Services The Plan will not cover orthodontia services for any Participant other than a Dependent Child through the age of 18 years;

Porcelain Veneers The Plan will not cover porcelain or other veneers of crowns and pontics placed on the molars. If veneers are used, payment will be the same as payment for a full cast gold crown or cast gold pontic;

Stabilizing Services The Plan will not cover services primarily to stabilize the teeth in their supporting structures. Examples include implantology and periodontal splinting;

Unnecessary Services or Supplies The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed unnecessary or inappropriate by the ADA or is otherwise deemed unnecessary or inappropriate in accordance with accepted dental standards and practice.

PART III. PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG SCHEDULE OF BENEFITS	
Covered Services	**Copayment Amount**
RETAIL PHARMACY	
Generic Copayment	$10 per prescription
Formulary Brand Name Copayment	$25 per prescription
Non-Formulary Brand Name Copayment	$40 per prescription
Supply Limit	120 days
MAIL ORDER PHARMACY	
Generic Copayment	$20 per prescription
Formulary Brand Name Copayment	$50 per prescription
Non-Formulary Brand Name Copayment	$80 per prescription
Supply Limit	120 days

This section describes the Prescription Drug Benefits. The Plan will provide Prescription Drug Benefits when services:

1. Are authorized by a Physician; and
2. Are rendered and billed by a Provider; and
3. Qualify as a Covered Service

RETAIL PRESCRIPTION DRUG COVERAGE

Covered Drugs are drugs that require a prescription under federal law, are approved for general use by the Food and Drug Administration and are dispensed for the Participant's Outpatient use by a licensed Pharmacy on or after the Participant's Effective Date. Each covered prescription is limited to a 120-day supply.

Under the Pharmacy Coverage, there are 3 different Copayment amounts: a Copayment that applies when the Participant purchases a generic drug; a Copayment that applies when the Participant purchases a preferred brand name drug; and a Copayment that applies when the Participant purchases a non-preferred brand name drug.

MAIL ORDER PRESCRIPTION DRUG COVERAGE

The Plan will also cover Covered Drugs for maintenance drugs which require a prescription under federal law, are approved for general use by the Food and Drug Administration and are dispensed for the Participant's Outpatient use by the Pharmacy Benefits Manager (PBM) handling mail order drug prescriptions. Each covered prescription is limited to a 120-day supply. Should the prescription be written for less than a 120-day supply, the PBM does not have the authority to adjust the quantity for any reason and must dispense the quantity prescribed or as may be limited under federal law or Medicare dispensing guidelines. The Participant's Copayment will not be prorated or reimbursed when receiving less than a 120-day supply.

Under the Pharmacy Coverage, there are 3 different Copayment amounts: a Copayment that applies when the Participant purchases a generic drug; a Copayment that applies when the Participant purchases a preferred brand name drug; and a Copayment that applies when the Participant purchases a non-preferred brand name drug.

MEDICARE PART D PRESCRIPTION DRUG COVERAGE

The Health Plan includes prescription drug benefits as part of the medical coverage. Covered Retirees, Survivors and Dependents enrolled in either Medicare Part A or Parts A and B will automatically be enrolled in the Plan Sponsor's Medicare Part D prescription drug plan (Employer Group Waiver Plan) upon becoming Medicare-eligible. The Plan Sponsor will pay the Medicare premium for the Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a Physician or appropriate licensed health care provider that require a prescription either by federal or state law;

2. All compounded prescriptions containing at least one prescription ingredient that is a legend drug;

3. Prescription insulin when prescribed by a Physician or appropriate licensed health care provider and non-prescription insulin;

4. Other diabetic supplies, including needles and syringes whether or not purchased at the same time as the insulin, and lancets;

5. Oral and non-oral contraceptive birth control including injectable contraceptives for covered females who are age 18 or older;

6. Inhaler assisting devices;

7. Retin A/Avita for Participants through the age of 36;

8. Legend prenatal vitamins;

9. Drugs that appear on the standard specialty drug list;

10. For diabetic Participants, the Plan will cover Prior Authorization prescription drug therapy with quantity limits for male erectile dysfunction (ED) after the Participant renders a Copayment.

11. For non-diabetic Participants, the Plan will pay 50% of prescription benefit coverage for Prior Authorization drug therapy with quantity limits for male ED in patients 18 years of age and older in accordance with the following criteria and after the Participant renders 50% of the drug cost:
    - ED caused by a diagnosed organic physical disorder
    - ED secondary to endocrine-related disorders (e.g. hypogonadism, hyperprolactinemia) in the presence of failure of or contraindication to hormonal therapies
    - Drug-induced ED for situations where the existing drug therapy cannot be altered or discontinued.

12. All covered FDA-approved nicotine replacement products and covered prescription drugs for tobacco cessation including but not limited to Chantix and Bupropion (e.g. Zyban).
    All covered over-the-counter (OTC) nicotine replacement products and drugs for tobacco cessation, with a prescription, subject to the existing three-tier copayment structure. (Including but not limited to nicotine gum, lozenges and nicotine patches.)
    Covered drugs will be available through the retail pharmacy network and mail-order pharmacy prescriptions submitted to the prescription benefits manager.
    Quantity limits for all covered tobacco cessation products and drugs of two 12-week treatments per year with no prior authorization.

EXCLUSIONS OR LIMITATIONS FOR PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefit	Excluded and Will Not Cover	Limitation
Charges for Administration or Injection of Any Drug	X	
Alcohol Swabs	X	
Allergy Serums	X	
Appetite Suppressants and Anti-Obesity Medication	X	
Biologicals, Immunization Agents and Vaccines	X	
Contraceptive Emergency Kits	X	
Cosmetic	X	
Dental Fluoride Products	X	
Drugs Without Prescriptions	X	Except non-prescription insulin
ED drugs including, but not limited to, Viagra, Levitra, Cialis and their generic equivalents		Coverage is not provided for ED drugs in situations where patients are receiving nitrate therapy
Excess Prescription Refills	X	
Experimental/Investigative	X	
Fertility Medication	X	
Services Payable by a Governmental Agency or Program	X	
GlucoWatch Devices and Related Products	X	
Growth Hormones	X	
Immunization Agents and Blood Expenses	X	Exclusion includes biological sera, blood, and blood plasma
Inpatient Prescription Drugs	X	
Prescriptions for Non-Covered Medical Condition	X	
Non-Covered and non-prescription Medication	X	
Physician/Provider Administered Medication in Member's Home	X	
Refills After One Year from Doctor's Order	X	
Therapeutic Devices or Appliances	X	Except insulin syringes and needles when purchased at the same time as insulin
Vitamins	X	Except prenatal vitamins, Iferex, and Nascobal
Prescriptions for Work-Related Illness or Injury	X	

PART IV. VISION BENEFITS

The Plan pays 85% of the Provider's Reasonable and Customary charges for a routine eye exam. The Plan pays 85% of charges for prescription lenses, frames and contact lenses up to a $500 maximum limit per Participant during the Benefit Period.

EXCLUSIONS OR LIMITATIONS FOR VISION BENEFITS

The Plan will cover a maximum of a twelve-month supply of disposable contact lenses each calendar year.

The Plan will not cover these items:

- Cosmetic Services
- Frames for non-prescription lenses
- Loss, theft, breakage, or replacement of frames or lenses
- Non-prescription glasses and non-prescription sunglasses
- Orthoptics
- Vision training
- Lasik type surgeries
- Safety glasses
- Service agreements on frames or lenses

VISION COVERAGE SCHEDULE OF BENEFITS	
Covered Benefits	**Benefit Amounts**
Coinsurance	Plan pays 85% of Provider's Reasonable and Customary charge; Participant pays 15%
Deductible	$0
Eye Exam (annual routine)	Plan pays 85% of Provider's Reasonable and Customary charge
Prescription Frames	Plan pays 85%
Prescription Lenses Including glass, polycarbonate or plastic, single vision, bifocal, trifocal or progressive prescription lenses and professional services (fitting fees, etc.)	Plan pays 85%
Contact Lenses Any type of prescription contact lenses and professional services (fitting fees, etc.)	Plan pays 85%
Maximum Benefit	Plan pays $500 per Participant per calendar year
No vision network of providers; Participant may choose provider.	

- Radial keratotomy or other eye care or surgery to correct refractive disorders

- Eye examinations for occupational condition, ailment or injury arising out of or in the course of employment

- Diagnostic and non-routine eye exam (covered under Medical Benefits)

PART V. GENERAL EXCLUSIONS

The following exclusions and limitations are the General Exclusions applicable to the Medical, Dental, Prescription, and Vision Plans.

Applicable Section For expenses which are payable under one section of this Plan will not be payable under any other section of this Plan;

Charges Incurred Due to Non-Payment The Plan will not cover charges for sales tax, mailing fees and surcharges incurred due to nonpayment;

Claims Time Frames The Plan will not cover charges for claims not received within one year from the date of service as specified under the section entitled Claims Information;

Controlled Substance The Plan will not cover charges for the care or treatment of an Illness or Injury resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered by a Physician;

Court Ordered Treatment The Plan will not cover charges for court ordered treatment not specifically mentioned as covered under this Plan;

Criminal Act The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;

Drugs The Plan will not cover expenses for over-the-counter or prescription drugs purchased and administered on an Outpatient basis. Prescription drugs administered while an Inpatient in a Hospital will be covered under the Plan;

Effective and Termination Date The Plan will not cover charges for services and supplies for which a charge was incurred before the Participant was covered under this Plan or after their date of termination;

Exclusions The Plan will not cover charges for services and supplies which are specifically excluded under this Plan;

Experimental/Investigative The Plan will not cover charges for services and supplies which are either experimental or investigational or not Medically Necessary, except as specified in the Schedule of Benefits and Covered Services sections in this Summary Plan Description for clinical trials;

Excess of Provider's Reasonable Charge The Plan will not cover charges for services and supplies for treatment which are in excess of the Provider's Reasonable Charge;

Family Member The Plan will not cover expenses or services received from a member of the Participant's household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her Spouse, brother, sister, parent or the Dependent Child. Immediate Family Member also includes the brother sister, parent or Dependent Child of the employee's Spouse;

Government Owned/Operated Facility The Plan will not cover charges for services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the Participant is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are eligible and which are not incurred during or from service in the Armed Forces of the United States or any other country;

Governmental Agency or Program The Plan will not cover any service the Participant could receive free or have paid for by some government agency or program, even if the Participant does not choose to apply for or to accept this assistance;

Hospital/Facility Employee The Plan will not cover charges for services billed by a Provider (Physician or nurse) who is an employee of a hospital or facility and is paid by the hospital or facility for the services rendered;

Legal Obligation The Plan will not cover charges for services and supplies for which the Participant has no legal obligation to pay or for which no charge has been made;

