RUTHERFORD COUNTY EMPLOYEE BENEFIT PLAN

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RUTHERFORD COUNTY EMPLOYEE BENEFIT PLAN

INTRODUCTION

Rutherford County, TN hereby amends and restates effective January 1, 2018, an employee benefit plan that is a "governmental plan" as defined in section 3(32) the Employee Retirement Income Security Act of 1974, known as the Rutherford County Employee Benefit Plan (hereinafter the "Plan"), originally established July 1, 1997, the terms of which are set forth in this Plan document and the Welfare Program documents. The Plan provides for the payment or reimbursement of certain medical, dental, vision, group term life, voluntary life, accidental death and dismemberment, voluntary accidental death and dismemberment, short-term disability, long-term disability, health flexible spending account, health reimbursement arrangement, wellness program, employee assistance program, voluntary accident, and voluntary critical illness benefits for Eligible Employees (and certain eligible dependents of such Employees) of Rutherford County, TN and the affiliated employers of the Employer described in ***Appendix B***.

The purpose of this Plan document is to set forth the essential terms and provisions of the Plan and to consolidate and combine into a single Plan document certain Welfare Programs maintained by the Employer, and to provide Participants and their beneficiaries with the benefits described herein and in the Welfare Programs which are incorporated into this Plan. Terms that are capitalized are defined in ARTICLE I.

Contributions are made by the Employer and Eligible Employees. These contributions are based on the amount of premiums and costs necessary to provide the coverage under the Plan. The level of Employee contributions is established by the Employer annually. All group benefits underwritten by an Insurance Company are paid solely from the general assets of the Insurance Company. All group benefits self-funded by the Employer are paid solely from the general assets of the Employer.

The payment of all benefits under the Plan is expressly subject to all the provisions, including amendments, of this Plan document, as well as the terms and conditions of the Welfare Programs, including amendments/riders to said Welfare Programs (the terms of which are incorporated herein by reference and shall be deemed part of this Plan document). In the case of any conflict between the terms of this Plan document and the terms of the Summary Plan Description, the terms of the Plan document shall control.

In the event that the provisions of any Welfare Program conflict with the other provisions of this Plan document or any other Welfare Program, the Plan Administrator shall, in its discretion, interpret the terms and purpose of the Plan so as to resolve any conflict; provided that if the terms of the Welfare Program are inconsistent with applicable law, the terms of this Plan document (disregarding the terms of the Welfare Program) shall prevail. The terms of this Plan document may not increase the rights of a Participant or his beneficiary to benefits available under any Welfare Program.

ARTICLE I
DEFINITIONS

Section 1.01 "**Claims Supervisor**" shall mean the person responsible for benefits administration under a Welfare Program. In the case of an insured Welfare Program, the Claims Supervisor shall mean the Insurance Company. In the case of a self-funded Welfare Program, the Claims Supervisor shall mean the Plan Administrator unless such power is

delegated to another party as described in writing, which writing is incorporated herein by reference, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to your benefits (e.g., Cigna or its successor).

Section 1.02 "**COBRA**" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, to the extent governmental entities (and this Plan) are required to comply with such law or similar law.

Section 1.03 "**Dependent**" shall have the meaning set forth in each Welfare Program, provided, however, that for medical, dental and vision Welfare Program benefits, "Dependent" is defined in ***Appendix E***, as it may be amended from time to time.

Section 1.04 "**Eligible Employee**" shall mean an Employee who is classified on the Employer's books and records as:

(a) An Employee who is regularly scheduled to work a minimum of 30 hours per week.

(b) An Employee who is regularly scheduled to work less than 30 hours per week, or a variable hour or seasonal Employee ("Variable Employee"), but only if such Variable Employee also is determined by the Employer (i) to average at least 30 hours per week during an applicable measurement period determined consistent with the PPACA, and (ii) to be an "Eligible Employee" for any given stability period, as specified by the Employer to avoid penalties under the PPACA or otherwise. Notwithstanding any provision in the Plan to the contrary, a Variable Employee who is determined to be an Eligible Employee as provided in this Section 1.04 shall be eligible solely for PPACA required medical benefits under a Welfare Program described in this Plan. In no event shall a Variable Employee be eligible to participate in any Welfare Program benefits other than PPACA required medical benefits. A Variable Employee who is determined by the Employer to be an Eligible Employee for a given stability period will remain an Eligible Employee for the entirety of such stability period, even if such Variable Employee is transferred during such stability period to a position in which the Variable Employee will work, or is expected to work on average less than 30 hours per week. The Variable Employee's stability period will not be interrupted as long as the Variable Employee remains an Employee of the Employer without a period of thirteen or more weeks during which the Variable Employee does not provide any hours of service (as that term is defined under PPACA) to the Employer. Notwithstanding the foregoing, in the event a Variable Employee terminates employment with the Employer and is rehired within 13 weeks, the Variable Employee's stability period will be reinstated effective the first day of the month following the Variable Employee's date of rehire. Each year, the standard measurement period means the twelve month period measured from October 1 through September 30; the standard administrative period means the 90 day period measured from October 1 through December 29; and the standard stability period means the twelve month period measured from December 30 through December 29; provided however that a new Employee's initial measurement period, initial administrative period, and initial stability period are based on the new Employee's initial date of employment. Such initial measurement period and initial administrative period combined shall not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the Employee's start date as required by Internal Revenue Service guidance. The Employer may adopt such policies and procedures as it deems necessary, in its sole discretion, to implement and administer the provisions of

the Plan relating to Variable Employees in a manner consistent with the PPACA ("Variable Employee Policy"). Any Variable Employee Policy adopted by the Employer, and any successor(s) thereto, are hereby incorporated into the Plan by reference.

(c) A former Employee who has terminated employment from the Employer and is eligible for retiree Welfare Program benefits to the extent provided in ***Appendix D*** ("Retiree").

Section 1.05 "**Employee**", except as otherwise defined in a Welfare Program, shall mean any individual who is employed by the Employer as a common-law employee, but shall not include any person who is providing services as an independent contractor. In addition, the term "Employee" shall not include any individual who, in good faith, is classified as an independent contractor by the Employer, even if such individual is later determined by any governmental agency or court to have been a common law employee of the Employer. Employees of the affiliated employers of the Employer described in ***Appendix B*** are specifically included as Employees hereunder. ***Appendix B*** may be amended from time to time by the Employer without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

Section 1.06 "**Entry Date**" shall mean the first day of the month following the date on which an Eligible Employee satisfies the eligibility requirements set forth in Section 2.01, or otherwise becomes eligible for specific benefits under the Plan. The foregoing notwithstanding, the Entry Date for a Variable Employee shall mean, with respect to the Welfare Programs for which such employee is eligible, the first day of the applicable stability period following the date the Employer determines the Variable Employee has satisfied the eligibility requirements of Section 2.01.

Section 1.07 "**Employer**" shall mean Rutherford County, TN or any successor.

Section 1.08 "**Insurance Company**" or "**Insurance Companies**" means any Insurance Company licensed to do business in the State of the Employer and/or such other States in which the Employer does business, with which the Employer has entered into a contract for the purposes of providing benefits under the Plan, or any other benefit provider contracted to provide specific benefits to Participants under the Plan.

Section 1.09 "**Participant**" shall mean any Eligible Employee who is employed on the relevant Entry Date, and who has not for any reason become ineligible to participate.

Section 1.10 "**Plan**" shall refer to the Rutherford County Employee Benefit Plan.

Section 1.11 "**Plan Administrator**" shall refer to the Employer, unless the Employer has designated another person, committee or entity to act in its place, as provided in Section 3.01.

Section 1.12 "**Plan Year**" means the 12-month period beginning January 1 and ending on December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's Entry Date and ending on the last day of such Plan Year.

Section 1.13 "**Policy**" or "**Policies**" shall mean the insurance contracts, as such contract or contracts may be amended or replaced with other insurance contracts, issued to the Employer by an Insurance Company or Companies (or such other contracts between the Employer and a benefit provider) for the purpose of providing benefits under the Plan. All such Policies (or contracts), the terms of which are incorporated herein by reference, shall be considered a part of this Plan.

Section 1.14 "**PPACA**" means the Patient Protection and Affordable Care Act, as amended.

Section 1.15 "**Spouse**" shall have the meaning set forth in each Welfare Program provided, however, that for medical, dental and vision Welfare Program benefits, "Spouse" is defined in ***Appendix E***, as it may be amended from time to time. The Plan Administrator has the sole and absolute authority to determine an individual's status as a spouse of a Participant for the purposes of the Plan, and any such determination shall be final, binding and conclusive on all parties ever claiming an interest in the Plan. "Spouse" shall also mean a domestic partner (a) who executes an acceptable affidavit of domestic partnership but only with respect to the group term life and voluntary life Welfare Programs detailed in ***Appendix A*** below or (b) as required and defined by any applicable state insurance laws with respect to insured benefits.

Notwithstanding any provision in the Plan or any related documents to the contrary, a Spouse is only eligible for medical Welfare Program coverage under this Plan if such Spouse is not offered medical coverage through such Spouse's employer.

Section 1.16 "**Summary of Material Modifications**" shall mean the document that describes minor amendments to the Plan or the benefits provided under the Plan. It is intended as an amendment or addendum to the Summary Plan Description.

Section 1.17 "**Summary Plan Description**" shall mean the document that describes the specific benefits under the Plan. The Summary Plan Description, as amended by any Summary of Material Modifications or as restated from time to time, shall be considered a part of the Plan, and is incorporated herein by reference.

Section 1.18 "**Welfare Program**" shall mean each arrangement identified in ***Appendix A***, as it may be amended from time to time by the Employer without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person. The terms of each Welfare Program, as they may be set out in the Policies, contracts, or other documents with respect to the Welfare Program, shall form a part of this Plan in the same manner as if all the terms and provisions thereof were included in this Plan document. The term "Welfare Program" shall also include: (a) the Employer's wellness program identified in ***Appendix C,*** as it may be amended from time to time by the Employer without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person and (b) the Health Reimbursement Arrangement identified in ***Appendix F***.

ARTICLE II
BENEFITS

Section 2.01 **Eligibility**.

(a) An Eligible Employee shall be eligible to become a Participant in the Plan on such Eligible Employee's initial date of employment, and shall enter the Plan as of the Entry Date as provided in Section 1.06 herein

(b) A Variable Employee shall be eligible to become a Participant in the Plan for an applicable stability period with respect to which the Variable Employee satisfies the PPACA requirements for "full-time" Employee status during the applicable measurement period, as provided in Section 1.04(b), as calculated by the Employer during the applicable administrative period.

(c) An Eligible Employee who is a Retiree is eligible to participate in this Plan for the benefits described in ***Appendix D*** and shall enter the Plan as a Retiree immediately on such Retiree's date of retirement as provided in ***Appendix D***.

An Eligible Employee who is eligible to participate in a Welfare Program shall become a Participant in such Welfare Program upon (1) meeting the eligibility requirements set forth in the applicable Policy or Welfare Program document, (2) enrolling in the Welfare Program at a time and in a manner set forth in the Welfare Program document and acceptable to the Plan Administrator, and (3) if applicable, satisfying any waiting period for initial enrollment as required by the Employer or the Welfare Program.

An eligible Dependent who is eligible to participate in a Welfare Program shall become covered under such Welfare Program upon (1) meeting the eligibility requirements set forth in the applicable Policy or Welfare Program document (or, in the case of the medical, dental and vision Welfare Programs, meeting both the eligibility and documentation/verification requirements set forth in ***Appendix E***), (2) enrolling in the Welfare Program at a time and in a manner set forth in the Welfare Program document and acceptable to the Plan Administrator, and (3) if applicable, satisfying any waiting period for initial enrollment as required by the Employer or the Welfare Program.

Section 2.02 **Extended Coverage**.

(a) **Continuation of coverage due to resolution or contract.** Notwithstanding the provisions of Section 2.03 and the termination provisions of the Employer's Welfare Programs, when the Employer is required through resolution by the Employer's board of commissioners or contractually obligated under a severance agreement or employment contract to provide coverage under the Plan for a designated time period after termination of employment with the Employer, or the total disability or death of an Employee, coverage under the Plan (and applicable Welfare Programs) will be extended in accordance with such resolution or contract, and unless such resolution or contract expressly provides otherwise, the COBRA or USERRA period, as applicable, will begin at the end of the designated time period set forth in the resolution or contract.

(b) **Continuation of coverage due to total disability**. For an Employee who would otherwise lose coverage under the medical Welfare Programs due to such

Employee's termination from employment related to total disability, the Employer will provide medical benefits secondary to Medicare under the following conditions:

(i) The Employee must not have any lapse in coverage under the Employer's medical Welfare Program between such Employee's termination date and becoming qualified for Social Security Medicare benefits as a totally disabled person.

(ii) The Employee must not have any other secondary medical coverage in force.

(iii) The Employee must be under age sixty-five (65) and must have completed at least ten (10) years of service with the Employer (the last five (5) years of which such Employee was on the Employer's Welfare Program prior to such Employee's total disability termination).

(iv) The Employee must have filed and qualified for Medicare disability.

(v) The Employee must pay the required premiums. If premiums are not paid timely, the Employee will have a 30 day grace period to catch up premiums before benefits will be terminated.

Except as required under COBRA, coverage for a disabled Employee will terminate when:

(1) The Employee is no longer considered qualified under Medicare disability.

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

(3) The Employee becomes covered under any other health care plan that provides similar benefits.

(4) The Plan is terminated or with respect to any particular coverage benefit or Welfare Program, upon termination of the portion of the Plan (or Welfare Program) providing that benefit.

(5) The Participant terminates coverage or declines further coverage under the Plan, effective as of the date specified by the Plan Administrator.

(6) The Participant no longer timely pays premiums. If the Employee's coverage terminates due to premiums not being paid, the Employee is not offered COBRA, except as required by law.

(7) The Participant dies.

(8) Except as required by PPACA, when it is determined that the Participant (or covered dependent) has submitted a fraudulent claim and the Participant is notified of such fraudulent claim.

For purposes of this Section 2.02, the terms "total disability" and "service" will be determined by the Plan Administrator in its sole discretion.

Section 2.03 **Termination of Participation**. Participation under the Plan shall cease when the Participant ceases to participate in all Welfare Programs. Except as provided in Section 9.05, an individual's coverage under the Plan may be terminated by the Plan Administrator for cause. "Cause" shall be determined by the Plan Administrator in its sole discretion, and includes but is not limited to submission of a fraudulent claim under any Welfare Program.

Except as required by law with respect to benefits subject to PPACA, a reemployed former Participant shall be eligible to become a Participant in the Plan when the Participant again satisfies the eligibility requirements set forth in Section 2.01; provided, however, Board of Education Employees who are rehired with no lapse in coverage and/or transferred from a 12 month to a 10 month position (or vice versa) will be allowed to continue participating in the Plan with no break in coverage.

Section 2.04 **Benefits**. Participants shall receive benefits under the Welfare Programs. Benefits shall be determined exclusively by the terms of the Welfare Programs, including eligibility for coverage, levels and amounts of coverage, the terms and conditions of coverage and when coverage begins and terminates. Benefits will be paid solely in the form and in the amount set forth under the Welfare Programs.

All of the benefits under the Plan are described in more detail in the Policies and Welfare Programs, the terms of which are incorporated herein and made a part hereof by reference. In the case of any conflict between the terms of the Plan document and the terms of the Policies or Welfare Programs, the terms of the Policies or Welfare Programs (as applicable) shall control.

Section 2.05 **Funding**. The terms of each Welfare Program shall govern the amount and timing of any Participant contribution required to be made by the Employee. Nothing herein requires an Employer to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant or his/her beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant or beneficiary shall have any right to, or interest in, the assets of the Employer. To the extent any insurer pays dividends, rebates, demutualization proceeds, or similar payments, such amounts shall be paid to and considered the sole property of the Employer to the extent permitted by PPACA or other law, unless the Employer elects to contribute such amounts to the Plan.

ARTICLE III
ADMINISTRATION OF THE PLAN

Section 3.01 **Plan Administrator**. The administration of the Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them. The Plan Administrator has full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. For this purpose, except to the extent otherwise provided under the terms of any Welfare Program, the Plan Administrator's powers include, but are not limited to, the following authority, in addition to all other powers provided by this Plan:

(a) The authority to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, including but not limited to determinations regarding eligibility for participation in and coverage under the Plan and the types and amounts of benefits payable under the Plan, and to make all necessary findings of fact. The discretion and authority to interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan. Decisions by the Plan Administrator may not be overturned unless found by a court to be arbitrary and capricious and having no foundation;

(c) The authority to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan;

(d) The authority to allocate and delegate its responsibilities under the Plan, and to designate other persons to carry out any of its responsibilities under the Plan; and

(e) The authority to enter into any and all contracts and agreements for carrying out the terms of this Plan and for the administration of the Plan, and to do all acts as it, in its sole discretion, may deem necessary or advisable. Such contracts and agreements shall be binding and conclusive on the parties hereto and anyone claiming benefits hereunder.

Notwithstanding the foregoing, to the extent the benefits under any Welfare Program are provided under a fully insured arrangement, the Insurance Company for such program shall have the responsibility for determining entitlement to benefits under the program and prescribing the claims procedures to be followed by Participants and beneficiaries thereunder. The Insurance Company will have the full power to interpret and apply the terms of any insured Welfare Program as they relate to benefits provided thereunder.

Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole and absolute discretion, that payment is merited pursuant to the terms of the Plan. Notwithstanding the foregoing, any claim which arises under a Policy is not subject to review under this Plan, and the Plan Administrator's authority does not extend to any matter as to which any other person or entity is empowered to make determinations under the Policy or documents evidencing such arrangement.

Section 3.02 **Reliance on Tables, Etc**. In administering the Plan, the Plan Administrator is entitled, to the extent permitted by law, to rely on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

Section 3.03 **Expenses**. The proper expenses of the Plan Administrator, including the compensation of its agents, will be paid by the Plan if not paid by the Employer.

Section 3.04 **Disclaimer of Liability**. Neither the Employer nor its delegates, employees or agents shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

ARTICLE IV
AMENDMENT AND TERMINATION

Section 4.01 **Modification and Amendment**. The Plan may be modified or amended at any time by the Employer. Such modification or amendment shall be effective as of the date of approval, or at such other date as the Employer shall determine.

The Welfare Programs may be modified or amended at any time by the Employer, provided that any Policy may only be modified or amended with the agreement of the issuing Insurance Company. Such modification or amendment shall be effective as of the date of approval, or at such other date as the Employer and, if applicable, Insurance Company shall determine.

In the event of a termination or reduction of benefits under the Plan or any Welfare Program, the Plan shall be liable only for benefit payments due and owing as of the effective date of such termination or reduction, and no payments scheduled to be made on or after such effective date shall result in any liability to the Plan, the Employer, any other affiliated employer set forth in ***Appendix B***, or any agent thereof.

Section 4.02 **Termination**. The Plan may be terminated at any time by the Employer upon the date of its due authorization. Such termination shall be binding on all Plan Participants.

Section 4.03 **Conflict**. Any conflict arising between the terms of this Plan document and the terms of the Summary Plan Description with respect to the provisions of this ARTICLE IV shall be resolved in favor of this Plan document.