Maximum Benefit The Plan will not cover charges for services and supplies which exceed the maximum benefit, as shown in the Schedule of Benefits or Eligible Expenses;

Military Benefits The Plan will not cover any service the Participant could receive free or have paid for as a military benefit. This applies if the Participant receives dental services or supplies while the Participant is in active military service or if the Participant receives services in a Veterans administration hospital;

Military Related Disability The Plan will not cover charges for services and supplies for any military service-related disability or condition;

Non-Medical Charges The Plan will not cover charges for: telephone consultations; failure to keep a scheduled visit; completion of a claim form; attending Physician statements; or requests for information omitted from an itemized billing;

Not Under Care of Physician The Plan will not cover charges for services and supplies not recommended and approved by a Physician; or services and supplies when the Participant is not under the care of a Physician;

Professional Medical Standards The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment;

Subrogation Failure The Plan will not cover charges for an Illness or Injury suffered by a Participant due to the action or inaction of any party if the Participant fails to provide information as specified under Subrogation;

Travel Outside United States The Plan will not cover charges for services and supplies obtained outside of the United States if the Participant traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;

Travel Expenses The Plan will not cover charges for travel, whether or not recommended by a Physician;

War The Plan will not cover any charge for services, supplies or treatment related to Illness, Injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear

explosion or nuclear accident. “War” means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces;

Work-Related Illness The Plan will not cover charges for services and supplies for any condition, disease, defect, ailment, arising out of and in the course of employment (for wage or profit), or in any way results from an illness which does. However, if proof is furnished to the Plan Administrator that a Participant covered under a Workers’ Compensation Law or other law of similar purpose is not covered for a particular illness under such law, that illness shall be considered “non-occupational” regardless of its cause and will therefore be considered an Illness that is eligible for Coverage under this Plan; and

Work-Related Injury The Plan will not cover an accidental bodily injury that arises out of or in the course of any work for pay or profit, or in any way results from an injury which does.

PART VI. CLAIMS AND APPEALS PROCESS

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 Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore may not 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 or provider, when applicable, is required to obtain approval from the Plan before obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See “Pre-Determination” above.) The fact that the Plan may grant 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 UMR CARE 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 may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent 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 their Personal Representative access to their 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, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

For Prescription benefits, a claim is considered filed when a Covered Person has submitted the claim for benefits under the Pharmacy benefit terms outlined in this SPD. The address for submitting Prescription claims is on the back of the identification card. If the Pharmacy refuses to fill the Covered Person's Prescription at the Pharmacy counter, the Covered Person should call the number on the back of the Pharmacy drug benefit identification card for further instructions on how to proceed.

A Covered Person who receives services in a country other than the United States is 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 the Covered Person 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 the paid date is not known.

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

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Employee
- 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's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's 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, an auto Accident, or another 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. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A Covered Person may request a Prescription claim form by writing to Optum Rx at PO Box 8082, Wausau WI 54402-8082, or by calling the number on the back of the Prescription drug card. A complete claim means that the Plan has all the information that is necessary in order 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 and explain the 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 a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service 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 the service 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 the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

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. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Modifiers or Reducing Modifiers, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the 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.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Reimbursement for Covered Expenses received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor; or
- 140 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

 A gap methodology may be utilized when CMS does not have rates published for certain procedural codes; or

 50 percent of the provider's billed charges when unable to obtain a rate published by CMS and/or gap methodology does not apply.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. 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.

For services received from a non-network 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. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

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 to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

For Prescription benefits, a Covered Person will receive an EOB when they file a claim directly with Optum Rx. See "Procedures for Submitting Claims" for more information.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may 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 may 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 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 may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Employee, 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.

- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational, or Unproven.
- 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, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), 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 may 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, Investigational, 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 their Personal Representative may 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 taking any outside legal action.

- The Covered Person 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 the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related 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.
- The Covered Person has 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 will 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 and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not 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 them 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 mandatory appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or their Personal Representative must submit a written request for a second review within 60 calendar days for 180 calendar days for Prescription benefits following the date they received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.

- The Covered Person 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.
- The Covered Person has 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 consider 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, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not 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 them 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.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Post-Service Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

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:

APPEALS COORDINATOR
OPTUM RX
PO BOX 25184
SANTA ANA CA 92799

Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

TIME PERIODS FOR MAKING DECISIONS 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 the Plan is 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.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or their authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, considering the medical exigencies, but no later than 72 hours after receiving the request for review.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 15 calendar days after the Plan receives the request for review for the first appeal, and another 15 calendar days for the second appeal, or a maximum of 30 calendar days for the two appeal levels.

- Post-Service Claims: Within a reasonable period of time, but no later than 30 calendar days after the Plan receives the request for review for the first appeal, and another 30 calendar days for the second appeal, or a maximum of 60 calendar days for the two appeal levels.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;
  - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR nor Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR’s receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.]

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's coverage 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.

PART VII. ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBLE EMPLOYEES

All full-time employees who are Actively Working and employees who are disabled under the Nashville Electric Service Disability Benefits Plan are eligible under the Plan and are offered coverage under the Plan. A full-time employee is an employee who is employed, on average, for at least 30 hours of service per week or 130 hours of service in a calendar month. Full-time employees may also elect coverage for their legally married Spouse and Dependent Child under age 26.

In addition, any employee who is covered under the Plan on the date of his or her retirement will continue to be eligible under the Plan in accordance with the rules of the Electric Employee Civil Service and Pension Board, provided the employee meets the eligibility requirements for retirement as defined in those rules. Such retired employee must have had a minimum of 5 years of service with the Employer to be eligible for continued Coverage as a retiree. Any Covered Employee who is eligible for Medicare under the employee's work record and who retires after the effective date of this Summary Plan Description will not be considered eligible for medical benefits unless he or she enrolled for both Medicare Parts A and B. Unless specifically stated otherwise, all references to "employee" in this Summary Plan Description will include retirees provided the retiree meets the eligibility rules under the Electric Employee Civil Service and Pension Board.

In addition, an employee who ceases to be Actively at Work due to a temporary layoff or approved leave of absence will continue to be eligible under the Plan for a period of time as permitted by the Employer. Contact the Employer for details concerning how loss of Actively Working status due to a temporary layoff or approved leave of absence will impact continued eligibility under the Plan.

Notwithstanding the preceding, an Employee whose coverage has been rescinded pursuant to the terms of the Plan shall be ineligible to participate in the Plan.

Impact of Breaks in Service

Any Employee who resumes Hours of Service following a Break in Service will be treated as a new hire and eligibility for coverage under the Plan upon return will be determined in accordance with the **"Enrollment Period and Effective Dates for New Hires and Rehires"** section below. If, however, the Employee experiences a period without any Hours of Service and resumes Hours of Service without experiencing a Break in Service, the Employee will be treated as a continuous employee. A continuous employee resuming Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with no Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date the employee resumes Hours of Service.

ELIGIBLE DEPENDENTS

The following persons are considered to be Eligible Dependents:

1. The Spouse of the Covered Employee who is legally married and who is not legally separated or divorced. The Employer may require that the Employee submit a copy of the marriage license or certificate at time of application;

2. For Medical, Dental and Vision Plans coverage: A child who is the Employee's natural child, step child, foster child, legally adopted child or who is in the Employee's legal guardianship or for whom the Employee is guardian pursuant to an interlocutory order of adoption and who is under age 18 at the time

of placement (Coverage eligibility begins from time of placement in the home for adoption whether or not the adoption proceedings have been completed) and is under the Dependent Limiting Age of 26;

3. A child who is an eligible Dependent Child of the non-custodial parent pursuant to medical child support order that has been issued by a Tennessee court in accordance with Title IV-D of the Social Security Act as set forth under the laws of Tennessee. Notwithstanding any Plan provision to the contrary, the medical child support order entitles such child to Coverage under the Plan, and such entitlement applies even if: (a) such child does not reside with the Covered Employee or is not dependent on the employee for support; and (b) the employee has not previously enrolled for Coverage under the Plan or does not have legal custody of the child. Such Dependent Child will be subject to the Dependent Limiting Age, if applicable, under this Plan; and

4. An unmarried child who is over the Dependent Limiting Age of the Plan and otherwise meets the definition of a Dependent Child and who is permanently disabled upon attainment of the Dependent Limiting Age. The Dependent Child must be incapable of self-sustaining employment by reason of mental retardation or mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must make application for continuation of Coverage to the Employer within 31 calendar days after the Dependent Child reaches the Dependent Limiting Age. Such application shall include proof satisfactory to the Employer of the Dependent Child's incapacity and dependence upon the Covered Employee.

Notwithstanding the preceding, a Dependent of an Employee whose coverage has been rescinded pursuant to the terms of the Plan shall be ineligible to participate in the Plan.

Examples of eligible Dependents include:

1. A legally married Spouse, as defined in this section; and
2. A natural child, stepchild, adopted child or child placed for adoption who is under the Dependent Limiting Age of 26 and who otherwise meets the eligibility requirements as set forth in this section; and
3. Any child for whom the Employee is the legal guardian, as defined in this section.

Examples of ineligible Dependents include:

1. A former Spouse (even if there is court order ordering the Employee to provide for the medical care of such former Spouse); and
2. Married or unmarried Dependent Child aged 26 and older for purposes of Plan eligibility; and
3. Parents, in-laws, siblings, relatives or any individual other than a legally married Spouse or Dependent Child as specifically defined in this section; and
4. Domestic partners; and
5. A live-in companion who is not legally married to the Employee as set forth in this section.

The Plan Administrator has the right to request information needed to determine the Participant's eligibility when a claim is filed. This includes but is not limited to a copy of the marriage license, birth certificate, divorce decrees, court orders, insurance eligibility documents, other insurance coverage and any other applicable documentation that is deemed to be necessary. In addition, the Plan Administrator has the right to request that the Covered Employee provide acceptable proof of the continuance of the incapacity and dependence of any Dependent Child who is permanently disabled. Failure to provide any documentation as requested by the Plan Administrator may result in a denial of Coverage. Examples of documentation required to add Dependents to the Plan can be obtained from the Compensation and Benefits Section.

Covered Employee requests and related documents necessary to add a new Dependent must be submitted to the Compensation and Benefits Section within 31 calendar days of the event (e.g. for marriage, within 31 days of the date of marriage and for birth or adoption or placement for adoption, within 31 days of the date of birth, adoption or placement for adoption). Refer to the "**Special Enrollment Periods and Effective Dates"** section below for additional details.