ARTICLE V
CLAIMS PROCEDURES

Section 5.01 **General**.

(a) **Claims Supervisor**.

(i) **Fully-insured Welfare Programs**. For purposes of determination of the amount of, and entitlement to, benefits of an insured Welfare Program provided under a Policy provided by an Insurance Company, the respective Insurance Company is the Claims Supervisor, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable Policy.

(ii) **Self-funded Welfare Programs**. For purposes of determining the amount of, and entitlement to, benefits under a self-funded Welfare Program provided through the Employer's general assets, the Plan Administrator is the Claims Supervisor, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

(b) To obtain benefits from an insured or self-funded Welfare Program, the Participant must follow the claims procedures prescribed under the applicable Welfare

Program. In the event that (i) the Welfare Program does not prescribe a claims procedure for benefits that satisfies applicable law or (ii) the Plan Administrator determines that the claims procedures described in the Welfare Program shall not apply, the claims procedure described in this ARTICLE V shall apply, in whole or in part, as determined by the Plan Administrator with respect to such Welfare Program.

Section 5.02 **Claims Procedures for Welfare Programs other than Group Health Claims and Disability Claims**.

(a) **Time for Decision on a Claim**. A claim shall be filed in writing with the Claims Supervisor and decided within 90 days by the Claims Supervisor unless the Claims Supervisor determines that special circumstances require an extension of time for processing the claim. If the Claims Supervisor determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or Welfare Program expects to render the benefit determination.

(b) **Notification of Adverse Determination**. Notice of the decision on such claim shall be furnished promptly to the claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan or Welfare Program provisions on which the determination is based; (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures.

(c) **Right to Review**. A claimant may review all pertinent documents and may request a review by the Claims Supervisor of such decision denying the claim. Any such request must be filed in writing with the Claims Supervisor within 60 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 60 days will constitute a waiver of the claimant's right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Claims Supervisor to consider.

(d) **Review Procedures**. During the review process, the Claims Supervisor will provide: (i) the claimant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to the claimant within 60 days unless the Claims Supervisor determines that special circumstances require an extension of time for processing the claim. If the Claims Supervisor determines that an extension of time for processing is

required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice will describe the special circumstances requiring an extension of time and the date by which the Plan or Welfare Program expects to render the determination on review.

(f) **Notification of Determination on Review**. Notice of the decision on such claim shall be furnished promptly to the claimant. Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (iv) a statement describing any voluntary appeal procedures, if any, offered by the Plan or Welfare Program and the claimant's right to obtain additional information about those voluntary review procedures, if any.

(g) **Legal Remedies**. Any further action may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

Section 5.03 **Disability Claims**.

(a) **Time for Decision on a Claim**. A claim shall be filed in writing with the Claims Supervisor and decided within 45 days after receipt of the claim by the Claims Supervisor. If the Claims Supervisor determines that an extension is necessary due to matters beyond the control of the Plan or Welfare Program, a maximum of two 30-day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

(b) **Notification of Adverse Determination**. Notice of the decision on such claim shall be furnished to the claimant within the applicable time periods set forth in subsection (a) above and shall contain the following information:

(i) For claims for disability benefits filed under this Plan or a Welfare Program on or before April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the

determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) For claims for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan or Welfare Program of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan or Welfare Program made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program do not exist; and (8) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of a claim for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by

law), the term "adverse benefit determination" also means any rescission of disability coverage with respect to a Participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(c) **Right to Review**. A claimant may review all pertinent documents and may request a review by the Claims Supervisor of such decision denying the claim. Any such request must be filed in writing with the Claims Supervisor within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant's right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Claims Supervisor to consider.

(d) **Review Procedures**. During the review process, the Claims Supervisor will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate individual shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vi) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; (vii) that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and (viii) effective after April 1, 2018 (or such other effective date as required by law), before an adverse benefit determination can be issued, the claimant shall be provided, free of charge and as soon as possible and sufficiently in advance of the date on which notice of the adverse benefit determination on review must be provided to the claimant to give the claimant reasonable opportunity to respond prior to the deadline, (A) any new or additional evidence considered relied upon, or generated by the Plan, Welfare Program, insurer, or other person making the benefit determination (or at the direction of the Plan, Welfare Program, insurer of such other person) in connection with the claim; and (B) any new or additional rationale that the disability benefit claim is based on.

(e) **Time for Decision on Review**. Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for

review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Supervisor expects to render a decision. The extension may be for up to 45 additional days from the end of the initial period.

(f) **Notification of Determination on Review**. Notice of the decision on such claim shall be furnished to the claimant within the applicable time periods set forth in subsection (e) above and shall contain the following information:

(i) For claims for disability benefits filed under this Plan or a Welfare Program on or before April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program and the claimant's right to obtain the information about such procedures; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) For claims for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program and the claimant's right to obtain the information about such procedures; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan or Welfare Program of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan or Welfare Program in connection with a claimant's adverse benefit

determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan or Welfare Program made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan or Welfare Program do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide oral language services that include answering questions in the non-English language and provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan or Welfare Program.

(g) **Legal Remedies**.

(i) Any further action may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

(ii) If the Plan (or Welfare Program) fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), the claimant is deemed to have exhausted the administrative remedies available under the Plan or Welfare Program, except as provided in the paragraph below.

(iii) Except as provided in the paragraph above, the administrative remedies available under the Plan (or Welfare Program) with respect to a claim for disability benefits filed under this Plan or a Welfare Program after April 1, 2018 (or such other effective date as required by law), will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan (or Welfare Program) demonstrates that the violation was for good cause or due to matters beyond the control of the Plan (or Welfare Program) and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan (or Welfare Program) and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan (or Welfare Program). The claimant may request a written explanation of the

violation from the Plan (or Welfare Program), and the Plan (or Welfare Program) must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan (or Welfare Program) to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan (or Welfare Program) met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's (or Welfare Program's) receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan (or Welfare Program) shall provide the claimant with notice of the resubmission.

Section 5.04 **Group Health Claims**.

(a) **Pre-Service Claim Determinations**. When a covered person requests a medical necessity determination prior to receiving care, the Claims Supervisor will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Supervisor will make the pre-service determination on an expedited basis. The Claims Supervisor will notify the covered person of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request to specify what information is needed. The covered person must provide the specified information to the Claims Supervisor within a reasonable amount of time (at least 48 hours), taking into account the circumstances. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Supervisor will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

(b) **Concurrent Claim Determinations**. When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of

treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Supervisor shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Supervisor will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

(c) **Post-Service Claim Determinations**. When a covered person requests a claim determination after services have been rendered, the Claims Supervisor will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice.

(d) **Notice of Adverse Determination**.

(i) To the extent that the Welfare Program is not subject to the PPACA, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's or Welfare Program's review procedures and the time limits applicable to such procedures; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) in the case of a

claim involving urgent care, a description of the expedited review process applicable to such claim.

(ii) To the extent that the Welfare Program is subject to the PPACA, every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the claimant, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures; (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; (7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (8) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (9) the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan or Welfare Program.

(e) **Appeal of Denied Claim**.

(i) First Level of Appeal. If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Supervisor. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Supervisor immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide

any additional material or information necessary to support the claim. Following review, the Claims Supervisor will issue a decision on review.

The Claims Supervisor's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 15 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 30 days in the case of a post-service claim.

(ii) Second Level of Appeal. If, after exhausting the first level appeal with the Claims Supervisor, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer or the Employer's designee (i.e., Cigna and any other Claims Supervisor or another fiduciary named by the Plan Administrator in writing, which writing is incorporated herein by reference) however, the review shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Supervisor's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

(iii) In the normal case, the Employer will make a determination on the basis of the supporting file documents and written statement as submitted. However, the Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

(iv) The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth in subsection (e)(i) above.

(v) To the extent that the Welfare Program is subject to the PPACA, after exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

(f) **Notice of Benefit Determination on Appeal**.

(i) To the extent that the Welfare Program is not subject to the PPACA, every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information (as defined below); (4) a statement describing any

voluntary appeal procedures offered by the Plan or Welfare Program; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) To the extent that the Welfare Program is subject to the PPACA, every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning to the extent that the Welfare Program is subject to the PPACA; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan or Welfare Program; (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or Welfare Program to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (8) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency.

(iii) Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(g) **Review Procedures on Appeal**. In the conduct of any review, the following will apply:

(i) No deference will be afforded to the initial adverse determination;

(ii) The review will be conducted by an appropriate individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) In deciding an appeal that is based in whole or in part on a medical judgment, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment shall be consulted;

(iv) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

(v) Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(vii) To the extent that the Welfare Program is subject to the PPACA, the claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

(h) **Deemed Exhaustion of Internal Claims and Appeals Processes**. To the extent that the Welfare Program is subject to the PPACA, if the Plan fails to strictly adhere to the internal claims and appeals requirements of 29 CFR 2590.715-2719(b)(2), the claimant may initiate an external review as provided in subsection (i) below.

A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis violations that do not cause, and are not likely to cause prejudice or harm to the claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the claimant and the Plan Administrator, Claims Supervisor or claims administrator. The claimant may request a written explanation of the violation from the Plan Administrator, which must be provided within 10 days, including the basis for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. Unless otherwise specified herein, the

claimant is required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

(i) **External Claims Procedure**. To the extent that the Welfare Program is subject to the PPACA, after receiving notice of an adverse benefit determination or a final internal adverse benefit determination (or been deemed to have exhausted the internal appeal process as described in Subsection (h) above), a claimant may file with the Plan a request for an external review, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the Plan is not eligible for the external review process. A claimant may request from the Claims Supervisor additional information describing the Plan's external review procedure.