COVERAGE FOR DEPENDENT CHILDREN WHEN MOTHER AND FATHER ARE BOTH EMPLOYEES

When two employees are married to each other, only one employee will be permitted to obtain Coverage for the Dependent Children (e.g., husband-employee may obtain Coverage for himself and the Dependent Child(ren) and wife-employee may obtain Coverage for herself). Should both employees who are husband and wife submit application for Dependent Children Coverage, the Employer reserves the right to select which employee will be permitted to enroll the Dependent Child(ren) to his or her Coverage. In this instance, the Employer will make the determination based on the employee who has the most seniority with the Employer.

In a situation involving two employees who (1) have children together and (2) were formerly married to each other, only one employee will be permitted to obtain Coverage for the Dependent Child(ren). In this situation, should both employees submit application for Dependent Children Coverage, the Employer reserves the right to select which employee will be permitted to enroll the Dependent Child(ren) under his or her Coverage, and such determination shall be based on the employee who has the most seniority with the Employer. However, in the event that a medical child support order has been issued by a Tennessee court in accordance Title IV-D of the Social Security Act as set forth under the laws of Tennessee, such Dependent Child will be entitled to Coverage in accordance with such court order regardless of how this provision would otherwise be applied. Refer to the **"ELIGIBLE DEPENDENTS"** section above for more details.

SURVIVING DEPENDENTS

When an Actively Working Covered Employee and a Covered Retiree dies, the covered Spouse and covered biological and adopted Dependent Child(ren) of such employee and retiree ("Surviving Dependent") may continue eligibility and Coverage under the Plan subject to the terms and conditions outlined in **Part IX, CONTINUED COVERAGE PROVISIONS** and **Part X, ADDITIONAL CONTINUATION COVERAGE (COBRA)**.

ELIGIBILITY DETERMINATIONS UNDER HIPAA

Federal Law, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), prohibits the Plan Sponsor from denying Coverage under the Plan based on any of the following health-related factors:

1. Health status;
2. Medical condition (including both physical and mental illnesses);
3. Receipt of healthcare;
4. Medical history;
5. Genetic information;
6. Evidence of insurability;
7. Disability; and
8. Claims experience

The term "evidence of insurability" includes conditions arising from acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

ENROLLMENT PERIOD & EFFECTIVE DATE FOR NEW HIRES AND REHIRES

For Eligible Employees who are newly hired or become eligible under the Plan, the Eligible Employee must complete and submit an enrollment application to the plan within 31 calendar days following the Eligible Employee's date of hire. For Eligible Employees whose application is submitted to the Employer on or prior to the date of hire, Coverage will become effective on the date of hire. For Eligible Employees whose application is submitted to the Employer after the date of hire but within the 31-day enrollment period, the employee will decide whether Coverage will become effective on the date of hire or the first day of the following month.

Also see the **"Late Enrollment"** section below.

SPECIAL ENROLLMENT PERIODS AND EFFECTIVE DATES

There are a number of circumstances that qualify as Special Enrollment Periods. The following events qualify as Special Enrollment Periods under the Plan:

1. **Loss of Other Coverage**: Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, subsequently lose coverage under the other plan and complete an application within 31 calendar days and submit it within 45 calendar days following the termination of coverage shall be made effective the first day of the month following the date of the loss of other coverage, as set forth below. In this event, loss of coverage must be due to:

    a. Exhaustion of COBRA benefits;
    b. Loss of eligibility under the prior coverage; or
    c. Termination of contributions by the employer under the prior plan.

    "Loss of eligibility" includes but is not limited to the following types of losses:

    a. Loss of eligibility under the other coverage due to divorce, dissolution, legal separation. In this instance, the Eligible Employee and any Dependent Children would be eligible to enroll;
    b. Loss of eligibility under the other coverage due to cessation of dependency status. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
    c. Loss of eligibility under the other coverage due to death of the employee. In this instance, the Eligible Employee (whose Spouse has died) and any Dependent Children would be eligible to enroll;
    d. Loss of eligibility under the other coverage due to termination of employment or reduction of hours. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
    e. Loss of eligibility under the other coverage because the individual no longer resides in the service area. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;

f. Loss of eligibility under the other coverage because the overall maximum benefit has been reached. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
g. Loss of eligibility under the other coverage because the other employer ceases to provide health care benefits to similarly situated individuals. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll.

This Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, provided application is submitted within the time frame set forth above and loss coverage under the other plan was for one of the reasons set forth above.

2. **Gaining Other Coverage**: In the event a covered Dependent Child or Spouse gains coverage under another health plan, the Eligible Employee may request to drop the dependent's coverage under this Plan by completing and submitting an enrollment application to the Plan within 31 calendar days following the covered dependent's effective date of other coverage. The Plan Administrator has the right to request that the Covered Employee provide acceptable proof of other coverage and the effective date of other coverage.

3. **Birth or Adoption**: In the event of a birth of a child or adoption or placement for adoption of a child, the child and the Eligible Employee and Spouse, if not covered, will be eligible to enroll for Coverage under this provision. In this event, application must be completed and submitted to the Plan within 31 calendar days following the date the dependent child becomes an Eligible Dependent. Coverage shall be made effective on the birth date of the child, or for an adopted child or child placed for adoption, on the date the Dependent Child becomes an Eligible Dependent.

4. **Marriage**: In the event a Covered Employee marries after his or her Coverage has become effective, the employee may add his or her Spouse to the Coverage by completing and submitting to the Plan an application within 31 calendar days of the event. In this event, Coverage will be effective on date of the marriage. In this instance, the Eligible Employee and all other Dependents, who are otherwise eligible under the Plan, and who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, are permitted to enroll during this special enrollment period.

SPECIAL ENROLLMENT RIGHTS UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2009

1. **Special Enrollment Right**: Employees and Dependents who are or become eligible under the State Children's Health Insurance Program (SCHIP) or Medicaid and then lose such eligibility, may enroll in the Plan (if they are otherwise eligible) within sixty (60) days of the date the Employee (or a Dependent) loses eligibility for the Medicaid or SCHIP program or within sixty (60) days of becoming eligible for premium assistance under Medicaid or SCHIP. This "special enrollment right" exists even though the timing may fall outside of a Plan's open enrollment period and the Employee previously refused Plan coverage. This enrollment allowance also applies to those who lose SCHIP or Medicaid coverage and then want to enroll in the Employer Plan.

2. **Premium Assistance**: The State may either: (1) reimburse the Employer directly for the cost differential to add family coverage (to add previously uncovered children to the Plan), or (2) require covered beneficiaries to pay the full family cost and reimburse the Employee. However, the Employer/Plan Sponsor can opt out of the first option and require the full cost of coverage from the covered Employee.

To qualify, residents and their Dependent(s) must be eligible for Plan coverage in which the Employer contributes at least 40% toward the coverage cost.

LATE ENROLLMENT

Employees or Dependents who fail to submit a registration application during the time periods set forth above, will be considered Late Enrollees. Late Enrollees may be permitted to enroll for Coverage during the Plan's Annual Open Enrollment Period, or, if applicable, a special enrollment period.

ANNUAL OPEN ENROLLMENT PERIOD AND EFFECTIVE DATE

The Annual Open Enrollment Period is the period designated by the Employer during which the Covered Employee may elect Coverage for him/herself and any eligible Dependents if he/she is not covered under the Plan and does not qualify for a Special Enrollment. During this Annual Open Enrollment Period, an Employee and his Dependents who are not covered under this Plan must complete and submit an enrollment form for Coverage. The Employer may require acceptable documentation when an enrollment form is submitted in order to determine eligibility and Coverage of the Covered Employee and Dependents.

The Annual Open Enrollment Period under this Plan occurs during the latter part of the calendar year. Coverage for Employees and Dependents who enroll during this Annual Open Enrollment Period will be effective the first day of January of the following year.

PART VIII: TERMINATION PROVISIONS

TERMINATION OF EMPLOYEE COVERAGE

Coverage will terminate for the Covered Employee and the employee's Covered Dependents on the earliest of the following:

1. The date the Plan terminates;
2. The date on which the Covered Employee ceases to be an Eligible Employee or, if applicable, an Eligible Retiree. This includes death or termination of Active Employment of the Covered Employee;
3. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees has not been submitted when due; and
4. The effective date of the rescission of the Covered Employee's coverage.

The Actively Working employee may be eligible for continued Coverage as described in Parts IX and X.

The Employer, in accordance with the rules of the Electric Employees Civil Service and Pension Board may continue Coverage for no more than three months for any employee who (1) is no longer an Actively Working employee provided such person is still classified as an employee by the Employer; or (2) is temporarily laid off or granted a leave of absence. Refer to the section PART VII. ELIGIBILITY AND ENROLLMENT PROVISIONS for more details

TERMINATION OF DEPENDENT COVERAGE

Coverage will terminate for the following Participant(s) on the earliest of the following:

1. The date the Plan terminates;
2. The date the Covered Employee's, or if applicable, the Covered Retiree's Coverage terminates;
3. The date of the Employee's death, unless the Dependent is entitled to receive Continued Coverage as a Surviving Dependent;
4. The date a Dependent loses dependency status or reaches the Dependent Limiting Age under the Plan;
5. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees has not been submitted when due;
6. The effective date of the rescission of the Covered Employee's coverage.

The Dependent may be eligible for continued Coverage as described in Parts IX and X.

RESCISSION OF COVERAGE

Under this Plan, coverage may be retroactively canceled or terminated (Rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is each Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also each Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, the cancellation may be retroactive, and such actions may be subject to prosecution under applicable law.

A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being Rescinded will be provided a thirty (30) day notice period.

A Rescission does not include any retroactive cancellations of coverage that would not constitute a Rescission under applicable law. For example, a retroactive cancellation is not a Rescission if it is attributable to a failure to timely pay required contributions toward the cost of coverage.

If the misrepresentation or fraud occurs before coverage became effective, the Plan may rescind coverage as of the effective date of coverage. If the misrepresentation or fraud occurs after coverage became effective, the Plan may rescind coverage as of the date the misrepresentation or fraud first occurred.

If coverage is rescinded, the Plan will return all premiums paid by a Covered Employee with respect to the Participant whose coverage was rescinded which were paid, if any, after the effective date of the Rescission, if any, reduced by any claims paid by the Plan after the effective date of the Rescission. If claims paid after the effective date of the Rescission are more than the premiums paid by the Covered Employee after such date, the Plan shall have the right to collect that amount from the Participant, as applicable, to the extent not prohibited by law.

PART IX: CONTINUED COVERAGE PROVISIONS

There are a number of continued Coverage provisions under this Plan. These provisions allow for continued benefits following the date Coverage would otherwise terminate for the Participant. Refer to the following provisions for an explanation of various continued Coverage provisions under this Plan.

CONTINUED COVERAGE FOR RETIREES

The Employer, in accordance with the rules of the Electric Employee Civil Service and Pension Board, will continue Coverage for any Covered Employee whose employment terminates due to retirement, provided the employee meets the eligibility requirements for retirement as defined in those rules. Coverage for such employee will include Coverage for any family member who was covered under the employee's Coverage on the date the employee's employment with the Employer ceased as the result of such retirement. The cost of such coverage is the same as for active employees, but paid monthly.

In any event, Coverage will automatically terminate for such retiree and any covered Dependents as set forth in **Part VIII, TERMINATION PROVISIONS.**

CONTINUED COVERAGE FOR SURVIVING DEPENDENTS

When an Actively Working employee and retiree dies, the Surviving Dependents of such employee and retiree may continue eligibility and Coverage following the employee's or retiree's death provided Coverage was in place for all such individuals at the time of the employee's or retiree's death.

In addition to the conditions noted in this section, a Surviving Dependent must also satisfy the eligibility conditions set forth in the section entitled **"Eligible Dependents"** In Part VII (e.g., Coverage for a Surviving Dependent Child will not continue beyond the child's Dependent Limiting Age).The cost of such coverage is the same as the cost of single active employee coverage.

In any event, Coverage will automatically terminate for such retiree and any covered Dependents as set forth in **Part VIII, TERMINATION PROVISIONS.**

CONTINUED COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 AS AMENDED (FMLA)

The employee may be entitled to a leave of absence and continued Coverage in connection with a leave of absence that meets the guidelines of the Family and Medical Leave Act of 1993 as amended (FMLA). If the Covered Employee requires additional details concerning FMLA, the Covered Employee should contact the Compensation and Benefits Section for details.

CONTINUED COVERAGE FOR EMPLOYEES IN UNIFORMED SERVICES

In the event the Covered Employee is required to be absent from work as the result of service in the Uniformed Services, Coverage for Medical Benefits may be continued for the Covered Employee in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

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

Period of Continued Coverage under the USERRA Provision

Coverage may be continued for the Covered Employee and his or her covered Dependents for a period which shall equal the lesser of the following:

1. The 24-month period beginning on the date on which the employee's absence begins; or
2. The period beginning on the date on which the employee's absence begins and ending on the day after the date on which the employee fails to apply for or return to a position of employment.

Cost of Continued Coverage

The Employer may require the Covered Employee or Dependent to pay the full cost of the continued Coverage. The monthly payment may not exceed 102% of the monthly payment being charged by the Employer for similarly situated employees. However, if the employee performs service in the Uniformed Services for less than 31 calendar days, such employee may not be required to pay more than 100% of the monthly payment being charged by the Employer for similarly situated employees.

Termination of Continued Coverage

The continuation of Coverage ends at the earliest of the following:

1. When the Participant becomes covered under another health plan without pre-existing condition limitation;
2. Upon the expiration of the continued period of Coverage;
3. When the required payments are not received on a timely basis; and
4. When the health plan is terminated and not replaced by the Employer with another health plan.

PART X: ADDITIONAL CONTINUATION COVERAGE (COBRA COVERAGE)

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) created continuation coverage of health benefits for employees and their families if certain criteria are met by the group health plan. A group health plan meets the basic criteria for applying COBRA if the group health plan is be sponsored by your employer and the employer employs at least 20 employees.

The Plan offers employees and their families the opportunity to elect COBRA coverage for Medical, Dental, and Vision Benefits ("Continuation Coverage") if the participant was receiving those benefits at the time of the Qualifying Event. If the Participant does not choose Continuation Coverage, the Coverage under the Plan will end. Employees and their families must meet the COBRA eligibility requirements described below under Qualifying Events.

There may be other coverage options for you and your family for which you can buy coverage through the Health Insurance Marketplace at www.healthcare.gov. In the Marketplace, what you pay for insurance depends on your income and you could be eligible for a tax credit that lowers your monthly premiums. The plans are offered by private insurance companies with a range of features and prices. You can see what your premium, deductibles and out-of-pocket costs will be before you decide to enroll. Being eligible for COBRA does not limit your eligibility to enroll through the Marketplace. Additionally, you may qualify for a special enrollment

opportunity for another group health plan for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

QUALIFIED BENEFICIARIES

A Qualified Beneficiary is a Participant who loses Coverage under the Plan as the result of a Qualifying Event.

QUALIFYING EVENTS

Qualifying Events are any one of the following events, which would normally result in termination of Coverage. These events will qualify a Participant to continue coverage as a Qualified Beneficiary beyond the termination date described in this Summary Plan Description. The Qualifying Events are listed below.

1. Death of the Covered Employee.
2. The Covered Employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for Coverage under the Plan. This includes an individual whose employment has terminated following the last day of leave under the Family Medical Leave Act.
3. Divorce or legal separation from the Covered Employee.
4. The Covered Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act if it results in the loss of coverage under this Plan.
5. A Dependent child no longer meets the eligibility requirements of the Plan.
6. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.
7. A Qualifying Event will also include termination of retirement benefits for a Covered Retiree under this Plan.

NOTIFICATION REQUIREMENTS

There are a number of notification requirements in connection with this Continuation Coverage provision. First, the Plan Administrator must be alerted to a Qualifying Event in order to offer Continuation Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Plan Administrator, either by the Employer, or by the Covered Employee or a Dependent. The nature of the Qualifying Event determines which party must notify the Plan Administrator. Second, once the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will provide notices to the Beneficiary. The notification requirements established under this are described in the Continuation Coverage section.

NOTIFICATION BY COVERED EMPLOYEE OR DEPENDENT

The Covered Employee or Dependent must notify the Plan Administrator when eligibility for Continuation Coverage results from one of the following events:

1. Divorce or legal separation from the Covered Employee; and
2. A Dependent child no longer meets the eligibility requirements of the Plan.

The Covered Employee or Dependent must provide this notice to the Plan Administrator within sixty (60) days of either the Qualifying Event or date of loss of Coverage, as applicable to the Plan.

For individuals who are requesting an extension of Continuation Coverage due to a disability, the individual person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial eighteen (18) month Continuation Coverage period and no later than sixty (60) days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within thirty (30) days of such change in status.

These notification requirements also apply to an individual who, while receiving Continuation Coverage, has a second or subsequent Qualifying Event.

The Covered Employee or Dependent, or their representative, must deliver this notice in writing to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above the Plan Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to Continuation Coverage.

To protect their rights, it is very important that Covered Employees and Dependents keep the Plan Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of Covered Employees and Dependents to advise the Plan Administrator of any address changes in a timely manner, in order to ensure that notices are deliverable.

Failure to provide notice to the Plan Administrator in accordance with the provisions of this notice requirement will result in the person forfeiting their rights to Continuation Coverage under this provision.

NOTIFICATION BY EMPLOYER

The Employer is responsible for notifying the Plan Administrator when eligibility for Continuation Coverage results from any events other than divorce or legal separation, or a Dependent becoming ineligible.

The Employer shall provide this notice to the Plan Administrator within thirty (30) days of either the Qualifying Event or date of loss of coverage, as applicable to the Plan. The Employer must include information that is sufficient to enable the Plan Administrator to determine the Plan, the Covered Employee, the Qualifying Event, and the date of the Qualifying Event.

The Employer must deliver this notice in writing to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted.

NOTIFICATION BY PLAN ADMINISTRATOR

Election Notice: Once the Plan Administrator receives proper notification that a Qualifying Event has occurred, Continuation Coverage shall be offered to each of the Qualified Beneficiaries by means of an Election Notice. The time period for providing the Election Notice shall generally be fourteen (14) days following receipt of notice of the Qualifying Event. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

Notice of Ineligibility: In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to coverage, the Plan Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect Continuation Coverage. A notice of ineligibility shall be sent within the same time frame as described for an Election Notice.

Notice of Early Termination: The Plan Administrator shall provide notice to a Qualified Beneficiary of a termination of Continuation Coverage that takes effect on a date earlier than the end of the maximum period of Continuation Coverage that is applicable to the Qualifying Event. The Plan Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

ELECTION OF COVERAGE

Upon receipt of Election Notice from Plan Administrator, a Qualified Beneficiary has sixty (60) days from the date the notice is sent to decide whether to elect Continuation Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect Continuation Coverage on an individual basis, regardless of family enrollment. For example, the employee's Spouse may elect Continuation Coverage even if the employee does not select the Coverage. Continuation Coverage may be elected for one, several or all dependent children who are Qualified Beneficiaries and a parent may elect Continuation Coverage on behalf of any dependent child.

In considering whether to elect Continuation Coverage, the Qualified Beneficiary should consider that a failure to continue Coverage may affect future rights under the Plan. For example, the Participant may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Participant also has special enrollment rights under HIPAA which allow him or her to enroll in another group health plan for which the Participant is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Participant also has the same special enrollment rights at the end of the Continuation Coverage if the Participant receives continued coverage for the maximum period available under the Plan. Starting in 2014, health plans may no longer impose pre-existing condition exclusions on any enrollees.

If the Qualified Beneficiary chooses to have continued coverage, the beneficiary must advise the Plan Administrator in writing of this choice. This is done by submitting a written Election Notice to the Plan Administrator. The Plan Administrator must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

1. The date Coverage under the Plan would otherwise end; or

2. The date the notice is sent by the Plan Administrator notifying the person of his or her rights to Continuation Coverage.

PERIOD OF CONTINUED COVERAGE

Under this continued coverage option, a Qualified Beneficiary who elects Continuation Coverage is afforded the opportunity to maintain Continuation Coverage for 36 months unless the beneficiary loses Coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required Continuation Coverage period is 18 months.

This 18-month period may be extended if a subsequent or second Qualifying Event (for example, divorce, legal separation, employee's becomes entitled to Medicare or death) occurs during that 18-month period. A second event may be a valid Qualifying Event only if it would have been a valid first Qualifying Event. That is, a second Qualifying Event shall qualify only if it would have caused a Participant to lose Coverage under the Plan if the first Qualifying Event had not occurred. A second or subsequent Qualifying Event is therefore limited to the following Qualifying Events:

1. Death of a Covered Employee;
2. Divorce or legal separation between the Spouse and the Covered Employee;
3. Dependent Child's loss of Dependent status under the Plan.

The Covered Employee's Medicare entitlement may also be considered a subsequent or second Qualifying Event for any Dependents who are Qualified Beneficiaries following the first Qualifying Event, but only if the Medicare entitlement would have resulted in loss of Coverage under the Plan had the first Qualifying Event not occurred.

Under no circumstances, however, will Coverage last beyond 36 months from the date of the event that originally made the Participant eligible to elect Coverage. Only a person covered prior to the original Qualifying Event or a child born to or Placed for Adoption with a Covered Employee during a period of continuation is eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event. Any other Dependent acquired during Continuation Coverage is not eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event.

COST OF COVERAGE AND PAYMENTS

The Employer requires that Qualified Beneficiaries pay the entire costs of their Continuation Coverage, plus a two percent administrative fee. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the Coverage in force.