(j) **Legal Remedies**. Any further action may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within one year after the final decision is provided, or if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

ARTICLE VI
QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Section 6.01 **Purposes**. The provisions of this ARTICLE VI shall apply with respect to any Welfare Program that does not contain provisions pertaining to QMCSOs (as defined below). The Plan Administrator adopts the following procedures for determining whether medical child support orders are "qualified" in accordance with applicable law. The Plan Administrator also adopts these procedures to administer payments and other provisions under Qualified Medical Child Support Orders ("QMCSOs"), and to enforce these procedures as legally required. The Plan Administrator may alter, amend or terminate these procedures and substitute alternative procedures in its sole discretion.

Section 6.02 **Definitions**. For purposes of the QMCSO requirements, the following terms have these meanings:

(a) "**Medical Child Support Order**" means any judgment, decree or order (including approval of settlement agreement) which:

(1) Provides for child support for a child of a Participant under a group health plan, or provides for health coverage to such a child;

(2) Is made pursuant to state domestic relations law (including a community property law); and

(3) Relates to benefits under such group health plan.

(b) "**Alternate Recipient**" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Participant.

Any term used in these QMCSO procedures that is also defined elsewhere in this Plan shall have the meaning assigned to such term under such definition.

Section 6.03 **Qualified Medical Child Support Order**.

(a) A Qualified Medical Child Support Order or QMCSO is a Medical Child Support Order which creates or recognizes 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 the group health portion of this Plan, and which the Plan Administrator has determined meets the requirements of Section 6.03(b) and Section 6.03(c).

(b) To be "qualified" as a QMCSO, a Medical Child Support Order must clearly:

(1) Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;

(2) Include a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;

(3) Specify the period to which such order applies;

(4) Specify the Plan to which such order applies; and

(5) Provide that the alternate recipient or parent of the alternate recipient will pay the applicable premium for family coverage under the Plan.

(c) In addition, a QMCSO must not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

(d) The alternate recipient's right to enroll in the Plan is dependent on the Participant's eligibility status in the Plan.

Section 6.04 **Procedures**. Upon receipt of a Medical Child Support Order, the Plan Administrator shall:

(a) Promptly notify in writing the Participant, each alternate recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and the Plan's procedures for determining whether such order is a QMCSO.

(b) Permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the Medical Child Support Order.

(c) Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a Qualified Order and notify the parties indicated in Section 6.04(a) of such determination.

(d) Ensure the alternate recipient is treated by the Plan as a beneficiary, such as by distributing to the alternate recipient (and/or his/her representative) a copy of the summary plan description and any subsequent summaries of material modification generated by a Plan amendment.

ARTICLE VII
GENERAL PROVISIONS

Section 7.01 **COBRA Rights**. With respect to each Welfare Program which is a group health plan, each Participant and his/her family members may have the right to purchase continuous coverage for a temporary period of time if coverage under the group health plan terminates due to certain COBRA qualifying events (such as termination of employment, reduction in work hours, divorce, death, or a child ceasing to meet the definition of dependent under the terms of the group health plan). In general, a Participant or family member must elect COBRA continuation coverage within 60 days following the date of the qualifying event, or if later, the date notice of the qualifying event is provided to the individual. If continuation coverage is elected, the individual will be responsible for paying the full cost of continuation coverage plus an administrative fee.

Section 7.02 **Newborns' and Mothers' Health Protection**. With respect to each Welfare Program that is a group health plan providing maternity benefits, the Plan will not 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 normal 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 newborn earlier than the above periods. In any case, such group health plan will not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Section 7.03 **FMLA**. The Employer will maintain benefits under each Welfare Program that is a group health plan for an Employee on FMLA leave on the same terms and conditions as if the Employee had continued to work. If an Employee returns from FMLA leave and chooses not to retain group health plan coverage during the leave, the Employer will reinstate the Employee in such group health plan coverage on the same terms as prior to the leave.

Section 7.04 **USERRA**. Except to the extent greater benefits are provided under a Welfare Program, a Participant who is performing service in the uniformed services and is covered under the Plan is entitled to continue coverage for himself and dependents if applicable, provided the Participant elects to continue coverage for the lesser of the following periods:

(a) The 24-month period beginning on the date the Participant's absence for the purpose of performing service begins; or

(b) The period beginning on the date the Participant's absence for the purpose of performing service begins, and ending on the date which the Participant fails to return from service or apply for a position of employment as provided in USERRA or the regulations thereunder.

COBRA continuation coverage provided under Section 7.01 and USERRA continuation coverage under this Section 7.04 are concurrent.

Section 7.05 **Subrogation and Reimbursement**. The provisions of this Section 7.05 pertaining to subrogation shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to subrogation, or (ii) a court, arbitrator, mediator or other judicial body determines that the subrogation provisions of a Welfare Program are not enforceable. The provisions of this Section 7.05 pertaining to a right of reimbursement shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to a right of reimbursement, or (ii) a court, arbitrator, mediator or other judicial body determines that the right of reimbursement provisions of a Welfare Program are not enforceable.

If a covered person becomes sick or injured and has the right to receive benefits under this Plan, but also has the right to receive compensation for the sickness or injury from a third party (such as an insurance company, for example), the Plan, or the Plan's designee, has a right of recovery.

The Plan's right of recovery includes the right to be reimbursed from any payment by the third party for the covered person's sickness or injury, for Plan benefits paid with respect to the sickness or injury. The Plan's right of recovery also includes the right of subrogation which means that the Plan can choose to assert the covered person's right of recovery against the third party. The Plan's right of recovery extends to any right of recovery the covered person's estate, spouse, dependents, guardian or other representative may have against the third party.

The Plan will have a first priority lien on any full or partial recovery by or on behalf of the covered person from the third party. The covered person (and the covered person's personal representative, beneficiary, or estate) shall agree to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the sickness or injury. The covered person (or the covered person's personal representative, beneficiary, or estate) shall serve as a constructive trustee over the funds due and owed to the Plan and hold such funds in trust.

The Plan's right of recovery will apply regardless of whether the covered person is made whole from the recovery against the third party, and will not be reduced or prorated by or on account of the covered person's attorneys' fees and costs. Any full or partial recovery by the covered person against a third party shall be deemed to be recovery for Plan benefits incurred with respect to the injury or sickness for which the third party is liable, regardless of whether or not the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically limited to certain kinds of damages or payments.

The Plan's right of recovery may be from the third party, any liability or other insurance covering the third party, malpractice insurance; the covered person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments ("Med-Pay"), no fault, personal injury protection ("PIP"); or, any other first or third party insurance coverages which are paid or payable.

If the Plan takes legal action to enforce its recovery rights, the Plan shall be entitled to recover its attorneys' fees and costs from the covered person.

The covered person shall not do anything to hinder the Plan's right of recovery. The covered person shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the third party or any insurance coverages to which the covered person may be entitled. The Plan is not obligated to pay Plan benefits incurred with respect to a covered person's injury

or sickness until the covered person, or someone legally qualified and authorized to act for the covered person, enters into a written agreement with the Plan regarding its right of recovery. Also, the Plan may suspend payment of Plan benefits if the covered person does not execute such an agreement or does not comply with the terms of such an agreement. Payment of Plan benefits by the Plan before such a written agreement is obtained, or while the covered person is not in compliance with the terms of such a written agreement, shall not constitute a waiver by the Plan of its right of recovery.

The Plan Administrator, in its sole discretion, may waive the Plan's right of recovery. Waivers may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. The Plan's waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to another claim; and the Plan's waiver of its right of recovery with respect to one covered person shall not constitute a waiver of its right of recovery with respect to another covered person.

Section 7.06 **Governing Law**. This Plan shall be governed and construed in accordance with the internal laws of Rutherford County, State of Tennessee without giving effect to any choice of law or conflict of law provision or rule (whether the Rutherford County, State of Tennessee or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the Rutherford County, State of Tennessee. Notwithstanding the foregoing, in the event that the laws of the Rutherford County, State of Tennessee are superseded by the Internal Revenue Code of 1986, as amended (the "Code") and/or other applicable Federal law, the Code and/or other applicable Federal law shall control.

Notwithstanding anything in the Plan to the contrary, the Plan Administrator intends in good faith to reasonably comply with such applicable state of Tennessee law, including, but not limited to, local law, requirements relating to the Plan as the Plan Administrator determines is appropriate and consistent with the underlying Welfare Programs. To the extent adopted by the Employer and/or Plan Administrator, any such provisions relating to Tennessee specific law that are not expressly in the Plan or underlying Welfare Programs are incorporated into the Plan by reference.

Section 7.07 **Construction of Plan Document**. The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

Section 7.08 **Severability Clause**. In case any provision of this Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan, and this Plan shall be construed and enforced as if such illegal or invalid provisions had never been inserted herein.

Section 7.09 **Plan in Effect at Termination of Employment Controls**. Unless expressly indicated otherwise, no provision of this Plan shall apply to any Employee who terminated employment prior to the effective date of such provision. In addition, unless expressly indicated otherwise, any amendment to this Plan shall not apply to any Eligible Employee who terminates employment prior to the effective date of such amendment.

Section 7.10 **No Guarantee of Employment**. This Plan shall not be deemed to constitute a contract between the Employer and any Eligible Employee or Participant, or to be consideration or an inducement for the employment of any Participant or Eligible Employee. Nothing contained in this Plan shall be deemed to give any Participant or Eligible Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Eligible Employee at any time, regardless of the effect which such discharge shall have upon such Eligible Employee as a Participant in the Plan.

Section 7.11 **Non-Alienation of Benefits**. No benefit, right or interest of any Participant or beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

Section 7.12 **Limitation of Rights**. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to give any person any legal or equitable right against the Employer, except as expressly provided herein or required by law.

Section 7.13 **Cooperation**. Circumstances may arise in which the Employer or the Plan Administrator may require a Participant or beneficiary to furnish information or pay an amount that directly or indirectly relates to participation in, or benefits paid or payable from a Welfare Program. Each Participant or beneficiary, in consideration of the coverage provided by such Welfare Program, must fully cooperate, provide any and all information requested, execute any and all documents that will enable the Employer or the Plan Administrator to access such information, and pay any amount due pursuant to the Welfare Program. In the event a Participant or beneficiary fails to comply with this cooperation provision within the time period set by the Sponsor in its sole and absolute discretion or provides false information in response to such request, payment of all benefits under the Welfare Program (whether or not such benefits relate to the requested information or failure to pay) may be suspended and/or coverage may be terminated either retroactively or prospectively in the Employer's sole discretion. In addition, the Employer or the Plan Administrator may pursue any other remedy available to it, including obtaining an injunction to require cooperation, or recovering from the covered person or beneficiary damages for any loss incurred by it as a result of the failure to cooperate or make payment, or the provision of false information.

Section 7.14 **Mental Health Parity and Addiction Equity Act**. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

Section 7.15 **Genetic Information Nondiscrimination Act (GINA)**. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act, including the Equal Employment Opportunity Commission (EEOC) regulations pertaining to wellness programs in which a Spouse may participate.

Section 7.16 **Children's Health Insurance Program Reauthorization Act of 2009**. The Plan will comply with the "group health plan" requirements relating to CHIP under the Children's Health Insurance Program Reauthorization Act of 2009.

Section 7.17 **Americans with Disabilities Act**. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Americans with Disabilities Act (ADA), including the

Equal Employment Opportunity Commission (EEOC) regulations pertaining to wellness programs which include a disability inquiry or medical exam (such as nicotine testing).

ARTICLE VIII
PLAN PRIVACY RULES

Section 8.01 **Introduction**. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") mandates strict privacy and security standards to protect Protected Health Information ("PHI") as defined below. In addition, the Plan will ensure that PHI that is Electronic Protected Health Information ("ePHI") pertaining to covered persons remains confidential. This ARTICLE VIII sets forth the guidelines the Plan Sponsor must follow when using and disclosing PHI.

Section 8.02 **Definitions**.

(a) "**Individually Identifiable Health Information**" means health information that either actually identifies an individual, or creates a reasonable basis to believe that the information would identify the individual.

(b) "**Protected Health Information**" ("PHI") means health information that:

(1) Is created or received by health care providers, health plans, or health care clearinghouses;

(2) Relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

(3) Identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

(c) "**Electronic Protected Health Information**" ("ePHI") is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

(d) "**Plan Sponsor**" means the Employer.

Section 8.03 **Permitted Uses and Disclosures**. The Plan Sponsor can use or disclose PHI without prior Participant authorization or consent in the following situations:

(a) When the PHI is used or disclosed to the Participant who is the subject of the PHI;

(b) When the PHI is used or disclosed for treatment, payment, or health care operations;

(c) When the PHI is used or disclosed incident to a use or disclosure otherwise permitted or required under the privacy rules set forth in this ARTICLE VIII, and such disclosure occurs despite reasonable Plan safeguards which are in place;

(d) When the PHI is used or disclosed pursuant to and in compliance with a valid authorization; and

(e) When the PHI is used or disclosed pursuant to an agreement with the Participant in situations where the Participant is given the choice to agree to or object to such use or disclosure.

Section 8.04 **Required Uses and Disclosures**. The Plan Sponsor must disclose PHI in the following situations:

(a) When Participants request access to their own PHI, or request an accounting of the Plan's disclosures of their own PHI; and

(b) When required by the U.S. Department of Health and Human Services to determine the Plan's compliance with the privacy rules set forth in this ARTICLE VIII.

Section 8.05 **Certifications**. The Plan Sponsor certifies and agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan or applicable law;

(b) Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(c) Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan;

(d) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan of which it becomes aware;

(e) Make a Participant's PHI available to such Participant;

(f) Allow a Participant to amend his/her PHI;

(g) Make an accounting of disclosures of PHI available to a Participant;

(h) Make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance;

(i) If feasible, return or destroy all PHI received from the Plan that it still maintains which is no longer needed for the purpose for which the disclosure was made; if destruction is not possible, limit further uses and disclosures; and

(j) Ensure adequate separation between the Plan and the Plan Sponsor.

Section 8.06 **Obligations with Respect to ePHI Obtained From the Plan**. As a condition of receiving ePHI from the Plan for Plan administrative functions, the Plan Sponsor specifically agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation, between the Plan Sponsor and persons who have no legitimate need to access such PHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.

Section 8.07 **Adequate Separation Between the Plan and the Plan Sponsor**.

(a) **Access to PHI**. The following Employees of the Plan Sponsor (and any successors to their current job titles/positions) may be given access to PHI because such access is essential for them to perform their Plan administration duties:

(1) Risk Management Director,

(2) Human Resource Director,

(3) HR Generalist,

(4) HR Coordinator,

(5) Benefit Specialist, and

(6) Effective on and after July 1, 2018, Benefit Analyst.

(b) **Restricted Access**. The Employees listed in (a) above shall have access to PHI that is restricted to Plan administration functions necessary and essential for the ongoing functioning of the Plan.

(c) **Procedures for Resolving Noncompliance**. The Plan's Privacy Officer has responsibility for facilitating and ensuring compliance with all privacy rules and procedures. All employees and contractors of the Plan Sponsor who handle PHI will be subject to enforcement sanctions administered in a manner that is consistent with the Plan Sponsor's human resources policies and procedures. Sanctions will be determined based on the nature of the violation, its severity, and whether or not the violation was intentional. Sanctions may include verbal warnings, written warnings, probationary periods, suspension or termination. Sanctions will be consistently applied in a nondiscriminatory manner based on the nature of the violation.

ARTICLE IX
PATIENT PROTECTION AND AFFORDABLE CARE ACT COMPLIANCE

Section 9.01 **Pre-Existing Conditions**. Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-

existing conditions for individuals. Any pre-existing condition exclusions will only apply during Plan years that begin before January 1, 2014.

Section 9.02 **Lifetime/Annual Limits**. Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. "Essential benefits" shall be those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Section 9.03 **Cost Sharing Requirements for Preventive Care Expenses**. With regard to non-grandfathered benefits under the Plan, there shall be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

Section 9.04 **Dependent Definition**. The term "dependent" shall include any child of a participant who is covered under an insurance contract, as defined in the contract, or under a self-funded plan, as defined in the plan, as allowed by reason of PPACA and the regulations and guidance issued thereunder.

Section 9.05 **No Rescission of Coverage**. Except to the extent permitted by law and approved by the Plan Administrator, the Plan and each Welfare Program that is group health plan shall not rescind coverage under this Plan or such Welfare Program to a Participant, unless that Participant or covered dependent performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of this Plan or such Welfare Program. To the extent required by applicable law, the Plan will provide at least 30 days advance written notice to each Participant who would be affected before coverage may be rescinded. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Section 9.06 **Selection of Providers**. If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a Participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each Participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the Participant, beneficiary, or enrollee. The plan or issuer must also permit the Participant to designate an in-network pediatrician who is available to accept the Participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the Participant, beneficiary, or enrollee.

Section 9.07 **Emergency Services**. With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

Section 9.08 **Cost Sharing Limits**. With respect to non-grandfathered benefits under the Plan, effective January 1, 2014, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. In 2018, these limits will be $6,650 for an individual and $13,300 for family coverage. After 2018, these amounts will be adjusted for health

insurance premium inflation. The foregoing notwithstanding, for the first plan year beginning on or after January 1, 2014, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the Plan will comply with the annual limitation on out-of-pocket maximums if (i) the Plan's major medical coverage (including mental health and substance use disorder benefits) complies with the out-of-pocket maximums, and (ii) the out-of-pocket maximums that apply to each other type of plan coverage (e.g., prescription drug coverage) separately satisfy the out-of-pocket maximums.

Section 9.09 **Clinical Trials**. With respect to non-grandfathered benefits under the Plan, effective January 1, 2014, this Plan shall not deny any "qualified individual," as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also shall not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan shall not discriminate against the individual on the basis of the individual's participation in such trial.

Section 9.10 **Provider Discrimination**. With respect to non-grandfathered benefits under the Plan, effective January 1, 2014, this Plan shall not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under the laws of the state issuing such license or certification, as required by Public Health Service Act §2706(a).

Section 9.11 **Applicability**. This ARTICLE IX shall apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

IN WITNESS WHEREOF, the Employer has caused its authorized officer to execute this Plan document as of the _____ day of _____, 2019, the same to be effective as of January 1, 2018, unless otherwise indicated herein.

RUTHERFORD COUNTY, TN

By: _____

Name: _____

Title: _____

PLAN APPENDIX A -
WELFARE PROGRAMS

Welfare Program	Insurance Company or Third Party Administrator	Policy or Contract Number
Self-funded Medical	Cigna Healthcare	3321836
Self-funded Dental	Cigna Healthcare	3321836
Self-funded Vision	Cigna Healthcare	3321836
Group Term Life	Standard Insurance Company	753796
Voluntary Life	Standard Insurance Company	753796
Accidental Death and Dismemberment	Standard Insurance Company	753796
Voluntary Accidental Death and Dismemberment	Standard Insurance Company	753796
Short-term Disability	Cigna/Life Insurance Company of North America	VDT-961403
Long-term Disability	Cigna/Life Insurance Company of North America	LK-962966
Health Flexible Spending Account	Wage Works	37202
Health Reimbursement Arrangement	Cigna Healthcare	3321836
Wellness Program	Cigna Healthcare	3321836
Employee Assistance Program	EAP LifeServices	Rutherford County, TN
Voluntary Accident	Unum	R0609404
Voluntary Critical Illness	Unum	R0609404

This ***Appendix A*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

This ***Appendix A*** is effective on and after: **January 1, 2018**.