For purposes of determining monthly costs for continued Coverage, a person originally covered as an Employee or as a Spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the continued Coverage. The initial payment must be made within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for continued Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received. However, a 30-day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received.

There may be no grace period for making payments, other than the grace period described above.

If the initial payment or any subsequent monthly payment is received that is insufficient, a notice will be sent to the Participant at the Participant's last known address. The remaining amount must be sent within 30 days to continue Coverage.

WHEN CONTINUATION COVERAGE BEGINS

When Continuation Coverage is elected and the contributions paid within the time period required coverage is reinstated back to the date of the Qualifying Event or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

DEPENDENTS ACQUIRED DURING CONTINUATION

A Spouse or Dependent child newly acquired during Continuation Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during Continuation Coverage. A Dependent acquired and enrolled after the original Qualifying Event, other than a child born to or Placed for Adoption with a Covered Employee during a period of Continuation Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

END OF CONTINUATION COVERAGE

Continuation Coverage will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment or termination of retirement benefits of the Covered Employee.
2. Thirty-six (36) months from the date continuation began for Dependents whose coverage ended because of the death of the Covered Employee, divorce or legal separation from the Covered Employee, the child's loss of Dependent status, or Medicare entitlement.
3. The end of the period for which contributions are paid if the Participant fails to make a payment on the date specified by the Employer or by the end of the grace period.
4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan.
5. The date the Participant first becomes entitled to Medicare after the election.
6. The date the Participant first becomes covered under any other group health plan without regard to a pre-existing condition after the election. If the replacing health plan has a pre-existing condition limitation, the Participant may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new health plan, or until he or she is no longer eligible under the Continuation Coverage. (Note: beginning in 2014, the health care reform law prohibits pre-existing condition exclusions)
7. The date the Participant is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause.
8. Thirty-six (36) months from the date continuation began for the surviving Spouse and Dependent children of a Retiree who dies, when the Retiree's Qualifying Event was the Employer's bankruptcy filing.

The Plan Administrator shall provide notice of any early termination. Refer to the **"Notification By Plan Administrator"** section above for more details.

The law also requires that an individual who has elected Continuation Coverage be permitted to enroll in any individual conversion health plan which is provided under the Plan. Contact the Plan Administrator about the availability of a conversion policy.

THE PLAN ADMINISTRATOR AND CONTACT INFORMATION

An employee may obtain additional information about his or her Continuation of Coverage rights from the Plan Administrator. If the employee has any questions concerning his or her Continuation of Coverage rights, the employee should contact the Plan Administrator.

Finally, in order to protect the employee's and his or her family's rights, the Participant should keep the Plan Administrator informed of any changes to his or her address and the addresses of family members. The employee should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

The name, address and telephone number of the Plan Administrator is:

Nashville Electric Service
1214 Church Street
Room 141
Attn: Compensation and Benefits Section
Nashville, Tennessee 37246
615-747-3942

It is important to note that the Plan Administrator has contracted with HealthSCOPE Benefits to perform certain services on behalf of the Plan. Therefore, the employee may also contact HealthSCOPE Benefits if the employee has questions about Continuation Coverage or wishes to inquire about his or her continuation rights. The address and telephone number for HealthSCOPE Benefits is:

HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, Arkansas 72205
877-385-3775

PART XI. COORDINATION OF BENEFITS AND ORDER OF BENEFITS DETERMINATION

COORDINATION OF BENEFITS PROVISION

All benefits provided as described in this Summary Plan Description are subject to Coordination of Benefits (COB). COB determines when a benefit plan is primary or secondary when a Participant is covered by more than one benefit plan.

This coordination of benefits provisions ("COB") applies when the Participant is also covered by an Other Benefit Plan. When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan. This plan is considered the primary plan. Any Other Benefit Plan is referred to as the secondary plan and pays a reduced benefit to prevent duplication of benefits.

By coordinating benefits under this provision, the total benefits payable by all Other Benefits Plans and this Plan will not exceed 100% of Allowable Expenses. A common set of rules is used to determine the order of benefits determination Other Benefit Plan.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. When this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefit Plans and this Plan do not exceed 100% of total Allowable Expenses. The actual amount payable by the Plan as the secondary plan will be the difference between the amount that has been paid by the primary plan and the amount that would have been paid by this Plan had it been the primary plan. If the amount paid by the primary plan equals or exceeds the amount that would have been payable this Plan if were the primary plan, then no further benefit payments will be made by the Plan in connection with that claim.

In no event shall the Participant recover under this Plan and all Other Benefit Plans more than the total Allowable Expenses under this Plan and all Other Benefit Plans. Nothing contained in this section shall entitle

the Participant to benefits in excess of the total Maximum Benefits of this Plan. The Participant agrees to refund to the Employer any excess benefits the Plan may have paid.

The Plan may exchange information with any Other Benefit Plans without the consent of or notice to any person, while coordinating benefits for a Participant. Any person claiming benefits under this Plan must furnish to the Employer the information necessary to coordinate benefits.

DEFINITIONS

As used in this Part, the following terms are defined as:

"Other Benefit Plan" means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program (not including Medicare).

"Allowable Expenses" means any Eligible Expenses incurred while the Participant is covered under this Plan, except that any Eligible Expenses incurred that apply toward the Participant's copayment, deductible or coinsurance requirement under this Plan or any Other Benefit Plan will not be included as an Allowable Expense.

ORDER OF BENEFITS DETERMINATION

Which plan provides primary or secondary Coverage will be determined by using the first of the following rules that applies:

1. **Active Employees vs. Retired Employees**. When a plan covers the Participant as an active employee or a Dependent of such employee and the Other Benefit Plan covers the Participant as a retired employee or as a Dependent of such person, the plan that covers the Participant as an active employee or Dependent of such employee is primary

2. **Dependent Child of Parents (Not Divorced or Legally Separated)**. When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a Dependent is covered by two benefit plans and the Other Benefit Plan does not have coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the Other Benefit Plan will determine the primary and secondary contract.

3. **Dependent Child of Parents Divorced or Legally Separated**. When a Dependent is covered by more than one plan of different parents who are separated or divorced, the following rules apply:

    a. if the parent with custody has not remarried, his or her coverage is primary;

    b. if the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last;

c. if a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary.

4. **Employee or Member**. The benefit plan covering the Participant as an employee, member or subscriber (other than a Dependent) is primary.

5. **Medicare Eligible**. If a Participant is eligible for Medicare, the order of benefits determination will be determined as set forth in the section entitled "Order of Benefits Determination for Medicare."

6. **No COB**. If the Other Benefit Plan contains no COB provision, it will always be primary.

7. **Rules Do Not Apply**. When the COB rules above do not apply, the plan that has covered the Participant longer is primary.

8. **Special Note Regarding Continued Coverage**. If the Participant is covered under an Other Benefit Plan that is primary but also has continued Coverage under this Plan (e.g., COBRA) due to the Other Benefit Plan's pre-existing condition exclusion, then this Plan will be primary for expenses incurred in connection with such pre-existing condition only.

ORDER OF BENEFITS DETERMINATION FOR MEDICARE

If, in addition to this Plan, the Participant is covered by Medicare, the order of benefits payments will be determined in the following manner:

Medicare Eligibility On The Basis of Age

Medicare is the secondary payer for the Medicare-eligible Working Aged. The Working Aged include an employee aged 65 or over and the employee's Spouse who is age 65 and over, who have coverage under a group health plan because of the employee's or Spouse's employment. This provision applies to employer-sponsored health plans that have 20 or more full time or part-time employees for each working day in each of 20 more calendar weeks in the current calendar or preceding calendar year. Based on this provision, the Covered Employee's Plan will be considered primary for the employee and the employee's Spouse as long as such employee remains Actively Working, and the Plan will not reduce or terminate Coverage of such employees and their spouses because of their entitlement to Medicare.

Medicare allows the Covered Employee or Spouse to choose Medicare as primary if eligible. In this event, the employee and Spouse will lose Coverage under this Plan for any benefits that would be considered Medicare eligible expenses. Additionally, an employee or Spouse who elects Medicare as the primary payer may purchase a Medicare supplement plan from a source other than the Employer. The Employer may not purchase or subsidize an individual Medicare supplement plan for the employee or Spouse.

Medicare Eligibility Due to Kidney Failure

Medicare is the secondary payer if the Participant has Medicare due to permanent kidney failure for a period of 30 months, beginning with the earlier of the following dates:

1. The month in which the Participant begins a regular course of renal dialysis; or,

2. The first month in which the Participant becomes entitled to Medicare, if he or she receives a kidney transplant within first beginning dialysis.

After a period of up to 30 months following this date expires, Medicare will become the primary payer. Once Medicare becomes primary, the benefits of this Plan will be applied only to any unpaid balance after the Participant receives Medicare benefits. In this event, Medicare benefits available to the Participant will be subtracted whether or not a Medicare claim is filed.

Medicare Eligibility Due to Other Disability

Medicare is the secondary payer for people under age 65 who have Medicare because of a disability (other than those with permanent kidney failure) and who are covered under a Large Group Health Plan (as defined in the next sentence) as an employee or Dependent of such person. To be eligible under this provision, the employee must be Actively Working in spite of the disability. Generally, a Large Group Health Plan is a health plan that has 100 or more full time, part time or seasonal employees. However, the Covered Employee or Spouse should contact the Plan Sponsor to determine whether or not Coverage is being provided under a Large Group Health Plan.

Medicare Eligibility for Medicare Eligible Retirees

For all other Participants eligible for Medicare (e.g. Retirees who are Medicare-eligible), Medicare will be determined the primary payer and the Plan will be considered the secondary payer. This means that Medicare benefits will be determined first and the benefits under the Plan will be applied only to any unpaid balance after Medicare benefits are received.

PART XII: THIRD PARTY RECOVERY AND SUBROGATION

WHAT IS SUBROGATION?

Subrogation applies to situations where the Participant is injured and another party is responsible for payment of health care expenses the Participant incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injuries on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Participant's injuries under the Plan may be recovered from the other party. Any payments made to the Participant for such injury may be recovered from the Participant from any judgment or settlement of his or her claims against the other party or parties.

The Participant must cooperate fully and provide all information needed under the Plan to recover payments and execute any papers necessary for such recovery. The other party may be sued in order to recover the payments made for the Participant under the Plan.

RIGHT OF REIMBURSEMENT AND RECOVERY

Specifically, by accepting Coverage under the Plan the Participant agrees that if the Participant receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from a) an individual responsible for the wrongdoing, b) a liability insurer for an individual

responsible for the wrongdoing, or c) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverage, or any other form of insurance coverage ("Recovery"), the Participant must repay the Plan in full for any benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

The Plan has the right to be paid from any such Recovery any and all monies: a) paid, b) payable to, or c) for the benefit of, a Participant to the extent of benefits paid by the Plan ("Subrogated Amount"), whether or not the Participant has been "made whole" for the injuries received. This right for first priority in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Participant or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney's fees or costs incurred by the Participant in the collection of damages.