PLAN APPENDIX B -
AFFILIATED EMPLOYERS

Employees of the following affiliated employers are considered "Employees" for purposes of eligibility to participate in the Plan. This ***Appendix B*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

Smyrna / Rutherford County Airport Authority
278 Doug Warpoole Road
Smyrna, TN 37167
62-1428799

Community Care of Rutherford County
901 County Farm Road
Murfreesboro, TN 37127
62-1356656

Rutherford County Emergency Communications District
591 Fortress Boulevard
Murfreesboro, TN 37129
62-1333738

This ***Appendix B*** is effective on and after: **January 1, 2018**.

PLAN APPENDIX C -
WELLNESS PROGRAM

Rutherford County, TN established, effective October 1, 2013, a Welfare Program, known as the Rutherford County, TN Wellness Program (hereinafter the "Wellness Program"), which is a part of the Employer's group medical program. The group medical program and the Wellness Program are Welfare Programs under the Rutherford County Employee Benefit Plan (the "Plan"). The terms of the Wellness Program are set forth in (i) the Employer's 2018 benefit information guide and included on the Employer's intranet (ii) any successor guides or pamphlets, and (iii) such other documents, communications, or enrollment materials provided by the Employer and Cigna, or its successor, describing the Wellness Program's benefits ("Pamphlets").

The Wellness Program is or may in the future be comprised of participatory and activity-only components and portions of the Wellness Program are paid through the Plan. Participants may qualify for an incentive or reward under the Wellness Program at least one time per year. The Wellness Program is reasonably designed to promote health and prevent disease, and includes the following elements:

1. Provides for physical and personal health assessment benefits and a rewards program which earns Eligible Employees a premium differential and/or other specified rewards.

2. Such additional programs and benefits as now or in the future are described in the Wellness Program Pamphlets and communicated to Employees.

Individuals are not required to participate in any particular component of the Wellness Program. Capitalized terms not defined in this ***Appendix C*** are defined in the Plan.

Purpose. The purpose of this ***Appendix C*** and the Wellness Program Pamphlets is to set forth the essential terms and provisions of the Wellness Program, and to provide Participants with the benefits described herein and in the Wellness Program Pamphlets, which are incorporated into the Plan by reference.

Eligibility. As described in Sections 1.02 and 2.01 of the Plan and the Wellness Program Pamphlets, only Employees and their dependents who participate in the Employer's medical plan may participate in the Wellness Program. Participation in the Wellness Program does not impact "eligibility" for (or other terms of) the Plan.

Participation in the Wellness Program is voluntary, but to receive benefits under the Wellness Program, Participants must satisfy the requirements of the Wellness Program. These requirements will be outlined in the Pamphlets and/or annual wellness informational packet provided to all eligible Participants. As discussed in the Pamphlets and/or annual wellness informational packet, the requirements to qualify for a reward under the Wellness Program can be satisfied in many different ways, regardless of health status. The wellness information outlined will include: program requirements, ways to meet requirements, program dates and deadlines, and any supplemental information regarding the Wellness Program.

Participatory Programs. The Wellness Program described in the aforementioned Wellness Program Pamphlets includes elements that are considered participatory. Participatory wellness programs must be made available to all similarly situated individuals, regardless of health status. Under a participatory wellness program, a Participant is required to engage in an activity

that is not related to a health factor (with no specific outcome required) to receive an incentive or a reward under the Wellness Program. The reward, as discussed in the Pamphlets, is the Participant's ability to receive a premium discount or other cash equivalent incentive upon satisfying the Wellness Program's standard(s).

Activity-Only Programs. The Wellness Program described in the aforementioned Wellness Program Pamphlets includes elements that are considered activity-only wellness programs. An activity-only wellness program requires a Participant to complete or to perform an activity related to a health factor in order to obtain the offered reward or incentive, but it does not require a Participant to attain any specific health outcome to receive the reward. The employer will provide safeguards to ensure individuals are given a reasonable opportunity to qualify for the incentive or reward (i.e., a reasonable alternative standard), or waive the condition for obtaining the reward, thus making the full reward available to all similarly situated individuals. Under an activity-only wellness program, it is permissible for a plan or issuer to seek verification, such as a statement from the individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard in an activity-only wellness program, if reasonable under the circumstances. If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness or waive the condition for obtaining the reward. The employer may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

Maximum Reward or Incentive Caps. The maximum permissible reward (or penalty) under the Wellness Program is capped. Specifically, the maximum rewards (or penalties) for the components of the Wellness Program that may be classified as (i) participatory wellness programs that include a medical examination or disability-related inquiry, (ii) activity-only wellness programs that (a) are offered in connection with the employer group health plan and/or (b) include a medical examination or disability-related inquiry, and/or (iii) outcome-based wellness programs that (a) are offered in connection with the employer group health plan and/or (b) include a medical examination or disability-related inquiry may not total up to more than 30% of the total cost of coverage (including both employer and employee contributions). In addition, the maximum permissible reward (or penalty) is 50% of the total cost of coverage for wellness program incentives designed to prevent or reduce tobacco use, but only if no medical examination, including biometric testing, is required to verify non-use.

Termination of Benefits. Termination of participation in the Wellness Program is described in the Wellness Program Pamphlets or on the date the Participant is no longer eligible under any of the medical Welfare Programs. An individual's coverage under the Wellness Program may be terminated by the Plan Administrator for cause as limited under Section 9.05 of the Plan. "Cause" shall be determined by the Plan Administrator in its sole discretion and shall disqualify the Participant's eligibility for the premium discount or other applicable rewards.

Benefits. Benefits under the Wellness Program are described in the Wellness Program Pamphlets.

Plan Provisions that Apply to the Wellness Program. All Plan funding, administrative, technical, and legal provisions apply to the Wellness Program.

GINA. Notwithstanding anything in the Plan and Wellness Program to the contrary and to the extent governmental entities (and this Wellness Program) are required to comply with such law, the Wellness Program shall comply with the Genetic Information Nondiscrimination Act of 2008, as amended. To ensure compliance with the Genetic Information Nondiscrimination Act of 2008, as amended ("GINA"), if a Participant completes the Employer's online personal health assessment, the Participant will still receive credit for completing the assessment if the Participant does not answer the questions on family medical history and other genetic information. Any genetic information disclosed in connection with the Wellness Program may be provided to the Employer only in the aggregate form. To the extent governmental entities (and this Wellness Program) are required to comply with such law, the Wellness Program shall comply with the Equal Employment Opportunity Commission (EEOC) regulations pertaining to wellness programs in which a Spouse may participate.

ADA and PPACA. The Wellness Program shall comply with the Americans with Disabilities Act, as amended ("ADA") and PPACA, as amended, as the Wellness Program is offered as part of the Employer's group health plan in compliance with the ADA and PPACA. To the extent governmental entities (and this Wellness Program) are required to comply with such law, the Wellness Program shall comply with the EEOC regulations pertaining to wellness programs which include a disability inquiry or medical exam (such as nicotine testing).

PLAN APPENDIX D -
RUTHERFORD COUNTY RETIREMENT
MEDICAL PLAN ELIGIBILITY AND BENEFIT INFORMATION

IMPORTANT INFORMATION REGARDING RUTHERFORD COUNTY MEDICAL PLAN AND HRA BENEFITS AT RETIREMENT:

- Adequate rate is the full premium amount needed to cover expected Medical Plan expenses within a given Plan Year. The adequate rate is determined for each Medical Plan option and may be adjusted annually.
- When a Retiree or a Retiree's participating Dependent reaches age 65 and is eligible for Medicare, such Retiree will be required to participate in Medicare to continue coverage through the Medical Plan.
- Participation in the Medical Plan, as defined in the eligibility requirements, may occur in non-consecutive years during the qualifying years of service for the Employee.
- Unpaid sick leave does not count towards years of service when determining Medical Plan benefits during retirement. Additional information can be found in the retirement section of the Rutherford County Employee Handbook.
- To the extent there is a disagreement regarding retirement or eligibility for benefits, the Medical Plan document and employment policies governing retirement criteria, as set forth by the Employer, will be the controlling documents.
- This ***Appendix D*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

DEFINITIONS:

- Medical Plan refers to certain options under the Rutherford County Medical Plan, a Welfare Program under this Plan in which Retirees and their Dependents are eligible to participate. Pre-65 Participants are eligible for the OAP Copay and OAP Deductible options under the Medical Plan. Post-65 Participants are eligible for the OAP65 option under the Medical Plan.
- HRA refers to the Rutherford County Health Reimbursement Arrangement ("HRA"), a Welfare Program under this Plan.
- Retiree refers to an Employee (as defined in the Medical Plan) who has retired.
- Dependent refers to an eligible Dependent as defined in the Medical Plan.
- Participant refers to a Retiree or such Retiree's Dependent enrolled in the Medical Plan.
- Pre-65 refers to a Participant who is less than age 65.
- Post-65 refers to a Participant who is age 65 or older.