The Participant has an obligation and duty to reimburse the Plan to the extent of the Subrogated Amount and is deemed to give the Plan the first lien on the Subrogated Amount. The Plan may, in its sole discretion, require the Participant, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Participant or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Participant.

PART XIII. GENERAL PROVISIONS OF THE PLAN

ALTERATION OF APPLICATION

An enrollment application may not be altered by anyone other than the applicant unless the applicant has given his or her written consent allowing alterations.

AMENDMENT OF THE PLAN

The Employer reserves the right to amend this Plan at any time in accordance with applicable law. Such amendment shall be binding upon the Employer and all Participants. The Employer shall make available to each Covered Employee a summary, written in a manner calculated to be understood by the average Covered Employee, of any modification to the Plan or change in the information required to be included in this Summary Plan Description

APPLICABLE LAW

This Plan shall be construed in accordance with the applicable laws of the State of Tennessee without regard to its conflicts of laws provisions and of the United States of America. Any provision of this Plan that conflicts with applicable law is amended to conform with the minimum requirements of that law.

ASSIGNMENT OF BENEFITS

The right of any Participant to receive any benefits or payments under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law. A request for direct payment to a Provider is not considered an assignment.

BENEFITS NOT TRANSFERABLE

Except as otherwise provided in this SPD, no person other than an eligible Participant is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

EFFECTIVE DATE

Except where specifically stated otherwise in this Plan, the provisions of this amended and restated Plan are effective January 1, 2019, and this Summary Plan Description shall supersede and replace all prior versions of the Plan as of that date.

EMPLOYMENT RIGHTS

The establishment of this Plan and the Covered Employee's participation in the Plan does not affect in any way the employee's employment rights, nor does the establishment or the employee's participation in this Plan confer any right upon any employee to be retained in the service of the Employer.

ERRONEOUS INFORMATION

If any information pertaining to any Participant is found to have been reported erroneously to the Plan Sponsor or to HealthSCOPE Benefits, as the claims administrator, and such error affects his or her Coverage, the facts will determine to what extent, if any, the Participant was or is covered under the Plan. See the **"Rescission of Coverage"** section in Part VIII.

EXEMPTION FROM ATTACHMENT

To the full extent permitted by law, all rights and benefits under the Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Employee or other Participant except the foregoing shall not preclude the enforcement of the Employer's rights pursuant to the terms of the Plan.

FINAL AUTHORITY OF THE PLAN DOCUMENT

The terms and provisions contained in this Summary Plan Description, as amended from time to time, shall be final and binding upon all Participants. Contradictory benefit information received from any other source, whether oral, written, or electronic, will not affect the terms of the Plan as set forth herein. Participants are advised to conclusively rely upon the benefit information provided in this Summary Plan Description only.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice to select a Hospital, Professional Provider or other Provider of health care services. However, benefits will be paid in accordance with the provisions of this Plan, and the Participant may have higher out-of-pocket expenses if the Participant uses the services of Non-Preferred Provider.

INTEREST IN PLAN ASSETS

Except with respect to the right of a Participant to receive benefits under this Plan, no employee or any other person shall have any right, title or interest in or to the assets of the Plan or in or to any contributions thereto, such contributions being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. Neither the Board of Directors of the Employer, the Plan Administrator, the Administrative Committee, the Claims Administrator nor the Employer in any way guarantees the Plan from loss or depreciation, nor guarantees the payment of any benefits that may be or become due to any person under the Plan. The liability of the Employer, the Board of Directors, the Administrative Committee, and the Plan Administrator Plan for payment of benefits under the Plan as of any date is limited solely to the then assets of the Plan. The liability of the Claims Administrator for the administration of claims under the Plan as of any date is limited solely to the funds have been provided by the Plan for the express purpose of funding claims or as of that date.

INTERPRETATION OF PLAN PROVISIONS

All provisions of this Plan shall be interpreted and administered in accordance with the provisions of applicable law in a non-discriminatory manner and in a manner that will assure compliance of the Plan's operation therewith. All persons in similar circumstances shall receive uniform, consistent, and non-discriminatory treatment hereunder.

LIABILITY AND LIMITATION OF ACTION

This Plan will not give the Participant any claim, right, action or cause of action against any person or entity other than the Provider rendering Covered Services to the Participant for acts or omissions of such Provider.

Contributions being made to and held by the Plan are made and held for the sole purpose of providing benefit payments under the Plan in accordance with its terms. As such, except with respect to the right of a Participant to receive benefits under this Plan, no Participant shall have any right or interest in or to the assets of the Plan or in or to any contributions to the Plan.

The Plan Sponsor and HealthSCOPE Benefits do not actually furnish health care services as described in this Summary Plan Description. Rather, Coverage will be provided for the health care services covered under the Plan when rendered by a Provider to the Participant.

PLAN RIGHT TO RECOVERY

Whenever payments have been made from the Plan in excess of the maximum amount of payment allowed according to the terms of the Plan, the Plan will have the right to recover the excess payments. Whenever payments have been made from the Plan that should not have been made in accordance with the terms of the Plan, the Plan will have the right to recover these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator's or Claims Administrator's own error.

REVERSION OF ASSETS

Except as permitted by applicable law, no part of the Plan assets, if applicable, shall revert to the Employer, or be used for, or diverted to, purposes other than the provision of benefits for the exclusive benefit of Covered

Employees and defraying the reasonable costs of administering the Plan, including the payment of insurance premiums.

RIGHT TO ENFORCE PLAN PROVISIONS

Failure by the Plan Sponsor, Administrative Committee or HealthSCOPE Benefits to enforce any provision of the Plan provision shall not affect the Plan Sponsor's, Administrative Committee's or HealthSCOPE Benefits' right thereafter to enforce such provision or any other provisions of the Plan.

SOURCE OF BENEFITS

All benefits under the Plan shall be provided solely from the Plan and applicable insurance contracts, if any, and neither the Employer nor its officers, directors, or agents (including, but not limited to, the Claims Administrator) shall have any liability or responsibility therefor. The Claims Administrator shall not be liable in any manner should there be insufficient funds in the Plan to provide for the payment of any benefit under the Plan.

TERMINATION OF THE PLAN

Right to Terminate: It is the intention of the Employer to continue this Plan indefinitely. However, the Plan Sponsor reserves the right to terminate this Plan at any time in accordance with applicable law.

Effect of Termination: Unless otherwise provided, upon the effective date of Plan termination, the Coverage of all Participants shall cease and no person shall become entitled to any benefits hereunder for any expenses incurred after the effective date of Plan termination. The Plan shall remain liable to pay benefits for expenses incurred prior to the effective date of Plan termination, but only to the extent of the assets set aside for that purpose.

TITLES ARE FOR REFERENCE ONLY

The titles used in the Plan are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

WORKER'S COMPENSATION COVERAGE

The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

WORD USAGE

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed to include the plural, feminine or neuter form.

PART XIV: OPERATION AND ADMINISTRATION OF THE PLAN

PLAN ADMINISTRATOR RESPONSIBILITIES

Plan Sponsor: The Plan has been established and shall be maintained by Nashville Electric Service, the Employer and Plan Sponsor, for the exclusive benefit of its employees. The Employer has retained the services of HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits") to administer the benefits described in this Summary Plan Description.

Plan Administrator: The Employer shall also function as the Plan Administrator unless the Employer appoints another individual or entity to act in this capacity and shall have full charge of the operation and management of the Plan. The Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the Plan and all related documents, to review all denied claims for benefits under the Plan, including, but not limited to, the denial of certification of the Medical Necessity of Hospital or medical services, supplies and treatment, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Discretion: Any discretion or judgment to be exercised by the Employer, its Board of Directors, or the Administrative Committee shall be exercised in their sole and absolute discretion. If a member of the Board of Directors or the Administrative Committee must exercise his/her discretionary authority under this Plan with respect to himself/herself as a Covered Employee in the Plan, then such discretionary authority shall be exercised solely and exclusively by a person designated by the other members of the Board of Directors or the Administrative Committee.

Funding: All costs of this Plan are provided from the contributions made by the Employer and by Covered Employees. All such contributions shall be paid to the Plan or used to pay premiums due on insurance policies held by the Plan and to defray the reasonable costs of administering the Plan. Benefits under this Plan shall be paid from such policies or from the contributions paid to the Plan. Contributions paid to the Plan for the payment of incurred claims shall be paid for directly by the Employer. For this reason, the Plan is considered to be self-funded, meaning an insurance company is not liable to pay benefit claims.

Administrative Committee: A committee of individuals may be appointed by an officer or officers of the Employer (as authorized by the board of directors of the Employer) to oversee administration of the Plan on behalf of the Employer. The members of the Administrative Committee shall serve at the pleasure of the officers of the Employer that appointed them. The Employer shall perform the following responsibilities except to the extent they have been delegated to the Administrative Committee:

1. Maintaining all Plan records;

2. Filing tax returns and reports required under federal and state law and complying with all other governmental reporting and disclosure requirements;

3. Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;

4. Hiring outside professionals to assist with Plan Administration and render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, consultants;

5. Establishing policies, interpretations, practices and procedures of the Plan;

6. Receiving all disclosures required of fiduciaries and other service providers under any federal or state law;

7. Acting as the Plan's agent for service of legal process;

8. Administering the Plan, including but not limited to the Plan's claims procedures as set forth in the Summary Plan Description;

9. Paying benefits under the Plan, by drawing checks, or instructing others to draw checks, against the Plan established for this purpose. With respect to claims that are administered by the claims administrator, HealthSCOPE Benefits, this responsibility includes instructing the claims administrator to withdraw monies from the funding account for the purpose of administering claims incurred under the Plan; and

10. Performing all other responsibilities allocated to the Plan Administrator by the Administrative Committee.

Resolutions by the Administrative Committee: All resolutions or other actions taken by the Administrative Committee of the Plan at any meeting shall be handled in accordance with the Committee's procedures.

Delegation of Responsibilities: The Employer and the Administrative Committee may delegate their responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities, and only if the board of directors or the Administrative Committee specifically authorize such delegation. The board of directors and the Administrative Committee may also delegate their responsibilities to officers or employees of the Employer.

Compensation of Certain Employees: Employees of the Employer who serve a fiduciary under the Plan shall not receive compensation under the Plan for services to the Plan; however, they may receive reimbursement for expenses actually incurred in the performance of such services.

Medical Committee: A committee consisting of representatives from management and the union may review medical healthcare information and may make plan change recommendations for the CEO to consider. If supported by the CEO, the recommendations may be presented to the Board for approval, if appropriate.

CLAIMS ADMINISTRATOR RESPONSIBILITIES

Under the Plan, HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits"), has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. The responsibilities of HealthSCOPE Benefits are spelled out in an agreement between the Plan Sponsor and HealthSCOPE Benefits ("Administrative Agreement") and include, but are not limited to, the administration of claims on behalf of the Plan Sponsor. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Summary Plan Description.

HealthSCOPE Benefits does not furnish health care services and is not liable for the quality of health care services received by a Participant. HealthSCOPE Benefits does not provide insurance coverage or benefits nor does HealthSCOPE Benefits underwrite the liability of this Plan. HealthSCOPE Benefits will not act nor assume the responsibility to act as the Plan Administrator. HealthSCOPE Benefits is merely providing

assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan. In the event the Administrative Agreement is terminated, HealthSCOPE Benefits will cease to process claims as of the termination of the Administrative Agreement.

PART XV: DEFINITIONS

Additional definitions limited to specific sections of this Summary Plan Description are found in those sections.

Actively Working/Actively At Work - Means all full-time employees who are performing their regular duties on behalf of and in the regular business of the Employer and who are being reasonably compensated by the Employer on a regular basis for such duties.

Ambulatory Health Facility - Means a facility which is organized and operated to provide medical care to Outpatients. The facility must provide preventive, diagnostic, therapeutic or rehabilitative services under the direction of a Physician. The facility must not be part of a Hospital.

Ambulatory Surgical Facility - Means a facility, with an organized staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
3. Does not provide Inpatient accommodations; and
4. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other Professional.

The facility must be accredited by entities such as the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association.

Annual Maximum Benefit – Means the Maximum Benefit that applies to all Non-Essential Health Benefits combined and is available to a Participant during the Plan year.

Benefit Period – Means the period beginning on January 1st and ending on December 31st of each year.

Break in Service – Means a period of at least 13 consecutive Weeks during which the Employee has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves absence prescribed herein).

Cardiac Rehabilitation Therapy - Means those Medically Necessary services that are rendered under the supervision of a Physician in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery. Treatment must begin within 12 weeks following the end of the initial treatment of the medical condition/myocardial infarction and must be rendered in a Facility covered by the Plan.

Chiropractic Treatment - Means treatment of the spine by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore

maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other Professional are required.

Coinsurance - Means a percentage of the Provider's Reasonable Charge that a Participant pays for Covered Services. The percentage of the Provider's Reasonable Charge that the Employer pays for Covered Services is referred to as the Plan's Coinsurance.

Community Mental Health Facility - Means a facility that is primarily engaged in the treatment of mental illness, including substance abuse. The facility must have in effect utilization and peer review plans. The facility must also be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by the Department of Health.

Confinement - Means an Inpatient stay in a Hospital or other Facility. Two successive Confinements will be considered one Confinement if readmission is for the same or related condition for which the Participant was previously confined and the readmission occurs within 90 days.

Coverage - Means the benefit payments for Covered Services as specified and limited by the Plan.

Covered Employee - Means the employee of the Employer who has satisfied the eligibility requirements under the Plan and has enrolled for Coverage under the Plan, and unless specifically stated otherwise, includes a Covered Retiree.

Covered Retiree – Means a retiree who satisfies the retiree requirements set forth in this Summary Plan Description who has applied for Coverage and been enrolled for continued Coverage under the Plan.

Covered Services - Means services or supplies which are considered eligible for payment under this Plan.

Deductible - Means the amount a Participant must pay for Eligible Expenses incurred in a Benefit Period before benefits begin to be paid for that person under the Plan.

An Individual Deductible is the amount that each Participant must pay during a Benefit Period before benefits begin to be paid for that person. A Family Deductible is the maximum amount that 2 or more family members covered under the same Family Coverage must pay in Deductible expense in a Benefit Period. Under the Family Deductible, Eligible Expenses incurred by all family members will be used to satisfy the Family Deductible. Once the Family Deductible is reached, the Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Benefit Period.

Dental Benefits - Means the Covered Services for non-medical dental related treatment and the payment made by the Plan for such services as set forth in this Summary Plan Description. The Dental Benefits are described in the section entitled "Dental Benefits."

Dental Hygienist - Means a person licensed to practice dental hygiene and who is working under the supervision and direction of a Dentist.

Dentist - Means a person licensed to practice dentistry as defined by the state in which the Covered Service is rendered.

Dependent - Means a Participant other than the Covered Employee as set forth in this Summary Plan Description.

Dependent Child(ren) – Means a child of the Covered Employee and/or covered Spouse who meets the eligibility requirements of a Dependent Child as set forth in this Summary Plan Description.

Dependent Limiting Age means the date on which the Dependent Child attains the age of 26.
Diagnostic Services - Means tests and procedures performed when the Participant has specific symptoms to detect or to monitor the Participant's disease or condition. Diagnostic Services include, but are not limited to, the following: X-ray and other radiology services; laboratory and pathology services; cardiographic, encephalographic and radioisotope tests.

Employee – Means a person who is a regular full-time Employee of the Employer, regularly scheduled to work at least 30 hours per week for the Employer in an employer-Employee relationship. Full-time employee status shall be determined by the Employer.

Effective Date - Means the date on which Coverage begins.

Eligible Expenses - Means expenses for Covered Services which are incurred by a Participant. Eligible Expenses do not include expenses in excess of the Provider's Reasonable Charge.

Emergency Care - Means care and treatment provided in the Outpatient emergency department of a Hospital or Other Facility Provider within 72 hours of the occurrence of an Injury or the onset of the Sickness.

Enrollment Date -Means the first day of coverage, or if there is a waiting period, the first day of the waiting period. As used in this definition, the waiting period means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the Plan can become effective.

Experimental/Investigative - Means any treatment, procedure, facility, equipment, drug, device or supply which is not recognized by the Plan as accepted medical practice or which did not have required governmental approval when the Participant received it.

Family Coverage - Means Coverage for the Covered Employee and one or more Dependents.

Family or Medical Leave of Absence - Means a paid or unpaid leave of absence to care for a newborn, newly adopted Dependent Child, a sick Dependent Child, Spouse or parent, military family leave, or a paid or unpaid leave of absence due to an employee's serious health condition pursuant to the Family and Medical Leave Act as amended.

Genetic Testing – means medical tests used to identify changes in chromosomes, genes or proteins.

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

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Therefore, this Plan will not discriminate in any manner with its participants on the basis of such genetic information.

Health Breach Notice Rule – Means 16 CFR Part 318.

Health Plan (also Plan) - Means a self-funded health coverage program provided and sponsored by the Plan Sponsor. The Plan is the Nashville Electric Service Health Plan.

Hearing Aid – Means any wearable, non-experimental, non-disposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including ear molds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

Home Health Care Provider - Means a facility which provides skilled nursing and other services on a visiting basis in the Participant's home and is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician. A Home Health Care Provider must be certified by Medicare or accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Hospital - Means an institution licensed by the jurisdiction in which it is located; approved by the Joint Commission on the Accreditation of the Health Care Organizations or certified under Medicare. It must provide Inpatient medical care and treatment, a staff of physicians and nurses, facilities for diagnosis and major surgery, but cannot be mainly a place for the aged or for treatment of alcoholism or drug addiction.

Hours of Service – Means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i): Vacation, Holiday, Illness or incapacity, Layoff, Jury duty, Military duty or leave of absence.

Illness - Means any physical disease or mental illness. Pregnancy, premature birth, congenital anomalies and birth anomalies are considered to be Illnesses. The term Illness will not include any illness that arises out of or in the course of any work for pay or profit, or in any way results from an illness which does. However, if proof is furnished to the Plan Administrator that a Participant covered under a Workers' Compensation Law or other law of similar purpose is not covered for a particular illness under such law, that illness shall be considered a non-occupational illness and will therefore be eligible for Coverage in accordance with the terms and conditions of the Plan as set forth in this Summary Plan Description.

In-Network - Refers to Covered Services rendered by a Preferred Provider.

Individual Coverage - Means Coverage for the Covered Employee only.

Injury - Means an accidental bodily injury caused by external and violent means. Injury to the teeth as a result of biting and chewing is not considered an accidental bodily Injury. An Injury will not include an injury that arises out of or in the course of any work for pay or profit, or in any way results from an injury which does.

Inpatient - Means a Participant who is admitted to a Hospital or Other Facility Provider as a registered Inpatient and who remains in the Hospital or Other Facility Provider for 24 or more hours.

Laboratory - Means a facility which is maintained to perform diagnostic tests and which is approved for Medicare reimbursement.

Lifetime Maximum Benefit – Means the Maximum Benefit that applies to all Non-Essential Medical Benefits combined and is available during each Participant's lifetime.

Maternity Services - Means services for normal pregnancy, complications of pregnancy, and miscarriage.

Maximum Benefit – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit. Refer to the Schedule of Benefits for maximum benefit amounts.

Medical Benefits Means the medical Covered Services described in the section entitled "Medical Benefits" and the payment made by the Plan for such services as set forth in this Summary Plan Description.

Medically Necessary (or Medical Necessity) - Means the criteria used by the Plan to determine the Medical Necessity of Covered Services under this Summary Plan Description.

To be Medically Necessary, Covered Services must:

1. Be rendered in connection with an Injury or Illness;
2. Be consistent with the diagnosis and treatment of the Participant's condition;
3. Be in accordance with the standards of good medical practice;
4. Not be considered Experimental or Investigative; and
5. Not be for the Participant's convenience or the convenience of the Participant's Physician.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only the Participant's medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate.

In order for Covered Services to be paid, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria will be the Covered Employee's responsibility.

The following definition applies to the Dental Benefits under the Plan:

To be Medically Necessary, Covered Services must:

1. Be rendered in connection with a dental condition;
2. Be consistent with the diagnosis and treatment of the Participant's dental condition;
3. Be in accordance with the standards of good dental practice;
4. Not be considered Experimental or Investigative; and
5. Not be for the Participant's convenience or the convenience of the Participant's Physician.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in accordance with the most appropriate dental procedure. Only the Participant's dental condition (not the financial status or family situation, the distance from a dental Provider or any other non-medical factor) is considered in determining which level of care or type dental treatment is appropriate.

In order for Covered Services to be paid, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria will be the Covered Employee's responsibility.

Medicare - Means the program of health care for the Medicare-eligible aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Negotiated Rate – Means the rate established by the contract in effect between the PPO Network and the Preferred Provider. Under this contract, the Preferred Provider has agreed to accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate.

Non-Preferred Provider - Means a Provider who is not participating in the PPO Network(s) to which the Participants have access under the Plan.