On 12/31/2010, if the Retiree had worked full-time with the Employer for a total of...	**Retiree eligibility requirements for Medical Plan benefits at the time of retirement...**	**Retiree benefits at retirement will be...**
Less than 6 months of service	Eligibility requirements are age 60 with 20 years of service with the Employer and 15 years on the Medical Plan, or any age with 30 years of service with the Employer and 15 years on the Medical Plan.	The Employer will contribute $300 per month or the adequate rate, whichever is less, into the HRA as established by the Employer for each eligible Retiree. All Medical Plan and HRA benefits will end with Medicare eligibility.
Six months up to 7 years of service	Eligibility requirements are age 60 with 20 years of service with the	The Employer will contribute $500 per month or the adequate rate, whichever is less, into the HRA for

On 12/31/2010, if the Retiree had worked full-time with the Employer for a total of...	Retiree eligibility requirements for Medical Plan benefits at the time of retirement...	Retiree benefits at retirement will be...
	Employer and 15 years on the Medical Plan, or any age with 30 years of service with the Employer and 15 years on the Medical Plan.	each eligible Retiree. Pre-65, pharmacy benefits under the Medical Plan cease when the Participant reaches age 65. If the Participant is age 65 or older (Post-65) at retirement, there will not be any pharmacy benefits under the Medical Plan.
7 up to 10 years of service	Eligibility requirements are age 60 with 20 years of service with the Employer and 15 years on the Medical Plan, or any age with 30 years of service with the Employer and 15 years on the Medical Plan.	Pre-65 and Post-65: A Retiree pays 50% of the adequate rate for such Retiree and 75% of the adequate rate for Dependents. Pre-65: Pharmacy benefits under the Medical Plan cease when a Participant reaches age 65. If the Participant is age 65 or older (Post-65) at retirement, there will not be any pharmacy benefits under the Medical Plan. A Retiree in the Pre-65 category may make a one-time election to take a $500 per month or adequate rate, whichever is less, into the HRA in lieu of participating in the Medical Plan. The amount will increase to $1,000 per month or adequate rate, whichever is less, effective on and after July 1, 2018. This may be elected at the onset of retirement or once during an open enrollment period during the time the Retiree is in the Pre-65 category. If elected, the Retiree must remain in the HRA while they are in the Pre-65 category. Within 30 calendar days when the Retiree turns age 65, the Retiree must contact Risk Management and return to participating in the Medical Plan at which time such Retiree will begin participating in the Post-65 Medical Plan or else such Retiree will lose all Medical Plan benefits offered by the Employer. The HRA contribution of $500 (or effective on and after July 1, 2018, $1000) per month or adequate rate, whichever is less, ceases when the Retiree reaches age 65. Should the Retiree return to the Medical Plan, the Retiree pays 50% of the adequate premium rate for such Retiree and 75% of the adequate premium rate for Dependents.
10 up to 20 years of service and have met one of the eligibility requirements as of 12/31/10, as described in the eligibility section for this category; if a Retiree does not meet all the required criteria in this section, Retiree must refer to the	Eligibility requirements are age 55 with 15 years of service with the Employer and 5 years on the Medical Plan, age 62 with 10 years of service with the Employer and 5 years on the Medical Plan, and any age with 30 years of service with the Employer and 5 years on the Medical Plan.	Pre-65: A Retiree pays 50% of adequate rate. A Retiree in this category may make a one-time election to take a $500 per month or adequate rate, whichever is less, into the HRA in lieu of participating in the Medical Plan. The amount will increase to $1,000 per month or adequate rate, whichever is less, effective on and after July 1, 2018. This may be elected at the onset of retirement or once during an open enrollment period during the time the Retiree is in the Pre-65 category. If elected, the Retiree must remain in the HRA while such Retiree is in the Pre-65 category. Within 30 calendar days when the Retiree turns age 65, the Retiree must contact Risk Management and return to participating in the Medical Plan at which

On 12/31/2010, if the Retiree had worked full-time with the Employer for a total of...	Retiree eligibility requirements for Medical Plan benefits at the time of retirement...	Retiree benefits at retirement will be...
following section for eligibility information.		time such Retiree will begin participating in the Post-65 Medical Plan or else the Retiree will lose all Medical Plan benefits offered by the Employer. The HRA contribution of $500 (or effective on and after July 1, 2018, $1000) per month or adequate rate, whichever is less, ceases when the Retiree reaches age 65. Should the Retiree return to the Medical Plan, the Retiree pays 50% of the adequate premium rate. Post-65: A Retiree pays 50% of adequate rate for Medicare supplement and the pharmacy benefits under the Medical Plan.
10 up to 20 Years of Service as of 12/31/2010 but the Retiree was not age 55 with 15 years of service and 5 years on the Medical Plan, age 62 with 10 years of service and 5 years on the Medical Plan or any age with 30 years of service and 5 years on the Medical Plan.	Eligibility requirements are age 60 with 20 years of service with the Employer and 10 years on the Medical Plan, or any age with 30 years of service with the Employer and 10 years on the Medical Plan.	Pre-65 and Post-65: A Retiree pays 50% of the adequate rate. A Retiree in the Pre-65 category may make a one-time election to take a $500 per month or adequate rate, whichever is less, into the HRA in lieu of participating in the Medical Plan. The amount will increase to $1,000 per month or adequate rate, whichever is less, effective on and after July 1, 2018. This may be elected at the onset of retirement or once during an open enrollment period during the time the Retiree is in the Pre-65 category. If elected, the Retiree must remain in the HRA while such Retiree is in the Pre-65 category. Within 30 calendar days when the Retiree turns 65, the Retiree must contact Risk Management and return to participating in the Medical Plan at which time such Retiree will begin participating in the Post-65 Medical Plan or else such Retiree will lose all Medical Plan benefits offered by the Employer. The HRA contribution of $500 (or effective on and after July 1, 2018, $1000) per month or adequate rate, whichever is less, ceases when the Retiree reaches age 65. Should the Retiree return to the Medical Plan, the Retiree pays 50% of the adequate premium rate. Pre-65, pharmacy benefits under the Medical Plan cease when the Participant reaches age 65. If the Participant is age 65 or older (Post-65) at retirement, there will not be any pharmacy benefits under the Medical Plan.
20 or more Years of Service	Eligibility requirements are 30 years of service with the Employer and 5 years on the Medical Plan as of 12/31/2009 to be eligible for benefits as described in number one (1) of the benefit section for 20 or more Years of Service; If a Retiree did not have 30 years of service with the Employer and 5 years on the Medical Plan as of 12/31/2009, eligibility requirements are age 55 with 15 years of service with the	1) Employees who had 30 or more of service as of 12/31/2009 are eligible for the following benefit: Pre-65: Retiree pays 50% of adequate rate for Participants. Post-65: Retiree pays 25% of adequate rate for such Retiree and 50% of the adequate rate for Dependents for Medicare supplement and pharmacy benefits under the Medical Plan. 2) Pre-65: Retiree pays 50% of adequate rate for Participants. Post-65: Retiree pays 50% of adequate rate for Medicare supplement and pharmacy benefits under

On 12/31/2010, if the Retiree had worked full-time with the Employer for a total of...	Retiree eligibility requirements for Medical Plan benefits at the time of retirement...	Retiree benefits at retirement will be...
	Employer and 5 years on the Medical Plan, age 62 with 10 years of service with the Employer and 5 years on the Medical Plan, or any age with 30 years of service with the Employer and 5 years on the Medical Plan and the benefit will be as described in number two (2) of the benefit section for 20 or more Years of Service.	the Medical Plan for Participants. Retirees in the Pre-65 category may make a one-time election to take a $500 per month or adequate rate, whichever is less, into the HRA in lieu of participating in the Medical Plan. The amount will increase to $1,000 per month or adequate rate, whichever is less, effective on and after July 1, 2018. This may be elected at the onset of retirement or once during an open enrollment period during the time the Retiree is in the Pre-65 category. If elected, the Retiree must remain in the HRA while such Retiree is in the Pre-65 category. Within 30 calendar days when the Retiree turns age 65, the Retiree must contact Risk Management and return to participating in the Medical Plan at which time such Retiree will begin participating in the Post-65 Medical Plan option or else such Retiree will lose all Medical Plan benefits offered by the Employer. The HRA contribution of $500 (or effective on and after July 1, 2018, $1000) per month or adequate rate, whichever is less, ceases when the Retiree reaches age 65. Should the Retiree return to the Medical Plan, the Retiree pays such Retiree's portion of the Post-65 Medical Plan premium based on eligibility as defined within this category.

This ***Appendix D*** is reviewed each year and the benefits described herein are subject to change or termination as determined by the Employer in its sole discretion.

This ***Appendix D*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

This ***Appendix D*** is effective on and after: **January 1, 2018**.