Occupational Therapy – Means therapy concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation. Occupational therapists use careful analysis of physical, environmental, psychosocial, mental, and cultural factors to identify barriers to occupation.

Other Benefit Plan – See **Part XI, COORDINATION OF BENEFITS AND ORDER OF BENEFITS DETERMINATION.**

Out-of-Network - Refers to Covered Services rendered by a Non-Preferred Provider.

Out-of-Pocket Limit - Means the maximum or limit on the Participant's Coinsurance requirement in a Benefit Period and acts as a cap or limit on the Coinsurance. In this event, 100% of Eligible Expenses will be paid for the remainder of the Benefit Period or until the Participant reaches the Maximum Benefits as described in this Summary Plan Description, whichever occurs first. Only the Coinsurance expense is used to meet the Out-of-Pocket Limit.

An Individual Out-of-Pocket Limit is the maximum amount each Covered Person is required to pay in Coinsurance expense in a Benefit Period. A Family Out-of-Pocket Limit is the maximum amount 2 or more family members covered under the same Coverage are required to pay in Coinsurance expense in a Benefit Period. Under the Family Out-of-Pocket Limit, the Coinsurance expenses for all family members combined will be used to satisfy the Family Out-of-Pocket Limit.

The Out-of-Pocket Limit applies to In-Network services only.

Outpatient - Means a Participant who receives medical care or treatment when he or she is not an Inpatient.

Participants - Means the Covered Employee and, under Family Coverage, the Covered Employee's Spouse and any Dependent Children who are eligible for Coverage.

Pharmacy - Means a facility which is a licensed establishment where prescription drugs are dispensed by a pharmacist under applicable state laws.

Physical Therapy - Means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other Professional are required.

Physician – Means one of these professionals licensed under the applicable state laws:

1. Doctor of Medicine (M.D.)
2. Doctor of Osteopathy (D.O.)
3. Podiatrist (D.P.M.) or Surgical Chiropodist (D.S.C.)
4. Dental Surgeon or Dentist (D.D.S.)
5. Chiropractor (D.C.)
6. Doctor of Optometry (O.D.)
7. Psychiatrist
8. Psychologist
9. Opthalmalogist
10. Hospitalist

Plan Administrator – Means the person designated to administer the Plan and whose responsibilities are set forth in **Part XIV, OPERATION AND ADMINISTRATION OF THE PLAN.**

Plan Document - Means this governing document for the NES Health Plan that has been adopted and sponsored by the Plan Sponsor.

Plan Sponsor – Means Nashville Electric Service.

PPO Network – Means the network(s) of Preferred Providers to which the Participants will have access under this Plan.

Preferred Provider - Means a Provider who is a member of the PPO network(s) that appears on the Participant's identification card.

Prescription Drug Benefits – Means the Covered Services for prescription drugs obtained from a Pharmacy and/or Mail Order Drug Company as described in the section entitled "Prescription Drug Benefits" and the payment made by the Plan for such services as set forth in this Summary Plan Description.

Protected Health Information – Means information that is created or received by Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any

other unique identifying number, characteristic, or code. Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. §160.103 that is received from, or created or received on behalf of the Plan.

Provider - Means for Medical Benefits, the Facility Providers or Professional Providers listed below which are licensed and are operating within the scope of that license:

Facility Provider – Means a Hospital and an Other Facility Provider.

Other Facility Provider – Means a Facility Provider other than a Hospital and includes the following:

1. Ambulatory Health Facility
2. Ambulatory Surgical Facility
3. Home Health Care Provider
4. Skilled Nursing Facility
5. Community Mental Health Facility
6. Specialized Hospital

Professional Provider – Means a Physician and an Other Professional Provider.

Other Professional Provider – Means a Professional Provider other than a Physician and includes the following:

1. Physical Therapist
2. Occupational Therapist
3. Speech Therapist
4. Registered Nurse Anesthetist (C.R.N.A.)
5. Registered Nurse (R.N.)
6. Licensed Practical Nurse (L.P.N.)
7. Pharmacy
8. Certified Nurse Midwife (C.N.M.)
9. Laboratory (must be Medicare approved)
10. Professional Ambulance Service
11. Licensed Social Worker

Provider's Reasonable Charge – Means the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments under the Plan. Payment will be subject to any applicable Deductible, Coinsurance and other applicable Plan provisions, the Plan will determine the Provider's Reasonable Charge for all Providers. With respect to the Preferred Providers, the Provider's Reasonable Charge will be based on the Negotiated Rate set forth in the PPO contract. For an Out-of-Network Provider, the Provider's Reasonable Charge will be based on 140% of Medicare.

Psychiatric Services – Means the Covered Services that are available under the Plan that are rendered in connection with the treatment of a psychiatric condition. Psychiatric Services include, but are not limited to, psychotherapy and psychological testing.

Qualified Medical Dependent Child Support Order (QMCSO) – Means a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient

the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan. An Eligible Employee may obtain a copy of such procedures from the Plan Sponsor.

Rehabilitation Facility – Means a facility that is primarily engaged in the Inpatient treatment and rehabilitation of the Participant as the result of an acute Illness or Injury, not including the rehabilitation of a condition resulting from substance abuse. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Rescission or Rescinded – see **Part VIII, TERMINATION PROVISIONS.**

Schedule of Benefits - Means a separate schedule showing vital information with respect to the Coverage under this Plan.

Skilled Nursing Facility - Means a facility which mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal custodial care, ambulatory or part time care or that provides treatment for mental illness, alcoholism, drug abuse or tuberculosis. The Skilled Nursing Facility must be certified by the Medicare program.

Special Enrollment Period – Means a period during which an enrollment application may be submitted following an event that qualifies the employee or dependent for a Special Enrollment Period. The events that qualify an employee or dependent for a Special Enrollment Period and the time periods during which an Enrollment Application must be submitted during such period is addressed in the section entitled Applying for Coverage and Effective Dates.

Specialized Hospital – Means a facility that is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must also be provided under the supervision of a registered nurse.

Speech Therapy – Means active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an active illness or disease.

Spouse – Means the legally married spouse of the Covered Employee or retiree, including both opposite-sex and same sex spouse, and who is not legally separated or divorced. The Employer will require that the Covered Employee submit a copy of the marriage license or certificate.

Summary Health Information – Means information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

Summary Plan Description (or SPD) – Means this document, which is provided by the Plan Administrator to describe the Participant's rights, benefits and responsibilities under this Health Plan.

Surviving Dependent – Means a Spouse or biological or adopted dependent child who otherwise meets the definition and eligibility criteria for a Dependent, and who is eligible for continued Coverage following the

death of the Covered Employee or Covered Retiree as set forth in the section entitled "Continued Coverage Provisions."

PART XVI: SPECIAL NOTICES

NOTICE OF PARTICIPANT'S RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Group health plans and issuers are required to provide Coverage for the following services to an individual receiving benefits in connection with a covered mastectomy:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema (swelling associates with the removal of lymph nodes).

The Plan is required to notify the Participant of his or her WHCRA rights each year.

NOTICE REGARDING PARTICIPANT'S RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE CONCERNING THE HIPAA PRIVACY AND SECURITY REGULATION

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Plan Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for, of which the Plan Sponsor becomes aware;

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
    (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    The employees or classes of employees that will be permitted access to PHI as set forth in this paragraph are: the Compensation and Benefits Manager, the Compensation and Benefits Supervisor, the Human Resource Assistant and Senior Human Resource Assistant in the Compensation and Benefits section, and the Plan health care consultants.
    (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third-party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

Permissible Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Permissible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse, neglect or domestic violence;

(b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
(c) locate and notify persons of recalls of products they may be using; and
(d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The Plan may also disclose, as authorized by law, PHI to organizations that handle organ, eye, or tissue donation and transplantation.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Inmates: The Plan may disclose PHI when to the correctional institution or law enforcement official for: the institution to provide health care to the Plan Participant; the Plan Participant's health and safety and the health and safety of others; or the safety and security of the correctional institution.

12. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counterintelligence, and other national security activities to authorized Federal officials.

13. Emergency Situations: The Plan may disclose PHI in an emergency situation, or if the Plan Participant is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. The Plan will use professional judgment and experience to determine if the disclosure is in the Plan Participant's best interest. If the disclosure is in the Plan Participant's best interest, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the Plan Participant's care.

14. Fundraising Activities: The Plan may disclose PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does not contact the Plan Participant for fundraising activities, the Plan will give the Plan Participant the opportunity to opt-out, or stop, receiving such communications in the future.

15. Group Health Plan Disclosures: The Plan may disclose PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Plan Participant. The Plan can disclose PHI to that entity if that entity has contracted with the Plan to administer the Plan Participant's health care program on its behalf.

16. Underwriting Purposes: The Plan may disclose PHI for underwriting purposes, such as to decide about a coverage application or request. If the Plan does not disclose the Plan Participant's PHI for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI that is genetic information.

Uses and Disclosures of PHI that Require Authorization

1. Sale of PHI: The Plan will request written authorization before it makes any disclosure that is deemed a sale of PHI, meaning the Plan is receiving compensation for disclosing the PHI in that manner.

2. Marketing: The Plan will request written authorization to use or disclose PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Plan Participant or when the Plan provides promotional gifts of nominal value.

3. Psychotherapy Notes: The Plan will request written authorization to use or disclose any of the Plan Participant's psychotherapy notes that may be on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described above will be made only with written authorization. If the Plan Participant provides the Plan with such authorization, it may be revoked in writing and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already used or disclosed, relying on the authorization.

Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

3. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

4. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Nashville Electric Service
Jeffrey Eck, Compensation and Benefits Manager
1214 Church Street, Room 141
Nashville, TN 37246
615-747-3942

PART XVII: GENERAL PLAN INFORMATION

1. **NAME OF THE PLAN**

Nashville Electric Service Health Plan

2. **NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN SPONSOR**

Nashville Electric Service
1214 Church Street, Room 141
Nashville, TN 37246
615-747-3942

4. **NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR**

The Plan Sponsor or its designee.

5. **NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS**

Same as Plan Sponsor.

6. **PLAN YEAR (for fiscal record keeping)**

January 1st through 12:00 a.m. on December 31st

7. **CLAIMS ADMINISTRATOR**

HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, Arkansas 72205
877-385-3775

Send PPO Medical claims to the PPO Network appearing on the front of the Identification Card.

Send Non-PPO Medical claims to HealthSCOPE Benefits to the address on the front of the Identification Card.

Send Vision and Dental Claims to HealthSCOPE Benefits to the address on the front of the Identification Card.

Send Mail Order Prescription Drug requests to OptumRx Home Delivery at the address listed on the request form.

8. **EFFECTIVE DATE OF THE PLAN**

The revised Effective Date of the Plan is January 1, 2019.

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