PLAN APPENDIX E –
DEPENDENT DEFINITION
JANUARY 1, 2018 – JULY 31, 2018

DEPENDENT ELIGIBILITY

Definitions & Required Documents

Revised June 2017

TYPE OF ELIGIBLE DEPENDENT	DEFINITION of DEPENDENT	REQUIRED DOCUMENT(S) FOR ELIGIBLE VERIFICATION
Spouse **Individuals NOT eligible:** • Ex-Spouse (even if court ordered) • Live-in companions who are not legally married to the Employee • Parents of Employee or Spouse	A current legal Spouse as defined by Tennessee state law. An ex-Spouse, common law Spouse or civil union partner is **not** an eligible dependent. The Eligible Employee's legal Spouse (or domestic partner for life insurance only) includes: • **For MEDICAL coverage**: An Eligible Employee's Spouse is only eligible for medical coverage if he or she does not have medical coverage available through his or her employer. • **For DENTAL and VISION coverage**: An Eligible Employee's Spouse is eligible regardless of coverage availability through an employer.	**If married in current calendar year:** • A Marriage Certificate • **AND** copy of the Dependents Social Security Card **If married longer than a year:** • Federal Tax Return: first page of most recent filed 1040, showing "married filing jointly" (if married filing separately, submit page 1 of (both returns) and form 8879 (electronic filing) OR other proof of filing status. • **AND** copy of the Dependents Social Security Card ***** OR ***** **Marriage Certificate, Social Security Card, & Proof of Joint Ownership:** Must have both name on the following (Issued within the last six months): • Bank Statement • Mortgage/ Lease statement • Credit Card Statement • Property Tax Statement- issued within the last 12 months
Child *Under the age of 26 **Individuals NOT eligible:** • Children over 26 who do not meet qualifications for incapacitation/ disability • Foster Children • Grandchildren of the Employee or Spouse (unless legal guardianship is obtained)	• **Biological Child** – Natural child • **Legally Adopted Child**- The creation of the parent-child relationship between individuals who are not naturally related • **Guardianship**- Person (other than the child's parent) who has legal custody and control over the child • **Stepchild**- A Child of a legally married Spouse	• **Biological Child**- Birth Certificate **AND** a copy of the Dependents Social Security Card • **Legally Adopted**- Official Adoption Court Documentation **AND** a copy of the Social Security Card • **Guardianship**- Legal Documentation **AND** a copy of the Dependents Social Security Card • **Stepchild**-Marriage Certificate (showing relationship between child and Spouse), copy of the Dependents Social Security Card, **AND** Birth Certificate ***** OR ***** Federal Tax Return (**IF** child is claimed as a Legal Dependent) **AND** a copy of the Dependents Social Security Card
Child (Qualified Medical Child Support Order) *All under 26	A requirement to provide coverage for child(ren) when participant has dependent(s)	• Court Documentation signed by a judge • Medical Support order issued by state agency
Child Disabled	A Dependent child of any age (who fell	• Proof of disability in form of Doctor letter. Must

*Must begin before age of 26 while covered under the Plan	in the above category prior to disability) in the event is deemed disabled due to mental physical disability that is unable to earn a living	be submitted within 30 days of child's coverage terminating due to age. • AND Copy of the Dependents Social Security card • Periodic proof that the dependent continues to be incapable of self-support is also required

* Dental and Vision benefits require separate verification for dependent children ages 19-25

TYPE OF ELIGIBLE DEPENDENT	ELIGIBILITY REQUIREMENTS for DENTAL and/or VISION BENEFITS (Age 19 up to 25 years of age)	REQUIRED DOCUMENT(S) FOR ELIGIBLE VERIFICATION
Child (Who falls under one of categories previously listed)	• An **unmarried** dependent child under the age of 25 **AND** • A full-time student at an educational institution including Colleges, Universities, Technical Schools, Mechanical Schools and Night Schools- (Night School is acceptable while the dependent child is enrolled for the number of hours or classes that is considered **full-time** attendance at a similar day school) The term educational institution **DOES NOT** include on the job training courses, correspondence courses and other related schools.	• A completed Affidavit from Rutherford County affirming the Eligible Employee's child is unmarried and a full-time student. **NOTE: This verification is required at the time a dependent child reaches age 19 and again at the beginning of each Plan Year.**

3 Options to Send Eligibility Documentation:

- Uploading Dependent Eligibility Documents to a Secure site
  - https://secure.rutherfordcountytn.gov/rmuploads/default
  - Please Contact Risk Management for password & Company name, the Eligible Employee will be given access at that time.
  - The Eligible Employee will receive an e-mail receipt once Documentation has been updated in the Computer
  - **This is the most convenient way to submit documents!!**
- Hand Deliver or Mail Copies
  Rutherford County Risk Management
  303 N. Church Street, Ste 201
  Murfreesboro TN, 37130
- NEVER send original documents via mail
- To receive an e-mail receipt for anything mailed in, include an email address with submission
  Fax: 615- 867- 4602
- To receive an e-mail receipt, include an email address with submission
  Risk Management Hours of Operation
  Monday – Friday
  8:00 AM- 4:30 PM

This ***Appendix E*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

This ***Appendix E*** is effective: **January 1, 2018 through July 31, 2018**.

PLAN APPENDIX E –
DEPENDENT DEFINITION
EFFECTIVE ON AND AFTER AUGUST 1, 2018

DEPENDENT ELIGIBILITY
Definitions & Required Documents **Revised August 2018**

TYPE OF ELIGIBLE DEPENDENT	DEFINITION of DEPENDENT	REQUIRED DOCUMENT(S) FOR ELIGIBLE VERIFICATION
Spouse **Individuals NOT eligible:** • Ex-Spouse (even if court ordered) • Live-in companions who are not legally married to the Employee • Parents of Employee or Spouse	A current legal Spouse as defined by Tennessee state law. (An ex-Spouse, common law Spouse or civil union partner is **not** an eligible dependent.) The Eligible Employee's legal Spouse (or domestic partner for life insurance only) includes: • **For MEDICAL coverage**: An Eligible Employee's Spouse is only eligible for medical coverage if he or she does not have medical coverage available through his or her employer. • **For DENTAL and VISION coverage:** An Eligible Employee's Spouse is eligible regardless of coverage availability through an employer.	**If married in current calendar year:** • A Marriage Certificate • **AND** copy of the Dependents Social Security Card • **AND** Spousal Healthcare Eligibility Affidavit **If married longer than a year:** • Federal Tax Return: first page of most recent filed 1040, showing "married filing jointly" (if married filing separately, submit page 1 of (both returns) and form 8879 (electronic filing) OR other proof of filing status. • **AND** copy of the Dependents Social Security Card • **AND** Spousal Healthcare Eligibility Affidavit ***** OR ***** **Marriage Certificate, Social Security Card, & Proof of Joint Ownership:** Must have both name on the following (Issued within the last six months): • Bank Statement • Mortgage/ Lease statement • Credit Card Statement • Property Tax Statement- issued within the last 12 months • **AND** Spousal Healthcare Eligibility Affidavit
Child *Under the age of 26 **Individuals NOT eligible:** • Children over 26 who do not meet qualifications for incapacitation/ disability • Foster Children • Grandchildren of the Employee or Spouse (unless legal guardianship is obtained)	• **Biological Child –** Natural child • **Legally Adopted Child-** The creation of the parent-child relationship between individuals who are not naturally related • **Guardianship-** Person (other than the child's parent) who has legal custody and control over the child • **Stepchild-** A Child of a legally married Spouse	• **Biological Child**- Birth Certificate **AND** a copy of the Dependents Social Security Card • **Legally Adopted**- Official Adoption Court Documentation **AND** a copy of the Social Security Card • **Guardianship**- Legal Documentation **AND** a copy of the Dependents Social Security Card • **Stepchild**-Marriage Certificate (showing relationship between child and Spouse), copy of the Dependents Social Security Card, **AND** Birth Certificate ***** OR ***** • Federal Tax Return (**IF** child is claimed as a Legal Dependent) **AND** a copy of the Dependents Social Security Card
Child (Qualified Medical Child Support Order) *All under 26	A requirement to provide coverage for child(ren) when participant has dependent(s)	• Court Documentation signed by a judge • Medical Support order issued by state agency
Child Disabled *Must begin before age of	A Dependent child of any age (who fell in the above category prior to	• Proof of disability in form of Doctor letter. Must be submitted within 30 days of child's coverage

26 while covered under the Plan	disability) in the event is deemed disabled due to mental physical disability that is unable to earn a living	terminating due to age. • **AND** Copy of the Dependents Social Security card • Periodic proof that the dependent continues to be incapable of self-support is also required

* Dental and Vision benefits require separate verification for dependent children ages 19-25.

TYPE OF ELIGIBLE DEPENDENT	ELIGIBILITY REQUIREMENTS for DENTAL and/or VISION BENEFITS (Age 19 up to 25 years of age)	REQUIRED DOCUMENT(S) FOR ELIGIBLE VERIFICATION
Child (Who falls under one of categories previously listed)	• An unmarried dependent child under the age of 25 **AND** • A full-time student at an educational institution including Colleges, Universities, Technical Schools, Mechanical Schools and Night Schools- (Night School is acceptable while the dependent child is enrolled for the number of hours or classes that is considered **full-time** attendance at a similar day school) The term educational institution **DOES NOT** include on the job training courses, correspondence courses and other related schools.	• A completed Affidavit from Rutherford County affirming the Eligible Employee's child is unmarried **and** a full-time student. **NOTE: This verification is required at the time a dependent child reaches age 19 and again at the beginning of each Plan Year.** ***** A qualifying event requires proof of a change in status. A student schedule is required with the following:** ○ **School name** ○ **Student name** ○ **Credit amount** ○ **Enrollment date**

3 Options to Send Eligibility Documentation:

- Uploading Dependent Eligibility Documents to a Secure site
  - https://secure.rutherfordcountytn.gov/rmuploads/default
  - Please Contact Risk Management for password & Company name, the Eligible Employee will be given access at that time.
  - The Eligible Employee will receive an e-mail receipt once Documentation has been updated in the Computer
  - **This is the most convenient way to submit documents!!**
- Hand Deliver or Mail Copies
  - Rutherford County Risk Management
    303 N. Church Street
    Murfreesboro TN, 37130
  - **NEVER** send original documents via mail
  - To receive an e-mail receipt for anything mailed in, include an email address with submission
- Fax: 615- 867- 4602
  - To receive an e-mail receipt, include an email address with submission
- Risk Management Hours of Operation
  - Monday – Friday
  - 8:00 AM- 4:30 PM

This ***Appendix E*** shall be subject to modification without any formal amendment to the Plan or other formal action of the Plan Administrator or any other person.

This ***Appendix E*** is effective on and after: **August 1, 2018**.

PLAN APPENDIX F -
HEALTH REIMBURSEMENT ARRANGEMENT

A copy of the signed Rutherford County Health Reimbursement Arrangement plan document is attached following this cover page.